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

March 19, 2020

Dear Governor Sisolak,

The State of Nevada's Commission on Behavioral Health has created this summary of the annual reports of the Regional Behavioral Health Boards, along with an update of Nevada's ranking in areas of mental and behavioral health, to provide you and your office a status update of our state's work in accordance with NRS 433.314. As these are trying times for us all in light of the COVID-19 virus and associated closures, this letter will simply highlight the unified goals and asks of the boards governing mental and behavioral health in our state; a summary of each region's work is provided at the end of this letter.

Mental Health America (mhanational.org) ranks Nevada 51st overall in the 2020 rankings. Data submitted from DCFS and DPBH are used by Mental Health America for the annual rankings and are a reflection of the state of our population. Adult mental health indicators include prevalence (total adults with any mental illness), substance use disorder rates, suicidal ideation rates, as well as access indicators which include access to insurance and affordability barriers to care. Nevada ranked 47th overall for adult indicators. Youth data focused on those having a major depressive episode within the past year, substance use disorder, access to individualized education plans for youth with emotional disturbance, and access to care. Nevada ranked 51st overall for youth data. Compared to other states, our state ranks 45th for prevalence of mental illness, which encompasses the total of the population diagnosed with a mental illness in the past year. Worse yet, we rank 49th in the nation for access to care. Access to care encompasses: adults and youth with mental illness who did not receive treatment, those who could not afford treatment, those uninsured, those without insurance to cover treatment costs, and those with private insurance that did not cover costs for treatment of mental illness. Our local boards are all acutely aware of the barriers to care and the difficulties facing our state, and all address these in their annual reports.

The four regional boards have met several times over the past year to address mental and behavioral health needs unique to their regions. As you will see with the board priority lists below, all regions are facing the need for funding resources to support mobile crisis response teams, creative funding to boost workforce (e.g. loan reimbursement, college incentives), a

focus on programming address the whole family rather than age silos, and support for programming addressing stigma reduction and prevention. Although there are differences in the specific recommendations per region, you will find all are aligned with the overall goal of raising Nevada's rankings in the areas of mental and behavioral health.

The **Clark** regional behavioral health priority board prioritizes:

1. Dedicated funding for crisis services in Clark County and Pahrump NV to include mobile crisis, additional triage centers and updated emergency management protocols that eliminate barriers to use of crisis services.
2. Increase capacity for current treatment services, increase the types of services available (e.g. respite, specialized childcare), early intervention services, and individualized services and supports to youth and families.
3. Workforce development (e.g. tuition reimbursement, enhanced service rates from insurers and Medicaid)
4. Finding ways to increase collaboration on the spectrum of substance misuse and its relation to mental health.

The **Rural** regional board's recommendations include:

1. Identifying and prioritizing funding streams that allow for piloting of rural and frontier behavioral health transportation solutions.
2. Support policies and programs that address the needs of the whole family, not minors or adults separately, and support policies that support a whole-family approach to treatment and behavioral health concerns.
3. Support policies and programs that reduce stigma surrounding the seeking out of behavioral health services, particularly on the part of young people.
4. Advocate for programs and data collection efforts that take a Community Based Participatory Research (CBPR) approach, or others that involve local communities in all planning and implementation efforts in a bottom up approach.
5. Prioritize funding to programs that would support the increase of behavioral health services providers to rural and frontier communities. These could be college incentivization programs, scholarships or other means to make working in frontier counties more appetizing and feasible to new providers.

The **Northern** regional board's recommendations include:

1. DHHS will be more effective through increased collaboration with local and regional community providers and leaders. State administrators and staff should listen to the sage

advice and counsel of those working with the issues first-hand through our various county behavioral health task forces and our regional behavioral health policy board. Decisions on the executive budget and state policy should also include us to reduce the multiple silos that currently exist.

