Behavioral Health Community Integration Strategic Plan

Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration

STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Public and Behavioral Health

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INTRODUCTION

In June of 2022, the Nation celebrated the 23rd year since the Olmstead ruling. Through the Olmstead lawsuit, the Supreme Court interpreted the Americans with Disabilities Act (ADA) and found that unnecessary segregation of people with disabilities is unlawful and upheld that people with disabilities have a right to live and receive services in the most integrated setting appropriate. More specifically, "[t]he Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity" (DOJ Civil Rights Division, n.d.).

Nevada's Behavioral Health Community Integration (BHCI) Strategic Plan Update (referred to throughout as the BHCI Plan) highlights resources and progress in developing the systems that provide opportunities for people with behavioral health disabilities to live and receive services in integrated, community-based settings that reflect their choices. This Plan uses behavioral health disabilities as an umbrella term that encompasses both mental health and substance use disorders (SUDs), including severe emotional disturbance (SED) or serious mental illness (SMI).[1]

Nevada's BHCI Plan intentionally centers on children and youth that meet criteria for SED and adults that meet criteria for SMI. It is important to consider that people with developmental or intellectual disabilities often have co-occurring behavioral health disorders (National Association of State Mental Health Program Directors, 2004) (Munir, 2022), making it critical for the BHCI Plan to complement and align to Nevada's Aging and Disabilities Services Division (ADSD) Olmstead Plan.

[1] Recent guidance from the U.S. Department of Justice (DOJ) further clarifies how the ADA protects people with SUDs including opioids (DOJ Civil Rights Division, 2022).

BACKGROUND

In 2018, Nevada developed its first BHCI Plan, engaging DPBH, other DHHS Divisions, and behavioral health community services stakeholders to increase understanding of the Olmstead decision and its implications for state action. This created a framework for a plan. Since 2018, major developments outlined in the Plan have advanced through intentional efforts that support the spirit and intention of the Olmstead decision.

This 2023 BHCI Plan arrives at a time of tremendous challenge. The period from 2018 to 2022 encompassed the COVID-19 pandemic, when public health and other services were diverted toward the most immediate needs. The pandemic disproportionately harmed people who have been historically marginalized (Tai, Sia, Doubeni, & Wieland, 2022), further deepening inequities that contribute to poorer health outcomes among racial and ethnic groups in Nevada (NOMHE, 2020). Also, during this time, communities across the nation and world documented worsening behavioral health (Nochaiwong, et al.). Emphasizing the concerns about young people, the U.S. Surgeon General issued a nationwide advisory regarding youth mental health (HHS, 2021).

Yet, the period from 2018 to 2022 also offered opportunities. Increased attention to health disparities helped to catalyze innovative solutions to persistent problems. As an example, telehealth services found new pathways during the pandemic, some that will continue to have durability beyond the COVID-19 pandemic. The severity and awareness of behavioral health focused State investments for Nevada's behavioral health systems (DHHS Public Information Officer, 2022). The American Rescue Plan Act (ARPA) and other federal funding brought forward new resources.

In October 2022, the U.S. Department of Justice (DOJ) Civil Rights Division released the results of their investigation, Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities, finding "reasonable cause to believe that the State of Nevada violates Title II of the Americans with Disabilities Act… by failing to provide services to children with behavioral health disabilities in the most integrated settings appropriate to their needs" (DOJ Civil Rights Division, 2022). Their findings underscore urgency and provide clarity to help Nevada move forward with a full implementation of behavioral health integration for its residents.

THE PLANNING PROCESS

The planning process for the 2023 BHCI Plan was first initiated in the summer of 2020 but was paused due to the COVID-19 pandemic; it began again in the fall of 2021 and was completed in December of 2022.

Under the direction of the DHHS, DPBH convened partners to update the 2018 BHCI Strategic Plan. This 2023 Plan has been developed by a cross-agency advisory team and informed by existing needs assessments, plans, and experts.

The planning process began by convening a cross-sector team to advise the Plan. The team reviewed the 2018 Strategic Plan and completed an assessment of strengths, challenges, opportunities, and threats. The group reviewed and agreed on foundational elements of the Plan. Next, the team walked through the 2018 goals and strategies to assess progress. Following the detailed progress assessment, the group revisited priorities.

Team members provided resources and information to inform the revised plan priorities. Once priorities were generated, the consulting team organized meetings with subject matter experts from Nevada, who helped to further assess progress and recommend key strategies and next steps. Whenever possible, the planning process leveraged existing Nevada plans and aligned to evidence-based or well-supported practices, and that had engaged people with lived experience in their development. One of the limitations of the planning process was limited data availability. Many metrics were reviewed for context; however, the data were not judged to stand alone without additional information. Potential data sources and indicators to track change are included in Measuring Progress on Priorities, an appendix in this Plan.

As the planning process was sunsetting during the fall of 2022, the DOJ released the results of their investigation, which were reviewed by the planning team and, when appropriate, integrated into this 2023 Plan.

Recognizing that individuals, agencies, and organizations are working to strengthen Nevada's systems for behavioral health, this Plan is intended to unite divisions, departments, organizations, and providers toward a shared strategic direction, ensuring that all Nevadans have access to services and supports in alignment with the ADA and Olmstead.

The BHCI Plan is intended to guide the period from 2023–2026 and should be updated in 2026 or sooner, should there be considerable shifts in the context for BHCI implementation.

STRATEGIC PLAN OVERVIEW

The DHHS Strategic Framework was first developed by ADSD for their Olmstead Plan. Once drafted, it was also used during the 2018 BHCI planning process. The Strategic Framework now applies across all of DHHS. The BHCI Plan includes an addition to the Strategic Framework, in adding a guiding principle for equity, as noted below. A theory of change and mindset shifts have also been added to direct and frame the BHCI Plan.

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

This BHCI Plan leverages the DHHS Strategic Framework.

- **Independence:** People should have options and the ability to select the manner in which 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
- **Equity:** Systems and services will center the priorities of people with diverse backgrounds and identities and include marginalized and under-represented groups in planning, strategies, and resource allocation toward equitable outcomes.

Equity as a Guiding Principle

The BHCI steering committee added equity as a guiding principle to shape and influence this Plan's goals, priority areas, and strategies. Achieving health equity—in which individuals have a fair and just opportunity to attain their highest levels of health—requires ongoing efforts, including changes to systems, policies, and practices, to:

- Address past and current injustices, including social determinants of health;
- Overcome obstacles to health and health care; and
- Eliminate preventable health disparities (Centers for Disease Control and Prevention, n.d.).

Equity is critical to the BHCI Plan because individuals with behavioral health disabilities often face challenges reaching their highest levels of health, and this issue is only compounded when they are also part of other groups who face current and historical barriers to health equity, including but not limited to

- Black, Indigenous, and other people of color, including those who are Hispanic, Latino, Asian, or Pacific Islanders
- LGBTQ+ people,
- veterans,
- individuals living in rural and frontier communities,
- individuals with co-occurring disabilities, and
- individual with needs for language translation and interpretation.

A key path to achieving equity involves engaging individuals and families impacted by behavioral health disabilities, elevating their voice, and ensuring they have opportunities for meaningful input related to planning, designing, and improving systems. Effective engagement requires expanding culturally relevant strategies that are co-designed by and for communities. Another key path to achieving equity in community integration is a commitment to routinely monitor the extent to which progress on BHCI strategies have resulted in greater equity, and, critically, adjust approaches when disparities or inequities are found.

Plan Goals

This Plan works toward the following goals for all Nevadans.

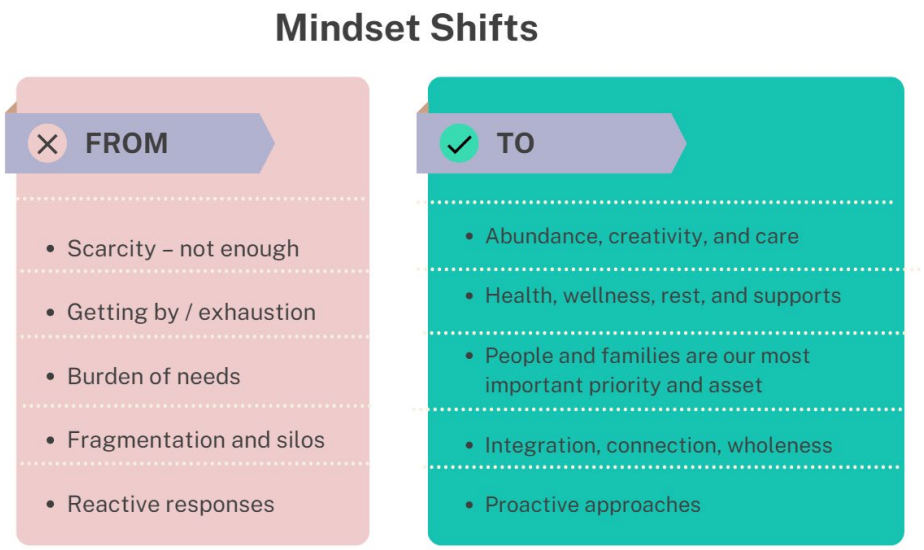
1. Ensure there is a continuum of high-quality support and care so individuals can attain or maintain stability, recovery, and resilience.
2. Ensure individuals have equitable access to appropriate, timely services in the most integrated setting based on their plan for self-determination.
3. Ensure that systems and services prevent inappropriate incarceration, hospitalization, institutionalization, or placement.

Theory of Change

The theory of change states that if agencies and organizations work intentionally, strategically, and collaboratively, informed by individuals and families with lived experience, they can align and grow the resources needed for a comprehensive, full continuum of community-based services in Nevada in service of people with or at risk of a behavioral health disability. Together with efforts on prevention, Nevada can ensure that people with SMI and SED and co-occurring disorders live in settings that are appropriate and informed by their choice, supporting stability, recovery, and resilience.

Transitions and Transforming Systems

Through discussion, the Steering Committee identified important mindsets or mental models that are widespread, but that are limiting in achieving the DHHS mission and vision for Nevadans. The group then identified shifts in mindsets that can help catalyze positive changes to the systems and supports in our communities.



HOW TO USE THIS PLAN

The BHCI Plan includes sections on priorities identified by the Steering Committee. Priorities within the Plan are interrelated and connected; however, implementation planning will be most effective by designating leads by section who focus on one or more strategies.

The appendices in this Plan include tools to help with implementation: an example of an array of services that may be considered in development of the System of Care, examples of metrics by plan priority, and a summary of strategies listed by priority.

System Priorities

Using an assessment of strengths, challenges, opportunities, and threats, several system issues were identified. System issues are beyond the direct scope of any one agency and require cross-sector, cross-agency attention. Improvements to these system issues also have impacts beyond behavioral health. However, they are critical levers that when attended to will advance this BHCI Plan. The System Priorities section of this Plan describes issues and strategies for:

A. Workforce Development and Sufficient Provider Network
B. Sustainable Funding and Reimbursement
C. Authority, Oversight, and Coordination
D. Prevention and Upstream Interventions

Population Priorities

The Plan is intended to improve systems and support across the lifespan, serving children, youth, and adults with behavioral health disabilities, including those with co-occurring intellectual or developmental disabilities or SUDs. Three sections of the Plan are dedicated to the issues and strategies relevant to specific age groups that were the focus of the BHCI Plan:

- Children up to the age of 21 years who have a diagnosable SED.[2]
- Young adults transitioning to adulthood between 14 and 25 years old who have a diagnosable SED, SMI, or SUD.[2, 3]
- Adults 18 years and older who have a diagnosable SMI.[3]

[2] SAMHSA defines childhood SED as "the presence of a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (SAHMSA, 2014).
[3] The National Institute of Mental Health defines SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."

Priorities for Children, Youth, and their Families

In addition to building from the 2018 Plan, these priorities are also responsive to the October 2022 DOJ report. The Priorities for Children and Youth section of this Plan describes issues and strategies for:

A. Accessible Community-Based Services
B. Appropriate Diversion from Institutional Settings
C. Transitions Back to the Community from Institutional Settings

Priority for Young Adults in Transition

This priority was added to highlight the challenges faced by individuals who must navigate the transition from child-serving to adult-serving systems and who require or benefit from specialty services and supports. The Priority for Young Adults in Transition section of this Plan describes issues and strategies for:

A. Coordinated Transitions between Child and Adult-Serving Systems Paired with Specialty Services and Supports

Priorities for Adults

Building from the 2018 Plan, the priorities for adults were confirmed with small adjustments. Access to Early Serious Mental Illness Services and Transportation were also added. The Priorities for Adults section of this Plan describes issues and strategies for:

A. Access to a Crisis Continuum
B. Access to Early Serious Mental Illness Services
C. Assertive Community Treatment Services
D. Supportive Housing
E. Transportation
F. Deflection and Diversion from Criminal Justice Systems

SYSTEM PRIORITIES

A. WORKFORCE DEVELOPMENT AND SUFFICIENT PROVIDER NETWORK

Status

Nevada has critical shortages in its behavioral health workforce (UNR Office of Statewide Initiatives' Nevada Health Workforce Research Center, 2019). Nearly all (95 percent) of the population resides in a federally designated health professional shortage area for mental health care (U.S. Health Resources & Services Adminstration, n.d.). These shortages impact all areas of healthcare—including primary, crisis, and inpatient care—as well as other key sectors, such as educational, criminal justice, and welfare systems (Girnus, 2022). A full behavioral health workforce includes, but is not limited to, psychiatrists, psychologists, social workers, counselors, and other critical roles including case managers, community health workers, and recovery coaches (SAMHSA, n.d.). While these workforce shortages affect all Nevadans, they are particularly devasting for individuals and families who are impacted by SED/SMI. For example, the DOJ investigation found that "Nevada has failed to ensure a sufficient provider network to deliver behavioral health services for children, resulting in a significant shortage in service providers for children at serious risk of residential placement" (DOJ Civil Rights Division, 2022).

Subject matter experts who participated in this planning process reported that workforce shortages result from long-standing issues along the entire career pathway, from engaging and recruiting youth and adults into the behavioral health field, to preparing and training them and, finally, to retaining and supporting them. Many of these conclusions were also echoed in a 2014 report from the Guinn Center (Guinn Center, 2014). Additionally, challenges that existed prior to the pandemic have become even more severe. Specific issues that were highlighted include:

Engaging/Recruiting

- **Limited capacity within higher education.** While Nevada's institutions have behavioral health programs, they do not have enough faculty to meet the demand from eligible applicants. Contributing factors include financial disincentives to become faculty given higher salaries in private practice and the low student-to-faculty ratios required by accrediting bodies.

Preparing/Training

- **Limited internship and practicum opportunities**. Providers that are qualified to support interns and practicums are often at capacity and not able to take on additional responsibilities.
- **Licensing** can be challenging, compared to other states, creating barriers to becoming a behavioral health professional in Nevada. Credentialing can also be cumbersome.

Recent efforts to increase training opportunities include the Nevada State College Board approving plans to create a psychology program, the College of Southern Nevada expanding certificate training programs, and UNR piloting a project to increase the number of approved supervisors.

Retaining/Supporting

- **Reimbursement rates** from Medicaid and other insurers are disproportionally low, and payments from insurers can be slow. (This topic is discussed in more detail under Sustainable Funding and Reimbursement, a section in this Plan.)
- **COVID-19 amplified stressors and burnout in the behavioral health workforce**.

Credentialing and reimbursement issues have contributed to a growing trend among providers to operate practices that only accept private pay rather than accepting insurance. These trends create a two-tiered system: practitioners have few incentives to enter or remain in the community-based and public-sector tier, where they generally receive lower pay and face more bureaucratic challenges. The DOJ reports that "challenges with Nevada Medicaid program requirements and reimbursement rates… result in a dearth of providers who will accept Medicaid" (DOJ Civil Rights Division, 2022). The population most negatively impacted by this growing trend includes those with the highest behavioral health needs and the most barriers to accessing care.

While the BH workforce issues are significant, the efforts to address them are also sizeable, including multi-sector coordination to mitigate concerns along the full workforce pipeline.

Strategies

1. **Elevate and support the efforts of the Nevada Healthcare Workforce and Pipeline Development Workgroup.** This group, which began meeting in early 2022 and will continue through June 2023, is working to identify and address gaps across the entire workforce pipeline. As an initial step, they recently completed a state survey of existing workforce development initiatives. Their focus is rural and underserved communities in three key areas: public health, primary care, and behavioral health. In each area, the Workgroup is

developing a "workforce pipeline development plan" that will define the entry points into the pipeline—including both traditional and non-traditional pathways (e.g., engaging adults)—and clear milestones for making progress towards careers of choice. This multi-sector effort aims to "reduce redundancies, leverage partnerships, enhance information sharing, and facilitate stakeholders' pursuit of funding opportunities."

2. **Consider adopting models used by other states—such as** Behavioral Health Education Center of Nebraska **—to pursue and monitor workforce goals**—i.e., increase the number of graduates who pursue behavioral health fields and who choose to intern and practice in Nevada, increase the number of providers who have the specialty training to fill the State's most critical provider shortages, and decrease the time from graduation to licensure for new providers. Recruitment and retention strategies for the state workforce providing direct behavioral health services are particularly critical: currently, the state has a 40 percent vacancy rate.
3. **Continue to expand efforts to support primary care providers, who can serve as critical behavioral health workforce extenders**, when they are provided with the necessary support, continuing education, and consultation. One current example is Nevada's Pediatric Access Line that provides free psychiatry consultation to primary care clinicians.
4. **Recruit, support, and retain a diverse workforce, inclusive of race/ethnicity, culture, language, and other dimensions of identity and experience.** A 2020 National Academies publication identified the following critical elements for recruiting, supporting, retaining, and promoting a diverse workforce. These were organizational support, opportunity to be authentic, support for students and professionals, integration with community, mentorship, community definitions of well-being and success, and self-care and support (National Academies of Sciences, Engineering, and Medicine; Division, Health and Medicine, 2020).
5. **Modify Medicaid's State Plan to allow community health workers to work under behavioral health providers.** (A 2021 law allowed Medicaid to pay community health workers, but not under behavioral health providers.) One focus of the Workgroup, discussed above, is the promise and expansion of community health workers as a provider extender for behavioral health.
6. More broadly, **adjust Medicaid rules and procedures to facilitate increased participation from behavioral health providers**. According to the DOJ, Nevada "could reasonably modify its [Medicaid] system by... supporting and managing its provider network to increase quality and access."
    a. For example, Medicaid providers caring for youth should be paid higher rates to account for the higher complexity involved in treating this population, including engaging families, schools, and other child-serving systems.

b. Explore allowing behavioral health providers to individually enroll in Nevada Medicaid to work in primary care or other healthcare settings.

7. **Explore other options for expanding the workforce that can serve individual with behavioral health disabilities.** For example,
    a. Expand the use of interstate licensure compacts to smooth the process of becoming a provider in Nevada. Currently, Nevada is only part of the Psychology Interjurisdictional Compact.
    b. Recruit behavioral health practitioners via J-1 visas.
    c. Consider creating parity between not-for-profit and for-profit behavioral health providers by allowing the latter to compete for state and federal funds to expand behavior health services.
8. **Improve access to and routinely analyze high-quality workforce data**. Nevada's ability to better understand and address its workforce shortages is limited by the lack of high-quality workforce data—e.g., from licensing boards, Medicaid, and other insurers. Nevada Revised Statute (NRS) 439A, enacted in 2021, partially addressed this issue but needs strengthening. One strength is the UNR Nevada Health Workforce Research Center in the Office of Statewide Initiatives, which has extensive knowledge and experience analyzing and interpreting data. See, for example, their Tenth Edition of the Nevada Rural and Frontier Health Data Book.
9. **Expand student loan repayments** for all levels of behavioral health professionals serving shortage areas, publicly funded healthcare, and behavioral health systems. One opportunity is to build on the existing state loan repayment program out of the UNR School of Medicine's Nevada Health Service Corps, which is a federal/state grant partnership with $1 million in funding for loan repayment in the current biennium. Another approach to loan repayments, which would also incentivize Medicaid participation, is a state-wide, Medicaid-funded program, such as the CalHealthCares program in California.
10. **Increase salaries of clinical staff and higher education faculty to be more competitive**. Bolster recruitment and retention of state employees who provide direct behavioral health services by adjusting compensation or other benefits, as needed. Maintain appropriate staffing levels within state direct services, prioritizing recruitment and retention with devoted resources toward clinical staff and higher education faculty (in areas of clinical training).

Key Partners

Many sectors, agencies, and institutions play key roles with behavioral health workforce issues, including the following.

- NSHE's health sciences resources, including Schools of Medicine, Public Health, and Social Work and programs focused on psychology and marriage and family therapy.
- Regional Behavioral Health Policy Boards
- Area Health Education Centers
- DCFS
- DPBH
- Department of Employment, Training, and Rehabilitation (DETR)
- NDE

BRIGHT SPOT: RESOURCES TO EXPAND WORKFORCE CAPACITY IN NEVADA

In recent progress, NDE received a five-year federal grant (NDE, n.d.), which began in Oct 2020, focused on recruitment, retention, and re-specialization of school counselors, psychologists, social workers, and other behavioral health providers. Additionally, recent ARPA funding has also focused on workforce development, including $1.5 million to support DCFS' Learning Collaboration for Children's Mobile Crisis Response Teams (MCTs) and CASAT's Pathways in Crisis Services (PICS) Project (DHHS, 2022). DCFS' Northern Nevada Child and Adolescent Services also received ARPA funds to pay for and expand student practicum placements in programs serving children with highest level needs.

B. SUSTAINABLE FUNDING AND REIMBURSEMENT

Status

Sustainable funding is essential for achieving the mission, vision, and goals of this BHCI Plan. Nevada has made many advancements in funding and reimbursement, including the use of grant dollars to build programming and enable system changes to better leverage Medicaid. Within the past decade, Nevada's systems for health care services changed considerably, catalyzed through Medicaid expansion covering people that were previously uninsured (Norris, 2022). Some of the major changes and improvements include:

Increased Sustainability via Medicaid

- In 2017, the Legislature enacted NRS 422.2704, which mandated that Nevada Medicaid complete a comprehensive Medicaid rate review for each provider type every four years (Nevada Medicaid, n.d.).
- The Centers for Medicare & Medicaid Services (CMS) approved Nevada's State Plan Amendment and Section 1915(b)(4) waiver application for CCBHCs. CCBHCs bill by encounter, rather than by service, without the need for prior authorization, which has increased both sustainability and access to important services. In addition, Medicaid fine-tuned the payment methodology to incentivize high-quality, evidence-based care. As of September 2022, Nevada had eight Medicaid-enrolled CCBHCs across the State and four additional CCBHCs operating as SAMHSA grantees (Nevada Medicaid, n.d.).
- DCFS and Nevada Medicaid partnered with NDE and schools to support Medicaid billing for behavioral health services. As of September 2022, eight school districts had Medicaid contracts in place, and others were in progress. Several new shared positions have been created between Medicaid and DCFS to support billing for school-based care.
- Several other changes to Medicaid have also improved sustainable funding:
    - The 1915(i) State Plan option was approved for children in specialized foster care for intensive in-home supports and services and crisis stabilization services.
    - The requirement for behavioral health outpatient providers to have a medical supervisor on site was eliminated.
    - Adult peer support was made more accessible through a modification to prior authorization requirements for substance use treatment providers.
    - Reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) was expanded from behavioral health providers to primary care providers.
- Nevada Medicaid contracted with Health Management Associates to provide analysis and guidance regarding how Medicaid could better support children's behavioral health in Nevada. Both system improvements and transformations have been identified, with implementation planned to begin in 2023.
- Nevada was one of twenty states to receive a CMS planning grant for qualifying community-based mobile crisis intervention services (Medicaid.gov, 2021). Additionally, Medicaid Managed Care Organizations (MCOs) are required to pay for crisis intervention services.
- Nevada has legislative approval to develop a 1915(i) State Plan Amendment to provide housing support services, and the State is currently developing Standards of Care (CSH, 2022).

