Steve Sisolak
Governor

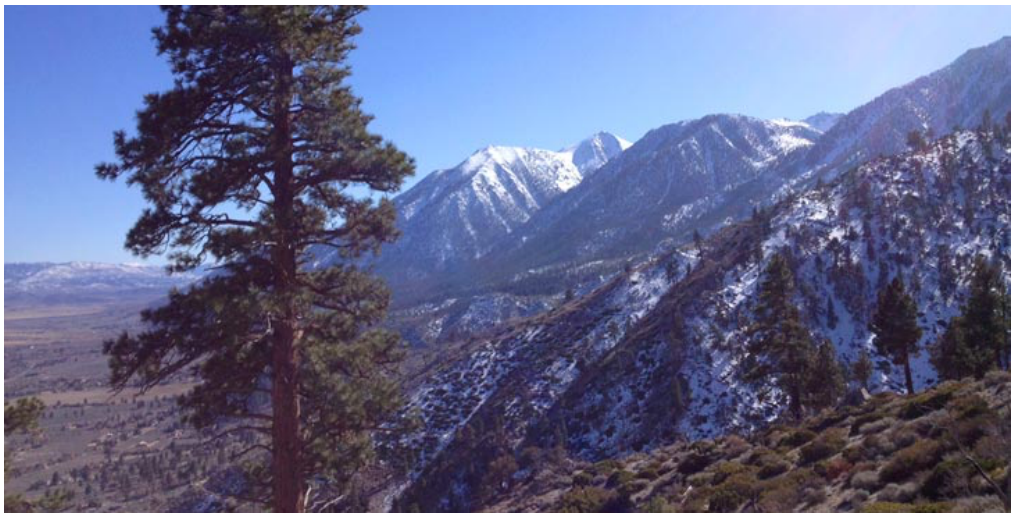
Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam,
Ph.D., M.D.
Chief Medical Officer

Northern Region



2021 NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD ANNUAL REPORT

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

Update on the Northern Regional Behavioral Health Policy Board's activities and an overview of the region's identified behavioral health gaps, issues and priorities for 2021.

EXECUTIVE SUMMARY

Overview

Members serving on the Northern Regional Behavioral Health Policy Board are community leaders, law enforcement, healthcare and treatment providers, family and peer advocates, and more. They bring diverse perspectives to the Board and are passionate about collaborating to improve the behavioral health system in the Northern Region. Collaboration facilitated by the Northern Regional Behavioral Health Policy Board and associated county behavioral health taskforces, has enabled stakeholders to develop a shared understanding of the behavioral health issues facing the region. This has allowed the Northern Board to achieve substantial progress on its goals by working with local, regional, and state partners to identify and align priorities and solutions whenever possible. Through ongoing discussion, the members of the Northern Regional Behavioral Health Policy Board, shown below, identified the Northern Region's gaps, needs, priorities and recommendations for this annual report.

- Assemblywoman Dr. Robin Titus, Nevada State Legislature
- Dr. Amy Hyne- Sutherland, Director of Mission Integration, Carson Tahoe Health
- Nicki Aaker, RN, Director, Carson City Health and Human Services
- Taylor Allison, Executive Director, Douglas County Partnership
- Erik Schoen, Executive Director, Community Chest
- Laura Yanez, Executive Director, NAMI Western Nevada
- Sandy Wartgow, Deputy Chief, Carson City EMS
- Ken Furlong, Sheriff, Carson City
- Lana Robards, Director, New Frontier Treatment Center, Fallon, Nevada
- Dr. Daniel Gunnarson, Psychologist, Aging and Disability Services Rural Regional Center
- Heather Korbulic, Executive Director, Silver State Insurance Exchange
- Dr. Ali Banister, PhD, Juvenile Probation Chief – First Judicial District
- Shayla Holmes, Executive Director of Lyon County Health and Human Services

Data highlights-

The Northern Region continues to see an increase in the number of adults seriously considering suicide and actual suicides. The region has also seen an increase in youth suicidal ideation. In addition, mental health related deaths and drug and alcohol related deaths continue to increase. In the past several years, the number Northern Nevada Adults have reported to experiencing difficulties because of physical, mental, or emotional conditions has increased a considerable amount as well.

Trends identified by local stakeholders

While the Northern Region does not have the data to quantify the issues below, stakeholders throughout the region have identified the following trends from various perspectives in the community:

- Provider staffing shortages and strain leading to reduced availability of behavioral health services

- An increase of youth experiencing suicidal thoughts and behaviors
- Problems for youth and family accessing outpatient treatment
- Increased crisis in older adults leading to increased need for crisis response and hospitalizations
- Behavioral health needs caused by COVID induced risk factors
- Behavioral health needs caused by socio-economic pressures

Legislative efforts

SB70, developed from the Northern Regional Behavioral Health Policy Board's bill draft, was passed by Nevada legislature, and signed into law by the Governor on June 4, 2021. This bill, focused on modernizing and further clarifying Nevada's mental health crisis hold and involuntary treatment laws, built upon the work of the Northern Board's first bill, AB85, passed in 2019. The Northern Board, collaborating with the Statewide Mental Health Crisis Hold Workgroup, composed of diverse stakeholders including hospitals, courts, public defenders, peer and family advocates, law enforcement and others, developed SB70 which included five major changes:

1. Updated and modernized the mental health crisis hold law
2. Updated and clarified assisted outpatient treatment (AOT)
3. Updated and clarified conditional release
4. Clarified the youth mental health crisis hold process
5. Updated the chemical restraint definition

Efforts to educate Nevada's stakeholders about the mental health crisis hold law continue. With participation from Northern Board member Dr. Daniel Gunnarson, the Statewide Mental Health Crisis Hold Workgroup has developed education about the adult and youth mental health crisis hold processes and a parent guide for navigating youth mental health. These brochures can be found at: https://nvbh.org/involuntary-hold/ . In addition, the Workgroup has scheduled a Mental Health Crisis Hold Summit on March 7th and 8th, focused on educating law enforcement, lawyers, hospitals, mental health professionals, peers, families, and others on the mental health crisis hold and involuntary treatment processes in Nevada. Nevada Division of Public and Behavioral Health is supporting these efforts through the development of videos that will provide an overview of the adult and youth mental health crisis hold processes. For more information on SB70 go to: https://nvbh.org/northern-behavioral-health-region/

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INTRODUCTION:

The Northern Region consists of Carson City, Churchill, Douglas, Lyon, and Storey Counties, stretching across 11,976.95 square miles in northwestern Nevada. The total population of the Northern Region is estimated to be 194,464 in 2020, slightly up from 192,723 in 2019. In terms of ethnicity, 76.5% residents in the Northern Region are White not of Hispanic origin, 16.9% residents are Hispanic, 3.0% of the population are Native American, 2.4%, Asian, and 1.1% of the population are Black. [1]

Over the past several years, the Northern Behavioral Health Region has made significant gains in enhancing its behavioral health system through programs such as the Mobile Outreach Safety Teams (MOST), Forensic Assessment Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory Crisis Center. Providers are now learning how to utilize new programs such as Assertive Community Treatment (ACT) and Certified Community Behavioral Health Centers (CCBHCs) and are seeing the positive impact of these new services.