2. Support the regional behavioral health coordinator position through establishing a sustainable funding stream for it. In addition, the policy board has tugged at the coordinator position's time ability to network, coordinate, train, and envision the future. DHHS should provide administrative support to the Board that will enable the coordinator to be a coordinator.
3. Continue to decrease silos within behavioral health to improve collaboration and cooperation.
4. Develop sustainable funding sources for MOST, FASTT, and CIT. Consider virtual training opportunities that do not take law enforcement and Fire/EMS outside of their community so they can maintain service levels while becoming better educated in behavioral health issues.
5. Support the regional implementation of the Crisis Now model, supporting efforts that respect community informed solutions in addressing local and regional gaps, challenges, and existing resources.
6. Implement evidence-based practices that support the locally identified need, allow for flexibility in evidence-based requirements with trial programs when those at the tip of the spear indicate the concept is working locally to improve outcomes.
7. Continue to pursue sustainable funding for the Mallory Crisis Center at Carson Tahoe Regional Medical Center facility while realizing cost savings are occurring in the Emergency Department, law enforcement, and fire/EMS.

The **Washoe** regional board recommends:

1. Increase regional capacity to provide crisis stabilization via detoxification services and short term residential treatment.
2. Increase the number of psychiatrists in Washoe County.
3. Increase the affordable housing options for low-income individuals and families, including short term housing.
4. Increase prevention programming in schools targeted to middle school age youth.
5. Increase the number and availability of case managers that are available to assist with care coordination for individuals with behavioral health care needs.

Our Commission respectfully requests your consideration for addressing our state's shortcomings though exercising creative funding strategies, stabilizing funding of existing programming, and tackling the public health indicators (housing, childcare, etc.) which strongly intersect with the mental and behavioral health of our communities.

Respectfully submitted,

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Lisa Ruiz-Lee MA, Vice-Chair
Tabitha Johnson, LMFT
Natasha Mosby, LCSW
Barbara Jackson
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Washoe Regional Board

The Washoe Regional Behavioral Health Policy Board (WCBHPB) continues to work on developing priorities, strategies, and recommendations that are based information obtained from a number of sources (i.e., programmatic research, epidemiological data). In accordance with their directive, the WCBHPB also supported legislation (AB66), which addressed the need for appropriate services for individuals who experience a mental health and/or substance abuse crisis by promoting the development of crisis stabilization centers. After several iterations and amendments, AB66 was passed unanimously and became effective July 1, 2019.

Based on information gleaned from a system-wide assessment conducted by Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA), the following were identified as the top five (unranked) priorities related to building behavioral health capacity to meet the needs of Washoe County substance abuse disorder services:

- Increase regional capacity to provide crisis stabilization via detoxification services and short-term (> 30 days) residential treatment.
- Increase the number of psychiatrists in Washoe County.
- Increase the affordable housing options for low- income individuals and families, including short-term housing.
- Increase prevention programming in schools targeted to middle school-age youth.
- Increase the number and availability of case managers that are available to assist with care coordination for individuals with behavioral health care needs.

Washoe Regional Behavioral Health Profile

Demographics

- The Washoe County population has grown approximately 10.5% since 2010.
- In 2017, Washoe County's inflation-adjusted household income level was 5.7% higher than Nevada and 1.6% higher than the United States.
- In 2017, the total percent of individuals experiencing poverty in Washoe County was 0.9% lower than Nevada and 1.3% lower than the United States.
- Among individuals aged 18 to 34 years, living below the poverty level was 2.5% higher in Washoe County compared to Nevada.
- From 2015 to 2017, the percent of persons under the age of 65 years without health insurance in Washoe County has increased 3.9%.

Mental Illness

- From 2015 to 2017, the percentage of Washoe County middle school students who reported attempting suicide one or more times during their life decreased by 4.2%, while Nevada increased by 1.9%.
- From 2013 to 2017, the percentage of Washoe County high school students who reported attempting suicide one or more times over the previous 12 months decreased by 4.8%, Nevada decreased by 3.3%, and the United States decreased by 0.6%.
- Both Washoe County and the United States have experienced their largest spikes in depression diagnoses from 2016 to 2018. Washoe County has increased 4.9%, while the United States has increased 4.2%.
- Between 2016 and 2018, there was a 1.8% increase in suicide attempts among UNR students.
- As of 2018 reports, suicide attempts within the prior 12 months are 1.2% higher among UNR students when compared to the United States.
- Between 2016 and 2017, Washoe County showed a dramatic change in deaths due to suicide, decreasing by 5.9 deaths per 100,000 population.
- The rate of death due to suicide among those aged 85+ in Washoe County was more than three times the rate for the United States (71.1% vs. 19.3%).
- In 2016, Nevada had a veteran suicide rate of 48.2 (per 100,000 population), while the Western Region had a rate of 35.0 and the United States a rate of 30.1.