Increased Funding and Sustainability via Non-Medicaid Avenues

- In August 2022, the State's Interim Finance Committee approved a large investment in health care resources and services through the ARPA, including $45 million for behavioral health services: MCTs, a new children's behavioral health authority, and in-home services for youth with intensive needs (Golonka, 2022).
- During the pandemic, reimbursement for services provided through telehealth helped to increase access. NRS 439.916, which passed in 2021, supports and expands this strategy by authorizing the use of audio-only telehealth communication for many services, as well as payment parity between face-to-face and telehealth modalities (Nevada Medicaid, 2022).
- Since 2021, Nevada model parity legislation, NRS 441A.150, requires "certain insurers and other organizations providing health coverage to submit information demonstrating mental health parity" (Nevada Legislature, 2021).
- 988, a national three-digit crisis line for behavioral health, was created through Congress' National Suicide Hotline Designation Act of 2020. 988 went live on July 16, 2022. Through Nevada's NRS 433.3, the state developed a funding stream through a surcharge for cell phone users, a sustainable mechanism to support the ongoing investment and management of Nevada's 988 system and related infrastructure to support crisis response (Committee on Health and Human Services, 2021).
- Nevada submitted a state plan for the federal Families First Prevention Services Act (FFPSA), which, when approved, will allow for draw down of federal funds for specific, well-supported, evidence-based services for children and youth in foster care or at risk or removal. The FFPSA places limitations on federal Title IV-E reimbursement on placements in settings other than family foster homes, such as congregate care settings, with exceptions made for specific populations' congregate care settings that meet the requirements for a Qualified Residential Treatment Programs (DCFS, 2021).

Gaps

The accomplishments above have improved the stability for Nevada's behavioral health systems; however, funding, reimbursement, and the larger issue of sustainability are still a priority, and stakeholders identified key challenges:

Underuse of federal resources, especially federal Medicaid dollars

Nevada relies largely on grant funding and state dollars to operate some essential behavioral health services, such as mobile crisis services. Several indicators suggest that Nevada could do more to leverage federal Medicaid dollars:

- Nevada ranks 48th in Medicaid per capita expenditures (Medicaid.gov, 2019).

- A DOJ review of a sample of children's records revealed that more than half who needed intensive support and had a psychiatric residential treatment facility (PRTF) stay did not receive any Medicaid-funded crisis services during a five-year period (DOJ Civil Rights Division, 2022).
- Federally mandated reporting regarding Nevada's Community Mental Health Services Block Grant (MHBG) from SAMHSA tracks the extent to which funding for community-based services is diversified and expanded beyond grant and state funding. Nevada's 2020 report indicated that only six percent of DPBH-controlled community-based services were funded by Medicaid in Nevada. In comparison, nationwide, Medicaid funds an average of 63 percent of the services controlled by State Mental Health Agencies (SAMHSA, 2020).

Overreliance on institutionalized, rather than community-based care

- In addition to the harms to individuals and families affected by behavioral health disorders, this overreliance is not sustainable or cost-effective. The DOJ reports that "community-based services cost just 25% of what residential treatment would cost, yielding an average annual savings of $40,000 per child served in the community" (DOJ Civil Rights Division, 2022).
- Federally mandated MHBG reporting tracks the proportion of DPBH-controlled expenditures dedicated to community-based, rather than institutional, care. In the most recent MHBG report, this proportion was 35 percent in Nevada, compared to 70 percent nationwide (SAMHSA, 2020).

Low reimbursement rates, with barriers for increases

- The quadrennial rate review process, authorized by NRS 422.2704, supports review of individual provider type rates. While the bill provides a process for rate studies, engagement from provider community is needed to justify rate increases. The survey response rates have been low, a barrier to increasing rates. Changes to rates for reimbursement require changes to the Medicaid State Plan (Nevada Medicaid, n.d.).

Not enough providers who will accept Medicaid (or other insurance)

- One participant in the BHCI planning meeting described the process as "cumbersome and time consuming, greatly exceeding the level of effort required to become a private insurance provider." Providers who are not licensed or certified—e.g., Qualified Behavior Aids, Qualified Mental Health Associates—face additional enrollment steps compared to other providers because of accountability measures embedded in Medicaid.

- The combination of low reimbursement rates and enrollment barriers for Medicaid, as well as other insurers, has created an environment in which many psychiatrists and other behavioral health providers do not accept any insurance at all. This issue is not specific to Nevada—but reflects broader challenges in insurance and in implementing behavioral health parity (Kaiser Family Foundation, 2022).

Policies and rates sometimes not yet aligned with the needs of individuals with behavioral health disorders, creating barriers to the most integrated care

- Some team-based interventions—e.g., some Wraparound in Nevada (WIN), Assertive Community Treatment (ACT), and MCTs—must bill separately for each service they provide, which does not facilitate collaborative care.
- Some providers expressed confusion about reimbursement rules and rates specific to crisis response such as reimbursement for transportation. Nevada has a federal Mobile Crisis Planning Grant and is in the process of establishing rates that will go into effect in July 2023; standards for billing are being updated and may resolve some of these issues that are not currently aligned to needs.
- Some services that would be considered part of the array of community-based services do not yet have Medicaid reimbursement pathways.

Strategies

1. **Increase efforts to leverage federal Medicaid funding as a key path to sustainability.**
    a. Continue to utilize ARPA and other grant funding as a bridge to sustainability by concurrently aligning the Medicaid State Plan to the new grant-funded services.
    b. Continue efforts to develop bundled rates where appropriate.
    c. Continue to support the sustainability of school-based behavioral health services by onboarding all school districts to billing Medicaid and other payers whenever possible, instead of using education dollars.
    d. Explore options for increased Medicaid enrollment—as well as improved access to care—for individuals re-entering the community from criminal justice setting. For example, many states use presumptive Medicaid eligibility strategies (Treatment Alternatives for Safe Communities, 2016).
2. **Explore feasibility and appropriateness of all Medicaid authorities** to support sustainability of the state's investment in developing home and community-based services and supports for children's behavioral health including but not limited to waiver authorities, state plan authorities, and managed care models (Health Management Associates, 2022).
3. **Ensure that Medicaid reimbursement rates and policies support providers in performing necessary behavioral health services** to Medicaid eligible individuals and to support

increased access and quality of care to the services most needed by individuals with behavioral health disorders**.** As a first step, Nevada Medicaid should 1) educate providers to increase their understanding of the role of quadrennial rate reviews in rate increases and 2) continue to conduct extensive marketing and outreach to existing behavioral health providers to ensure robust participation.

4. **Fully fund and certify all CCBHCs, including those currently funded by SAMHSA.**
5. **Monitor the proportion of behavioral health expenditures dedicated to community-based, rather than institutional care to ensure that Nevada is prioritizing the former.** Expand monitoring beyond MHBG—e.g., by including Medicaid and third-party claims and encounters.
6. **Consider reinvesting resources saved through diversion and deflection from criminal and juvenile justice settings to community-based behavioral health services**. For adults, NRS 176.0129 provides authority for such reinvestments; a similar approach for youth may prove valuable.
7. **Leverage Title IV-E funding to expand services for children in foster care and those at risk of removal.**
8. **Operationalize enforcement of Nevada's 2021 law regarding mental health parity for health care insurers** (NRS 687B.404).
9. **Through SUPPORT Act Planning Grant, continue improvement and awareness of substance use treatment and expansion of services through the 1115 demonstration waiver**.

Key Partners

Many sectors, agencies, and institutions play key roles with sustainable funding and reimbursement, including the following.

- DCFS
- DPBH
- Nevada Medicaid, along with CMS
- MCOs
- Grant administrators
- Legislators (amendments to Medicaid State Plan)
- Nevada Division of Insurance
- Provider networks, licensing boards, and collaborative

BRIGHT SPOT: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS ARE BUILDING SUSTAINABLE OPTIONS IN COMMUNITIES

CCBHCs are an important success story for Nevada. They serve all individuals who need behavioral health services, regardless of age or ability to pay. In addition to providing behavioral health services, they aim to integrate behavioral and physical healthcare, embracing a no-wrong-door approach. A core CCBHC responsibility is care coordination—across services, providers, and facilities. Nationally, CCBHCs have been shown to "improve health outcomes while lowering costs" (The White House, 2022).

CCBHCs were first defined in federal legislation in 2014. Subsequently, Nevada:

1. was selected by SAMHSA as one of twenty-four states to receive a CCBHC planning grant (SAMHSA, n.d.);
2. was selected as one of eight states to launch a demonstration program;
3. received approval from CMS for its CCBHC State Plan Amendment and Section 1915(b)(4) waiver application; and
4. received $13.7 million in two-year expansion grants from SAMHSA (SAMHSA, n.d.).

To date, Nevada has eight Medicaid-certified CCBHCs sites, plus an additional five SAMHSA-certified sites. Medicaid CCBHCs are paid a daily rate per patient regardless of which services are provided, without the need for prior authorization. This daily rate is intended to cover their costs and is adjusted periodically based on cost reports. This payment methodology, which is similar to federally qualified health centers, increases both sustainability and access to services.

The CCBHC model is relatively new, both in Nevada and nationally. BHCI Steering Committee members noted that many Nevadans do not know about CCBHCs or their services, emphasizing the need for additional community outreach. DOJ reported that "State officials told us that the program is currently serving few children." As CCBHCs mature, the State will need to carefully monitor the federally mandated quality measures to ensure that CCBHCs continue to work as intended and improve the lives of the individuals they serve.

C. AUTHORITY, OVERSIGHT, AND COORDINATION

Status

Achieving an integrated system that serves—and prevents harm—to individuals and families affected by SED/SMI is complex. It requires state-sanctioned authority, rigorous oversight and quality assurance processes, and coordination. Coordination must occur across settings (such as schools, homes, clinics, and PRTFs), geographic areas, funding streams, and governmental and non-governmental entities.

Individuals and families affected by SED/SMI are often impacted by many different governmental systems including behavioral health, education, employment, criminal/juvenile justice, and welfare. Within DHHS alone, a family may be affected by the policies and decision-making across the five DHHS Divisions. While DPBH is the authority for adult behavioral health, DCFS is the authority for children. Developmental services are consolidated under ADSD (Nevada Legislature, 2013), and DWSS and Nevada Medicaid have crucial roles to play in supporting peoples' connections to benefits, such as Medicaid. To add further complexity, Nevada is one of two states that administers child welfare from both state and local levels, also known as a "hybrid" model (U.S. HHS Administration for Children & Families, n.d.).

To ensure that individuals and families do not fall through the gaps among systems or get entangled in their service parameters, a key challenge for Nevada is to continue building coherent governance structures that 1) define decision-making authority, 2) carry-out rigorous oversight, 3) require and facilitate coordination, and 4) elevate individuals and families' voices and choices.

Existing systems that support oversight and quality

Nevada has several entities that support oversight of behavioral health systems via certification, training, technical assistance, and quality assurance processes, including Substance Abuse Prevention and Treatment Agency, CASAT, DPBH Bureau of Health Care Quality and Compliance, and Nevada Medicaid.

Nevada Medicaid has drafted a strategy for quality for managed care members that is in review. This strategy "is the foundational managed care tool that articulates managed care priorities, including goals and objectives to improve the quality of healthcare services" (Health Services Advisory Group, 2020).

NRS 458 codifies certification and division standards for providers serving people with SUD. The infrastructure that has been built to support these systems includes oversight for some

providers that serve people with co-occurring disorders and for SUD providers that also serve youth and adults.

Progress towards a Children's System of Care

A Children's System of Care focuses on the areas where individual child-serving systems—such as child welfare, education, juvenile justice, and behavioral health—do not have the capacity to act independently to achieve optimal outcomes. Systems of Care are designed to address the experiences of children and families who are caught in the gaps between systems and authorities. Funding from federal grants has spurred progress toward a Children's System of Care, and DCFS is working towards the development of program standards and a governance structure (how the various entities work together and make decisions), oversight, accountability, technical assistance, and training for providers serving children and youth and training.

Strengths in Coordination and Communication

Many cross-agency relationships are strong, and many structures are in place to support collaboration. Examples include:

- The development of 988 and a Crisis Response System Implementation Plan by a statewide planning coalition is creating infrastructure that supports coordination across behavioral health resources.
- Shared data systems, such as Open Beds, support coordination and communication across providers. Schools providing behavioral health are also working to adopt data systems that allow for billing Medicaid. If used across systems, this will considerably improve coordination across organizations and entities.
- Many entities provide leadership and coordination at regional or state levels, including:
    - the three regional Children's Mental Health Consortia;
    - five Regional Behavioral Health Policy Boards;
    - the recently established Substance Use Response Group (SURG) and Advisory Committee for a Resilient Nevada (ACRN) that are focused on SUDs; and
    - the State Epidemiological Workgroup and Behavioral Health Planning and Advisory Committee provide leadership and coordination.

Gaps

However, significant gaps remain regarding authority, oversight, and coordination.

The lack of a single state entity, with authority across DHHS Divisions, has created a fragmented behavioral health system.

No single entity has the authority to ensure that Nevada's behavioral health system

- provides high-quality services,
- addresses the broad range of needs of individuals,
- maintains a sufficient provider network, and
- has an array of accessible community-based services—delivered in accordance with best practices and available regardless of the payer (Medicaid, state general funds, or grants)—to reduce the risk of individuals being institutionalized unnecessarily.

The DOJ investigation echoes this finding, noting that state officials lacked information regarding: 1) who is providing what services, 2) the needed capacity for services, or 3) the quality of services (DOJ Civil Rights Division, 2022). Too often in Nevada, problems in the quality and appropriateness of available care have been identified too late, resulting in harm. These gaps point to a lack of proactive authority and oversight (Potter, 2021).

Lack of authority and coordination place especially high burdens on certain populations

- **Young adults in transition are particularly vulnerable to gaps and contradictions because they cross both child and adult-serving systems**. (Strategies for this population are discussed in more detail in Priority for Young Adults in Transition, a section in this Plan.)
- **Similarly, individuals with co-occurring intellectual and developmental disabilities suffer from fragmentation across DHHS divisions and the lack of tailored specialty services.** For example, state officials acknowledged fragmentation and confusion over which entities should serve children with SED with co-occurring intellectual and developmental disabilities (DOJ Civil Rights Division, 2022)**.** Because these children, particularly those with aggressive behaviors, cannot receive the intensive and consistent services they need to avoid institutionalization, many enter PRTFs. According to the DOJ, 18 percent of a random sample of children who had recent stays at PRTFs had intellectual or developmental disabilities.

Core System of Care components, which rely on both authority and coordination, are not yet in place

- **The "no wrong door" approach advocated by SAMHSA and others is not yet in place in Nevada.** Siloed approaches within departments, divisions, and other settings impacts individuals' ability to seamlessly access necessary services and supports.
- **A lack of consistency in screening and assessment tools and practices across settings** impedes communication among service entities and timely access to the most appropriate care. Both in Nevada and across the country, different settings—including school, criminal and juvenile justice, child welfare, and health care settings—often use different tools and have established different practices for screening and assessment. Even within some single settings, Nevada has not achieved consensus regarding the most appropriate tools. However, Nevada has made progress since the last BHCI Plan, gaining experience with standardized, evidenced-based tools in various settings. For example, as part of recent reform efforts, Nevada's juvenile justice system began using a standardized assessment tool (DCFS, 2018).
- **A lack of integrated data systems and data sharing agreements limit coordination and collaboration**. When agencies and organizations can share information and provide close-loop referrals, people have fewer barriers to accessing care.

Improvements are needed in Nevada's processes for making and tracking SMI/SED determinations

An SMI/SED determination provides an individual with access to a broad array of services. In other words, the determination process is a critical step in providing equitable access to services, as well as a safeguard to ensure that service provision matches individuals' needs. Individuals are not found to have SMI or SED based solely on a particular diagnosis; a licensed mental health or medical professional must also determine whether they meet the level of functional impairment defined by Nevada Medicaid to be determined SMI or SED.

Some states have standardized or centralized the determination process. Arizona, for example, contracts with a single entity to make SMI/SED determinations. Such a formalized structure provides:

- a fair and transparent process for individuals impacted by SMI/SED,
- a cost-containment mechanism to ensures that services match needs, and
- a way to easily monitor and analyze trends in size and make-up of SMI/SED populations.

Strategies

1. **Establish a single Nevada Behavioral Health Authority to ensure clear lines of leadership, oversight, and accountability**. Clearly define leadership roles and responsibilities, authority, and oversight of the public behavioral health system and align with proposed statutory changes, regulations, policies, memoranda of understanding, and other formal mechanisms. The goal of this single Behavioral Health Authority is to reduce fragmentation and diffusion of authority within DHHS and across the state. This new umbrella Authority would:
    a. Define, delineate, and operationalize other related authorities, such as the Children's Behavioral Health Authority, State Mental Health Authority, and State Mental Health Agency.
    b. Develop policies and procedures aligned to best practices to avoid unnecessary institutionalization and segregation.
    c. Develop standards of care and provide training and technical assistance for providers, including topics such as System of Care principles and high-fidelity wraparound.
    d. Collect and analyze information to determine who is providing what services and to what extent the current array of services meets the needs of individuals and families.
    e. Continue efforts to develop "no wrong door" or single point of entry for services and supports in Nevada. As one example, New Jersey has one phone number that families can call for information about behavioral health, SUDs, and developmental disabilities.
    f. Ensure that all Nevadans including individuals affected by SED/SMI, government staff, and providers can access clear information about the resources, roles, and responsible entities for services related to behavioral health.
    g. Explore or expand capabilities for close-loop referrals to help people to access support for other social determinants of health (American College of Physicians, 2019).
2. **Create a DHHS oversight body for community integration that is responsible for reviewing progress for this BHCI Plan across all divisions**, alongside the ADSD Olmstead Plan. This oversight body would fall under the Behavioral Health Authority, once established.
3. **Continue development and expansion of the Children's System of Care.** The Behavioral Health Authority should provide the leadership and authority to establish the cross-agency governance structures needed for a robust Children's System of Care.
    a. Improve coordination and communication across Departments (e.g., health, educations, corrections, employment) through an interagency leadership team, as

well as across DHHS Divisions. Consider further development of memoranda of understanding to clarify relationships between agencies; these can address, for example, a shared commitment to trauma-informed practice and System of Care principles.

   b. To better serve children with co-occurring intellectual and developmental disabilities and their families, develop and implement tailored, cross-agency approaches. Identify and address the gaps that providers face in better serving this population through professional development and team approaches to care and support.
   c. Work with NSHE to ensure adequate coursework in dual diagnosis is included into all behavioral health educational curriculum.
   d. Leverage the experience and leadership of the Children's Mental Health Consortia by including them in the governance structure.

4. **Exercise robust oversight of community-based providers.** The State should ensure that community-based behavioral health services are of sufficient quality to allow individuals with behavioral health disabilities to remain in their homes and communities, where appropriate.
   a. Strengthen the processes to review providers' use of evidence-based and well-supported programs and services.
   b. Strengthen protocols to monitor safety and quality of services and supports.
5. **Exercise robust oversight and quality assurance in institutional settings**, including hospitals, PRTFs, congregate care settings, and criminal justice settings.
6. **Elevate family choice and voice within the Behavioral Health Authority governance structure, ensuring opportunities for meaningful input related to planning, designing, and improving systems.** Engagement of individuals, inclusive of children, youth, and families, impacted by behavioral health disabilities is a key path to achieving equity in health outcomes and community integration.
   a. Engage individuals and families to help prioritize which services to stand up first.
   b. Strengthen family advisory structures at state and local levels; consider elections, compensation for roles, and other ways to formalize a community voice.
   c. Provide training and guidance for decision makers on ways to better hear and incorporate the experiences of people with lived experience.
7. Within individual settings—including school, criminal and juvenile justice, child welfare, and health care settings—**continue work toward universal screenings and assessments for behavioral health**. In addition, identify opportunities to adopt shared tools across settings, as well as other practices to improve coordination and communication across settings and timely access to the most appropriate care**.**
8. **Improve the process for making and tracking SMI/SED determinations.** Consider adopting the model used or similar to the one used in Arizona.

Key Partners

Many sectors, agencies, and institutions play key roles with authority, oversight, and coordination, including the following.

- DHHS Divisions
- Children's Mental Health Consortia
- Individuals and families with lived experience
- Advocacy organizations
- Legislators and community leaders
- MCOs

BRIGHT SPOT: POTENTIAL FOR AN INTEGRATED DATA SYSTEM

One critical component to establishing an integrated System of Care is piloting, selecting, and implementing a single, HIPAA-compliant, data system that would serve schools as well as other settings. Currently, three Nevada school districts are piloting (different) data systems. Core requirements for a statewide data system are:

- It serves all children and families, regardless of insurance status—i.e., it is not just for Medicaid beneficiaries. However, the system's backend would handle billing to Medicaid, as well as other payers.
- It is accessible to families, allowing them to easily access their records.
- It facilitates communication among all staff and providers involved in a child's care, inside and outside of schools, with families controlling who has access to what information. For example, with parental consent, a discharge plan from an PRTF could be included in the data system, eliminating the need for a family to repeat their story to various teachers and school-based providers.
- It provides the user-friendly scaffolding needed by all staff and providers, including tools for screening, assessment, and interventions.

BRIGHT SPOT: INTEGRATION ACROSS SETTINGS

While schools can improve outcomes for children with or at risk for behavioral health issues by standing up their own behavioral health systems, a key to long term success will be integration across various settings. These include homes, schools, clinics, other community-based settings, as well as institutional settings. This is especially important for children with the highest needs.

NDE and DHHS launched a Behavioral Health Learning Collaborative in November 2022 to address key questions regarding integration. Ultimately, the Children's Behavioral Health Authority—discussed in Authority, Oversight, and Coordination, a section in this Plan—will facilitate ongoing collaboration. Key questions include: how can Nevada best integrate school-based services—including education—with critical home-and-community-based services or with residential treatment? Can some children receiving residential treatment or in a juvenile justice setting continue to attend their own school? Our schools provide some examples.

Connect Washoe County involves a partnership with the School District, Nevada's Office of Suicide Prevention, The Children's Cabinet, and Renown Health. It strives to improve linkages, build creative and non-traditional care avenues, improve and support data collection, analysis, and dissemination efforts, and develop a multi-tiered communication strategy with joint messaging.