However, the region continues to face significant barriers across the behavioral health continuum. For example, there is limited access to outpatient and inpatient treatment for youth with and without insurance. There is extremely limited access to Intensive Outpatient Treatment (IOP), and virtually no existing intensive in-home services for families and youth. For adults, there continues to be limited availability for most levels of care. These challenges are only amplified by staffing shortages, burnout in the behavioral health workforce, recent closures of significant providers, and lack of supportive housing.

In response, the Northern Regional Behavioral Health Policy Board is open to innovative ideas including use of telehealth, community health workers, and peer support specialists. In addition, the Northern Region's leaders are passionate about participating in the development of the Crisis Response System, valuing community driven and locally based programs.

This report provides a framework to improve behavioral health services and enhance quality of life within the Northern Region's communities, focusing on identified behavioral health gaps and needs, as well as strategies and recommendations to address the most pressing issues in the region.

OVERVIEW:

The Northern Board used quantitative and qualitative data, described earlier in the report to inform the following themes:

Challenges and Issues

- Behavioral health issues continue to rise in the Northern Region. For instance:
    - From 2010- 2020, deaths related to alcohol and mental health issues trended upward in the region.
    - Cannabis use rates have dramatically increased, which could be attributed to a change in Nevada law and social norms.

[1] Nevada Statewide Demographer's Office

    - ER visits and hospitalizations related to anxiety and depression continue to increase.
- The region is seeing increasing trends of suicidal thoughts and behavior in youth and adults.
- There continues to be a lack of access to appropriate levels of care and challenges with behavioral health infrastructure. This leads many individuals in our region to utilize 911 and hospital emergency departments even though they are not set up to respond to behavioral health.
- The Region is still experiencing a substantial lack of clinical behavioral health workforce, which significantly inhibits resource and program development.

Progress and solutions

- The Northern Board is addressing these challenges in the following strategies:
    - Aligning with national best practices while staying true to local values and resources specific to the region.
    - Mitigating workforce issues and increase access to care through use of non-clinical roles such as community health workers, peer support specialists, and family peer advocates.
    - Gathering more sophisticated and accurate data to better understand trends and the impacts of significant events such as disasters and the current pandemic.
    - Exploring innovative solutions to address identified problems including housing and local/ regional behavioral health infrastructure concepts.
    - Developing a system that emphasizes person centered and community-based care.

Northern Regional Behavioral Health Policy Board 2021 Gaps, Needs, Priorities and Recommendations

Over the past year, the Northern Board used a variety of information sources described below to inform their priorities, strategies, and recommendations for 2021.

Methodology for identifying needs and gaps:

The Northern Regional Behavioral Health Policy Board used a variety of methods to identify needs and gaps in the behavioral health region including the following:

- *County Behavioral Health Taskforces:* The Board obtained local community stakeholder input through hearing regular updates from the region's county behavioral health taskforces. These taskforces, composed of diverse community stakeholders including law enforcement, EMS, hospitals, treatment providers, social service, community coalition, and peer and family advocates, meet monthly and focus on identifying and addressing behavioral health issues, needs, and gaps.

- *Northern Board survey:* Members of the Northern RBHPB participated in multiple surveys to assess issues and priorities to be included in the Northern Board's strategic plan.
- *Community survey:* The Northern Board supported a community and provider behavioral health survey that was distributed by the region's coalitions and other community providers.

- *Regional and Statewide Data provided by Nevada Division of Health and Human Services (DHHS) Office of Analytics:*
  The Office of Analytics provides each Behavioral Health Region with data derived from multiple sources including the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), hospital billing data, and other sources.

NORTHERN REGION PRIORITIES, STRATEGIES, AND RECOMMENDATIONS

The following priorities are presented to include underlying needs and gaps, strategies utilized by the Northern Board, and recommendations from the Northern Board for forward progress.

1. Regional Board infrastructure development
   Need/Gap:
   Several areas have been identified where additional infrastructure could lead to greater efficiency as the Northern region works to develop a more sophisticated behavioral health system.

   Strategies:

   - Regional Behavioral Health Authorities: To address the identified needs above the board reviewed current board authority and legislative intent and explored concepts for system solutions. The Northern Board spent time exploring Regional Behavioral Health Authorities, as an entity like this may allow the region to secure additional funding sources, support the state in an administrative capacity, as well as enhancing coordination of local programs. The Northern Board developed and submitted a concept paper for Regional Behavioral Health Authorities to DHHS to express their intent. (Please see the Northern Region's white paper of Behavioral Health Authorities at https://nvbh.org/northern-behavioral-health-region/).

   - Board support positions: The Northern Board continues to advocate for sustainable funding for the Regional Behavioral Health Coordinator (RBHC) position, as this role has been critical to making progress in addressing behavioral health issues in the region and meeting the legislative duties of the Northern

Board. In addition, the Northern Board was interested in obtaining a full-time data analyst position to assist the region in developing data collection systems for prioritized topics to make data driven decisions. (This position was recently obtained when the region received funding from the Comprehensive Opioid Stimulant and Substance Abuse Program (COSSAP) grant submitted by the Attorney General's Office.) The Northern Board is motivated to further develop current regional behavioral health policy board mandates such as the electronic repository of behavioral health resources and data described in NRS 433.4295e.

- Northern Region Behavioral Health Emergency Operations Plan (BHEOP): The Northern Board also adopted the Northern Regional Behavioral Health Emergency Operations Plan in early 2021. The region's emergency management leadership participated in a Northern Regional BHEOP table-top exercise at the beginning of 2022. The region plans to continue developing behavioral health emergency response protocols and systems and psychological first aid training in each county through the county behavioral health taskforces.

Recommendations:

- Develop sustainable funding mechanism for Regional Behavioral Health Coordinator position
- Support need for local data aligned with Northern Board priorities.
- Increase transparency, coordination, and accountability of behavioral health funding mechanisms recognizing limited capacity at the state level through additional DPBH staff participation in regional meetings, providing a presentation on state capacity, and exploring opportunities for collaboration.
- Strengthen coordination of funding and programs between state and local stakeholders.
- Expand awareness of and access to psychological first aid trainings
- Each county formally adopts the Northern Regional Behavioral Health Emergency Operations Plan.

2. Affordable and supportive housing and other social determinants of health

Need/Gap:

The region's communities are experiencing many individuals who have behavioral health issues and are homeless. These individuals with complex needs deteriorate on the street or become stuck in hospitals or jails for long periods of time with no safe discharge plan available. In addition, the board sees a gap in resources to address social determinants of health. There is no supportive housing aligned with best practice for residents with mental health issues in the region.

Strategies:
The Northern Board is motivated to learn about and advocate for housing models that support individuals with behavioral health issues. The Board heard a presentation from the Nevada Housing Coalition and has developed a subcommittee to explore behavioral health housing. The Northern Board plans to have a presentation on social determinants of health in the upcoming future.