Substance Use

- Among Washoe County high school students, alcohol use decreased 8.3% from 2015 to 2017.
- Marijuana use among UNR students has shown an 8.9% increase between 2010 and 2018.
- In 2018, reported binge drinking among UNR students showed a 6.1% decrease from 2016.
- From 2008 to 2017, the average rate of alcohol-induced deaths in Washoe County (16.7 persons per 100,000 population) was higher than Nevada (11.5) and the United States (7.7).
- From 2008 to 2017, the average rate of drug-induced deaths in Washoe County (22.6 persons per 100,000 population) was higher than Nevada (20.7) and the United States (14.9).

Northern Behavioral Health Policy Board
(Carson City, Churchill, Douglas, Lyon, Mineral and Storey Counties)

The Northern Behavioral Health Policy Board continues to make good progress. All five counties have initiated or are continuing efforts in developing and sustaining programs such as Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), and Crisis Intervention Training (CIT), which have been identified as core interventions in local Sequential Intercept Model (SIM) mapping efforts, and are aligned with the Stepping Up. The Northern Region continues to advocate for increased and sustainable funding for MOST, FASTT, and CIT training as the region has experienced great success with these pilot programs and would like to see their continuation and expansion to adequately serve the region's population of nearly 200,000. Although the region has made progress, it continues to experience significant needs in terms providers and services to continue care for clients pre and post crisis. The region has implemented the following new services and levels of care added to its behavioral health system:

- Nevada DPBH awarded funding for two new Certified Community Behavioral Health Clinics (CCBHCs) in the region including Community Counseling Center (Carson City) and Rural Nevada Counseling (Silver Springs and Yerington, Lyon County).
- Vitality Unlimited, an existing provider in Carson City, was awarded a federal Substance Abuse Mental Health Services Agency (SAMHSA) grant to develop CCBHC sites in Carson City and Dayton.
- Carson Tahoe Behavioral Health Services (BHS) successfully partnered with DPBH to develop a First Episode Psychosis Program using the evidence based NAVIGATE model, and providing services to the Northern Region as well as Washoe County
- Carson Tahoe BHS also successfully partnered with DPBH to develop Assertive Community Treatment for the Northern Region.

Nevada Statewide Health Needs Assessment:

The Nevada Statewide Health Needs Assessment, conducted in 2019 with DPBH funding, provided additional insight into the Northern Region's behavioral health needs and priorities. Below are some of the highlights of note:

- In 2019, behavioral health was identified as the highest priority by stakeholders interviewed in the assessment for all counties within the Northern Region.
- Churchill and Storey Counties were ranked among the worst counties regarding the percentage of adults reporting 14+ poor mental health days in the past 30 days, and the percent of adults who have even been told they have a form of depression. (2015-2018)

• Carson City was ranked among the worst Nevada counties in the percentage of students who reported never/ rarely getting help needed when they felt sad, empty, hopeless, angry, or anxious. (2017)

• Storey County was ranked among the worst counties for heavy and binge drinking. (2015-2018)

• Carson City ranked among the worst counties for alcohol poisoning/ overdose mortality for emergency department and inpatient hospital admissions per 100,000 population and for percentage of adults who use marijuana. (2015-2018)

• Lyon County ranked among the worst counties for high opioid poisoning/ overdose emergency department and hospital admission encounters. (2015-2018)

• Douglas County ranked among worst of Nevada counties for almost all risky youth substance use behaviors including drinking alcohol, driving or riding in cars with youth who had used alcohol or substances, taking prescription medications, and using tobacco. (2017)

Northern Region Epidemiological Profile:

- The Healthy Communities Coalition (HCC) region, containing Lyon and Storey Counties, had a significantly higher percentage of the population who reported more poor days of mental health than the rest of the state.
- The Churchill Communities Coalition (CCC) region, which is composed of Churchill County, (Along with the PACE Coalition region) had significantly higher emergency department visits for anxiety and depression than the rest of the state.
- The HCC and CCC regions in the Northern Region had significantly higher inpatient admissions of anxiety and PTSD than statewide.
- The age adjusted mental health related death rate of 62.6 deaths per 100,000 is significantly higher than the statewide rate.
- Northern Nevada high school students have a greater suicide risk than high school students statewide.
  - 18% considered suicide in comparison to 16.6% statewide
  - 16.4% planned suicide versus 14.4% statewide
  - 10.8% attempted suicide versus 8.5% high school youth statewide.