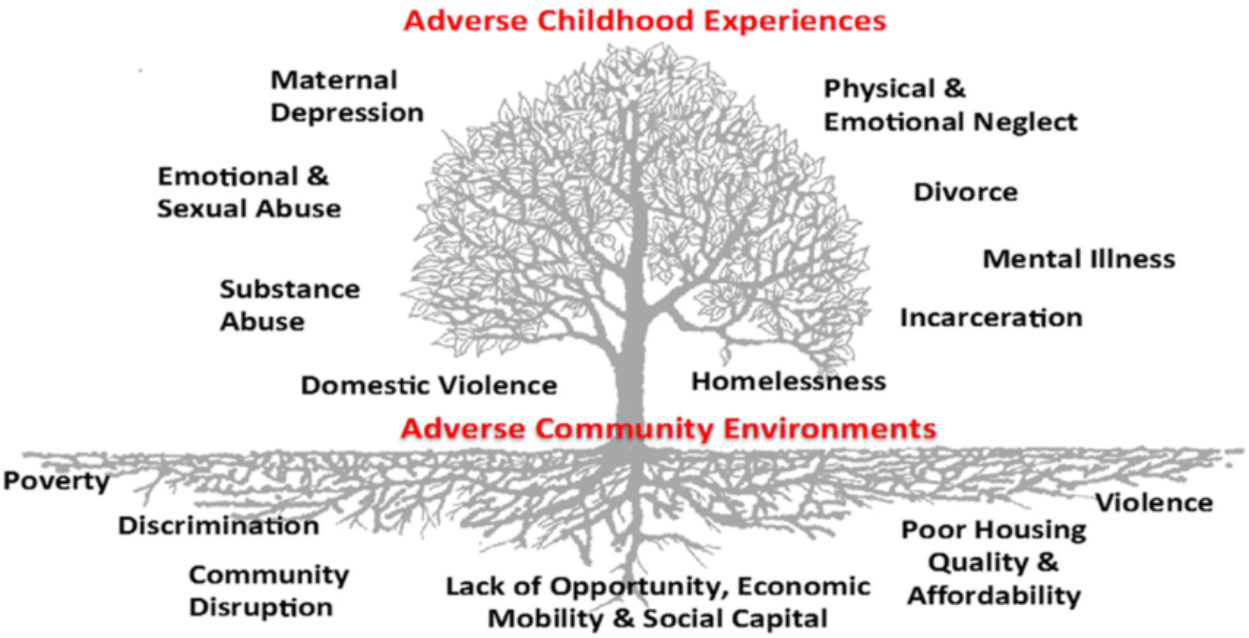
The Lifeline Project, a Clark County School District initiative, uses the evidence-based Panorama software system for measuring well-being and social-emotional learning of students in schools. It uses a collaborative problem-solving team to help identify, assess, and provide tiered interventions and supports for at-risk students.

D. PREVENTION AND UPSTREAM INTERVENTIONS

Status and Gaps

"Upstream" has become an important concept in public health, alluding to the importance of addressing root causes, not just visible symptoms, problems, or crises. Prevention efforts can reduce harm to individuals, improve health outcomes, and save costs. A related concept of behavioral health promotion encompasses strategies for well-being. Promotion is aimed at optimizing positive behavioral health (Youth.gov, n.d.). Prevention and promotion are complementary. Well-designed prevention and promotion activities are generally understood to provide a return on investment (World Health Organization, 2002). Prevention and promotion are some of the most powerful system levers to achieve the mission and vision of the BHCI Plan.

Research underscores the impact of Adverse Childhood Experiences (ACEs). Accumulation of ACEs is associated with lifelong negative health outcomes. Building on ACEs research, practitioners at George Washington University developed the Pair of ACEs tree to demonstrate the relationship between individual and community environments (Dietz, 2017). When ACEs are paired with community violence, a lack of resources, or other factors, the impacts are more severe and can contribute to harmful cycles. In contrast, efforts that create and sustain healthy childhoods, healthy families, and nurturing relationships and environments are the foundation for well-being.



In a recent publication, authors suggest that "prevention of psychiatric problems requires a coherent and multifaceted strategy, including at least five levels" (Nordentoft, Jeppesen, & Elgaard Thorup, 2021). For young people, they suggest:

- universal primary prevention to improve well-being (e.g., mental health literacy, parenting support, etc.);
- universal primary prevention to prevent development of mental illness (e.g., prevention of preterm births, reducing ACEs, and reducing risk of SUD);
- selective primary prevention to reduce the risk of mental illness in risk groups (e.g., interventions geared specifically to children with parents that have mental illness);
- indicated primary prevention for youth with indicators suggesting emerging issues or disorders (e.g., high risk groups or children with common mental health problems); and
- secondary prevention for early stages of mental illness.

Strategies

1. **Invest in early intervention**, both throughout the lifespan and early in the onset of illness.
    a. Increase use of Medicaid's tool for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to identify opportunities to connect children and youth to appropriate services and supports.
    b. For youth and adults, intervention in early stages of psychosis can improve outcomes. (Discussed further in the Access to Early SMI Services section of this Plan.)
    c. Continue and expand efforts to support primary care providers, who can serve as critical behavioral health workforce extenders, when they are provided with the necessary support, continuing education, and consultation.
    d. Encourage primary care settings (including pediatrics) to integrate behavioral health professionals into health care settings.
2. **Continue investment in Nevada's Multi-Tiered Systems of Support and Social-Emotional Learning in all K–12 schools**, as recommended by ACRN (DHHS, 2022).
    a. Full-Service Community Schools provide an opportunity to coordinate mental health alongside other important community services (U.S. Department of Education, Office of Primary and Secondary Education, 2022).
3. **Increase support for families**. Family stress can be both a contributor to and a result of mental health problems in youth. Family support programs can improve youth mental health by reducing stress within the family (Kuhn & Laird, 2014).
4. **Increase the number of people trained to offer trauma-informed approaches across sectors and over the lifespan** (Youth.gov, 2013).

a. Offer trauma-informed training to all provider types, not just primary care providers, as well as to school personnel.
b. Use Mental Health First Aid in both school and primary care settings to educate individuals about childhood trauma and available resources.
c. Provide education on recognizing the signs of trauma and providing appropriate treatment to facilitate earlier intervention and prevention efforts, as recommended by ACRN (DHHS, 2022).
d. Explore opportunities to provide ACE certification for training across the state.

5. **Attend to social determinants of health and their roles in both prevention and promotion**. Social determinants of health include but are not limited to economic stability, social and community contexts, neighborhoods and built environments, health care quality and access, and education. Structural, institutional, and interpersonal racism and discrimination contribute to disparities across health outcomes; efforts to address these root causes support individuals and families including those impacted by behavioral health and other disabilities (Mental Health America, n.d.). Designing services and systems that address inequities in social determinants is a key path to achieving equity in health outcomes and community integration.
6. **Expand culturally relevant strategies, co-designed by and for communities**. The entire service delivery system (including primary care clinics, dentists, schools, etc.) must build the cultural competence to equitably welcome and serve individuals with behavioral health disabilities—including those with co-occurring disabilities. Community health workers and promotores (a Spanish word used to describe trusted individuals who empower through education and linkages) provide examples of strategies that can help build health literacy and connect people to resources (Center for the Study of Social Policy, 2019). Mental health prevention and promotion for native and indigenous people and on tribal lands should be relevant to the cultural factors and community context (Mental Health America, n.d.).

Key Partners

Many sectors, agencies, and institutions play key roles with prevention and upstream interventions, including the following.

- ADSD
- DCFS
- DPBH, including the Maternal, Child and Adolescent Health (MCAH) program
- Nevada Medicaid
- Children's Mental Health Consortia
- Advocacy organizations
- Individuals and families with lived experience
- NDE
- Nevada Early Childhood Advisory Council (NECAC)
- NAVIGATE Program
- NOHME

BRIGHT SPOT: SCHOOLS TAKING A LEAD IN INTEGRATING CARE ACROSS SETTINGS

Nevada's schools, in partnership with DHHS, have been important leaders in piloting a community integrated approach to behavioral health care. They have secured funding across several years working to build a "gold standard." Schools are critical access points, as well as service providers, for behavioral health services for Nevada children. For example, a large portion of visits to the school nurses are related to behavioral health, (Bohnenkamp, et al., 2019) and research has shown that school-based mental health has many advantages, including successful clinical outcomes, better engagement of families, and reduced stigma (Kang-Yi, et al., 2018).

A key Nevada innovation includes a partnership between DHHS and NDE to fund shared positions that facilitates the development of an integrated system with uniform policies. One outcome has been the development of a School-Based Behavioral Health Toolkit to support schools and districts to stand up their systems (DPBH & NDE). In alignment with ADA, the Toolkit guides schools to maximize the integration of children with behavioral health issues by implementing practices to support teachers in the classroom with children who need higher levels of support.

Districts use a Multi-Tiered Systems of Support framework to address the unsustainable reality that many schools are currently operating in a crisis mode, providing Tier 3 (intensive) services to as many as 30-50 percent of the school's student population. When implemented with fidelity, this framework aims to support all children with Tier 1 (universal) supports, such as prevention services and universal screenings. This significantly lowers the need for Tier 2 (targeted) and Tier 3 (intensive) supports to 15-20 percent and 3-5 percent of children, respectively. A core component of Tier 1 support is ensuring that all students, families, teachers, and other staff have mental health literacy so that everybody develops a shared language and knows what to do during a crisis. Currently, the Washoe County School District is developing Tier 3 interventions co-located at school sites that include assessment, diagnosis, psychotherapy, and psychiatry support.

School settings provide an opportunity to reach children and families where they are. While there is still considerable work to fully stand-up support within schools, these approaches allow schools and teachers to focus on education instead of behavioral and mental health challenges of students. When structured together with more comprehensive coordination, family engagement, and trust building, schools provide an accessible access point for students in the neighborhood where they live and with people they know and trust.

PRIORITIES FOR CHILDREN AND YOUTH

A. ACCESSIBLE COMMUNITY-BASED SERVICES

Status

Accessible community-based services are at the center of this Plan. In Nevada, many developments have taken place since 2018 to increase services; however, services are not yet available at a level to accommodate need.

Subject matter experts in Nevada agreed that ensuring that community-based services are accessible and available with sufficient intensity to prevent unnecessary institutionalization requires establishing and maintaining an integrated System of Care (Institute for Innovation and Implementation, 2021). Concerns regarding gaps in services were also noted by the DOJ, who reported that "children who are appropriate for community-based services are placed in—or at serious risk of placement in—segregated settings…because Nevada does not ensure access to necessary community-based services." (DOJ Civil Rights Division, 2022).

Gaps

Specific gaps have been identified in the service system. Many of these gaps are in the process of being addressed through prior recommendations from Nevada's Children's Mental Health Consortia (Clark County Children's Mental Health Consortium, 2021) (Rural Children's Mental Health Consortium, 2021) (Washoe County Children's Mental Health Consortium, 2021), as well as other groups. Progress has been also supported by focusing ARPA funds on these issues and leveraging technical assistance.

- **Intensive in-home supports and services**. DOJ identified this as a "primary gap" in Nevada's array. DCFS is currently working with experts from Washington State to develop a request for proposals to solicit providers.
- **Intensive care coordination**. In Nevada, this is offered through WIN and is intended for children with the most complex mental health needs. According to the DOJ, the number of children who received WIN in fiscal year 2020 was less than a fifth of the number who were hospitalized for psychiatric care and fewer than the number served in PRTFs. Additionally, the number served by WIN dropped by nearly 60 percent between fiscal years 2017 and 2020 (DOJ Civil Rights Division, 2022).
- **Mobile crisis response and stabilization services.** A variety of stakeholders have identified concerns regarding the availability, capacity, and fidelity of mobile crisis. As the DOJ noted, "capacity issues have substantially increased the response time to crisis

calls, leaving many children and families to seek care from hospitals" (DOJ Civil Rights Division, 2022).

- **Peer support, respite, and other family-based supports**. Nevada currently offers self-directed respite in rural communities and some urban settings for families using WIN. One identified gap is the need for trained respite providers and planned respite. Peer-based support for families is an evidence-based practice (SAMHSA, 2017) and shows promise for being cost-effective (Acri, Hooley, Richardson, & Moaba, 2017). Nevada funds families involved with state mental health services through Nevada PEP.
- **Therapeutic foster care**. The DOJ "learned of numerous instances of children in foster care who were unnecessarily placed in segregated settings or forced to stay in such settings longer than necessary because of an inability to identify traditional or therapeutic foster homes that would accept them and meet their needs" (DOJ Civil Rights Division, 2022).
- **Early childhood mental health services.** According to Nevada's Behavioral Health Chart Pack, early childhood mental health service usage declined from 313 to 139 from fiscal year 2017 to 2022 (DHHS, 2022). This finding is echoed in the DOJ report, which noted that "[m]any of the existing services are oriented toward school-age children and teens… there are few behavioral health services for very young children."

Strategies

1. **Continue to stand up the array of essential community-based services** to ensure that quality care from culturally informed providers is available to families at the time, at the location, and in the language needed. (See, for example, System of Care's Array of Services and Supports, an Appendix in this Plan.) Use ARPA as bridge funding while concurrently expanding access via changes to Medicaid. Adjust rules that impose limitations on the amount and frequency of needed services that disproportionately harm children with the highest needs.[4]
2. **Expand the use of behavioral health screening and assessment tools across settings.** In clinical settings, as part of the required Medicaid EPSDT benefit, leverage Medicaid as a

[4] While DOJ acknowledges that Nevada has included the "key building blocks of an effective community-based service system in its Medicaid State Plan," it emphasizes that Medicaid could "reasonably modify its system by expanding the availability of these services" (DOJ Civil Rights Division, 2022).

resource to enforce or incentivize behavioral health screenings. In addition, explore options for incentivizing screenings and assessments across all payer types.

3. **Set up high quality residential treatment to bring Nevada beds to national standards.** Reduce and eliminate the number of children leaving the State for residential care. In the long term, work to reduce the use of residential care for youth overall.
4. **Use authority and oversight to ensure that services and supports for children and youth are evidence-based whenever possible,** with allowances for well-supported programing when evidence-based programs are not available.
5. **Strengthen pathways for engaging the voices of children and their families in program planning and improvements.** This strategy is aligned with the Children's Mental Health Consortia's objectives and growing experience (Clark County Children's Mental Health Consortium, 2021) (Rural Children's Mental Health Consortium, 2021) (Washoe County Children's Mental Health Consortium, 2021). Examples include having "Youth and Family Voice" as a dedicated agenda item and exploring options to add a youth representative as a voting member.
6. **Develop training and certification for family peer support providers and include these services in Medicaid's service array**. Training and certification will advance ethical practice, minimum standards, and core competencies.
7. **Expand resources for early intervention by further integrating behavioral health into primary care.** This is especially important for very young children and their families. DCFS' Pediatric Mental Health Care Access project, funded via the federal Health Resources and Services Administration, which began enrolling providers in 2020 and addresses the integration of mental health into pediatric primary care, provides one avenue to address this gap.
8. **Improve mobile crisis response and stabilization to meet the needs of children and their families, which differ from the needs of adults.** Ensure that these services are delivered by individuals who are specifically trained to work with children and families in crisis. National standards for children and youth include several critical elements, such as:
    a. a face-to-face, timely response without the involvement of law enforcement;
    b. eight weeks of follow-up;
    c. working step-by-step to ensure that the youth is ready for each intervention; and
    d. considering the needs and dynamics of the whole family.

    Establish protocols for schools to work with mobile crisis response in a manner that respects families' critical roles and engage juvenile justice partners in mobile crisis to support diversion efforts (SAMHSA, 2022).
9. **Continue and expand collaboration for integration across settings** such as in homes, schools, clinics, other community-based settings, and institutional settings.

10. **Based on input from families that have navigated systems, work to address and take down barriers to service access**.
11. **Work toward integrated data systems and data sharing agreements among child-serving agencies.** Leverage the experience gained by Nevada school districts who are currently piloting data systems. Integrated data systems provide families, caregiving professionals, and policy makers timely access to information to make critical decisions.
12. **Continue to develop and expand evidence-based practices for services to youth in foster care through the FFPSA and Title IV-E Plan.**

Key Partners

Many sectors, agencies, and institutions play key roles with accessible community-based services, including the following.

- DHHS Divisions, including ADSD, DPBH, DCFS, and Nevada Medicaid
- Children's Mental Health Consortia
- Individuals and families with lived experience
- Advocacy organizations
- Nevada PEP
- UNLV Department of Psychiatry and Behavioral Health
- UNR Department of Psychiatry
- NDE
- MCOs
- Community-based organizations
- Private providers and provider networks

BRIGHT SPOT: STATES' PROGRESS IN STRENGTHENING SYSTEMS FOR CHILDREN'S BEHAVIORAL HEALTH

Several states have made progress in aspects of authority and oversight to improve gaps for children and youth services. These examples can be helpful as Nevada continues to strengthen interagency coordination and collaboration.

The Minnesota Comprehensive Children's Mental Health Act laid the foundation for establishing authority and governance for providing children's mental health services. Rules, policies, and procedures are compiled in one page.

California's recent law added section 16521.6 to the Welfare and Institutions Code set up interagency leadership teams with responsibility for coordinating services through memoranda of understanding, using the Integrated Core Team Practice Model, and moving agencies from siloed approaches to more coordinated systems of child welfare, juvenile probation, and behavioral health.

In New Jersey, the Children's System of Care, PerformCare, directs families to one resource for screening, behavioral health, intellectual disability services, substance use treatment, and suicide prevention.

OhioRISE is a specialized managed care program for youth with complex behavioral health and multisystem needs. It features a 1915(c) Medicaid waiver that is intended to keep families supported in the community to prevent institutionalization.

BRIGHT SPOT: SAFE BABIES COURT TEAMS

The Safe Babies Court Team™ (SBCT) is a community engagement and systems change initiative focused on improving how the courts, child welfare agencies, and related child-serving organizations work together to improve and expedite services for young children who are under court supervision. The SBCT is designed to:

- Protect babies from further harm and address the damage already done
- Expose the structural issues in the child welfare system that prevent families from succeeding

Each SBCT is convened by a judge with jurisdiction over foster care cases and by child welfare agency leaders, and includes other judges, child welfare staff, attorneys, service providers, and community leaders. Once the SBCT is established, they work with individual families, learning important lessons that are applied to subsequent cases and to updating the policies,

regulations, and laws governing child welfare practice, creating the basis for wider practice and systems change (Casanueva, Carr, C., Harris, S, & Burfeind, 2017).

Families who participate in the SBCT program can expect:

- more frequent contact with their children through supported interactions;
- timely assessment and evaluation of both the child and parents' needs and prioritized access to evidence-based interventions and treatment;
- access to parent/child intervention and treatment models that enable parents who can do so, to directly participate with their child in developmental and social/emotional services;
- access to "Parent Advocates" who have "lived experience" within the child welfare system, who have completed their own child reunification plan successfully and are maintaining active engagement in their ongoing recovery program;
- more direct and frequent court hearings and carefully facilitated SBCT "Child/Family Team" meetings where parental voice is supported and valued.

The Nevada Division of Child and Family Services (DCFS) was awarded a five-year grant to develop and implement the NV Infant-Toddler Court Program Expansion Project. The NV ITCP Expansion Project goals and objectives are tied to the specific needs of Nevada's infants, toddlers, and their families and the benefits that have been identified according to California Evidence-Based Clearinghouse for Child Welfare. According to research studies (Casanueva, Carr, C., Harris, S, & Burfeind, 2017; Casanueva C. H., 2019; Faria, 2020) across ITCP sites utilizing the Safe Babies Court Team TM (SBCT) model will include:

- Increasing timely receipt of infant and toddler screenings and referrals to needed services;
- Limiting out-of-home placements for infants and toddlers;
- Increasing timely placement permanency;
- Decreasing recurrence of maltreatment among families served; and
- Lessening racial and ethnic disparities found in the broader population.

The NV ITCP Expansion Project will support the expansion of the SBCT TM model in Nevada to two identified sites: the 8th Judicial District Court in Clark County and the 1st Judicial Court in the Consolidated Municipality of Carson, and enhance the current capacity of the existing SBCT TM in Washoe County. The Carson SBCT, through an American Recovery Plan Act (ARPA) funding request in 2022, has commenced work with ZERO TO THREE and will be ready to serve its first family in early 2023.

BRIGHT SPOT: FAMILIES FIRST PREVENTION SERVICES ACT

In 2018, Congress passed the Title IV-E and the FFPSA. This was an important development, allowing for the first-time prevention services for children in child welfare systems. Nevada developed and submitted a state plan that is under review. This plan lays out the approach to stand up new and expand existing services to children and their families. Children and families that experience these systems often have a behavioral health disability.

In a nationwide 2015 study by the Annie E. Casey Foundation,

> "Too many teens are being placed in group settings, whether in child welfare or in juvenile justice systems. These group placements have been shown to be developmentally harmful when used as long-term living situations. What's more, research shows that experimenting with risky behaviors is part of adolescent development. During these challenging years, teens need stronger relationships, access to effective behavioral health services and opportunities for positive growth, not residential group placements. Group placement facilities were not designed with these teens' needs in mind, and evidence indicates that teens who live in such settings often age out without the childhood experiences of safety, permanency and well-being that are the building blocks of successful adulthood" (Annie E. Casey Foundation, 2015).

The progress in developing Nevada's response to the FFPSA Act will help to strengthen the systems and supports available to children and youth.

Through FFPSA planning, Nevada is developing its first Qualified Residential Treatment Program, which is a new classification and national model of congregate care facility designed to provide treatment level care to children with behavioral health needs through providing high quality care to children.

FFPSA and related reforms are an important structural change that has helped reduce or eliminate group homes, a form of institutionalization.

B. APPROPRIATE DIVERSION FROM INSTITUTIONAL SETTINGS

Status and Gaps

Insufficient access to community-based services leads to a cascade of negative consequences for children and their families. When people cannot access the services they need in settings like doctor's offices, clinics, schools, and their homes, issues often escalate, and people turn to hospitals and emergency departments, which often act as gateways to restrictive, more institutionalized care, including PRTFs. However, residential treatment should be avoided whenever possible, and when necessary, lengths of stays should be minimized. Researchers have found that residential treatment is associated with higher rates of physical and sexual abuse and self-harm; may increase the likelihood of behavioral issues, including delinquency and criminal activity; and may psychologically harm children (Dozier, et al., 2014).

Insufficient access to community-based services also leads to an overreliance on other institutional settings within juvenile justice and foster care systems. As discussed in the DOJ report, "[i]n some cases, children with behavioral health disabilities enter the child welfare or juvenile justice system based on the belief that children receive more services through these public systems. Parents have told us that primary care physicians and police officers recommended they relinquish custody to get their children the care they need" (DOJ Civil Rights Division, 2022).

Overall, Nevada has seen success over the last decade in diverting children away as Juvenile Justice Detention Alternatives and Preventing the School to Prison Pipeline. About 70 percent of referrals lead to diversion. However, there are still considerable challenges. According to the most recent Juvenile Justice Annual Report (DCFS Juvenile Justice Programs Office, 2022),

- African American youth make up 2.3 percent of the youth population in Nevada in fiscal year 2021 but 22 percent of referrals to the system.
- 2,534 youth were placed in a juvenile detention facility in fiscal year 2021; 153 youth were placed in a juvenile youth camp in fiscal year 2021.
- 174 youth were committed to DCFS in fiscal year 2021.
- The most common re-arrest type is a probation/parole violation.
- Recidivism for youth committed/re-committed to a state facility within 12 months is 30 percent.

Additionally, the proportion of kids in the juvenile justice system with behavioral health issues is significant. According to national data, "between 65 percent and 70 percent of the 2 million

children and adolescents arrested each year in the United States have a mental health disorder" (National Conference for State Legislatures). Interviews with justice partners validated these percentages in Nevada jurisdictions. Nevada also has seen increases in children sent to more secure detention settings.