Recommendations:

- Recommendations are being developed in the behavioral health housing subcommittee
- Increase caregiving support to enable to individuals to live in the community:
    - Increase the reimbursement rates and/or add supplemental rate for nurses and others who provide home healthcare so that home healthcare agencies can offer wages competitive with that of hospitals. Right now, nurses are disincentivized from doing home health because hospitals are able to offer higher wages; this puts the burden and stress of caregiving on families and caregivers.

3. Behavioral health workforce with capability to treat adults and youth

Needs/ Gaps:
The Northern Region faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. In addition, the Northern Board believes that the CHW and peer professions have not been fulling developed and utilized. This gap impedes timely access to treatment and prevents providers from expanding quality services.

Strategies:
The Northern Board supports a tiered approach for a calibrated mental health system that includes a robust relationship between clinicians, community health workers (CHW), and peers. Following this model, the Northern Board has been exploring strategies to increase the clinical workforce and expand use of CHWs and peers to bridge the gaps caused by lack of clinical providers. The Northern Board plans to obtain more education on CHWs and are interested in advocating for Medicaid reimbursement and other sustainable funding to be expanded for behavioral health services. The Northern Board also wants to learn more about the meaningful role of peer support specialists in region to avoid misuse.

Recommendations:

- Support local agencies facilitating CHW and peer workforce development.

- Provide technical assistance to communities in differentiating between CHW and peer, and peer family support roles are being utilized within their appropriate scope of practice.
- Address financial barriers to CHW and peer training and certification process.
- Expand ability of CHWs to bill for Medicaid out from under only a "medical provider" and expand to include all behavioral health / substance abuse providers.
- Increase reimbursement rates for all behavioral health professions where there is a low ratio of active providers to population to attract more to the workforce.
- Develop and expand additional incentives for practitioners providing services in rural counties. (e.g., Expand application time window and streamline process to complete HRSA loan forgiveness application as a provider agency and provider; provide housing stipends, etcetera)
- Support policy change by the Department of Insurance that simplifies the insurance paneling process for behavioral health clinicians
- Evaluate network adequacy related to insurance company credentialling
- Support family caregivers through supporting access to reimbursement, increasing access to services, training, and respite care across the life span.

4. Development of a regional crisis response system while obtaining sustainable funding for current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)

   Needs/ Gaps:

   Individuals experiencing crisis in the Northern Region often cannot find the care they need when they need it. These individuals encounter hospitals, emergency medical services, and law enforcement, which are not set up to respond to a behavioral health crisis. The Northern Region has made progress in addressing this gap through the following community-based crisis stabilization and jail diversion programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory Crisis Center. (Please see https://nvbh.org/education/ for more information on these programs.) These were developed to improve response to individuals with behavioral health issues experiencing crisis, however, they do not currently have sustainable funding and more crisis response interventions are needed.

   With the implementation of 988 in Nevada, there is a need to coordinate local infrastructure into the state crisis response system.

Strategies:
While progress is being made in obtaining sustainable funding for these programs, the Northern Board continues to hold this as a priority until long term program sustainability is achieved.

In addition, the Northern Board is very interested in participating in the development of the region's crisis response system. Stakeholder engagement meetings were scheduled in Carson, Douglas, Lyon, and Storey Counties to obtain input to provide to the Division of Public and Behavioral Health. The Board wrote a position statement on behalf of the region which can be found here on the Statewide Regional Behavioral Health Policy Board's website: https://nvbh.org/northern-behavioral-health-region/.

Recommendations:
- Develop sustainable funding mechanism for current local crisis response and jail diversion programs including MOST, FASTT, CIT programs and Mallory Crisis Center.
- Develop sustainable Medicaid reimbursement rate and other funding sources to sustain Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs.
- Develop 988 infrastructure in coordination with local agencies in accordance with the Northern Region's crisis response system position statement found here: https://nvbh.org/northern-behavioral-health-region/.
- Support Certified Community Behavioral Health Centers in providing full range of services in coordination with communities.

5. Increase access to treatment in all levels of care

Needs/ gaps
Stakeholders in the region identified lack of insurance as a barrier for access to behavioral health care. Furthermore, there is significant concern about access to care for youth and adults who have insurance. While there is no quantitative data on this, there are many stakeholder reports of struggling to obtain outpatient appointments for youth and adults. They also report not having adequate access to intensive outpatient treatment for youth and inpatient treatment for youth as many youths are waiting in hospitals for acute psychiatric treatment. Notable gaps in the region are the lack of intensive in-home services, crisis stabilization centers, and respite care for youth.

Strategies:
In exploring access to care issues for individuals who are under-insured or lack insurance, the Northern Board identified some opportunities to connect uninsured individuals with care, including the youth trauma recovery grant and the region's Certified Community Behavioral Health Centers (CCBHCs). The Northern Board is planning to continue to learn more about the topic including solutions for

underinsured individuals and increasing use of CCBHCs. The Northern Board is also interested in exploring other models of care including peer drop-in centers, living room models, and community support centers.

Recommendations:

- Increase reimbursement rate and funding opportunities for all youth and adult behavioral health services to ensure access to treatment.
- Increase navigators in communities to assist individuals in understanding and enrolling in insurance.
- Increase availability of behavioral health services for all individuals and identify and work to mitigate barriers for some subgroups such as indigent populations.
- Develop funding opportunities for respite care, peer drop- in centers, living room models, and community support centers.
- Provide vouchers for drop- in day care to take other children to care and treatment.

6. Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker)

Needs/ Gaps:
For years, stakeholders in the Northern Region have identified issues with continuity of care across the continuum. There are barriers in linkages to care that include lack of formalized referral systems, lack of coordination and communication, and limited provider capacity.

Strategies:
The Northern Board is very interested in utilizing community health workers to address challenges in continuity of care for individuals with behavioral health issues. The Northern Board also plans to identify other strategies, such as peers, to support discharge planning and continuity of care in the region and investigate structural solutions to strengthen warm hand offs.

Recommendations:
- Support formal agreements between CHWs and various existing programs such as Healthlink, OpenBeds, and hospitals.
- Identify role of peers and family peer supports in encouraging clients to follow self-determined treatment plan and engage in treatment.
- Provide increased support, funding, mandates, and training as needed for providers to utilize OpenBeds.