- Northern Nevada middle school youth experience mental health risk behaviors at a higher rate than middle school youth statewide.
  - 23.0% considered suicide in comparison to 21.3% statewide.
  - 9.7% attempted suicide in comparison to 8.2% statewide
  - 21.2% cut/burned themselves in comparison to 18.4% of middle school youth statewide.

Regional Priorities:

- To implement Crisis Now. A statewide initiative that aligns with the region's current efforts in developing a cohesive behavioral health crisis response system as an alternative to traditional crisis response services such as law enforcement.
- Further revise NRS 4331 to update stigmatizing and inaccurate language, develop standardized procedures statewide, improve patient rights, and enhance continuity of care.
- Appropriately fund the resources needed within the region that was cut during the recession and as result, behavioral health services were greatly affected.
- Establish a sustainable funding stream to maintain the regional behavioral health coordinator position.

North Region Policy Group Service Recommendations:

1. DHHS will be more effective through increased collaboration with local and regional community providers and leaders. State administrators and staff should listen to the sage advice and counsel of those working with the issues first-hand through our various county behavioral health task forces and our regional behavioral health policy board. Decisions on the executive budget and state policy should also include us to reduce the multiple silos that currently exist.
2. Support the regional behavioral health coordinator position through establishing a sustainable funding stream for it. In addition, the policy board has tugged at the coordinator position's time ability to network, coordinate, train, and envision the future. DHHS should provide administrative support to the Board that will enable the coordinator to be a coordinator.
3. Continue to decrease silos within behavioral health to improve collaboration and cooperation.
4. Develop sustainable funding sources for MOST, FASTT, and CIT. Consider virtual training opportunities that do not take law enforcement and Fire/EMS outside of their community so they can maintain service levels while becoming better educated in behavioral health issues.
5. Support the regional implementation of the Crisis Now model, supporting efforts that respect community informed solutions in addressing local and regional gaps, challenges, and existing resources.
6. Implement evidence-based practices that support the locally identified need, allow for flexibility in evidence-based requirements with trial programs when those at the tip of the spear indicate the concept is working locally to improve outcomes.

7. Continue to pursue sustainable funding for the Mallory Crisis Center at Carson Tahoe Regional Medical Center facility while realizing cost savings are occurring in the Emergency Department, law enforcement, and fire/EMS.

The Rural Regional Behavioral Health Policy Board

Humboldt, Pershing, Elko, Lander, Eureka, and White Pine Counties

The Board's overall priority areas for 2020 include:

- Transportation
- Medicaid reimbursement rates
- Behavioral health workforce development
- Data quality and communication
- Board visibility
- Develop a robust BDR for the 2021 session of the Nevada Legislature
- Children, youth, and family services

The Rural Regional Behavioral Health Policy Board's current recommendations:

- Identify and prioritize funding streams that allow for the piloting of rural and frontier behavioral health transportation solutions.
- Support policies and programs that address the needs of the whole family, not minors or adults separately.
- Support policies and programs that reduce stigma surrounding the seeking out of behavioral health services, particularly on the part of young people.
- Support policies and programs that support a whole-family approach to treatment for behavioral health concerns.
- Advocate for programs and data collection efforts that take a Community Based Participatory Research (CBPR) approach, or others that involve local communities in all planning and implementation efforts in a "bottom up" approach.
- Prioritize funding to programs that would support the increase of behavioral health services providers to rural and frontier communities. These could be college incentivization programs, scholarships, or other means to make working in frontier counties more appetizing and feasible to new providers.

Board activities for 2019:

In the spring of 2019, the Nevada Department of Health and Human Services, Division of Public and Behavioral Health (DPBH) engaged all of the Regional Behavioral Health Coordinators

(RBHCs) to assist in the implementation of the CAST Assessment for each of the regions they serve. The purpose of the CAST Assessment is to identify the region's positive and negative contributing factors and assets in the context of behavioral health.