Diversion in Juvenile Justice has worked better for children without behavioral health issues than for children with behavioral health issues. Subject matter experts from Clark and Washoe Counties attribute this disparity to the lack of capacity in institutional or community-based settings to provide the types and intensity of behavioral health services that some children require. Subject matter experts also point to a shift in state policy that decreased the amount of funding available for group homes. In other words, subject matter experts report that children with behavioral health disabilities end up in a juvenile justice setting because they are not able to access necessary services elsewhere. Notably, in addition to disproportionately housing children with behavioral health disabilities, they report that juvenile justice settings also house a disproportionate number of Black, Latinx, and Indigenous youth.

Appropriate diversion from institutional settings will require work across agencies and partners, as well as State oversight and management. The emerging Children's Behavioral Health Authority (discussed in Authority, Oversight, and Coordination, a section in this Plan) will play a critical role, including coordinating across Departments and Divisions and with other entities that serve children and youth, from private providers to county juvenile justice services. As Nevada continues to build, strengthen, and coordinate its array of essential community-based services, its ability to divert children safely and successfully from institutional settings will increase. Navigating this transitional period will be challenging.

Specific gaps related to diversion that were identified include:

- A lack of community-based options;
- Insufficient PRTFs to meet Nevada's need leading to out-of-state placements;
- Insufficient alternatives to residential and institutional placement, including for very young children. Stakeholders report that youth aged 5 to 9 are most vulnerable to being placed out-of-state.

Strategies

1. **Provide oversight and management to properly assess children and youth at risk of being institutionalized**. Ensure that children who are appropriate for community-based services are not sent to PRTFs; care teams (rather than individual assessors) should make determinations about which children are appropriate for PRTF admissions. Children are not unnecessarily sent to a more restrictive setting, such as juvenile justice, in lieu of a less restrictive setting, such as residential treatment. A key strategy for diverting children from unnecessary placements is state oversight and management such as the establishment of a robust Children's Behavioral Health Authority (discussed in Authority, Oversight, and Coordination, a section in this Plan). A core authority function will be to establish protocols and processes for 1) assessing children at serious risk of institutional placement to determine whether their needs can be met via community-based services and, if so, 2) quickly connecting them to appropriate services. The protocols would, for example, establish when such assessments should be administered.
2. **Support emerging crisis response and stabilization services, with attention to national best practices for children and youth**. This can include implementing the recently published national guidelines for children's crisis care, which differ from the guidelines for adults.
3. **Provide oversight to routinely and systematically assess why children are placed under institutional care to prevent future unnecessary placements**. Review data including race, ethnicity, and other information to help identify inequities in institutional placements.
4. **Periodically assess the sufficiency of Nevada's PRTF capacity**. While it continues to shift resources away from institutional settings and towards community-based services, Nevada should also ensure that:
    a. Children who need PRTF care can receive that care in Nevada.
    b. Children are not denied PRTF admission because their needs are too high. Stakeholders report, for example, that some PRTFs refuse to admit children with aggression issues.
    c. When a PRTF is appropriate, children can access this care directly from the community, without the need for a hospital or emergency department to act as a gatekeeper.
    d. As recommended by the Nevada Commission on Mental and Behavioral Health, ensure that necessary PRTF care is not impeded by low staffing due to insufficient payment rates to frontline behavioral health workers.
5. **Engage juvenile justice partners to deflect and divert children with behavioral health issues into more appropriate settings**.

a. Expand standardized crisis intervention training (inclusive of law enforcement and other first responders) that includes a robust component on children and youth behavioral health.
b. Continue to engage courts in the goals of the BHCI Plan through the development and expansion of specialty courts. Review opportunities for new court models that meet specific needs, such as domestic violence court for youth.
c. Standardize or elevate training for judges to understand best practices for youth and behavioral health.
d. Expand adoption of the One Family One Judge model, required by NRS 3.025, to minimize conflicts and maximize connections to appropriate services.

Key Partners

Many sectors, agencies, and institutions play key roles with appropriate diversion from institutional settings, including the following.

- ADSD
- DCFS
- DPBH
- Nevada Medicaid
- Individuals and families with lived experience
- Advocacy organizations
- NDE
- NOHME
- Counties' juvenile justice, probation, court partners, and school districts
- UNLV Department of Psychiatry and Behavioral Health
- UNR Department of Psychiatry
- Children's Mental Health Consortia
- Health Management Associates
- Regional Behavioral Health Policy Boards

BRIGHT SPOT: CONTINUING MOMENTUM IN JUVENILE JUSTICE DEFLECTION AND DIVERSION

Overall, Nevada has seen success over the last decade in diverting children away as Juvenile Justice Detention Alternatives and preventing the school-to-prison pipeline. About 70 percent of referrals lead to diversion.

Nevada continues to expand its efforts to divert children from the juvenile justice system. For example, Clark County is piloting a truancy prevention program given the association between truancy and criminal behaviors, as well as a program to divert children involved in domestic violence disputes away from juvenile justice. They also recently established a nationally recognized model, School Justice Partnership, to address the school-to-prison pipeline.

Improvements in juvenile justice shows that progress is possible, and juvenile justice can be a critical partner in the work of behavioral health community integration. Despite gains, attention and efforts are needed to address disproportionality for Black youth, youth with behavioral health disabilities, and others disproportionately represented in the juvenile justice systems. Alongside more and improved community-based services and supports, study and improvement of probation and parole may be another important opportunity to help more youth.

C. TRANSITIONS BACK TO THE COMMUNITY FROM INSTITUTIONAL SETTINGS

Status and Gaps

Transitions back to the community from institutional settings require attention including State oversight and management. The emerging Children's Behavioral Health Authority (discussed in Authority, Oversight, and Coordination, a section in this Plan) will play an important role. This priority is essential to prevent unnecessarily long institutional stays, as well as readmissions.

Some strengths that Nevada has in this priority include:

- DCFS is using Positive Behavioral Interventions and Supports (PBIS)—an evidence-based framework shown to reduce disciplinary incidents, increase of safety and support, and academic outcomes—in PRTFs.
- DCFS is building an Intensive In-Home Step-Down Team within mobile crisis to support re-entry.
- Washoe County Juvenile Services is collaborating with The Children's Cabinet to create a reentry and aftercare program.

Below we detail core strategies for the Children's Behavioral Health Authority to adopt to ensure successful transitions back to the community.

Strategies

1. **Ensure successful discharge planning**. Discharge planning should begin at admission, regardless of the institutional settings (e.g., PRTF, juvenile justice, shelter). Additionally, the success of this priority relies heavily on the success of the earlier priority, Accessible Community-Based Services (a section in this Plan), including access to intensive in-home supports and services, WIN, respite, and re-entry specific services. However, discharges must not be delayed by inadequacy of community-based services. The current transitional period—as Nevada strengthens its array of community-based services—will require additional state oversight to support safe and successful transitions back to the community.
2. **Establish policies and procedures for meaningfully including children and their families into discharge and transition planning**. Employ person-centered planning principles in all discharge and transition planning.
3. **Oversee quality assurance in any institutional setting that provides behavioral health services** including PRTFs, group homes, and juvenile justice and child welfare settings. One quality issue identified in the DOJ report was overly restrictive PRTFs, in particular, the use of "level systems" in which children gain or lose points based on their behaviors; a child's score then dictates what they can and cannot do, including having contact with their family.

These systems have been criticized for decreasing autonomy, being disconnected from the real world, and prolonging lengths of stay (Association of Children's Residential Centers, 2019).

4. **Follow up with children with recent discharges to verify they are receiving appropriate community-based services**. Put systems and incentives in place to continue to engage with children and families after they have been discharged. Identify who is responsible for ensuring that services in the discharge plan are accessible to the child.
5. **Reimburse community-based providers for engaging in the discharge planning of their patients from institutional settings**.
6. **Track and measure progress related to child and youth transitions to the community**, using data such as state hospital readmission rates and follow-up rates post-discharge. Compare data to national or leading state standards.

Key Partners

Many sectors, agencies, and institutions play key roles with transitions back to the community from institutional settings, including the following.

- DCFS
- DPBH, including the Office of Public Health Investigations and Epidemiology (OPHIE)
- Nevada Medicaid
- Individuals and families with lived experience
- Counties' juvenile justice, probation, court partners, and school districts
- Children's Mental Health Consortia
- Regional Behavioral Health Policy Board
- WIN teams
- UNLV Department of Psychiatry and Behavioral Health
- UNR Department of Psychiatry

PRIORITY FOR YOUNG ADULTS IN TRANSITION

A. COORDINATED TRANSITIONS BETWEEN CHILD AND ADULT-SERVING SYSTEMS PAIRED WITH SPECIALTY SERVICES AND SUPPORTS

Status and Gaps

Young adults in transition (ages 14–25) are recognized as an underserved, and often vulnerable population. Nevada's System of Care Strategic Plan identifies them as "particularly in need of services" (DCFS, 2020), and a U.S. Department of Education study found that young adults in transition with disabilities, including SMI/SED, "continue to face challenges in graduating and achieving other milestones towards independence after high school" (U.S. Department of Education, n.d.). While the strategies discussed under both the Children and Youth section in this Plan and the Adult section also apply to this population, they also require additional tailored strategies.

During the transition into adulthood, youth face not only psychological, social, and physical changes but also significant logistic and bureaucratic challenges. This is especially true in Nevada, which has bifurcated systems with different agencies serving children while others serve adults. Young adults in transition are aging out of children-serving services and programs that may cross several sectors (e.g., child welfare, education, healthcare, and justice systems). As they are making this complex shift to adult-serving systems, decision-making is often transitioning from parents or guardians to themselves. All these changes occur when their brain development—which continues far into the twenties—is incomplete. As a result, young adults in transition often experience significant gaps in essential services, and face severe, sometimes insurmountable challenges.

In 2019, as mandated by NRS 432B.591 – 595, DCFS established a workgroup to study how to improve outcomes for youth who were leaving child welfare systems. The workgroup's primary recommendation was to implement the federal Title IV-E extended foster care program, which is now being implemented, as directed by SB 4397 (DCFS, n.d.).

DPBH has several existing strategies tailored to young adults in transition. In urban areas, both Southern and Northern NAMHS are licensed to serve individuals who are at least 18 years old. However, state legislation allows them to carry young adults in transition caseloads to provide tailored support and wraparound services. Individuals can start this programming six months prior to turning 18 years old. Programming focuses on relationship-building, coordinates transition meetings with child welfare and youth providers, and includes activities such as tours of adult-serving programs. Southern NAMHS has additional "bridge" programs, in partnership with The Harbor and Mission High School, to further facilitate warm handoffs into adult

systems, including tokens to incentivize appointment attendance and gas cards to decrease access burdens.

In rural areas, because DPBH clinics serve patients of all ages, young adults in transition can stay in the same treatment system. Clinics provide tailored services to support these clients with forward thinking, life planning, and decision-making and smooth the transition to other adult systems by coordinating with child welfare agencies and educational settings.

Strategies

1. **Establish a well-coordinated inter-agency plan to address Nevada's bifurcated systems** and to ensure that youth do not lose access to behavioral health services as they transition into adulthood. The plan would include:
    a. establishing which agency assumes the lead role with young adults in transition;
    b. developing inter-agency communication and coordination, timelines, and funding, including memoranda of understanding to clarify each agency's roles and responsibilities when needed;
    c. designing and implementing a comprehensive program that leverages existing resources, while tailoring components to meet the special needs of young adults in transition.
2. **Implement specialty behavioral health teams** who use the WIN model and have the flexibility and ability to work with an individual, from age 14 to 25, in both the child-serving and adult-serving systems to bridge and support their transition.
3. **Create more opportunities for independent living** including housing specific for young adults in transition, which facilitates age-specific community learning and self-help (i.e., cooking, cleaning, budgeting, transportation).
4. **Expand the authority of children's MCTs to serve young adults in transition** so that they can access the associated case management services that are not part of the adult-serving program.
5. **Create drop-in centers tailored to young adults in transition**, where they can obtain support and care, while simultaneously taking an active role in their own care to create independence, self-sufficiency, and stability.
6. **Consider policy changes to allow child-serving systems to serve individuals into their early twenties,** including extending foster care to the mid-twenties. Similarly, consider more flexible licensing for acute inpatient and PRTFs to create smoother transitions between youth-serving and adult-serving facilities. (Currently, for example, there is a 24-hour gap at the eighteenth birthday in which neither system can serve the individual.)

7. **Support young adults in transition with community engagement and competitive integrated employment.** "Place and train" approaches in which individuals are first placed in an employment setting and then provided with individualized training, services, supports, and accommodations are particularly promising for dismantling pipelines to segregated institutionalized settings (U.S. Department of Education's Office of Special Education and Rehabilitative Services, 2022). These strategies align with Strategy 3.1 from ADSD's 2016 Olmstead Strategic Plan (ADSD, 2016).
8. **Continue implementing a virtual Intensive Outpatient Program targeting young adults in transition in rural areas**. The Washoe County Children's Mental Health Consortium reported some progress in this area in its 2021 Annual Report, stating that Pacific Behavioral Health began a virtual Intensive Outpatient Program for young adults in transition that focuses on rural Nevada (Washoe County Children's Mental Health Consortium, 2021).

Key Partners

Many sectors, agencies, and institutions play important roles in supporting young adults in transition, including the following.

- ADSD
- DCFS
- DPBH, including the Office of Public Health Investigations and Epidemiology (OPHIE) and Office of Suicide Prevention
- DWSS
- Nevada Medicaid
- DETR
- Individuals and families with lived experience, especially current and former foster youth
- Counties' juvenile justice, probation, court partners, and school districts
- County and local housing advocates and providers
- Children's Mental Health Consortia
- Regional Behavioral Health Policy Boards
- Hospitals, PRTFs
- WIN teams

BRIGHT SPOT: THE HARBOR

The mission of The Harbor is to be responsive to the well-being of youth, families, and victims by providing meaningful services to improve connectedness to the community through academic achievement, reducing truancy, and providing a safe place for guidance. The Harbor has five locations in Southern Nevada and currently serves teens (to age 17). Many of the youth and families that visit the Harbor are experiencing challenges related to behavioral health, and the Harbor provides services like counseling, anger management, mentorship, and help with SUDs. The Harbor also completes outreach related to preventing and helping students and families overcome common root causes of truancy.

The Harbor has become a trusted support for youth and families that offers walk-in appointments, evidence-based assessments, and connection to services. The Harbor is open seven days a week, from 8 am to 10 pm, eliminating a common barrier of "business hours" for people with school and work.

The Harbor is implemented through partnerships that include cities, school districts, police, DCFS, DWSS, Juvenile Justice, and private providers. This collaborative effort provides a model of a system that can support behavioral health among youth. Similar services or supports customized to meet specific needs of the larger age group may be one solution for young adults in transition.

PRIORITIES FOR ADULTS

A. ACCESS TO A CRISIS CONTINUUM

Status

Individuals experiencing behavioral health crises in Nevada too often experience significant delays in accessing appropriate services, which can lead to serious negative outcomes, including unnecessary decompensation, frequent utilization of jails and emergency departments, increased trauma and stigma, and suicide. Suicide rates have climbed nearly 30% since 1999 and are increasing among young people and older adults. Suicide is most often preventable. For every person who dies by suicide, there are 280 people who seriously consider suicide but do not kill themselves (SAMHSA, 2021). To address delays in response and behavioral health crises, Nevada is building a Crisis Care Response System (CRS) for children, youth, and families, and adults.

Crisis behavioral health care in the United States is inconsistent and inadequate when it falls short of aligning with the best practice. This is tragic in that good crisis care is widely recognized as:

1. An effective strategy for suicide prevention;
2. An approach that better aligns care to the unique needs of the individual;
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crises;
4. A key element to reduce psychiatric hospital bed overuse;
5. An essential resource to eliminate psychiatric boarding in emergency departments;
6. A viable solution to the drains on law enforcement resources in the community; and
7. Crucial to reducing the fragmentation of behavioral health care (SAMHSA Center for Mental Health Services, 2020).

Nevada's CRS has an established mission that, "Everyone in Nevada will have immediate access to effective and culturally informed behavioral health services, crisis services, and suicide prevention through 988 and the Crisis Response System." Nevada began work on the CRS in 2018 and convened the first statewide behavioral health Crisis Now Summit in October 2019, as part of the Office of Suicide Prevention's annual conference, which engaged stakeholders to learn about CRS. From June to July 2020, stakeholders participated in a seven-week webinar series on Nevada's CRS, culminating in a Statewide Virtual Summit. During the Summit, community partners conducted an analysis of assets and gaps of crisis response in Nevada,

which was informed by assessments conducted by Regional Behavioral Health Policy Board Coordinators using the Crisis Now Scoring Tool (Social Entrepreneurs, Inc., 2020).

In March 2020, SAMHSA released its National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit (SAMHSA Center for Mental Health Services, 2020), providing a baseline of best practices for Nevada. These guidelines establish the four major components for individuals experiencing a behavioral health crisis including: 1**) Someone to call, 2) Someone to come to you, 3) A welcoming place to go, and 4) Best practices for care that are woven throughout the entire crisis response continuum.**

A subsequent grant funded the establishment of a Planning Coalition that developed a plan to implement a CRS, including a statewide 988 call center hub to respond to persons in crisis, stand up MCTs to go to a person in crisis, and create crisis stabilization units (CSUs) to provide a warm and welcoming place to go in lieu of the emergency department or jail. (DPBH, 2022). NRS 433.708, enacted in 2021, called for the establishment of an account, funded by a fee, to support 988 and the CRS. The Crisis Response Account has been established, and the fee setting process is underway.

Gaps

Challenges identified include funding, capacity and systems building, and the need for implementation support and quality assurance as the CRS is implemented to achieve the vision that, "the Crisis Response System and 988 will serve as the foundation of Nevada's behavioral health safety net. We will reduce behavioral health crises, strive to attain zero suicides in our state, and provide a pathway to recovery and well-being" (DPBH, 2022). Each challenge area is described as follows:

Funding

- Sufficiently funding 988 as a Lifeline center to ensure adequate staffing so that calls are answered in a timely and appropriate manner.
- Implementing "designated" MCTs, who will be certified and reimbursed at an enhanced rate. This will require establishing a Medicaid MCT rate; completing a State Plan Amendment to gain CMS approval for enhanced federal financial participation; and obtaining approval from Nevada's legislature for the budget authority.
- Implementing a CMS-approved Medicaid rate for CSUs is essential to supporting and expanding this needed service area.

Capacity and Systems Building

- Building capacity for the 988 system, as well as other CRS components, such as MCTs and CSUs. Nevada currently lacks any mobile crisis resources that can be dispatched

through Nevada's 988 center, and no CSUs operate with fidelity to the National Guidelines.

- Ensuring that a Call Center Hub can respond to volume projections for calls, chats, and texts. The Call Center Hub should also link to MCTs (designated, co-responder, and children's models for MCTs) and CSUs and to a bed registry to ensure that users receive the appropriate level of care as soon as possible.
- Tailoring a specific CRS to children, youth, and their families—who require a distinct approach from adults—in alignment with National Guidelines (SAMHSA Center for Mental Health Services, 2022).

Implementation Support and Quality Assurance

- Designing the Call Center Hub data system to link all aspects of the CRS, generate reports that align with SAMHSA's key performance indicators (KPIs), and demonstrate the results of the Crisis Response Account investments.
- Establishing certification and licensing for designated MCTs and CSUs.
- Providing implementation support to ensure coordination between public service answering programs, which handle 911 calls, and the Call Center Hub, which will handle 988 contacts, so that contacts made to either number are addressed appropriately.
- Focusing on quality assurance during implementation to help contracted vendors achieve fidelity to best practices for the population being served.

Strategies

1. **Implement a Call Center Hub** by building the capacity of the state-contracted Lifeline Center to handle estimated contacts. This relies on establishing an adequate fee to support 988 and the CRS to ensure staffing is sufficient to address the anticipated volume of calls, chats, and texts. This would ensure that anyone in crisis who contacts 988 by call, chat, or text will have a trained person to talk to regarding their crisis.
2. **Complete the Mobile Crisis Planning Grant and implement designated MCTs** covering as broad a geographic area as possible, including the use of CCBHCs. This includes establishing practice standards and adequate reimbursement rates so that persons who cannot be de-escalated via 988 have a qualified, responsive team to meet them where they are at.
3. **Implement CSUs**. This includes developing and communicating practice standards—such as ensuring a warm, living-room like environment—and coordinating with rural hospitals to provide CSU services in their facilities. This will reduce trauma, divert people from jails and emergency departments, and provide skilled care to manage people through and after the crisis episode.
4. **Implement all CRS services in accordance with the National Guidelines**, including:
    a. ensuring that care and services are trauma-informed,
    b. utilizing peers in significant roles for MCTs and CSUs,

c. integrating Zero Suicide/Suicide Safer Care throughout the CRS,
d. directing CRS providers to adopt policies to ensure the safety and security for staff and people in crisis,
e. building upon existing partnerships with law enforcement, dispatch, and emergency medical services.

5. **Utilize National Guidelines for Children and Youth to ensure that children's MCTs and CSUs are tailored according to best practices**. Provide training and technical assistance to all state-contracted CRS vendors on the National Guidelines. This is intended to build a system that is appropriate for children and youth and to serve their families in a supportive manner.
6. **Establish and use authority and oversight to ensure services and supports for children, youth, and adults are aligned with evidence-based practices**.
    a. Establish quality assurance positions within DPBH.
    b. Develop and implement quality assurance systems to work with and support CRS contractors and state staff overseeing the Crisis Response Account.
    c. Implement quality assurance systems and take steps to increase quality based on monitoring and reporting.
    d. Evaluate CRS contractors and support implementation guidance with contractors based on National Guidelines.
7. **Establish clear protocols for post-crisis follow-up care** to ensure a continuum of care and to understand the effectiveness of interventions. This will include defining follow-up timelines tracking results of interventions to ensure that people receive the right service at the right time in the right setting.
8. **Ensure resources are available for referrals to persons in crisis**. This is essential in connecting people to ongoing care and laying a pathway to recovery.

Key Partners

Many sectors, agencies, and institutions play key roles with ensuring access to a crisis continuum, including the following.

- DPBH, including the Bureau of Health Care Quality and Compliance
- Nevada Medicaid
- Regional Behavioral Health Coordinators
- Vendors, contractors, hospitals, MCOs
- Local governments, including law enforcement
- NOHME
- Nevada Prevention Coalitions
- NAMI, Mental Health Consortia
- Nevada 2-1-1, Open Beds
- Behavioral health providers
- Children's and Local jurisdiction based MCTs

BRIGHT SPOT: LEGISLATION AND FUNDING FOR A CRISIS CONTINUUM

In 2021, to support 988 and other CRS elements, Nevada enacted NRS 433.708 that, among other advances, established a telecommunications fee, capped at 35 cents per line per month, to fund a Crisis Response Account. A public hearing is planned to set the fee. Nevada has also benefited from other legislation and funding to support the development of CRS including:

- Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, 2018),
- Mobile Crisis Planning Grant
- National Suicide Hotline Designation Act of 2020,
- The expansion of CCBHCs from 9 to 15 throughout Nevada, and
- The endorsement of hospital-based CSUs by NRS 449.0915 during the 2021 legislative session.