2021 Northern Regional Behavioral Health Board Activities

The Northern Regional Behavioral Health Policy Board met eleven times in 2021, hearing a variety of presentations from local, regional, and state organizations on ongoing activities and priorities. The board carried out ongoing activities on the following topics:

- **Legislation**: The Board received monthly updates on its legislative bill SB70 (For more information on this legislation, please see https://nvbh.org/northern-behavioral-health-region/) and other legislation associated with behavioral health throughout the legislative session. The board also provided multiple letters of support for legislative bills aligning with it priorities. Taylor Allison, the Chair, also provided education and resources to legislators on behalf of the Northern Board.
- **Advocacy**: The Northern Board wrote multiple letters to DHHS, advocating for expansion and development of resources in the Northern Region including funding for additional DWSS Targeted Outreach Program Workers, a data analyst for the region, development of Regional Behavioral Health Authorities, and the gap caused by the decrease in funding of the China Spring Youth Camp. The Northern Board also submitted multiple advocacy letters, including a position statement to DHHS on Nevada's crisis response system (Please see https://nvbh.org/northern-behavioral-health-region/).
- **Strategic planning:** The Northern Board spent a significant amount of time reviewing stakeholder input, identifying priorities, and developing next steps forward to achieve those priorities.
- **Education:** Many of the presentations received were related to priorities, including expanding access to treatment through Certified Community Behavioral Health Centers and developing an understanding of what a behavioral health crisis response system might look like in the region.
- **Coordination with local taskforces:** The Northern Board received regular updates regarding the county behavioral health task forces in the region which ensured ongoing coordination between local stakeholders and the region.
- **Other board development activities:** In 2021, the Northern Board reviewed and adopted bylaws and adopted the Northern Regional Behavioral Health Emergency Operations Plan. The Board also provided input into the statewide Regional Behavioral Health Policy Board website.

Northern Regional Behavioral Health Policy Board Meetings and Presentations

All presentations, materials, and minutes provided to the Northern Regional Behavioral Health Policy Board can be found on the Board's website at: http://dpbh.nv.gov/Boards/RBHPB/Board_Meetings/2018/Northern_Regional/ The table below provides an overview of notable presentations, initiatives, and actions initiated by the Board in 2021. * The board's actions are in bold print.

Date	Topic	Presenters/ Participants
1.05.21	– **Reviewed regional survey results to develop priorities and recommendations on gaps and needs in the region.**	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
3.04.21	– Discussion of legislative bills moving through the Nevada Legislature related to behavioral health and consideration of sending letters of support for bills. Review and approval of Northern Board recommendations to be included in annual report. – **Reviewed and adopted Northern Regional Emergency Operations Plan.**	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
4.01.21	– Discussion of legislative bills moving through Nevada Legislature related to behavioral health and consideration of sending letters of support for bills. – **The Northern Board voted to provide letters of support for SB56, SB69, and SB156. The Northern Board also supported the development of a letter of support for China Spring Youth Camp stating that budget cuts to its programming would present a gap in services.** – Development of strategic plan for the Northern Board.	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
5.06.21	– Overview of substance use treatment and recovery model of care – Update on successful collaboration between Mobile Outreach Safety Teams (MOST) and Assertive Community Treatment (ACT) Teams in Northern Region. – Discussion of legislative bills moving through Nevada Legislature related to behavioral health and consideration of sending letters of support for bills.	Morgan Green, Center of Abuse and Substance Abuse Technology (CASAT) MOST and ACT team members Taylor Allison, Board Chair and board members, and Jessica Flood Abrass,

	– **The Northern Board voted to provide letters of support for SB44, SB390, and AB154.**	Regional Behavioral Health Coordinator.
5.20.21	– **The Northern Board voted to send letter to staff at DHHS advocating for DHHS to allocate additional Division of Welfare and Supportive Services (DWSS) outreach workers to rural counties to assist providers in connecting individuals to insurance and other benefits.** – Northern Board strategic planning session	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
6.03.21	– Presentation by Division of Child and Family Services, Rural System of Care grant regarding funding, priorities, and opportunities for collaboration – Update on Division of Public and Behavioral Health (DPBH) Rural Clinics programming. – Discussion of Regional Behavioral Health Authorities – SB70 was signed into law by the Governor	Kathy Wellington- Cavakis, DCFS Michelle Sandoval, Division of Public and Behavioral Health Rural Clinics
8.05.21	– Overview and update on Nevada 988 Planning Coalition, "Building a Crisis Response System in Nevada" – **The Northern Board voted to write letter in support of developing Regional Behavioral Health Authorities in Nevada** – **The Northern Board voted in support of Chair submitting proposal to Governor for American Rescue Plan funding for a data coordinator position for the board.**	Kelly Marschall, President of Social Entrepreneurs
9.02.21	– Presentation of Recovery System - "Building Recovery Ready Communities" – **Board reviewed and approved bylaws**	Sean O'Donnell, Executive Director of Foundation for Recovery
10.07.21	– Presentation on background and legislative roles of Regional Behavioral Health Policy Boards – **The Board appointed or reappointed the following members:**	Legislative Council Bureau

	○ Lana Robards, Executive Director of New Frontier ○ Nicki Aaker, Director of Carson Health and Human Services ○ Laura Yanez, Executive Director of NAMI Western Nevada ○ Heather Korbulic, Executive Director of Silver State Insurance Exchange – Presentation on Role and Duties of a Board of Directors – Northern Board reviewed and provided input for new Statewide Regional Behavioral Health Policy Board website (now nvbh.org)	Erik Schoen, Board members and Executive Director of Community Chest
11.04.21	– The Board appointed Sandy Wartgow, Division Chief of Carson City Fire. – Presentation on Department of Education (DoE) efforts to expand youth behavioral health workforce and school capacity to bill for Medicaid. – Presentation on Certified Community Behavioral Health Center (CCBHC) certification team on status and role of CCBHCs in the crisis response system. – Northern Board voted to support Northern Regional Crisis Response Planning Statement be developed and submitted to DHHS.	Board members and Jessica Flood, Regional Behavioral Health Coordinator Dana Walburn and Ruby Kelly, DoE Mark Disselkoen, CASAT
12.02.21	– Presentation from Nevada Housing Coalition discussing status of housing behavioral health policy and recommendations for Board consideration.	Christine Hess, Executive Director of Nevada Housing Coalition

Northern Region Behavioral Health Profile

The data trends highlighted in this section reflect the experience reported by community stakeholders and providers that have participated in the county behavioral health taskforces and on the Northern Regional Behavioral Health Policy Board for several years now. The region continues to see high rates of hospital emergency department (ED) encounters and admissions for anxiety and depression that have significantly increased over the past decade. This data speaks to the awareness that a portion of the population experiencing behavioral health crisis or in risk of future crisis.

Below are a few snapshots of behavioral health trends in the Northern Region. More data can be found below in Appendix A and on the Regional Behavioral Health Policy Board data dashboard at https://nvbh.org/dashboard/ .