The 4 top priorities coming out of the CAST Assessment were as follows:

1. Recovery: Transportation—increase the availability of transportation resources
2. Recovery: Housing Support—increase the number of housing available to support people in recovery
3. Treatment: Outpatient—increase the availability of outpatient treatment by leveraging technology
4. Treatment: Outpatient treatment for co-occurring disorders—increase the availability of outpatient treatment for co-occurring disorders

AB47

As stated in NRS 433, each of the Regional Behavioral Health Policy Boards has the opportunity to put forward a bill draft request (BDR) each legislative session. The Rural Regional Behavioral Health Policy Board's (Rural RBHPB) BDR moved on to be Assembly Bill 47 (AB 47) and went initially to the Assembly Committee on Health and Human Services.

The original language of the bill indicated a pilot program would be put in place that would connect rural law enforcement with a mental health professional for assessment on calls, as well as provide administrative assistance and case management of persons involved in the program. However, the original language was somewhat convoluted, in addition to not including content regarding reimbursement for mental health services requested by some Board members. In April 2019, an amendment was passed that clarified the communities that would be served, how the mental health professional would be accessed (largely via telepsychology mechanisms) and the number of pilot sites. The final fiscal ask associated with AB47 was $575,000. While AB47 was passed out of the Assembly Committee on Health and Human Services, it was not heard further in the Finance Committee, and eventually died.

Lessons learned from this process include:

- Avoid putting forward a BDR with any sort of fiscal note attached unless absolutely necessary.
- Gather stakeholders into a planning group before the BDR is drafted to ensure support of all relevant stakeholders and Board members.
- Ensure the BDR submitted is backed by evidence-based practices and viable data.
- Start conversations early on in the process with relevant legislators, including all those who represent the behavioral health region, early on so they understand what is being

asked for and ensure their concerns and questions from their constituents are being addressed.

Clark Region

This summary has been prepared with data provided by the Clark Regional Behavioral Health Policy Board's recommendations in their 2019 report.

The board and the Commission on Behavioral Health believe that these four recommendations are top priority:

- Dedicated funding for Crisis Services in Clark County and Pahrump, NV to include mobile crisis, additional triage centers, and updated emergency-management protocols that eliminate barriers to use of crisis services

- Increase capacity for current treatment services, increase the types of services available (e.g. respite, specialized childcare), early intervention services, and individualized services and supports to youth and families

- Workforce development (e.g. tuition reimbursement, enhanced rates, etc.)

- Finding ways to increase collaboration on the spectrum of substance misuse and its relation to mental health

The need for added crisis services in Clark County and Pahrump, NV is great. Currently only one mobile crisis team serves one zip code in Downtown Las Vegas. This team responded to over 2000 calls in one year. Though there are plans to expand the team's reach if additional funding is secured, this expansion will not be enough to cover the growing needs of Clark County. The recommendation is also to expand crisis response in Pahrump, NV.

With regards to increasing capacity of the types of services available for children and families in Clark County, the rationale is to avoid sending Clark County youth with SED (Serious Emotional Disturbance) out of state for residential treatment. Separating youth from their immediate family and support system is not best practice. According to the report given by the Clark County Children's Mental Health Consortium, as of July 2019, 46.6% of Nevada youth in the fee-for-service Medicaid system (ages 0-22) were placed out of state for residential treatment. Though the numbers of youth being sent out of state had decreased, the total 12-month cost was over $7,000,000 more than the cost of in-state residential treatment. Residential care has not been shown effective in improving the outcomes for SED youth. The board and Commission believe strongly in increasing prevention services for these youth, such as respite care for families, specialized childcare, and early intervention services.

Increasing prevention services for youth also requires increased workforce development. Though Nevada has seen steady growth in the availability of qualified mental health providers, our region still falls well below the average of providers per capita. The board and Commission are committed to investigating what measures can be taken to improve the workforce supply in Nevada. These efforts will be coordinated by working with the various state licensing boards, the MCOs, Nevada State Medicaid, and other stakeholders such as DCFS and DPBH.

Another recommendation by the board and supported by the Commission is that the region must "work to build a bridge that connects prevention, treatment and recovery providers to mental health professionals in order to create innovative solutions and systems change." Mental health and substance use disorders are co-occurring and we must work to join resources in order to raise the health equity in Southern Nevada. Historically, mental health providers and substance abuse professionals were often siloed out and operated independently. Now with Nevada adding Certified Community Behavioral Health Clinics (CCBHCs), there is an opportunity to continue building the bridge between mental health and substance abuse professionals, to provide innovative care to the clients who desperately need trained professionals.