Nevada is in the process of establishing Medicaid rates for CSUs and has been granted an MCT planning grant, which will help build the case for establishing MCTs as Medicaid reimbursable services. Non-legislative investments to date include prioritizing the CRS through SAMHSA's MHBG and Supplemental Block Grant, ARPA funding, and Medicaid reimbursement. These braided funding streams will allow Nevada to build an evidence-based CRS that responds to all persons in crisis who contact 988, ultimately diverting them from emergency rooms and jails and linking them to services based on their needs.

BRIGHT SPOT: ELEMENTS OF THE CRS ARE ALREADY IN PLACE

One CRS component that has been in place for decades is the state-contracted Crisis Support Services of Nevada, which is one of six National Suicide Prevention Lifelines in the country. It has been successful in deescalating crises and, when necessary, deploying resources. In addition, NAMI operates a warmline that coordinates with Crisis Support Services but does not operate 24/7. Lastly, the State operates a hotline for children and adults, which Crisis Support Services refers to.

Children's MCTs are operating in Nevada with plans for expansion. Co-responder MCTs are also in place in some communities. CCBHCs exist across Nevada and can be leveraged to provide care, particularly with use of MCTs.

B. ACCESS TO EARLY SERIOUS MENTAL ILLNESS SERVICES

Status

Historically, mental health services focused on the later stages of SMI, with interventions typically offered only after crises and following prolonged periods of untreated illness. Restricting the definition of treatable SMI to later stages and traditional treatment regimens is no longer necessary due to recent advances in clinical models. The types and timing of treatment interventions have been significantly expanded—from the earliest mild and non-specific signs and symptoms to the first full episodes of diagnosable illness to the later stages of chronic illness. The estimated prevalence of psychotic disorder in the general population is 3 percent (Perälä J, 2007). The emphasis on early intervention is due to a relatively new understanding that a longer duration between the onset of psychosis and the beginning of treatment is predictive of severity of illness, poorer social functioning, lower quality of life, and social isolation (Addington J. et al., 2015) (Jonas, Fochtmann, & Perlman, 2020) (Oduola, Craig, & Morgan, 2021).

Nevada's Early Treatment Programs for First Episode of Psychosis

In Nevada, access to evidence-based practices to serve people with early SMI has been developed and implemented through SAMHSA's MHBG and Competitive Award. Since the 2018 BHCI Plan, Nevada has launched five new early treatment programs for ESMI, providing access to the vast majority of Nevadans. Individuals ages 15 to 44 are eligible for services. Nevada selected NAVIGATE—based on the evidence-based Coordinated Specialty Care model—for the three early treatment programs for first-episode psychosis (FEP) because a clinical trial found it to be effective and feasible for implementing within community mental health settings and in rural and low-density population regions. Nevada currently has FEP programs in three Behavioral Health Regions—Northern, Clark, and Washoe—which serve approximately 95 percent of residents. FEP treatment teams receive training and ongoing consultation support from national NAVIGATE experts and from the UNR School of Medicine's ECHO program.

Expansion of Nevada's Early Treatment Programs for Early Serious Mental Illness

UNLV PRACTICE's Early Treatment Program for Early Bipolar Disorder with Psychotic Features (known as POWER): Nevada's early SMI (ESMI) services were initially focused on schizophrenia spectrum and other psychotic disorders; however, coordinated specialty care services are currently being tailored to other ESMIs, such as affective disorders with psychotic features. UNLV PRACTICE, for example, is developing and implementing an early treatment program for bipolar disorder with psychotic features.

The Nevada Clinical High Risk for Psychosis (CHR-P) Program for Youth: There is growing recognition that the coordinated specialty care model for FEP can be successfully applied to even earlier stages of emerging illness through identification of clinical symptoms and syndromes associated with a high risk for psychosis (Fusar-Poli, McGorry, & Kane, 2017). Nevada recently received a new SAMHSA Competitive Award that will fund CHR-P Program for Youth, which aims to prevent or lessen the impact of psychotic disorders in help-seeking adolescents and young adults in transition in southern Nevada who are at clinical high risk for psychosis. Nevada CHR-P will implement a stepped-care model to provide evidence-based interventions in a trauma-informed manner that is designed to prevent or delay the onset of illness. This model emphasizes the staging of clinical interventions throughout a young person's participation, with lower intensity and lower risk treatments provided as first-line interventions. Decisions about treatment completion, maintenance therapy, or a progression to more intensive care are based on objective measures of treatment response.

Gaps

Despite recent improvements in access to evidence-based coordinated specialty care services for individuals with ESMI, gaps remain:

- Like many interventions discussed in this Plan, ESMI services remain dependent on grant funding. Moreover, the full array of specialty care services is not currently reimbursed by Medicaid, which limits the State's capacity to sustain and expand services for the ESMI population.
- Access to services for ESMI is currently available to approximately 95 percent of Nevada's population. However, this access is limited to the most populous regions of the State.

Strategies

1. **Develop sustainable funding mechanisms via Medicaid and other payers to maintain and expand ESMI services in Nevada**. Expansion will help improve access by, for example, increasing workforce capacity to provide coordinated specialty care for ESMI.
2. **Ensure rural areas statewide have access to ESMI services**. Ensuring people in rural areas have access to ESMI services will reduce trauma, decrease travel times for services, and likely prevent both involuntary holds and emergency transportation to urban areas for persons who have escalated into a behavioral health crisis as a result of not receiving ESMI services.
3. **Expand eligibility for ESMI services in terms of diagnostic categories of mental illness**.

Key Partners

Many sectors, agencies, and institutions play key roles for ESMI, including the following:

- DPBH
- Nevada Medicaid
- Nevada's ESMI programs, including NAVIGATE, POWER, and CHR-P
- ECHO Clinics for FEP
- Behavioral health providers

C. ASSERTIVE COMMUNITY TREATMENT SERVICES

Status and Gaps

ACT is an evidence-based, multi-disciplinary, team-based approach of 24/7 comprehensive and flexible treatment, support, and services within the community. Sometimes described as a "hospital without walls," ACT provides intensive support to people with behavioral health disabilities who have a history of high use of emergency, hospital, and law enforcement services. Research shows that ACT reduces hospitalization, increases housing stability, and improves quality of life (Case Western Reserve University: School of Applied Social Sciences: Center for Evidence-Based Practices, n.d.). Each team includes at least five full-time staff—including a licensed mental health provider, a psychiatric prescriber, and a registered nurse—and serves about twelve people at any one time (DPBH, 2018). One of the biggest obstacles to implementing and maintaining an ACT team is staffing. (See the Workforce Development section in this Plan for related strategies.)

All CCBHCs are required to provide ACT services as one of their ten core services. Given the intensity and complexity of the ACT intervention, this was one of the last core services that CCBHCs implemented. Five other entities, funded by SAMHSA, also provide ACT services. CASAT certifies and provides technical assistance to ACT teams in Nevada, based on the Division Criteria for the Certification of ACT Teams.

Strategies

1. **Pursue sustainable funding for ACT services via Medicaid and other insurers.** While, long-term, the ACT model has been shown to save money systemwide, its implementation costs are high and individual organizations typically need significant startup funds to begin providing these services. Currently, SAMHSA grants and ARPA funds are driving the expansion of ACT Teams. Sustainability will rely on an ongoing commitment from Medicaid and other insurers to adequately pay for ACT services. This commitment likely relies on continued data collection establishing that the ACT model reduces inpatient stays and, therefore, costs. Given the intensity and high costs of the intervention, sustainability will also rely on ensuring fidelity to appropriate eligibility criteria, targeting the highest need individuals, and on establishing an appropriate number and distribution of ACT teams throughout Nevada.
2. **Ensure adequate reimbursement for all ACT teams statewide**. Like federally qualified health centers, CCBHCs are paid a daily rate per patient regardless of which services are provided, including ACT services. This daily rate is intended to cover CCBHCs costs and is adjusted periodically based on CCBHCs' cost reports. Other ACT teams, operating outside of

CCBHCs, must bill Medicaid separately for each service they provide. To facilitate team-based collaborative care, which defines ACT, teams should be paid an adequate bundled rate.

3. **Tailor the ACT model to ensure availability of ACT services statewide, including in rural areas**. The Division criteria establishes different requirements for rural areas and, during annual evaluations, CASAT uses a different fidelity/quality assurance tool, developed specifically for rural areas. One strategy for increasing statewide coverage would be to integrate telehealth into the ACT model.

Key Partners

Many sectors, agencies, and institutions play key roles for ACT services, including the following.

- CASAT
- DPBH
- Nevada Medicaid
- Behavioral health providers, especially CCBHCs
- County and local housing advocates and providers

D. SUPPORTIVE HOUSING

Status

Research shows an association between supportive housing and improvements in both health outcomes and costs (Kaiser Family Foundation, 2017). While progress has been made since the 2018 BHCI Plan—in particular, the addition of the 1915(i) waiver to the Medicaid State Plan—significant gaps remain, especially because housing affordability has worsened considerably in Nevada during the past four years. Rents have increased, fewer landlords accept vouchers, and more Nevadans are homeless.

Nevada's Interagency Council on Housing and Homelessness emphasized that Nevada must "establish the infrastructure for a work group on supportive housing to create accountability to guide state policy…" (Nevada Interagency Council on Housing and Homelessness, 2022). Core elements of supportive housing include no limits on length of stay, affordability to people with extremely low or no income, and support services tailored to meet individual needs. It is targeted to people facing severe obstacles to housing stability, including (but not limited to) those with disabilities.

Supportive housing can be "scattered site," with units distributed throughout a community; mixed affordability, with units interspersed within an affordable housing development; and "single site," in which all units are supportive housing. According to CSH, to best align with Olmstead guidance, the two former models "should be the primary approach, but there are instances in which people will choose a single-site setting where a majority of people with disabilities reside" (CSH, 2016). One potential benefit of single site, as well as mixed affordability, is the availability of on-site services.

Supportive housing—even single site—differs in important ways from congregate residential programs, such as group homes, in a manner that aligns with Olmstead guidance:

- Residents have the rights and responsibilities of tenancy—e.g., they sign a lease and are free to come and go or have guests.
- Housing and services are decoupled—i.e., residents are not required to participate in services to obtain or maintain their housing. Following Housing First principles, residents are not required to meet threshold criteria (e.g., sobriety).
- Residents select the services, activities, and providers of their choice.
- Residents usually occupy their own bedroom, bathroom, and kitchen; if sharing any common areas, they choose their own roommates.

Supportive housing is a complex, multi-agency intervention involving three core components:

- **Capital**—i.e., developers who build the housing.
- **Operations**—e.g., housing authorities that finance affordable housing by supplying the vouchers that cover or subsidize room and board and U.S. Department of Housing and Urban Development (HUD) funded local Continuum of Care organizations who implement processes for determining eligibility and priorities.
- **Services**—i.e., community-based providers who provide housing-related services that support an individual's ability to obtain and maintain housing. Medicaid can play a large role in facilitating and financing housing-related services; however, they are prohibited (by federal statute) from paying for room and board (CMS, 2015). The Behavioral Health Chart Pack suggests a steady decline in the number of individuals receiving housing support (DHHS, 2022, p. 22).

Gaps

Individuals with behavioral health disabilities face significant gaps in receiving adequate supports and services that allow them to live independently in the community of their choice. Of particular concern is that individuals with similar levels of functional impairment—or with similar needs with activities of daily living—have disparate access to necessary supports and services depending on their type of disability. Currently, in Nevada, compared to individuals with behavioral health disabilities, those with developmental disabilities have significantly greater access to necessary supports and services to maintain independent living in the community. Nevada could remedy this inequity by leveraging available tools, such as Medicaid waiver authorities and federal housing supplemental funding programs, which would allow Nevada to access federal funds to pay for these essential services.

Lack of supportive housing and permanent supportive housing for individuals with behavioral health related disabilities increases the risk of unstable housing, homelessness, use of unlicensed board and care homes, and overuse of institutional levels of care.

Additionally, Nevada does not currently have a current Social Security Income (SSI) and Social Security Disability Income Outreach (SSDI), Access, and Recovery (SOAR) coordinator. The SOAR program provides an opportunity to reduce or end homelessness through access to SSI/SSDI income supports.

Strategies

1. **Define and begin building a statewide supportive housing initiative.** Building statewide access to and maintaining supportive housing will require extensive cross-agency

coordination and communication, as well as organizational infrastructure. Initial steps include:

a. clarifying the definition of Supportive Housing in statute,
b. developing a Supportive Housing State Plan, and
c. building the business case for implementation.

The Apple Health and Homes Act passed in Washington State provides one model for states to follow (CSH, 2022). Currently, the Nevada Housing Coalition, in partnership with CSH, is playing a lead role, including running a Supportive Housing Academy, as well as a Supportive Housing Working Group that meets monthly. Federal Medicaid guidance also clarifies that state Medicaid agencies can receive Federal Financial Participation for state-level strategic, collaborative activities (CMS, 2015).

2. **Leverage Medicaid, as well as other tools, to sustainably finance the required supports and services that individuals with behavioral health disabilities required to maintain independent living in the community.**
    a. Continue standing up Medicaid's 1915(i) initiative. Nevada Medicaid has taken steps to stand up a 1915(i) initiative to provide housing-related services to Medicaid beneficiaries, including amending its State Plan and working with CASAT to develop provider qualifications. Currently, however, Nevada does not have an operational organization or dedicated staff to implement the initiative. Additionally, many of the community-based organizations who have traditionally provided housing-related services are not Medicaid providers. They require support and education to leverage Medicaid financing, which will allow them to redirect their limited resources to, for example, supporting residents' housing costs (CSH, 2016).
    b. As enabled by state legislation, pursue an 1115 waiver for individuals with SMI or SED.
    c. Continue expanding and formalizing the housing supports and services provided via Medicaid MCOs. Unlike the state Medicaid agency, MCOs can pay for room-and-board, along with other tenancy supports. Currently, these services are not required in MCO contracts with the State; rather they are provided as "value-added" programming, with each MCO developing its own approach. Notably, MCOs are establishing a business case for housing supports, showing that they not only improve outcomes for certain beneficiaries but also save money. MCOs began providing these services after determining that most of their highest utilizers suffered from housing instability. One strategy that Nevada Medicaid is pursuing is shifting these MCO services from "value-added" to "in-lieu of" services, which would bring them under the MCOs' contracts, broadening access.

3. **Develop appropriate incentives for developers to target lower income levels.** Historically, developers of affordable housing have focused on households earning at least 60 percent of the poverty level. Nevada needs to develop appropriate incentives and/or regulations—for example, a 20 percent set-aside in affordable housing developments for lower income households.
4. **Implement appropriate preferences to support Olmstead efforts**. For example, according to HUD, public housing agencies, Continuum of Care organizations, and other HUD-funded entities who supply housing vouchers "may offer certain preferences that will enable individuals with disabilities to transition from institutions more quickly or enable an individual at serious risk of institutionalization to remain in integrated, affordable housing in the community" (HUD, 2013).
5. **Explore opportunities to engage a SOAR coordinator for Nevada**, connecting individuals facing homelessness to SSI/SSDI income supports and benefits (SOARWORKS).

Key Partners

Many sectors, agencies, and institutions play key roles with supportive housing, including the following.

- Developers
- Housing Authorities
- Continuum of Care organizations
- Nevada Medicaid
- Individuals and families with lived experience
- Community-based providers of housing supports and services
- Advocacy and governmental entities such as the Nevada Interagency Council of Homelessness, CSH, and the Nevada Housing Coalition

E. TRANSPORTATION

Status

Research has shown that millions of people nationwide miss or delay medical care each year because they lack available or affordable transportation. At the same time, research shows that providing access to non-emergency medical transport is often cost-effective for states because it avoids the downstream costs of delayed care (Kaiser Family Foundation, 2016). Users are often individuals and families facing behavioral health disabilities.

State Medicaid programs are required to provide non-emergency medical transport, and Nevada offers this service via the broker Medical Transportation Management, Inc. (MTM). MTM services require prior authorization and may include bus passes, gas mileage reimbursement, use of third parties (e.g., taxies, Uber, and Lyft), as well as curb-to-curb delivery services. A recent State Plan Amendment added an additional transportation service: Non-Emergency Secure Behavioral Health Transports, for individuals in behavioral health crises or with behavioral health conditions. This new service is provided by enrolled Medicaid providers (Specialty 987 under Provider Type 35) in a secure vehicle (Nevada Medicaid, 2021).

Gaps

However, transportation-related barriers to behavioral health services remain, including the following:

- While covered by Medicaid, non-emergency medical transport is not covered for all individuals and families facing behavioral health disabilities, including those covered by Nevada Checkup or Medicare.
- Individuals and families facing behavioral health disabilities sometimes struggle with the MTM processes for arranging transportation or receiving reimbursement.
- Maintaining an adequate transportation network remains a challenge, particularly in rural areas, where MTM relies primarily on taxies, Uber, or Lyft.
- The MTM mileage reimbursement rate is low, 22 cents per mile, which is approximately one-third of the rate for Nevada's state employees.

Strategies

1. **Assess the extent to which the new Medicaid service, Non-Emergency Secure Behavioral Health Transports, improved access to behavioral health services.** Collecting wait list and utilization of service data would provide a sense of the scale of the unmet need and would document the degree to which the transportation barrier has been addressed as well as remaining gaps in access to transportation.
2. **Determine what transportation-related barriers remain for individuals and families facing behavioral health disabilities and how best to address them.** This could include, for example,
    a. Determining to what extent individuals and families continue to rely on MTM services and what challenges they face.
    b. Raising the MTM mileage reimbursement rate.
    c. Simplifying the MTM processes for both arranging for transportation and obtaining reimbursement.
    d. Identify the geographic areas that struggle the most with an inadequate transportation network.
    e. Assess to what extent and in what ways individuals without Medicaid face transportation barriers and explore innovative options that will work across Nevada's geographies. As an example, brought forward by a subject matter expert, the (Emergency Telehealth and Navigation) ETHAN project allows for telehealth in the field with a professional to avoid unnecessary transports to emergency rooms and other settings (Emergency Telehealth and Navigation, n.d.).

Key Partners

Many sectors, agencies, and institutions play key roles transportation, including the following.

- Local jurisdiction-based MCTs
- Nevada Medicaid
- MCOs
- State, county, and local law enforcement
- Individuals and families with lived experience
- Emergency Medical Services (EMS) and other first responders
- County and city governments, including transportation boards or commissions
- Behavioral health providers
- Private partners (e.g., taxis, Uber, and Lyft)

F. DEFLECTION AND DIVERSION FROM CRIMINAL JUSTICE SYSTEMS

Status

Nevada has adopted the Sequential Intercept Model, depicted in Figure 1, to deflect and divert individuals with behavioral health disorders from the criminal justice system (Policy Research Associates, 2022). An important policy milestone, NRS 289.450, which was enacted in 2019, "changed the way that behavioral health services are utilized, not only for those who are incarcerated, but also for the purpose of jail diversion" (Woodard, 2022). NRS 176.0132 – 0139 included an innovative provision to calculate the costs averted by this legislation and to reinvest these resources in deflection, diversion, and re-entry services—such as transitional housing for individuals re-entering the community (Legislative Counsel Bureau, 2020).

Intercept 0: Community Services

At this intercept, the goal is to deflect individuals from the criminal justice system, connecting them with treatment or services instead of arresting or charging them with a crime. Success depends on the availability of robust community-based services, discussed in earlier sections of this Plan, including Access to a Crisis Continuum and Supportive Housing. Other interventions at this intercept include training in crisis intervention for law enforcement and the Behavioral Health Field Response Grant Program, which funds law enforcement agencies (via costs averted by NRS 176.0132 – 0139) to partner with behavioral health professionals to better serve individuals with behavioral health disorders. In addition, ARPA funding includes $2.2 million to Nevada Behavioral Health Systems for Forensic Assertive Community Treatment teams, which builds on the ACT model by adapting to criminal justice issues—in particular, addressing criminogenic risks and needs (SAMHSA, 2019).

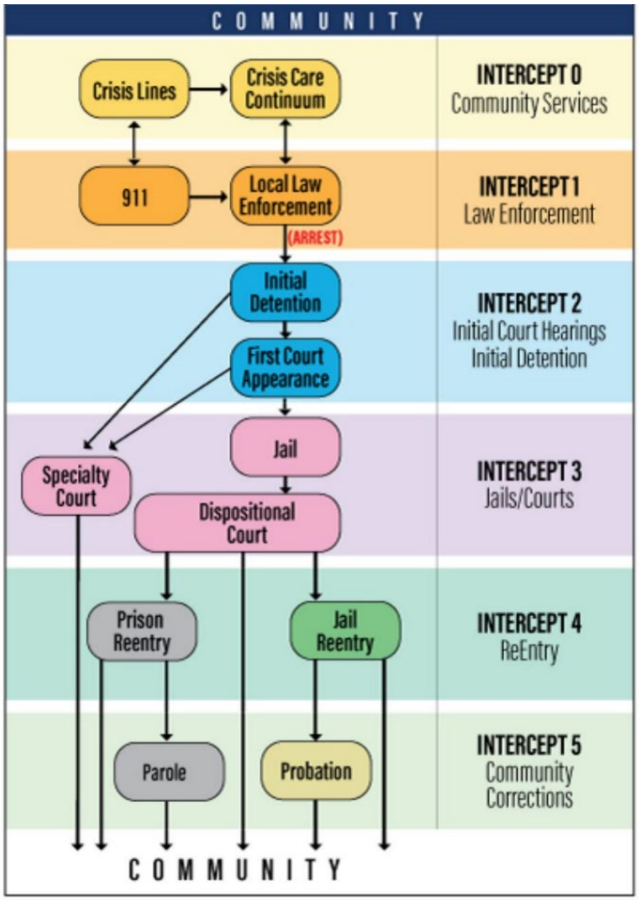


Figure 1: Sequential Intercept Model

Intercept 1: Law Enforcement

At this intercept, law enforcement and other providers look for opportunities to divert individuals to treatment rather than arresting or booking them. Again, the Access to a Crisis Continuum, discussed in an earlier section of this Plan, plays a key role. A notable program at this intercept is the Law Enforcement Intervention for Mental Health and Addiction (LIMA) in Clark County, in which the Judicial District and the Las Vegas Police Department refer individuals to treatment and services, such as withdrawal management, case management, and housing.

Intercept 2: Initial Court Hearing and Detention

At this and later intercepts, an emerging national consensus is that standardized evidence-based assessments of individuals' needs and risks are essential, particularly for individuals with behavioral health disorders to ensure they are quickly connected to needed treatments and services (Council of State Governments Justice Center, 2012). Nevada, for example, adopted statewide use of its Pretrial Risk Assessment in 2019 (Nevada Administrative Office of the Courts, 2019), and NRS 213.1078 established the use of such an assessment by the Division of Parole and Probation. Interventions at this intercept include:

- Pre-trial Community Supervision Programs;
- Pre-sentencing Investigation Reports; and
- Forensic Assessment Services Triage Teams (FASTT), which currently operate in Douglas, Lyon, Churchill, and Carson City as partnerships between jails and community providers to connect individuals to treatment and services.

Intercept 3: Jails/Courts

Interventions at this intercept include:

- Jail-based withdrawal management;
- An Opioid Treatment Program at the Washoe County Detention Center, which offers FDA-approved medications for opioid use disorder;
- Behavioral health treatment programming;
- Medication management; and
- Specialty Courts, including Medication-Assisted Treatment for SUD, Drug, Family Drug, Youth Offender, and Veteran Courts.