Data Highlights from the DPBH SAPTA 2020 Northern Region and Statewide Epidemiological Profiles

- Between 2018 and 2020, there has been a total of 175 suicide related deaths in Northern Nevada with an average of 58 suicides per year. Suicides have increased 18.8% of this timespan.
- During the 10-year period of 2010 to 2020, there was a total of 1,731 mental health related deaths in Northern Nevada. Mental health related deaths increased 76.47% between 2017 to 2019. There was a slight decrease in mental health deaths in 2020, but the overall there has been a significant increase, making the average number of deaths 157.4.
- Northern Nevada has seen an increase in drug and alcohol related deaths. Drug and alcohol related deaths have sharply increased 25.5% from 2018 to 2020.
- Drug related deaths in Northern Nevada have steadily decreased 28% from 2017 to 2020.
- Since 2017, Northern Nevada has seen a steady increase of 31.7% in the amount of people who have reported to seriously considering committing suicide. There was an increase of 22% from 2017 to 2018, and a 0.4% increase from 2018 to 2019.
- Since 2017, Northern Nevada Adults have reported to experiencing difficulties because of physical, mental, or emotional conditions has increased a considerable amount. The amount of people having difficulty doing errands alone has increased 41.3% between 2017 and 2019. There was a 18.8% increase in the number of adults experiencing difficulty concentrating, remembering, or decision making due to physical, mental, or emotional health conditions.
- Between 2018 and 2019, the number of Northern Nevada adults that reported to using marijuana/hashish to get high in the last 30 days increased 40.9%. In contrast, the

number of adults who reported to using illegal drugs to get high in the last 30 days decreased 42.9% and the number of adults that reported to using painkillers to get high in the last 30 days decreased 28.6%.

- In both Northern Nevada and the state of Nevada as a whole, there has been an increase in the number of adult women who are considered to binge drink alcohol. The number of women in Northern Nevada who reported to binge drinking has increased 51.6% between 2018 and 2019.

Data Limitations:

While this quantitative data provides perspective on prevalence rates in behavioral health, the Board recognizes the need to capture and identify additional and more accurate data sources to understand the true gaps and needs in the Northern Region. In addition, the quantitative data above was collected prior to the COVID pandemic. The Northern Board looks forward to obtaining more recent data to understand the pandemic's profound effects on our communities.

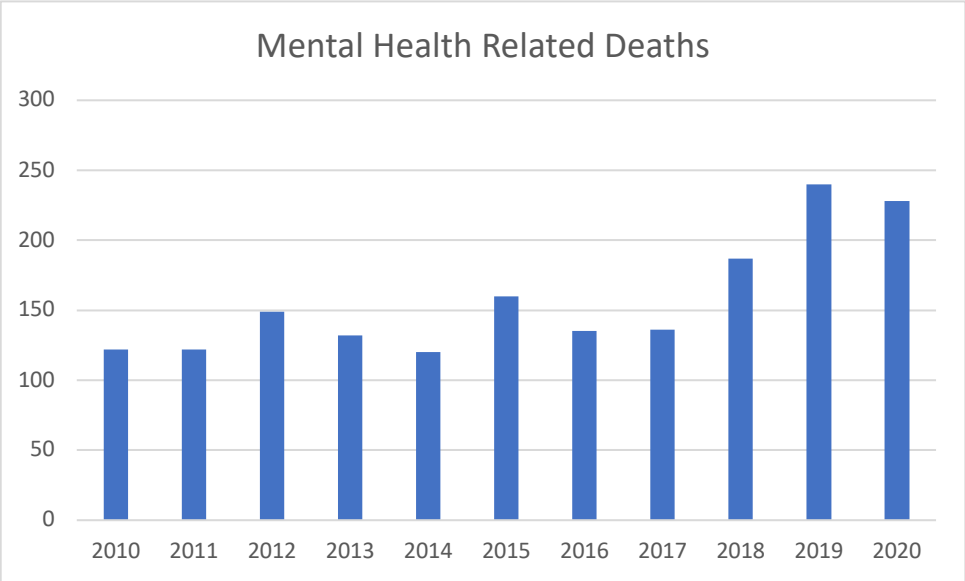
Conclusion:

The Northern Board was very active in 2021, meeting monthly, actively participated in the development of a strategic plan and wrote numerous advocacy letters on topics relevant to the region.

The Northern Board aims to continue learning more about priority topics, practicing advocacy, and moving forward with implementation of recommendations and identified solutions. Board members request coordination and partnership with the state as the region works to develop access to behavioral health and the impending 988 system.

Appendix A: Behavioral Health Data for the Northern Region

Mental Health Related Deaths in Northern Nevada



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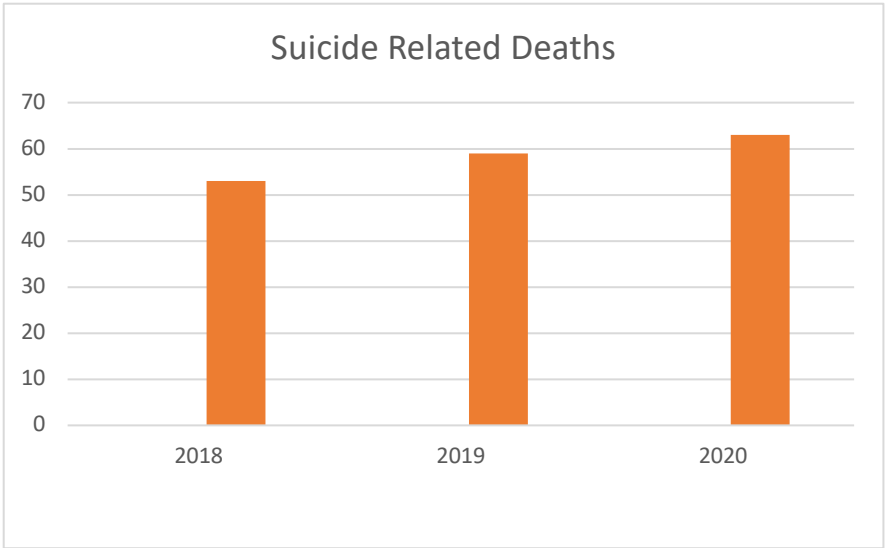
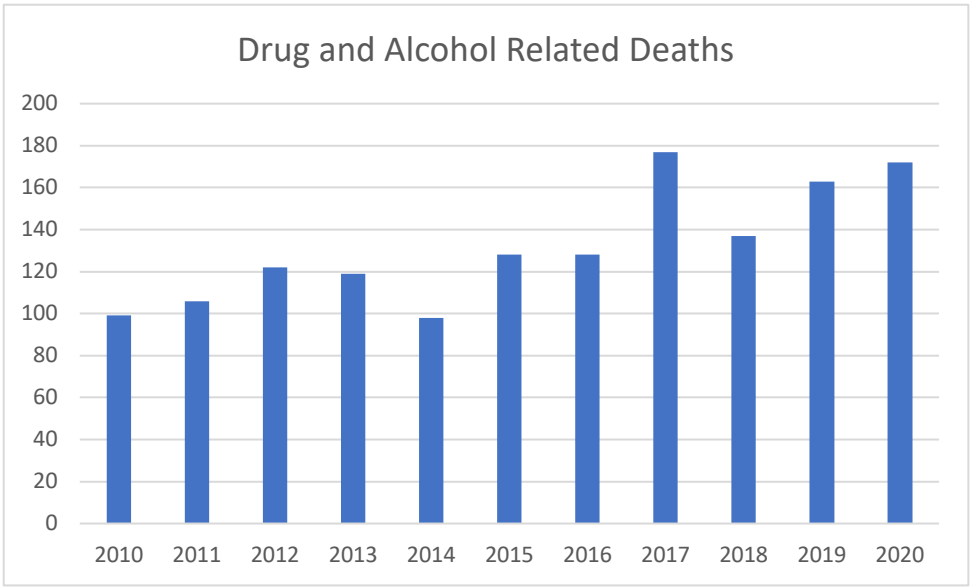
Suicide Related Deaths in Northern Nevada



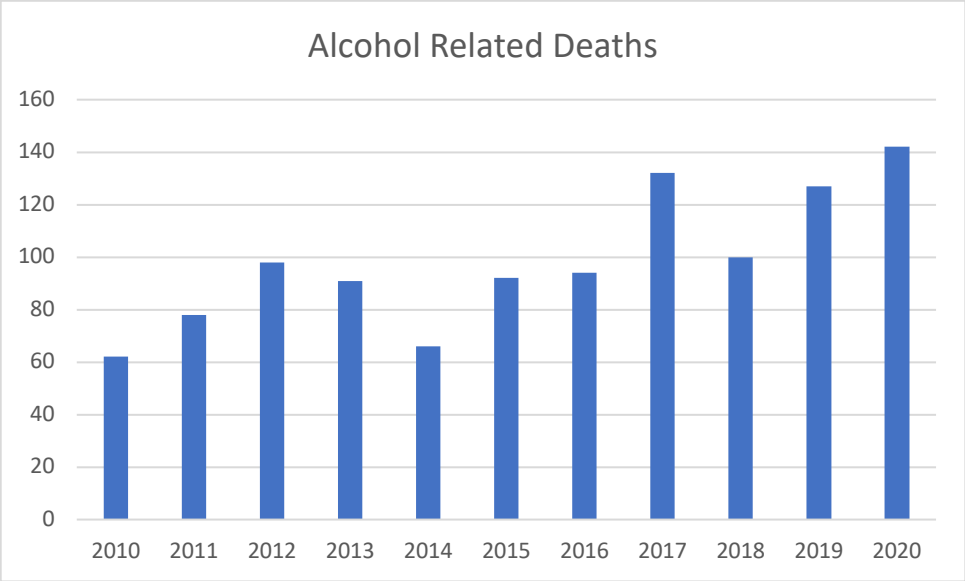
Between 2018 and 2020, there has been a total of 175 suicide related deaths in Northern Nevada with an average of 58 suicides per year. Suicides have increased 18.8% of this timespan.

Drug and Alcohol Related Deaths in Northern Nevada



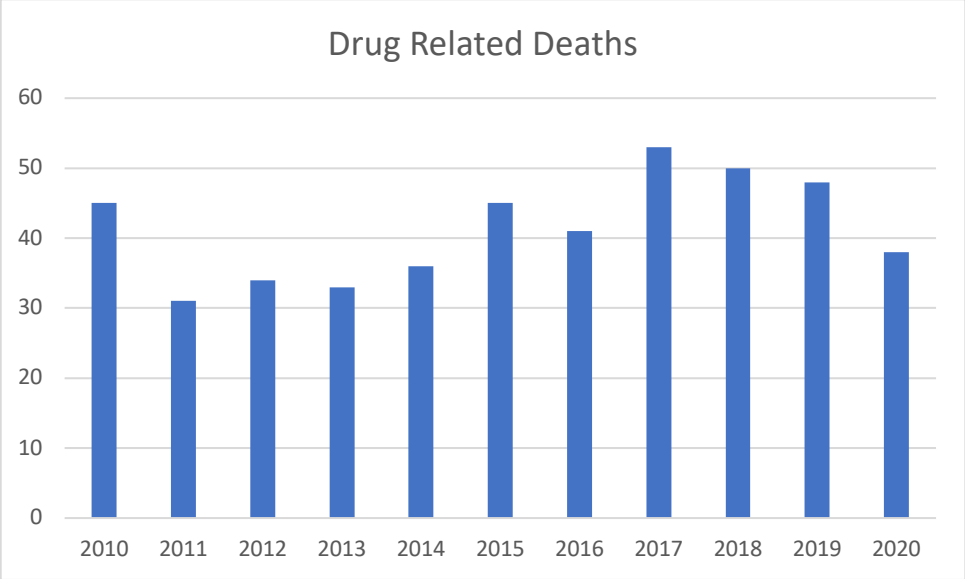
Northern Nevada has seen an increase in drug and alcohol related deaths. Drug and alcohol related deaths have sharply increased 25.5% from 2018 to 2020.

Alcohol Related Deaths in Northern Nevada



From 2010 to 2020, Northern Nevada has had 1,081 deaths associated with alcohol consumption, with each year having an average of 98 deaths.

Drug Related Deaths in Northern Nevada



Drug related deaths in Northern Nevada have steadily decreased 28% from 2017 to 2020.

Behavioral Risk Factor Surveillance System Data

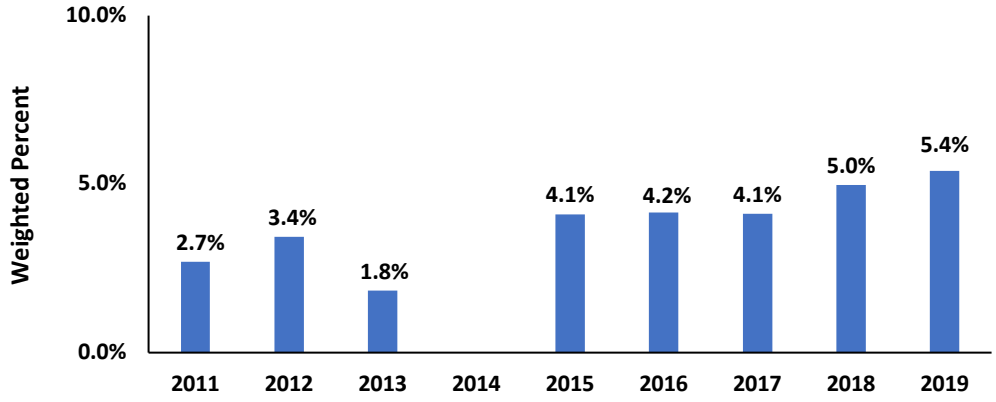
The Behavioral Risk Factor Surveillance System (BRFSS) is a statewide survey focused on health risk behaviors, preventative health practices, chronic health conditions, and the community's use of preventative services.

The survey collects information annually on physical and mental health, suicide ideation and attempts, substance use, tobacco use, adverse childhood experiences, sexual orientation, and gender identity.

The limitations to the data collected include possibilities of a small sample size that does not reflect the entire population and that the state specific questions cannot be compared nationally. Survey questions vary from year to year and the information collected only reflects the willingness of the responses.