Intercept 4: Re-entry

NRS 176A had several re-entry provisions for the Department of Corrections, including requiring:

- The development of a reentry plan six months prior to release that considers community-based housing and treatment;
- Interagency collaboration regarding housing and treatment;
- That individuals leaving prison have a photo id, clothing, transportation, transitional housing (if available), Medicare or Medicaid enrollment (if eligible), and a 30-day prescription of existing medications.

Another notable intervention at this intercept includes the Re-Entry Court at the 8th Judicial District, which was designed to reduce overdoses and relapses upon re-entry.

Intercept 5: Community Corrections

NRS 176A.7 included new provisions for parole and probation to improve re-entry outcomes and decrease recidivism, including training regarding evidence-based practices and prohibiting probation revocation based solely on alcohol consumption or a positive drug test.

While these efforts hold promise, there are still considerable challenges. Throughout the nation, jails and prisons continue to serve as behavioral health institutions. About 20 percent of people in prison have an SMI and 30 to 60 percent have an SUD; some estimates are higher. More broadly, half of males and three-quarters of females in prisons—and slightly larger proportions in jails—will experience a mental health problem in any given year. An estimated 40 percent of people with SMI will spent time in jail, prison, or community corrections (Aufderheide, 2014). Nevada reported that 4.5 percent of the individuals served under SAMHSA's MHBG reside in prison or jail, nearly three times the national average of 1.5 percent (SAMHSA, 2020).

While Nevada has made progress across all intercepts, gaps remain. Many interventions are not available statewide. For example, Nevada currently has only two Assisted Outpatient Treatment (AOT) programs, which were authorized under NRS 176A.7. The number of individuals receiving these services has remained flat in northern Nevada, averaging about 70 per year, and has deceased in southern Nevada from a peak of 41 in fiscal year 2019 to 10 in fiscal year 2022 (DHHS, 2022). Similarly, some regions of Nevada lack specialty courts focused on behavioral health issues, and the number of people served by Adult Mental Health Courts declined by about half from fiscal year 2017 to fiscal year 2022 (DHHS, 2022).

One of the pressure points for states are requirements to admit people with gross misdemeanors or felonies in a timely manner. The number of people requiring admission has put a great burden on systems and has shifted priorities on the continuum of service to readiness to stand trial. Nevada has experienced increased need for services in forensic beds, with a decline in beds for civil commitments. Greater demand for court-ordered defendants, paired with staffing and fiscal constraints has reduced diversionary options with persons with SMI entering the forensic system. Interventions need to be in place—all along the intercept model.

Justice systems continue to disproportionately impact people of color. As an example, in Nevada in 2017, Black or African American people made up 9% of the total state population but made up 24% of people in jail and 31% of people in prison (Kang-Brown, n.d.).

Housing and other community supports for people that have a criminal history and behavioral health disabilities can be especially challenging. Sometimes, people exhaust housing options; adequate supervision and support may not be available, smaller communities may not have intensive supported living, and housing prices and inventory are issues that compound these challenges for communities that are working to keep people from reentering jails or being unhoused.

Strategies

1. **Continue implementation of the Sequential Intercept Model** across all intercepts. Ensure access to deflection, diversion, and re-entry services statewide, including Assisted Outpatient Treatment and Specialty Courts.
2. **Develop data systems to be able to routinely monitor successes and challenges with Sequential Intercept Model implementation**, such as
    a. rates of behavioral health disorders across criminal justice settings, including arrests associated with behavioral health;
    b. deflection and diversion rates, by type of intervention;
    c. completion rates from specialty courts;
    d. rates of housing, employment, and connection to treatment and services after re-entry; and
    e. recidivism rates for individuals with and without behavioral health disorders.
3. **Assess the impact of NRS 176A.7 and expand the associated programs and interventions that have had the most impact**. Evaluate the extent to which standardized assessments of needs and risks, across all criminal justice settings, have helped to connected people with behavioral health disorders to treatment and services.

4. **Expand statewide agreements through a summit on behavioral health in justice settings** (planned in 2023) that will bring together partners to identify strategies to improve outcomes for people with behavioral health concerns that interface with law enforcement and carceral systems.
5. **Strengthen systems of support for people post-release** to include compliance with medication, attendance in health sessions and appointments, connection to social support, and housing.
6. **Review the degree to which the application of cultural competence and cultural safety guidance has been effective** (in both juvenile and adult) justice settings.
7. **Consider a pilot and related study to determine if trauma-informed approaches in Nevada jails and prisons can improve outcomes for people with SMI**. Some states have had early success with these approaches.

Key Partners

Many sectors, agencies, and institutions play key roles deflection and diversion, including the following.

- DPBH
- DWSS
- Department of Corrections (DOC)
- Local jurisdiction-based MCTs
- People with lived experience
- Advocacy organizations
- NOHME
- State, county, and local law enforcement
- Court partners (judges, district attorneys, and public defenders)
- Emergency Medical Services (EMS) and other first responders
- Housing providers and organizations supporting people post-release

APPENDIX 1: SYSTEM OF CARE'S ARRAY OF SERVICES AND SUPPORTS

The System of Care is often referred to as principle-guided, rather than defined by a specified menu of services. However, some System of Care documents have identified components to consider in building the array. The following list, developed by the Institution for Innovation and Implementation (Stroul, Blau, & Larson), is provided as a reference.

Home and Community-Based Services

Screening
Assessment & Diagnosis
Outpatient Therapy
Medication Therapies
Tiered Care Coordination
Intensive Care Coordination
Intensive In-Home Mental Health Treatment
Crisis Response Services
Parent & Youth Peer Support
Trauma-Specific Treatments
Intensive Outpatient & Day Treatment
School-Based Mental Health Services
Respite Services (Including Crisis Respite)
Outpatient SUD Services
Medication Assisted Treatment for SUD
Integrated Mental Health & SUD Treatment
Therapeutic Behavioral Aide Services
Behavior Management Skills Training
Youth & Family Education
Mental Health Consultation (e.g., to Primary Care, Education)
Therapeutic Mentoring
Telehealth (Video & Audio)
Adjunctive & Wellness Therapies (e.g., Creative Arts Therapies, Meditation)
Social & Recreational Services (e.g., After School Programs, Camps, Drop-In Centers)
Flex Funds
Transportation

Residential Interventions

Treatment Family Homes
Qualified Residential Treatment Programs
Residential Treatment Services
Residential Crisis & Stabilization Services
Inpatient Medical Detoxification
Residential Substance Use Interventions

Promotion, Prevention, and Early Intervention

Mental Health Promotion Interventions
Prevention Interventions
Screening for Mental Health & SUD
Early Intervention
School-Based Promotion, Prevention, & Early Intervention

Specialized Services for Youth and Young Adults in Transition

Supported Education & Employment
Supported Housing
Youth & Young Adult Peer Support
Specialized Care Coordination (Including Focus on Life & Self-Determination Skills)
Wellness Services (e.g., Exercise, Meditation)

Specialized Services for Young Children and Their Families

EPSDT
Family Navigation
Home Visiting
Parent-Child Therapies
Parenting Groups
Infant & Early Childhood Consultation
Therapeutic Nursery
Therapeutic Day Care

APPENDIX 2: MEASURING PROGRESS ON PRIORITIES

A key component of implementing this BHCI Plan will include routine monitoring of progress in the priority areas discussed above. This monitoring could fall into two primary domains—policy changes and data indicators—discussed in more detail below. In alignment with the guiding principles of this Plan, monitoring the extent to which progress has been equitable, in particular for marginalized and under-represented groups, must be a priority. This could involve, for example, disaggregating data by race, ethnicity, LGBTQ+, veteran status, etc.

Monitoring Policy Changes

One method for measuring progress is to carefully track any policy changes that affect BHCI principles, goals, or priorities. Policies could include legislation, regulations, contracts, the Medicaid State Plan, funding and reimbursement decisions, certification standards, or clinical practice guidelines for providers. Policies can also direct organizational changes, such as the creation or elimination of staffing positions or services. In addition to tracking policy changes, the State must assess the impact of policy changes on BHCI principles, goals, or priorities, using, for example, the data indicators discussed below.

Establishing, Routinely Monitoring, and Publishing BHCI Data Indicators

A complementary method for measuring progress is to identify and routinely monitor key data or performance indicators. In addition to being feasible to measure, indicators must be clearly relevant to BHCI principles, goals, or priorities—in other words, relevant to the individuals affected by behavioral health disabilities.

Data Sources and Analytic Resources

According to the DOJ, in Nevada, "State agencies do not have good data on who is providing children's behavioral health services in the State, the needed capacity for community-based services, or the quality of services." That said, Nevada has some initial building blocks, including access to various data sources, as well as other analytic resources, that are needed to establish and monitor indicators. Examples of existing data sources and resources include:

- Medicaid claims and encounters data, along with reports such as Medicaid's annual Behavioral Health Report Card;
- Federally mandated reporting regarding Nevada's MHBG, including annual Uniform Reporting System (URS) reports;
- DHHS' Behavioral Health Chart Pack, managed by the Office of Analytics, which is based on reporting by hospitals and other service providers;

- DCFS's dashboard of Children and Youth and Out-of-State PRTFs, which only provides information about children who were transferred to PRTFs from foster care or juvenile justice systems;
- Nevada's Homeless Management Information System (HMIS);
- Nevada's System of Care Expansion Grant Strategic Plan, which includes a rich set of process and outcome measures relevant to BHCI (DCFS, 2020); and
- Nevada's all-payer Health Information Exchange.

Each resource has its limitations. For example, Medicaid data only captures information about Medicaid beneficiaries. On the other hand, while the URS reports on all individuals, regardless of insurance status, it does not cover the full ranges of services that Medicaid data covers. In later years, the State could focus on identifying and addressing gaps in its ability to track progress across all priority areas, expanding indicators and data sources as needed.

Nationally Recognized Indicators

Several national entities, both governmental and non-governmental, have developed indicators that are relevant this BHCI Plan's priority areas, such as:

- The Community Integration Self-Assessment Tool (CISA);
- CCBHC Quality Measures;
- National Core Indicators, which are focused on community integration and other goals for individuals with intellectual, developmental, aging, or physical disabilities; and
- Stepping Up, which supports counties to establish and reach measurable goals to reduce the prevalence of SMI across the justice system.

Sample Indicators by Priority

As a first step in establishing a minimum set of relevant indicators, the table below provides sample indicators for most of the priority areas discussed in this Plan. It was developed by researching national indicators, assessing Nevada's existing data sources and reports, and responding to input from the various stakeholders who informed this Plan.

As the State moves forward in operationalizing indicators, it will have to carefully define each—e.g.,

- The population to which the indicator applies
- Individuals with behavioral health disabilities
- Services and needs by age groups
- Socio-demographics of persons served

While the focus population is generally individuals with behavioral health disabilities, sometimes comparing indicators for individuals with and without disabilities may be valuable—for example, to determine whether admissions to juvenile justice settings are changing at different rates for these two populations.

- What timeframe should be included in the data—for example, is the lookback period one year?
- What limitations apply? For example, does the available data source only cover individuals insured by Medicaid?

Priority	Sample Indicators	Notes
System Lever Priorities		
Workforce Development and Sufficient Provider Network	1. # of graduates from Nevada high schools who pursue behavioral health fields 2. # of graduates from Nevada schools who choose to intern and practice in Nevada 3. Average time from graduation to licensure for new providers	• From AB 37 (2023 legislative session)
Sustainable Funding and Reimbursement	4. % of behavioral health expenditures for community-based care vs. psychiatric inpatient care 5. % of behavioral health expenditures for community-based care covered by Medicaid	• CISA indicator (#4) • Similar indicators reported in URS • #5 may be a good proxy for assessing sustainability—e.g., the extent to which funding for community-based services continues to be diversified and expanded beyond the MHBG, ARPA, etc.
Prevention and Upstream Interventions	6. # or % of children accessing early intervention service 7. # or % of children on wait list for early intervention services 8. Changes in the number of evidence-based programs and services available for children, youth, and families by community	

Priority	Sample Indicators	Notes
	9. Budget and community priorities to address social determinants of health to address disproportionality	
Priorities for Children and Youth		
Accessible Community-Based Services	10. # or % of individuals receiving home and community-based services, by type of service 11. # of ED visits for primary behavioral health condition 12. CCBHC Quality Measures (e.g., Suicide Risk Assessment, Depression Remission at 12 months	• Similar to CISA indicators • Several existing reports track usage of some community-based services—e.g., Behavioral Health Chart Pack, URS, Medicaid Behavioral Health Report Card
Appropriate Diversion from Institutional Settings	13. # or % of individuals admitted to institutional setting, overall and by type of setting (e.g., jail, PRTF) and by in-state vs. out-of-state	• Similar to CISA, Stepping Up, and URS indicators • Several existing reports track usage of some institutional settings—e.g., Behavioral Health Chart Pack, URS, Medicaid Behavioral Health Report Card
Transitions Back to the Community from Institutional Settings	14. # or % of admissions to institutional setting with length of stay (LOS) > 1 year 15. Average LOS 16. # or % of individuals who received home and community-based follow-up care after discharge	• See Notes in row above • Additionally, follow-up care and readmission rates are CCBHC indicators

Priority	Sample Indicators	Notes
	17. # or % of individuals readmitted to institutional setting(s)	
Priority for Young Adults in Transition The indicators for both Children/Youth and Adults apply to this population. It will be important to assess indicators by age group.		
Coordinated Transitions Paired with Specialty Services & Supports	18. # or % of individuals who are linked to educational, vocational, or employment services	• Similar to System of Care Expansion Grant indicator
Priorities for Adults Many of the indicators for children/youth also apply to adults. It will be important to assess indicators by age group. For adults, in addition to the indicators below, according to CISA, the State should consider monitoring indicators that assess the size of the at-risk population—e.g., # of individuals with (fatal, non-fatal) suicide attempts or the # or % with co-occurring SUDs.		
Access to a Crisis Continuum	19. Crisis Call Services a. Call Volume b. Speed of Answer c. Length of Call d. Abandonment Rate e. # connected to crisis bed f. # mobile teams dispatched	Key Performance Measures have been issued by SAMHSA, which will be integrated into all CRS provider contracts and the Call Center Hub contract. Dispensation of Calls, Mobile Teams, and CSU contacts will be collected through the Call Center Hub data system, when implemented.

Priority	Sample Indicators	Notes
	20. Mobile Teams a. # served per eight-hour shift b. Average response time c. % resolved in the community d. % transported to CSU and/or hospital 21. Crisis Stabilization Units a. # served b. % referrals accepted by source c. Average length of stay d. % reporting improvement in ability to manage future crises	
Access to Early Serious Mental Illness Services	22. # who accessed ESMI services	
Assertive Community Treatment Services	23. # or % of individuals who used ACT services	• URS indicator
Supportive Housing	24. # or % residing in HUD-subsidized units 25. # or % receiving housing services, by type of service 26. # or % who are homeless or housing insecure	• Similar to CISA, URS, Behavioral Health Chart Pack, and CCBHC indicators • Nevada's Homeless Management Information System is likely a key data source

Priority	Sample Indicators	Notes
Transportation	27. # or % of individuals who used Medicaid's non-emergency medical transportation	
Deflection and Diversion from Criminal Justice Systems	28. # or % who accessed deflection/diversion services, overall and by type of service (e.g., Mental Health Court)	• Behavioral Health Chart Pack tracks use of mental health court • Also, see indicators from the priorities "Appropriate Diversion from Institutional Settings" and "Transitions Back to the Community from Institutional Settings"

APPENDIX 3: GLOSSARY OF ABBREVIATIONS

ACE	Adverse Childhood Experience
ACRN	Advisory Committee for a Resilient Nevada
ADA	Americans with Disabilities Act
ADSD	Aging and Disabilities Services Division
ARPA	American Rescue Plan Act
BHCI	Behavioral Health Community Integration
CANS	Child and Adolescent Needs and Strengths
CASAT	Center for the Application of Substance Abuse Technologies
CCBHC	Certified Community Behavioral Health Clinic
CISA	Community Integration Self-Assessment
CMS	HHS Centers for Medicare & Medicaid Services
CRS	Crisis care response system
CSU	Crisis stabilization unit
DCFS	Division of Child and Family Services
DETR	Dept of Employment, Training, and Rehabilitation
DHHS	Nevada Department of Health and Human Services
DOJ	U.S. Department of Justice
DPBH	Division of Public and Behavioral Health
DWSS	Division of Welfare and Support Services
EPSDT	Early & Periodic Screening, Diagnostic, & Treatment
ESMI	Early serious mental illness
FEP	First-episode psychosis
FFPSA	Families First Prevention Services Act
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MHBG	Community Mental Health Services Block Grant
MTM	Medical Transportation Management, Inc.
NAMHS	Nevada Adult Mental Health Services
NAMI	National Alliance on Mental Illness
NDE	Nevada Department of Education
NOMHE	Nevada Office of Minority Health and Equity
NRS	Nevada Revised Statute
NSHE	Nevada System of Higher Education
PRTF	Residential treatment facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Severe emotional disturbance
SUD	Substance use disorder
SMI	Serious mental illness
UNLV	University of Nevada Las Vegas
UNR	University of Nevada Reno
URS	SAMHSA's Uniform Reporting System
WIN	Wraparound in Nevada

APPENDIX 4: BIBLIOGRAPHY

Acri, M., Hooley, C., Richardson, N., & Moaba, L. (2017). Peer Models in Mental Health for Caregivers and Families. *Community Mental Health Journal*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5555254/

Addington J. et al. (2015). Duration of untreated psychosis in community treatment settings in the United States. *Psychiatric Services*, 66(7):753-756.

ADSD. (2016). *A Plan to Guide Services for Older Nevadans and Persons with Disabilities.* Retrieved from https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Boards/COA/DHHS%20Olmstead%20Plan%20ADSD%20Strategic%20Plan%202016%20Final.pdf

American College of Physicians. (2019). *Transforming Clinical Practice Initiative.* Retrieved from Closing-the-Loop: https://innovation.cms.gov/files/x/tcpi-san-pp-loop.pdf

Annie E. Casey Foundation. (2015). *Too many teens - Preventing uneccesary out of home placements.*

Association of Children's Residential Centers. (2019, April). *Redefining Residential: Trauma Informed Practice: Moving Away from Point and Level Systems .* Retrieved from https://togetherthevoice.org/wp-content/uploads/2020/02/ACRC_position-paper-15.pdf

Aufderheide, D. (2014). Mental Illness In America's Jails And Prisons: Toward A Public Safety/Public Health Model. *Health Affairs*. doi:https://www.healthaffairs.org/do/10.1377/forefront.20140401.038180

Bohnenkamp, J. H., Hoover, S. A., Connors, E. H., Wissow, L., Bobo, N., & Mayzyck, D. (2019, July 2022). The Mental Health Training Intervention for School Nurses and Other Health Providers in Schools. *J Sch Nurs.* Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7036278/

Casanueva, C. H. (2019). *Evaluation in multiple sites of the Safe Babies Court Team™.*

Casanueva, C., Carr, C., C., Harris, S, C., & Burfeind, C. (2017). *Final evaluation report of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams.* Triangle Park, NC:: RTI International. Retrieved from https://www.zerotothree.org/document/1813

Case Western Reserve University: School of Applied Social Sciences: Center for Evidence-Based Practices. (n.d.). *Assertive Community Treatment*. Retrieved from https://case.edu/socialwork/centerforebp/practices/assertive-community-treatment

Center for the Study of Social Policy. (2019). *Integrating Promoatores Model to Strengthen Community Partnerships.* Retrieved from https://cssp.org/wp-content/uploads/2019/02/CSSP-Toolkit-4-RBA-Integrating-Promotores.pdf

Centers for Disease Control and Prevention. (n.d.). *What is Health Equity?* Retrieved from https://www.cdc.gov/healthequity/whatis/index.html

Clark County Children's Mental Health Consortium. (2021). *Status Report.* Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Meetings/ADA_CCCMHC_2021_Status_Report_1_29_21.pdf

CMS. (2015). *Coverage of Housing-Related Activities and Services for Individuals with Disabilities.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

Committee on Health and Human Services. (2021). SB 390. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Text

Condray, R. (2021, October 14). *Early Treatment Program for Early Serious Mental Illness.* Retrieved from DPBH: https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalBHSP/Meetings/Nevada_NAVIGATE_presentation.pdf

Council of State Governments Justice Center. (2012). *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery.* Retrieved from https://csgjusticecenter.org/wp-content/uploads/2020/02/9-24-12_Behavioral-Health-Framework-final.pdf

CSH. (2016). *Supporting Housing and Olmstead.* Retrieved from https://www.csh.org/wp-content/uploads/2012/12/olmstead-2016.pdf

CSH. (2022). *Summary of State Actions: Medicaid & Housing Services.* Retrieved from https://www.csh.org/wp-content/uploads/2022/02/Summary-of-State-Action-Medicaid-and-Supportive-Housing-Services-2022-02.pdf

CSH. (2022, March 31). *Washington Passes Historic Bill to Pair Affordable Housing With Supportive Services to Combat Homelessness*. Retrieved from

https://www.csh.org/2022/03/washington-passes-historic-bill-to-pair-affordable-housing-with-supportive-services-to-combat-homelessness/

DCFS. (2018). *Juvenile Justice System Reform Act of 2017: Implementation Guide.* Retrieved from https://dcfs.nv.gov/uploadedfiles/dcfsnvgov/content/Programs/JJ_Oversight_Commission/JJOC_Implementation_Guide.PDF

DCFS. (2020). *Nevada System of Care Expansion Grant: Strategic Plan 2019-2023.* Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Boards/RBHPB/Meetings/2018/NV%20SOC%20Rural%20Implementation%20_Strategic%20Plan%20_%20FINAL.pdf

DCFS. (2021). *Family First Prevention Services Act (FFPSA) in Nevada*. Retrieved from https://dcfs.nv.gov/Programs/CWS/FFPSA/

DCFS. (n.d.). *AB 150.* Retrieved from https://dcfs.nv.gov/ab150/workgroup/

DCFS Juvenile Justice Programs Office. (2022). *Juvenile Justice Annual Report.* Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/2021_Juvenile_Justice_Report.pdf

DCFS. (n.d.). *Nevada System of Care*. Retrieved from https://dcfs.nv.gov/Programs/CMH/SOC/Nevada_System_of_Care/

DHHS. (2022). *Behavioral Health Chart Pack*. Retrieved from https://app.powerbigov.us/view?r=eyJrIjoiZDQ0MmY5ZjAtOTEwMy00NTM1LTk1OGItNGQzZWY2YmQwOWNhIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

DHHS. (2022). *Biennial Report of the Advisory Committee for a Resilient Nevada .* Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/2022%20Nevada%20ACRN%20Report%20to%20DHHS.pdf

DHHS. (2022, April 8). *More than $36 million awarded to support behavioral health needs*. Retrieved from https://dhhs.nv.gov/Reports/Press_Releases/2022/More_than_$36_million_awarded_to_support_behavioral_health_needs/

DHHS Public Information Officer. (2022). *More than $43 million awarded to support behavioral health needs.* Carson City.

Dietz, E. W. (2017). A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. Retrieved from https://doi.org/10.1016/j.acap.2016.12.011

DOJ Civil Rights Division. (2022). *Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities.*

DOJ Civil Rights Division. (2022). *The Americans with Disabilities Act and the Opioid Crisis: combatting discrimination against people in treatment and recovery.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.rsat-tta.com/Files/ADA-opioid_guidance

DOJ Civil Rights Division. (n.d.). *Information and Technical Assistance on the Americans with Disabilities Act*. Retrieved from ada.gov: https://archive.ada.gov/olmstead/olmstead_about.htm

Dozier, M., Kobak, R., Sagi-Schwartz, A., Shauffer, C., van IJzendoorn, M., & Kaufman, J. (2014). Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association. *Am. J. of Orthopsychiatry*.