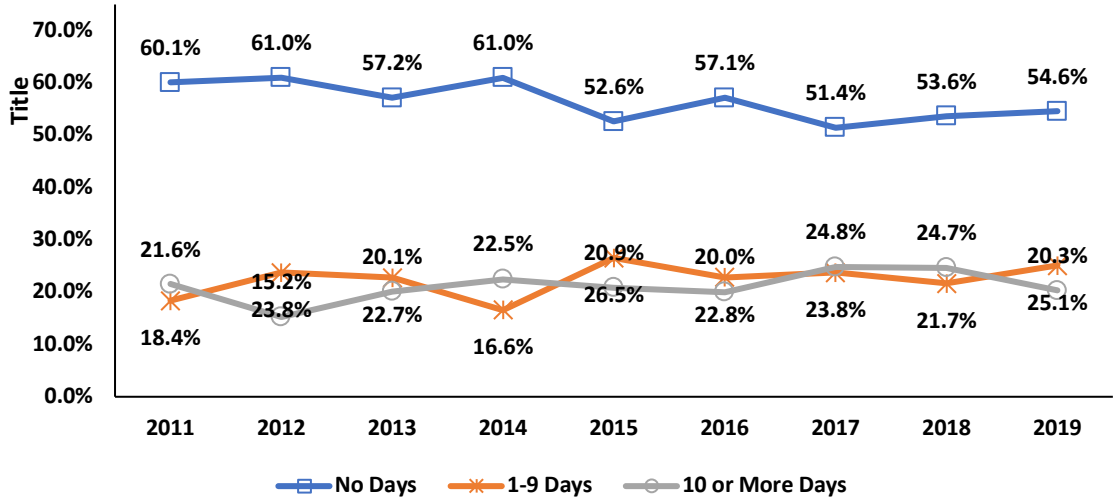
Mental and Physical Health Charts

Percentage of Northern Nevada Adults Who Have Seriously Considered Suicide



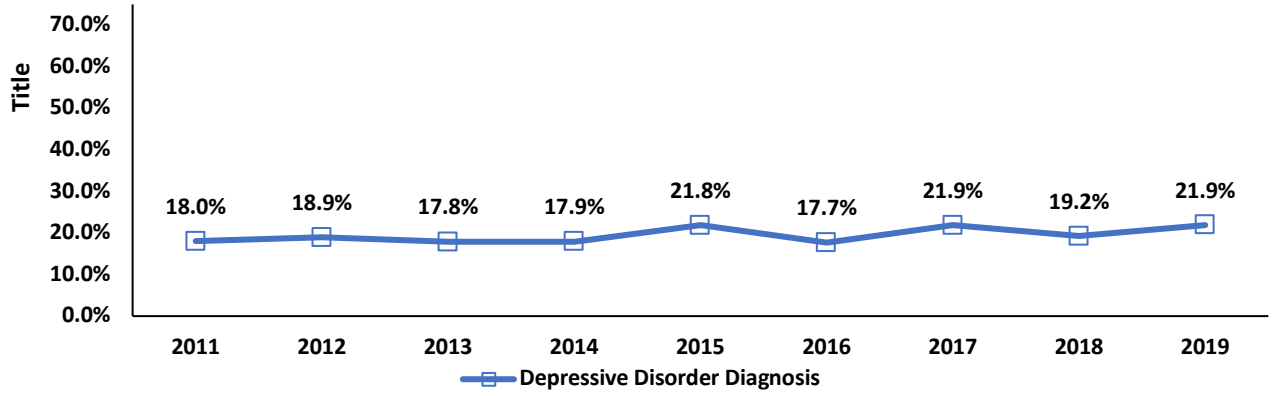
Since 2017, Northern Nevada has seen a steady increase of 31.7% in the amount of people who have reported to seriously considering committing suicide. There was an increase of 22% from 2017 to 2018, and a 0.4% increase from 2018 to 2019.

Percentage of Northern Nevada Adults Who Experienced Poor Mental or Physical Health That Prevented Them from Doing Usual Activities



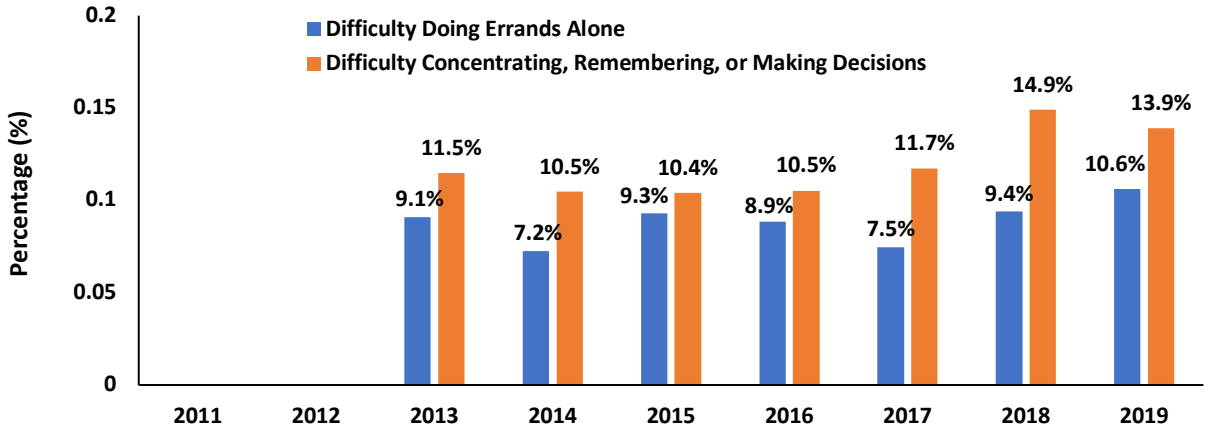
In 2019, 20.3% of Northern Nevada adults reported to experiencing poor mental or physical health that prevented them from doing their usual activities that lasted for a period of 1 to 9 consecutive days. This is a substantial increase of 15.7% from the previous year.

Percentage of Northern Nevada Adults Who Reported a Depressive Disorder Diagnosis