DPBH & NDE. (n.d.). *Nevada School-Based Toolkit.*

DPBH. (2018). *Program Guide.* Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/Overview/DPBH-Program-Guide.pdf

DPBH. (2022). *Nevada's 988 and Crisis Response Implementation Plan.* Reno: Social Entrepreneurs, Inc.

Emergency Telehealth and Navigation. (n.d.). *ETHAN program works to improve emergency transportation*. Retrieved from Team Health: https://www.teamhealth.com/news-and-resources/featured-article/ethan-program-works-to-improve-emergency-transportation/?r=1

Faria, A. e. (2020). *The Safe Babies Court Team Evaluation: Changing the Trajectories of Children in Foster Care.* American Institutes of Research. Retrieved from https://www.air.org/sites/default/files/Safe-am-Evaluation-FINAL-092520.pdf

Fusar-Poli, P., McGorry, P., & Kane, J. (2017). Improving outcomes of first-episode psychosis: an overview. . *World Psychiatry*, 16 (3): 251-265.

Girnus, A. C. (2022, April 25). Lack of mental health resources increases demand on Nevada's child welfare system say adminstrators . *Nevada Current*. Retrieved from https://www.nevadacurrent.com/2022/04/25/lack-of-mental-health-resources-increases-demand-on-nvs-child-welfare-system-say-administrators/

Golonka, S. (2022, August 17). Parents, lawmakers praise $200 million investment in public and mental health funding. *The Nevada Independent*. Retrieved from https://thenevadaindependent.com/article/parents-lawmakers-praise-200-million-investment-in-public-and-mental-health-funding

Guinn Center. (2014). *Nevada's Mental Health Workforce: Shortages and Opportunities.* Retrieved from https://guinncenter.org/wp-content/uploads/2014/10/Guinn-Center-Policy-Brief_Mental-Health-Workforce-Final.pdf

Health Services Advisory Group. (2020). *DHCFP Quality Strategy.* Nevada Medicaid. Retrieved from https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf

HHS. (2021, December 7). U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic.

Home | SOAR Works! . (n.d.). Retrieved from https://soarworks.samhsa.gov/

HUD. (2013). *Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of Olmstead.* Retrieved from https://www.hud.gov/sites/documents/OLMSTEADGUIDNC060413.PDF

Institute for Innovation and Implementation. (2021). *The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families.* Retrieved from https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

Jonas, K., Fochtmann, L., & Perlman, G. e. (2020). Lead-time bias confounds association between duration of untreated psychosis and illness course in schizophrenia. *Am J Psychiatry;*, 177(4):327-334.

Kaiser Family Foundation. (2016). *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers.* Retrieved from https://files.kff.org/attachment/issue-brief-medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers

Kaiser Family Foundation. (2017). *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples.* Retrieved from https://files.kff.org/attachment/Issue-Brief-Linking-Medicaid-and-Supportive-Housing-Opportunities-and-On-the-Ground-Examples

Kaiser Family Foundation. (2022, August 22). *Mental Health Parity at a Crossroads*. Retrieved from kff.org/private-insurance/issue-brief/mental-health-parity-at-a-crossroads/

Kang-Brown, J. (n.d.). *Incarceration trends in Nevada Fact Sheet* . Retrieved from Vera.or: www.vera.org/downloads/pdfdownloads/state-incarceration-trends-nevada.pdf

Kang-Yi, C. D., Wolk, C. B., Locke, J., Beidas, R., Lareef, I., Pisciella, A. E., . . . Mandell, D. S. (2018). Impact of School-Based and Out-of-School Mental Health Services on Reducing School Absence and School Suspension among Children with Psychiatric Disorders. *Eval Program Plann*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5835186/

Kuhn, E. S., & Laird, R. (2014). Family support programs and adolescent mental health: review of evidence. *Adolesc Health Med Ther.*

Legislative Counsel Bureau. (2020). *Criminal Justice Reform in Nevada.* Retrieved from https://www.leg.state.nv.us/Division/Research/Documents/Justice-Reinvestment-Initiative-2020.pdf

Medicaid.gov. (2019). *Medicaid Per Capita Expenditures*. Retrieved from Medicaid.gov: https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html#2019-met-expenditures

Medicaid.gov. (2021). *State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services*. Retrieved from Medicaid.gov: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html

Mental Health America. (n.d.). Retrieved from Racism and Mental Health: https://www.mhanational.org/racism-and-mental-health

Mental Health America. (n.d.). *Native and Indigenous Communities and Mental Health*. Retrieved from https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health

Munir, K. (2022). The co-occurrence of mental disorders in children and adolescents with intellectual disability/intellectual developmental disorder. *Curr Opin Psychiatry*, 95–102.

NAMI. (n.d.). *Psychosis*. Retrieved from https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis

National Academies of Sciences, Engineering, and Medicine; Division, Health and Medicine. (2020). *Board on Global Health; Global Forum on Innovation in Health Professional Education;.* (C. P. Forstag EH, Ed.) Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK563948/

National Association of State Mental Health Program Directors. (2004). *Serving individuals with co-occuring develpmentmental disablities and mental illnesses: system barriers and strategies for reform.*

National Conference for State Legislatures. (n.d.). *The Mental Health Needs of Juvenile Offenders.* Retrieved from https://www.ncsl.org/documents/cj/jjguidebook-mental.pdf

NDE. (n.d.). *School Based Mental Health Services Grant/Subrecipient Opportunity*. Retrieved from https://doe.nv.gov/layouts/Page_Style_1.aspx?id=334252

Nevada Administrative Office of the Courts. (2019). *Committee Materials related to Pre-Trial Risk Assessment*. Retrieved from https://nvcourts.gov/supreme/news/nevada_pretrial_risk_assessment_training_created_for_nevada_justice_system

Nevada Interagency Council on Housing and Homelessness. (2022). *Strategic Issues and Goals.*

Nevada Legislature. (2013). *AB 488*. Retrieved from Nevada Legislature: https://www.leg.state.nv.us/Session/77th2013/Bills/AB/AB488_EN.pdf

Nevada Legislature. (2021). *AB 181*. Retrieved from Nevada Legislature: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7551/Text

Nevada Medicaid. (2021). *Billing Guide: Non-Emergency Secure Behavioral Health Transports.* Retrieved from

https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT35_Spec_987.pdf

Nevada Medicaid. (2022, May). Telehealth. Retrieved from https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/MCAC/2022/MCAC_05-25-22_Telehealth_Presentation.pdf

Nevada Medicaid. (n.d.). *Nevada CCBHCs*. Retrieved from Nevada Medicaid: https://dhcfp.nv.gov/Pgms/CCBHC/CCBHC_Main_NEW/

Nevada Medicaid. (n.d.). *Rate Analysis & Development*. Retrieved from Nevada Medicaid: https://dhcfp.nv.gov/Resources/Rates/AB_108_Reviews/

Nochaiwong, S., Chidchanok , R., Kednapa , T., Hutton, B., Awiphan, R., & Chabaphai, P. (n.d.). Global prevalence of mental health issues among the general population during the coronavirus disease-2019 pandemic: a systematic review and meta-analysis. *Nature*.

NOMHE. (2020). *Update on Nevada's Health Disparities.* Prepared for Nevada State Legislature. Retrieved from http:s//efaidnbmnnnibpcajpcglclefindmkaj/https://dhhs.nv.gov/uploadedFiles/dhhs.nv.gov/content/Programs/CHA/MH/DHHS_NVHealthDisparities.pdf

Nordentoft, M., Jeppesen, P., & Elgaard Thorup, A. A. (2021). Prevention in the mental health field should be implemented synergically at different levels. *World Psychiatry*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8129867/

Norris, L. (2022, February 22). *Nevada and the ACA's Medicaid expansion*. Retrieved from Health Insurance Org: https://www.healthinsurance.org/medicaid/nevada/

Oduola, S., Craig, T., & Morgan, C. (2021). Ethnic variations in duration of untreated psychosis: report from the CRIS-FEP study. . *Social Psychiatry and Psychiatric Epidemiology*, 56:931-941.

Perälä J, S. J. (2007). Lifetime prevalence of psychotic and bipolar I disorders in a general population. *Arch Gen Psychiatry*, 64:19-28.

Policy Research Associates. (2022). *The Sequential Intercept Model*. Retrieved from https://www.prainc.com/sim/

Potter, S. (2021). Nevada Gets a D+ for Children's Mental Health: Report. *Public News Service*. Retrieved from https://www.publicnewsservice.org/2021-10-12/mental-health/nevada-gets-a-d-for-childrens-mental-health-report/a76093-1

Rural Children's Mental Health Consortium. (2021). *Annual Report.* Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Meetings/RCMHC_Annual_Report_January_2021.pdf

SAMHSA. (2017). *Family, Parent and Caregiver Peer Support in Behavioral Health.* Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf

SAMHSA. (2019). *Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System.* Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf

SAMHSA. (2020). *Nevada 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System.* Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt35309/Nevada.pdf

SAMHSA. (2021). *988 and the National Suidice Prevention Lifeline.* Retrieved from https://www.vibrant.org/wp-content/uploads/2020/07/988_two_pager_2021-2.pdf

SAMHSA. (2022). *National Guidelines for Children and Youth Behavioral Health Crisis Care.* Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf

SAMHSA Center for Mental Health Services. (2020). *National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit.* Rockville: SAMHSA.

SAMHSA Center for Mental Health Services. (2022). *National Guidelines for Child and Youth Behavioral Health Crisis Care.* Rockville, MD: www.samhsa.gov.

SAMHSA. (n.d.). *NV Discretionary Funding Fiscal Year 2021*. Retrieved from https://www.samhsa.gov/grants-awards-by-state/NV/discretionary/2021/details

SAMHSA. (n.d.). *Section 223 Demonstration Program for Certified Community Behavioral Health Clinics.* Retrieved from https://www.samhsa.gov/section-223

SAMHSA. (n.d.). *Worforce*. Retrieved from https://www.samhsa.gov/workforce

Social Entrepreneurs, Inc. (2020). *Nevada's Crisis Care Response System, 2020 Statewide Assets and Gaps Analysis.* Carson City: State of Nevada Department of Health and Human Services.

Stroul, B. A., Blau, G. M., & Larson, J. (n.d.). *The evolution of the system of care appraoch for children, youthk and young adults with mental health conditions and thier famiilies.* The Institute for Innovation & Implementation, University of Maryland School of Social Work.

Tai, D., Sia, I. G., Doubeni, C. A., & Wieland, M. L. (2022). Disproportionate Impact of COVID-19 on Racial and Ethnic Minority Groups in the United States: a 2021 Update. *J Racial Ethn Health Disparities*, 2334-2339.

The White House. (2022, October 18). *Statement by President Joe Biden on New Mental Health Funding*. Retrieved from https://www.whitehouse.gov/briefing-room/statements-releases/2022/10/18/statement-by-president-joe-biden-on-new-mental-health-funding/

Treatment Alternatives for Safe Communities. (2016). *Medicaid Policy Series: Presumptive Eligibility for Individuals Involved in the Justice System.* Retrieved from https://www.centerforhealthandjustice.org/tascblog/Images/documents/Publications/MedicaidPolicySeries-PresumptiveEligibility.pdf

U.S. Department of Education. (n.d.). *National Longitudinal Transition Study 2012*. Retrieved from Institute of Education Sciences: https://ies.ed.gov/ncee/projects/evaluation/disabilities_nlts2012.asp

U.S. Department of Education, Office of Primary and Secondary Education. (2022, November). *Full-Service Community Schools Program (FSCS)*. Retrieved from https://oese.ed.gov/offices/office-of-discretionary-grants-support-services/school-choice-improvement-programs/full-service-community-schools-program-fscs/

U.S. Department of Education's Office of Special Education and Rehabilitative Services. (2022). *A Framework for Community Engagement: A Pathway to Competitive Integrated Employment.* Retrieved from https://rsa.ed.gov/sites/default/files/subregulatory/A%20Framework%20for%20Community%20Engagement_0.pdf

U.S. Health Resources & Services Adminstration. (n.d.). *Health Providers Shortage Areas*. Retrieved from https://data.hrsa.gov/tools/shortage-area/hpsa-find

U.S. HHS Administration for Children & Families. (n.d.). *State vs. County Administration of Child Welfare Services*. Retrieved from Child Welfare Information Gateway: https://www.childwelfare.gov/pubs/factsheets/services/

UNR Office of Statewide Initiatives' Nevada Health Workforce Research Center. (2019). Health Workforce Supply and Demand in Nevada: Implications for Network Adequacy. Retrieved from https://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Insurers/Griswold_Network_Adequacy_Presentation_3-12-20.pdf

Washoe County Children's Mental Health Consortium. (2021). *Annual Report.*

Woodard, S. (2022, August). Senior Advisor on Behavioral Health, DHHS. *Sequential Intercept Model: Intersection Between Criminal Justice and Behavioral Health.*

World Health Organization. (2002). Prevention and Promotion in Mental Health. Retrieved from http://efaidnbmnnnibpcajpcglclefindmkaj/https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf

Youth.gov. (2013). *Implenting a Trauma Informed Approach for Youth Accross Sectors.* Retrieved from https://youth.gov/docs/Trauma_Informed_Approach_508.pdf

Youth.gov. (n.d.). *Mental Health Promotion and Prevention*. Retrieved from https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/#26

APPENDIX 5: SUMMARY OF STRATEGIES BY PRIORITY

Strategies by priority are consolidated to support implementation.

Plan Priority	#	Summary of Strategy
System: Workforce	1	**Elevate and support the efforts of the Nevada Healthcare Workforce and Pipeline Development Workgroup.** This group, which began meeting in early 2022 and will continue through June 2023, is working to identify and address gaps across the entire workforce pipeline. As an initial step, they recently completed a state survey of existing workforce development initiatives. Their focus is rural and underserved communities in three key areas: public health, primary care, and behavioral health. In each area, the Workgroup is developing a "workforce pipeline development plan" that will define the entry points into the pipeline—including both traditional and non-traditional pathways (e.g., engaging adults)—and clear milestones for making progress towards careers of choice. This multi-sector effort aims to "reduce redundancies, leverage partnerships, enhance information sharing, and facilitate stakeholders' pursuit of funding opportunities."
System: Workforce	2	**Consider adopting models used by other states—such as Nevada's Behavioral Health Education Center—to pursue and monitor workforce goals**—i.e., increase the number of graduates who pursue behavioral health fields and who choose to intern and practice in Nevada, increase the number of providers who have the specialty training to fill the State's most critical provider shortages, and decrease the time from graduation to licensure for new providers. Recruitment and retention strategies for the state workforce providing direct behavioral health services are particularly critical: currently, the state has a 40 percent vacancy rate.
System: Workforce	3	**Continue to expand efforts to support primary care providers, who can serve as critical behavioral health workforce extenders**, when they are provided with the necessary support, continuing education, and consultation. One current example is Nevada's Pediatric Access Line that provides free psychiatry consultation to primary care clinicians.
System: Workforce	4	**Recruit, support, and retain a diverse workforce, inclusive of race/ethnicity, culture, language, and other dimensions of identity and**

		experience. A 2020 National Academies publication identified the following critical elements for recruiting, supporting, retaining, and promoting a diverse workforce. These were organizational support, opportunity to be authentic, support for students and professionals, integration with community, mentorship, community definitions of well-being and success, and self-care and support.
System: Workforce	5	**Modify Medicaid's State Plan to allow community health workers to work under behavioral health providers.** (A 2021 law allowed Medicaid to pay community health workers, but not under behavioral health providers.) One focus of the Workgroup, discussed above, is the promise and expansion of community health workers as a provider extender for behavioral health.
System: Workforce	6	More broadly, **adjust Medicaid rules and procedures to facilitate increased participation from behavioral health providers**. According to the DOJ, Nevada "could reasonably modify its [Medicaid] system by... supporting and managing its provider network to increase quality and access." a. For example, Medicaid providers caring for youth should be paid higher rates to account for the higher complexity involved in treating this population, including engaging families, schools, and other child-serving systems. b. Explore allowing behavioral health providers to individually enroll in Nevada Medicaid to work in primary care or other healthcare settings.
System: Workforce	7	**Explore other options for expanding the workforce that can serve individual with behavioral health disabilities.** For example, a. Expand the use of interstate licensure compacts to smooth the process of becoming a provider in Nevada. Currently, Nevada is only part of the Psychology Interjurisdictional Compact. b. Recruit behavioral health practitioners via J-1 visas. c. Consider creating parity between not-for-profit and for-profit behavioral health providers by allowing the latter to compete for state and federal funds to expand behavior health services.
System: Workforce	8	**Improve access to and routinely analyze high-quality workforce data**. Nevada's ability to better understand and address its workforce

		shortages is limited by the lack of high-quality workforce data—e.g., from licensing boards, Medicaid, and other insurers. NRS 439A, enacted in 2021, partially addressed this issue but needs strengthening. One strength is the UNR Nevada Health Workforce Research Center in the Office of Statewide Initiatives, which has extensive knowledge and experience analyzing and interpreting data. See, for example, their Tenth Edition of the Nevada Rural and Frontier Health Data Book.
System: Workforce	9	**Expand student loan repayments** for all levels of behavioral health professionals serving shortage areas, publicly funded healthcare, and behavioral health systems. One opportunity is to build on the existing state loan repayment program out of the UNR School of Medicine's Nevada Health Service Corps, which is a federal/state grant partnership with $1 million in funding for loan repayment in the current biennium. Another approach to loan repayments, which would also incentivize Medicaid participation, is a state-wide, Medicaid-funded program, such as the CalHealthCares program in California.
System: Workforce	10	**Increase salaries of clinical staff and higher education faculty to be more competitive**. Bolster recruitment and retention of state employees who provide direct behavioral health services by adjusting compensation or other benefits, as needed. Maintain appropriate staffing levels within state direct services, prioritizing recruitment and retention with devoted resources toward clinical staff and higher education faculty (in areas of clinical training).
System: Funding & Reimbursement	1	**Increase efforts to leverage federal Medicaid funding as a key path to sustainability.** a. Continue to utilize ARPA and other grant funding as a bridge to sustainability by concurrently aligning the Medicaid State Plan to the new grant-funded services. b. Continue efforts to develop bundled rates where appropriate. c. Continue to support the sustainability of school-based behavioral health services by onboarding all school districts to billing Medicaid and other payers whenever possible, instead of using education dollars. d. Explore options for increased Medicaid enrollment—as well as improved access to care—for individuals re-entering the community

		from criminal justice setting. For example, many states use presumptive Medicaid eligibility strategies.
System: Funding & Reimbursement	2	**Explore feasibility and appropriateness of all Medicaid authorities** to support sustainability of the state's investment in developing home and community-based services and supports for children's behavioral health including but not limited to waiver authorities, state plan authorities, and managed care models.
System: Funding & Reimbursement	3	**Ensure that Medicaid reimbursement rates and policies support providers in performing necessary behavioral health services** to Medicaid eligible individuals and to support increased access and quality of care to the services most needed by individuals with behavioral health disorders. As a first step, for the quadrennial rate review process authorized by AB 108, Nevada Medicaid should 1) educate the provider network to support understanding of how the quadrennial rate reviews are a necessary step in communicating the need for rate increases for services and 2) continue to conduct extensive marketing and outreach to existing behavioral health providers to ensure robust participation.
System: Funding & Reimbursement	4	**Fully fund and certify all CCBHCs, including those currently funded by SAMHSA.**
System: Funding & Reimbursement	5	**Monitor the proportion of behavioral health expenditures dedicated to community-based, rather than institutional care** to ensure that Nevada is prioritizing the former. Expand monitoring beyond MHBG—e.g., by including Medicaid and third-party claims and encounters.
System: Funding & Reimbursement	6	**Consider reinvesting resources saved through diversion and deflection from criminal and juvenile justice settings to community-based behavioral health services**. For adults, NRS 176.0129 provides authority for such reinvestments; a similar approach for youth may prove valuable.
System: Funding & Reimbursement	7	**Leverage Title IV-E funding to expand services for children in foster care and those at risk of removal.**

System: Funding & Reimbursement	8	**Operationalize enforcement of Nevada's 2021 law regarding mental health parity for health care insurers (NRS 687B.404)**.
System: Funding & Reimbursement	9	**Through SUPPORT Act Planning Grant, continue improvement and awareness of substance use treatment and expansion of services through the 1115 demonstration waiver**.
System: Authority, Oversight & Coordination	1	**Establish a single Nevada Behavioral Health Authority** to ensure clear lines of leadership, oversight, and accountability. Clearly define leadership roles and responsibilities, authority, and oversight of the public behavioral health system and align with proposed statutory changes, regulations, policies, memoranda of understanding, and other formal mechanisms. The goal of this single Behavioral Health Authority is to reduce fragmentation and diffusion of authority within DHHS and across the state. This new umbrella Authority would: a. Define, delineate, and operationalize other related authorities, such as the Children's Behavioral Health Authority, State Mental Health Authority, and State Mental Health Agency. b. Develop policies and procedures aligned to best practices to avoid unnecessary institutionalization and segregation. c. Develop standards of care and provide training and technical assistance for providers, including topics such as System of Care principles and high-fidelity wraparound. d. Collect and analyze information to determine who is providing what services and to what extent the current array of services meets the needs of individuals and families. e. Continue efforts to develop "no wrong door" or single point of entry for services and supports in Nevada. As one example, New Jersey has one phone number that families can call for information about behavioral health, SUDs, and developmental disabilities. f. Ensure that all Nevadans including individuals affected by SED/SMI, government staff, and providers can access clear information about the resources, roles, and responsible entities for services related to behavioral health. g. Explore or expand capabilities for close-loop referrals to help people to access support for other social determinants of health.

System: Authority, Oversight & Coordination	2	**Create a DHHS oversight body for community integration that is responsible for reviewing progress for this BHCI Plan across all Divisions**, alongside the ADSD Olmstead Plan. This oversight body would fall under the Behavioral Health Authority, once established.
System: Authority, Oversight & Coordination	3	**Continue development and expansion of the Children's System of Care.** The Behavioral Health Authority should provide the leadership and authority to establish the cross-agency governance structures needed for a robust Children's System of Care. a. Improve coordination and communication across Departments (e.g., health, educations, corrections, employment) through an interagency leadership team, as well as across DHHS Divisions. Consider further development of memoranda of understanding to clarify relationships between agencies; these can address, for example, a shared commitment to trauma-informed practice and System of Care principles. b. To better serve children with co-occurring intellectual and developmental disabilities and their families, develop and implement tailored, cross-agency approaches. Identify and address the gaps that providers face in better serving this population through professional development and team approaches to care and support. c. Work with NSHE to ensure adequate coursework in dual diagnosis is included into all behavioral health educational curriculum. d. Leverage the experience and leadership of the Children's Mental Health Consortia by including them in the governance structure.
System: Authority, Oversight & Coordination	4	**Exercise robust oversight of community-based providers.** The State should ensure that community-based behavioral health services are of sufficient quality to allow individuals with behavioral health disabilities to remain in their homes and communities, where appropriate. a. Strengthen the processes to review providers' use of evidence-based and well-supported programs and services. b. Strengthen protocols to monitor safety and quality of services and supports.
System: Authority,	5	**Exercise robust oversight and quality assurance in institutional settings**, including hospitals, PRTFs, congregate care settings, and criminal justice settings.

Oversight & Coordination		
System: Authority, Oversight & Coordination	6	**Elevate family choice and voice within the Behavioral Health Authority governance structure, ensuring opportunities for meaningful input related to planning, designing, and improving systems.** Engagement of individuals, inclusive of children, youth, and families, impacted by behavioral health disabilities is a key path to achieving equity in health outcomes and community integration. a. Engage individuals and families to help prioritize which services to stand up first. b. Strengthen family advisory structures at state and local levels; consider elections, compensation for roles, and other ways to formalize a community voice. c. Provide training and guidance for decision makers on ways to better hear and incorporate the experiences of people with lived experience.
System: Authority, Oversight & Coordination	7	Within individual settings—including school, criminal and juvenile justice, child welfare, and health care settings—**continue work toward universal screenings and assessments for behavioral health**. In addition, identify opportunities to adopt shared tools across settings, as well as other practices to improve coordination and communication across settings and timely access to the most appropriate care**.**
System: Authority, Oversight & Coordination	8	**Improve the process for making and tracking SMI/SED determinations.** Consider adopting the model used in or similar to the one used in Arizona.
System: Prevention & Upstream	1	**Invest in early intervention**, both throughout the lifespan and early in the onset of illness. a. Increase use of Medicaid's tool for EPSDT to identify opportunities to connect children and youth to appropriate services and supports. b. For youth and adults, intervention in early stages of psychosis can improve outcomes. c. Continue and expand efforts to support primary care providers, who can serve as critical behavioral health workforce extenders, when

		they are provided with the necessary support, continuing education, and consultation. d. Encourage primary care settings (including pediatrics) to integrate behavioral health professionals into health care settings.
System: Prevention & Upstream	2	**Continue investment in Nevada's Multi-Tiered Systems of Support and Social-Emotional Learning in all K–12 schools**, as recommended by ACRN. a. Full-Service Community Schools provide an opportunity to coordinate mental health alongside other important community services.
System: Prevention & Upstream	3	**Increase support for families**. Family stress can be both a contributor to and a result of mental health problems in youth. Family support programs can improve youth mental health by reducing stress within the family.
System: Prevention & Upstream	4	**Increase the number of people trained to offer trauma-informed approaches across sectors and over the lifespan**. a. Offer trauma-informed training to all provider types, not just primary care providers, as well as to school personnel. b. Use Mental Health First Aid in both school and primary care settings to educate individuals about childhood trauma and available resources. c. Provide education on recognizing the signs of trauma and providing appropriate treatment to facilitate earlier intervention and prevention efforts, as recommended by ACRN. d. Explore opportunities to provide ACE certification for training across the state.
System: Prevention & Upstream	5	**Attend to social determinants of health and their roles in both prevention and promotion**. Social determinants of health include but are not limited to economic stability, social and community contexts, neighborhoods and built environments, health care quality and access, and education. Structural racism and discrimination contribute to disparities across health outcomes; efforts to address these root causes support individuals and families including those impacted by behavioral health and other disabilities. Designing services and systems that

		address inequities in social determinants is a key path to achieving equity in health outcomes and community integration.
System: Prevention & Upstream	6	**Expand culturally relevant strategies, co-designed by and for communities**. The entire service delivery system (including primary care clinics, dentists, schools, etc.), must build the cultural competence to equitably welcome and serve individuals with behavioral health disabilities—including those with co-occurring disabilities. Community health workers and promotores provide examples of strategies that can help build health literacy and connect people to resources. Mental health prevention and promotion for native and indigenous people and on tribal lands should be relevant to the cultural factors and community context.
Children & Youth: Community-Based Services	1	**Continue to stand up the array of essential community-based services** to ensure that quality care from culturally informed providers is available to families at the time, at the location, and in the language needed. (See, for example, System of Care's Array of Services and Supports, an Appendix in this Plan.) Use ARPA as bridge funding while concurrently expanding access via changes to Medicaid. Adjust rules that impose limitations on the amount and frequency of needed services that disproportionately harm children with the highest needs.
Children & Youth: Community-Based Services	2	**Expand the use of behavioral health screening and assessment tools across settings.** In clinical settings, as part of the required Medicaid EPSDT benefit, leverage Medicaid as a resource to enforce or incentivize behavioral health screenings. In addition, explore options for incentivizing screenings and assessments across all payer types.
Children & Youth: Community-Based Services	3	**Set up high quality residential treatment to bring Nevada beds to national standards.** Reduce and eliminate the number of children leaving the State for residential care. In the long term, work to reduce the use of residential care for youth overall.
Children & Youth: Community-Based Services	4	**Use authority and oversight to ensure that services and supports for children and youth are evidence-based whenever possible,** with allowances for well-supported programing when evidence-based programs are not available.
Children & Youth:	5	**Strengthen pathways for engaging the voices of children and their families in program planning and improvements.** This strategy is

Community-Based Services		aligned with the Children's Mental Health Consortia's objectives and growing experience. Examples include having "Youth and Family Voice" as a dedicated agenda item and exploring options to add a youth representative as a voting member.
Children & Youth: Community-Based Services	6	**Develop training and certification for family peer support providers and include these services in Medicaid's service array**. Training and certification will advance ethical practice, minimum standards, and core competencies.
Children & Youth: Community-Based Services	7	**Expand resources for early intervention by further integrating behavioral health into primary care.** This is especially important for very young children and their families. DCFS' Pediatric Mental Health Care Access project, funded via the federal Health Resources and Services Administration, which began enrolling providers in 2020 and addresses the integration of mental health into pediatric primary care, provides one avenue to address this gap.
Children & Youth: Community-Based Services	8	**Improve mobile crisis response and stabilization to meet the needs of children and their families, which differ from the needs of adults.** Ensure that these services are delivered by individuals who are specifically trained to work with children and families in crisis. National standards for children and youth include several critical elements, such as: a. a face-to-face, timely response without the involvement of law enforcement; b. eight weeks of follow-up; c. working step-by-step to ensure that the youth is ready for each intervention; and d. considering the needs and dynamics of the whole family. Establish protocols for schools to work with mobile crisis response in a manner that respects families' critical roles and engage juvenile justice partners in mobile crisis to support diversion efforts.
Children & Youth: Community-Based Services	9	**Continue and expand collaboration for integration across settings** such as in homes, schools, clinics, other community-based settings, and institutional settings.

Children & Youth: Community-Based Services	10	Based on input from families that have navigated systems, **work to address and take down barriers to service access**.
Children & Youth: Community-Based Services	11	**Work toward integrated data systems and data sharing agreements among child-serving agencies.** Leverage the experience gained by Nevada school districts who are currently piloting data systems. Integrated data systems provide families, caregiving professionals, and policy makers timely access to information to make critical decisions.
Children & Youth: Community-Based Services	12	**Continue to develop and expand evidence-based practices for services to youth in foster care through the FFPSA and Title IV-E Plan.**
Children & Youth: Diversion from Institutions	1	**Provide oversight and management to properly assess children and youth at risk of being institutionalized**. Ensure that children who are appropriate for community-based services are not sent to PRTFs; care teams (rather than individual assessors) should make determinations about which children are appropriate for PRTF admissions. Children are not unnecessarily sent to a more restrictive setting, such as juvenile justice, in lieu of a less restrictive setting, such as residential treatment. A key strategy for diverting children from unnecessary placements is state oversight and management such as the establishment of a robust Children's Behavioral Health Authority. A core authority function will be to establish protocols and processes for 1) assessing children at serious risk of institutional placement to determine whether their needs can be met via community-based services and, if so, 2) quickly connecting them to appropriate services. The protocols would, for example, establish when such assessments should be administered.
Children & Youth: Diversion from Institutions	2	**Support emerging crisis response and stabilization services, with attention to national best practices for children and youth**. This can include implementing the recently published national guidelines for children's crisis care, which differ from the guidelines for adults.
Children & Youth:	3	**Provide oversight to routinely and systematically assess why children are placed under institutional care to prevent future unnecessary**

Diversion from Institutions		**placements**. Review data including race, ethnicity, and other information to help identify inequities in institutional placements.
Children & Youth: Diversion from Institutions	4	**Periodically assess the sufficiency of Nevada's PRTF capacity**. While it continues to shift resources away from institutional settings and towards community-based services, Nevada should also ensure that: a. Children who need PRTF care can receive that care in Nevada. b. Children are not denied PRTF admission because their needs are too high. Stakeholders report, for example, that some PRTFs refuse to admit children with aggression issues. c. When an PRTF is appropriate, children can access this care directly from the community, without the need for a hospital or emergency department to act as a gatekeeper. d. As recommended by the Nevada Commission on Mental and Behavioral Health, ensure that necessary PRTF care is not impeded by low staffing due to insufficient payment rates to frontline behavioral health workers.
Children & Youth: Diversion from Institutions	5	**Engage juvenile justice partners to deflect and divert children with behavioral health issues into more appropriate settings**. a. Expand standardized crisis intervention training (inclusive of law enforcement and other first responders) that includes a robust component on children and youth behavioral health. b. Continue to engage courts in the goals of the BHCI Plan through the development and expansion of specialty courts. Review opportunities for new court models that meet specific needs, such as domestic violence court for youth. c. Standardize or elevate training for judges to understand best practices for youth and behavioral health. d. Expand adoption of the One Family One Judge model, required by NRS 3.025, to minimize conflicts and maximize connections to appropriate services
Children & Youth: Transitions to Community	1	**Ensure successful discharge planning**. Discharge planning should begin at admission, regardless of the institutional settings (e.g., PRTF, juvenile justice, shelter). Additionally, the success of this priority relies heavily on the success of the earlier priority, Accessible Community-Based Services (a section in this Plan), including access to intensive in-home supports and services, WIN, respite, and re-entry specific services. However,

		discharges must not be delayed by inadequacy of services. The current transitional period—as Nevada strengthens its array of community-based services—will require additional state oversight to support safe and successful transitions back to the community.
Children & Youth: Transitions to Community	2	**Establish policies and procedures for meaningfully including children and their families into discharge and transition planning**. Employ person-centered planning principles in all discharge and transition planning.
Children & Youth: Transitions to Community	3	**Oversee quality assurance in any institutional setting that provides behavioral health services** including PRTFs, group homes, and juvenile justice and child welfare settings. One quality issue identified in the DOJ report was overly restrictive PRTFs, in particular, the use of "level systems" in which children gain or lose points based on their behaviors; a child's score then dictates what they can and cannot do, including having contact with their family. These systems have been criticized for decreasing autonomy, being disconnected from the real world, and prolonging lengths of stay.
Children & Youth: Transitions to Community	4	**Follow up with children with recent discharges to verify they are receiving appropriate community-based services**. Put systems and incentives in place to continue to engage with children and families after they have been discharged. Identify who is responsible for ensuring that services in the discharge plan are accessible to the child.
Children & Youth: Transitions to Community	5	**Reimburse community-based providers for engaging in the discharge planning of their patients from institutional settings**.
Children & Youth: Transitions to Community	6	**Track and measure progress related to child and youth transitions to the community**, using data such as state hospital readmission rates and follow-up rates post-discharge. Compare to national or leading state standards.
Young Adults: Coordinated Transitions &	1	**Establish a well-coordinated inter-agency plan** to address Nevada's bifurcated systems and to ensure that youth do not lose access to behavioral health services as they transition into adulthood. The plan would include

Specialty Services		a. establishing which agency assumes the lead role with young adults in transition; b. developing inter-agency communication and coordination, timelines, and funding, including memoranda of understanding to clarify each agency's roles and responsibilities when needed; c. designing and implementing a comprehensive program that leverages existing resources, while tailoring components to meet the special needs of young adults in transition.
Young Adults: Coordinated Transitions & Specialty Services	2	**Implement specialty behavioral health teams** who use the WIN model and have the flexibility and ability to work with an individual, from age 14 to 25, in both the child-serving and adult-serving systems to bridge and support their transition.
Young Adults: Coordinated Transitions & Specialty Services	3	**Create more opportunities for independent living** including housing specific for young adults in transition, which facilitates age-specific community learning and self-help (i.e., cooking, cleaning, budgeting, transportation).
Young Adults: Coordinated Transitions & Specialty Services	4	**Expand the authority of children's MCTs to serve young adults in transition** so that they can access the associated case management services that are not part of the adult-serving program.
Young Adults: Coordinated Transitions & Specialty Services	5	**Create drop-in centers tailored to young adults in transition,** where they can obtain support and care, while simultaneously taking an active role in their own care to create independence, self-sufficiency, and stability.
Young Adults: Coordinated Transitions & Specialty Services	6	**Consider policy changes to allow child-serving systems to serve individuals into their early twenties,** including extending foster care to the mid-twenties. Similarly, consider more flexible licensing for acute inpatient and PRTFs to create smoother transitions between youth-serving and adult-serving facilities. (Currently, for example, there is a 24-hour gap on at the eighteenth birthday in which neither system can serve the individual.)

Young Adults: Coordinated Transitions & Specialty Services	7	**Support young adults in transition with community engagement and competitive integrated employment.** "Place and train" approaches in which individuals are first placed in an employment setting and then provided with individualized training, services, supports, and accommodations are particularly promising for dismantling pipelines to segregated institutionalized settings. These strategies align with Strategy 3.1 from ADSD's 2016 Olmstead Strategic Plan.
Young Adults: Coordinated Transitions & Specialty Services	8	**Continue implementing a virtual Intensive Outpatient Program targeting young adults in transition in rural areas**. The Washoe County Children's Mental Health Consortium reported some progress in this area in its 2021 Annual Report, stating that Pacific Behavioral Health began a virtual Intensive Outpatient Program for young adults in transition that focuses on rural Nevada.
Adults: Crisis Continuum	1	**Implement a Call Center Hub** by building the capacity of the state-contracted Lifeline center to handle estimated contacts. This relies on establishing an adequate fee to support 988 and the CRS to ensure staffing is sufficient to address the anticipated volume of calls, chats, and texts. This would ensure that anyone in crisis who contacts 988 by call, chat, or text will have a trained person to talk to regarding their crisis.
Adults: Crisis Continuum	2	**Complete the Mobile Crisis Planning Grant and implement designated MCTs** covering as broad a geographic area as possible, including the use of CCBHCs. This includes establishing practice standards and adequate reimbursement rates so that persons who cannot be de-escalated via 988 have a qualified, responsive team to meet them where they are at.
Adults: Crisis Continuum	3	**Implement CSUs**. This includes developing and communicating practice standards—such as ensuring a warm, living-room like environment—and coordinating with rural hospitals to provide CSU services in their facilities. This will reduce trauma, divert people from jails and emergency departments, and provide skilled care to manage people through and after the crisis episode.
Adults: Crisis Continuum	4	**Implement all CRS services in accordance with the National Guidelines**, including a. ensuring that care and services are trauma-informed, b. utilizing peers in significant roles for MCTs and CSUs,

		c. integrating Zero Suicide/Suicide Safer Care throughout the CRS. d. directing CRS providers to adopt policies to ensure the safety and security for staff and people in crisis, e. building upon existing partnerships with law enforcement, dispatch, and emergency medical services.
Adults: Crisis Continuum	5	**Utilize National Guidelines for Children and Youth to ensure that children's MCTs and CSUs are tailored according to best practices**. Provide training and technical assistance to all state-contracted CRS vendors on the National Guidelines. This is intended to build a system that is appropriate for children and youth and to serve their families in a supportive manner.
Adults: Crisis Continuum	6	**Establish and use authority and oversight to ensure services and supports for children, youth and adults are aligned with evidence-based practices**.
Adults: Crisis Continuum	7	**Establish quality assurance positions within DPBH.**
Adults: Crisis Continuum	8	**Develop and implement quality assurance systems** to work with and support CRS contractors and state staff overseeing the Crisis Response Account.
Adults: ESMI Services	1	**Develop sustainable funding mechanisms via Medicaid and other payers to maintain and expand ESMI services in Nevada**. Expansion will help improve access by, for example, increasing workforce capacity to provide coordinated specialty care for ESMI.
Adults: ESMI Services	2	**Ensure rural areas statewide have access to ESMI services**. Ensuring people in rural areas have access to ESMI services will reduce trauma, decrease travel times for services, and likely prevent both involuntary holds and emergency transportation to urban areas for persons who have escalated into a behavioral health crisis as a result of not receiving ESMI services.
Adults: ESMI Services	3	**Expand eligibility for ESMI services in terms of diagnostic categories of mental illness**.

Adults: ACT Services	1	**Pursue sustainable funding for ACT services via Medicaid and other insurers.** While, long-term, the ACT model has been shown to save money systemwide, its implementation costs are high and individual organizations typically need significant startup funds to begin providing these services. Currently, SAMHSA grants and ARPA funds are driving the expansion of ACT Teams. Sustainability will rely on an ongoing commitment from Medicaid and other insurers to adequately pay for ACT services. This commitment likely relies on continued data collection establishing that the ACT model reduces inpatient stays and, therefore, costs. Given the intensity and high costs of the intervention, sustainability will also rely on ensuring fidelity to appropriate eligibility criteria, targeting the highest need individuals, and on establishing an appropriate number and distribution of ACT teams throughout Nevada.
Adults: ACT Services	2	**Ensure adequate reimbursement for all ACT teams statewide**. Like federally qualified health centers, CCBHCs are paid a daily rate per patient regardless of which services are provided, including ACT services. This daily rate is intended to cover CCBHCs costs and is adjusted periodically based on CCBHCs' cost reports. Other ACT teams, operating outside of CCBHCs, must bill Medicaid separately for each service they provide. To facilitate team-based collaborative care, which defines ACT, teams should be paid an adequate bundled rate.
Adults: ACT Services	3	**Tailor the ACT model to ensure availability of ACT services statewide, including in rural areas**. The Division Criteria establishes different requirements for rural areas and, during annual evaluations, CASAT uses a different fidelity/quality assurance tool, developed specifically for rural areas. One strategy for increasing statewide coverage would be to integrate telehealth into the ACT model.
Adults: Supportive Housing	1	**Define and begin building a statewide supportive housing initiative.** Building statewide access to and maintaining supportive housing will require extensive cross-agency coordination and communication, as well as organizational infrastructure. Initial steps include a. clarifying the definition of Supportive Housing in statute, b. developing a Supportive Housing State Plan, and c. building the business case for implementation.

Adults: Supportive Housing	2	**Leverage Medicaid, as well as other tools, to sustainably finance the required supports and services that individuals with behavioral health disabilities required to maintain independent living in the community.** a. Continue standing up Medicaid's 1915(i) initiative. Nevada Medicaid has taken steps to stand up a 1915(i) initiative to provide housing-related services to Medicaid beneficiaries, including amending its State Plan and working with CASAT to develop provider qualifications. Currently, however, Nevada does not have an operational organization or dedicated staff to implement the initiative. Additionally, many of the community-based organizations who have traditionally provided housing-related services are not Medicaid providers. They require support and education to leverage Medicaid financing, which will allow them to redirect their limited resources to, for example, supporting residents' housing costs. b. As enabled by state legislation, pursue an 1115 waiver for individuals with SMI or SED. c. Continue expanding and formalizing the housing supports and services provided via Medicaid MCOs. Unlike the state Medicaid agency, MCOs can pay for room-and-board, along with other tenancy supports. Currently, these services are not required in MCO contracts with the State; rather they are provided as "value-added" programming, with each MCO developing its own approach. Notably, MCOs are establishing a business case for housing supports, showing that they not only improve outcomes for certain beneficiaries but also save money. MCOs began providing these services after determining that most of their highest utilizers suffered from housing instability. One strategy that Nevada Medicaid is pursuing is shifting these MCO services from "value-added" to "in-lieu of" services, which would bring them under the MCOs' contracts, broadening access.
Adults: Supportive Housing	3	**Develop appropriate incentives for developers to target lower income levels.** Historically, developers of affordable housing have focused on households earning at least 60 percent of the Poverty Level. Nevada needs to develop appropriate incentives and/or regulations—for example, a 20 percent set-aside in affordable housing developments for lower income households.

Adults: Supportive Housing	4	**Implement appropriate preferences to support Olmstead efforts**. For example, according to HUD, public housing agencies, Continuum of Care organizations, and other HUD-funded entities who supply housing vouchers "may offer certain preferences that will enable individuals with disabilities to transition from institutions more quickly or enable an individual at serious risk of institutionalization to remain in integrated, affordable housing in the community."
Adults: Supportive Housing	5	**Explore opportunities to engage a SOAR coordinator for Nevada,** connecting individuals facing homelessness to SSI/SSDI income supports and benefits (SOARWORKS).
Adults: Transportation	1	**Assess the extent to which the new Medicaid service, Non-Emergency Secure Behavioral Health Transports, improved access to behavioral health services.** Collecting wait list and utilization of service data would provide a sense of the scale of the unmet need and would document the degree to which the transportation barrier has been addressed as well as remaining gaps in access to transportation.
Adults: Transportation	2	**Determine what transportation-related barriers remain for individuals and families facing behavioral health disabilities and how best to address them.** This could include, for example, a. Determining to what extent individuals and families continue to rely on MTM services and what challenges they face. b. Raising the MTM mileage reimbursement rate. c. Simplifying the MTM processes for both arranging for transportation and obtaining reimbursement. d. Identify the geographic areas that struggle the most with an inadequate transportation network. e. Assess to what extent and in what ways individuals without Medicaid face transportation barriers and explore innovative options that will work across Nevada's geographies. As an example, brought forward by a subject matter expert, the ETHAN project allows for telehealth in the field with a professional to avoid unnecessary transports to emergency rooms and other settings.
Adults: Criminal Justice Diversion	1	**Continue implementation of the Sequential Intercept Model** across all intercepts. Ensure access to deflection, diversion, and re-entry services statewide, including Assisted Outpatient Treatment and Specialty

		Courts.
Adults: Criminal Justice Diversion	2	**Develop data systems to be able to routinely monitor successes and challenges** with Sequential Intercept Model implementation, such as a. rates of behavioral health disorders across criminal justice settings, including arrests associated with behavioral health. b. deflection and diversion rates, by type of intervention; c. completion rates from specialty courts; d. rates of housing, employment, and connection to treatment and services after re-entry; and e. recidivism rates for individuals with and without behavioral health disorders.
Adults: Criminal Justice Diversion	3	**Assess the impact of NRS 176A.7 and expand the associated programs and interventions that have had the most impact**. Evaluate the extent to which standardized assessments of needs and risks, across all criminal justice settings, have helped to connected people with behavioral health disorders to treatment and services.
Adults: Criminal Justice Diversion	4	**Expand statewide agreements through a summit on behavioral health in justice settings** (planned in 2023) that will bring together partners to identify strategies to improve outcomes for people with behavioral health concerns that interface with law enforcement and carceral systems.
Adults: Criminal Justice Diversion	5	**Strengthen systems of support for people post-release** to include compliance with medication, attendance in health sessions and appointments, connection to social support, and housing.
Adults: Criminal Justice Diversion	6	**Review the degree to which the application of cultural competence and cultural safety guidance has been effective** (in both juvenile and adult) justice settings.
Adults: Criminal Justice Diversion	7	**Consider a pilot and related study to determine if trauma-informed approaches in Nevada jails and prisons can improve outcomes for people with SMI.** Some states have had early success with these approaches.