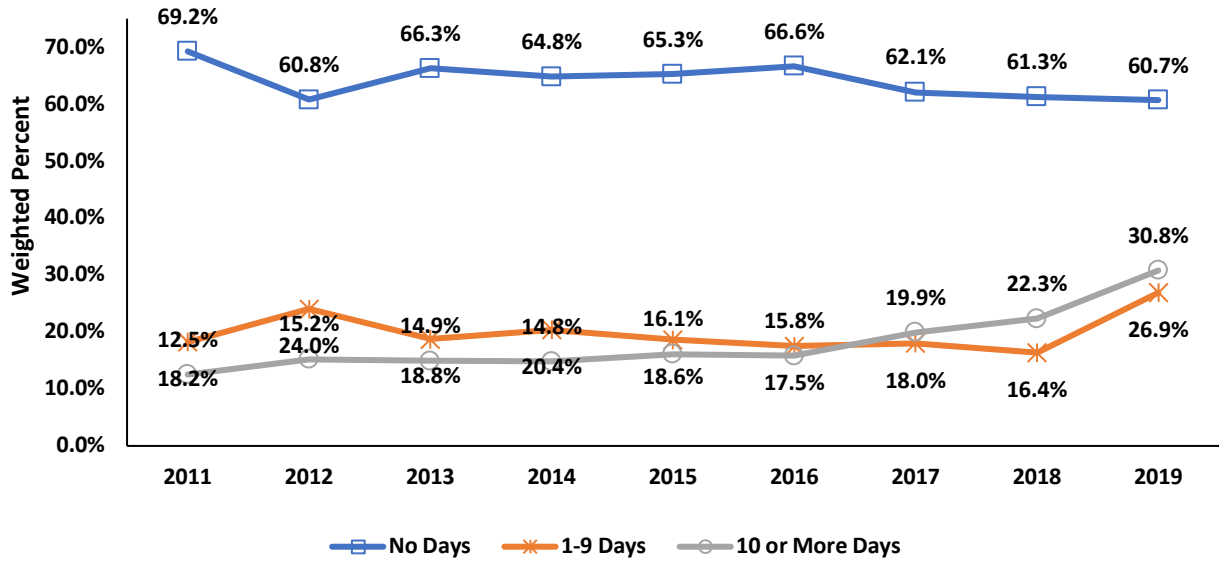
Between 2019 and 2020, the amount of Northern Nevada adults with a depressive disorder diagnosis increased 14.1%.

Percentage of Northern Nevada Adults Who Experience Difficulties Because of Physical, Mental, or Emotional Conditions



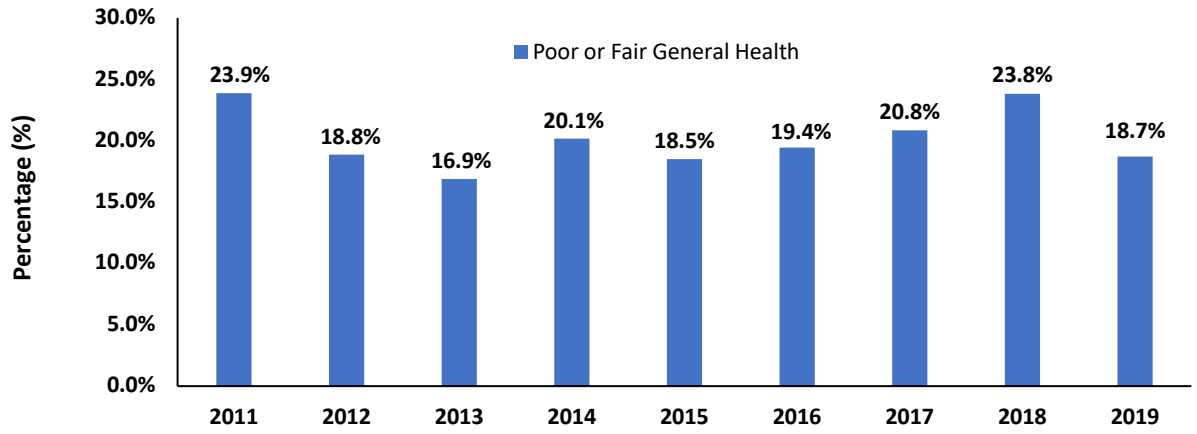
Since 2017, Northern Nevada Adults have reported to experiencing difficulties because of physical, mental, or emotional conditions has increased a considerable amount. The amount of people having difficulty doing errands alone has increased 41.3% between 2017 and 2019. There was a 18.8% increase in the number of adults experiencing difficulty concentrating, remembering, or decision making due to physical, mental, or emotional health conditions.

Percentage of Northern Nevada Adults Whose Mental Health Was Not Good Due To Amount Of Days Affected



The number of adults in Northern Nevada who identified with their overall mental health is being negatively impacted by the number of days they are experiencing difficulties has been steadily increasing since 2011. Between 2018 and 2019, there has been a 38.1% increase in adults identifying with 10 or more difficult days that has affected their overall mental health. Correlative data shows a 64% increase in adults identifying with 1 – 9 days difficult days affecting their mental health.

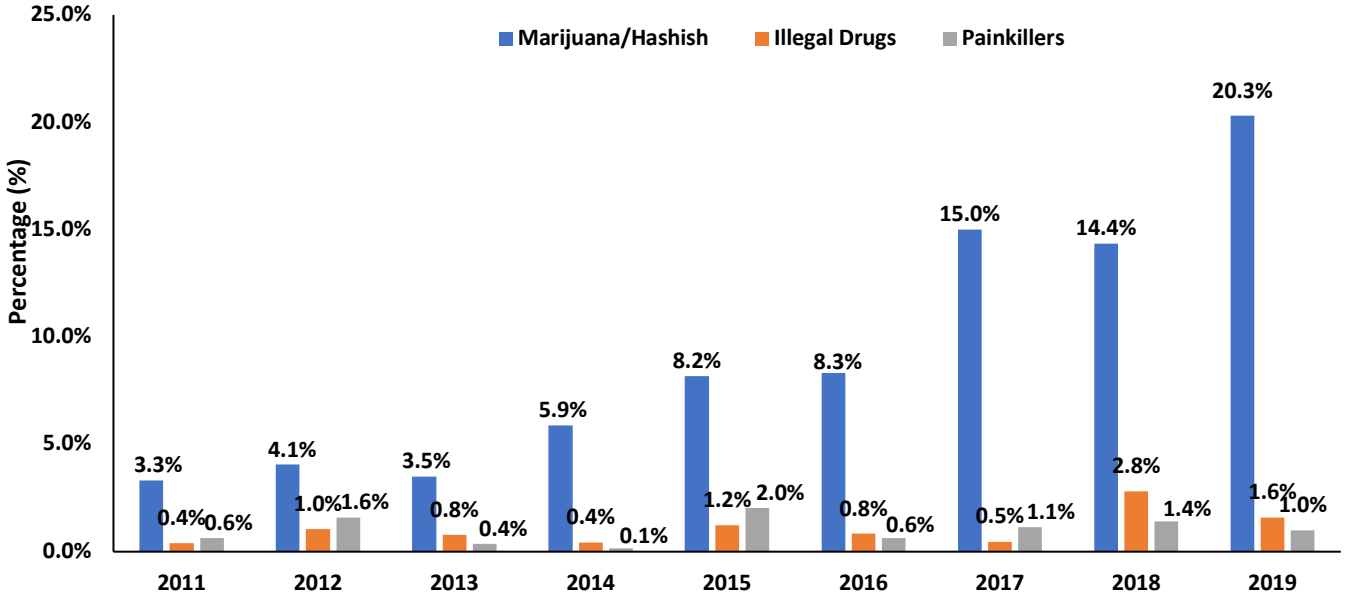
Percentage of Northern Nevada Adults Who Rated Their General Health as Poor or Fair



Between 2018 and 2019, there was a 21.4% decrease in the amount of Northern Nevada adults who rated their general health as being poor or fair.

Substance Abuse Charts

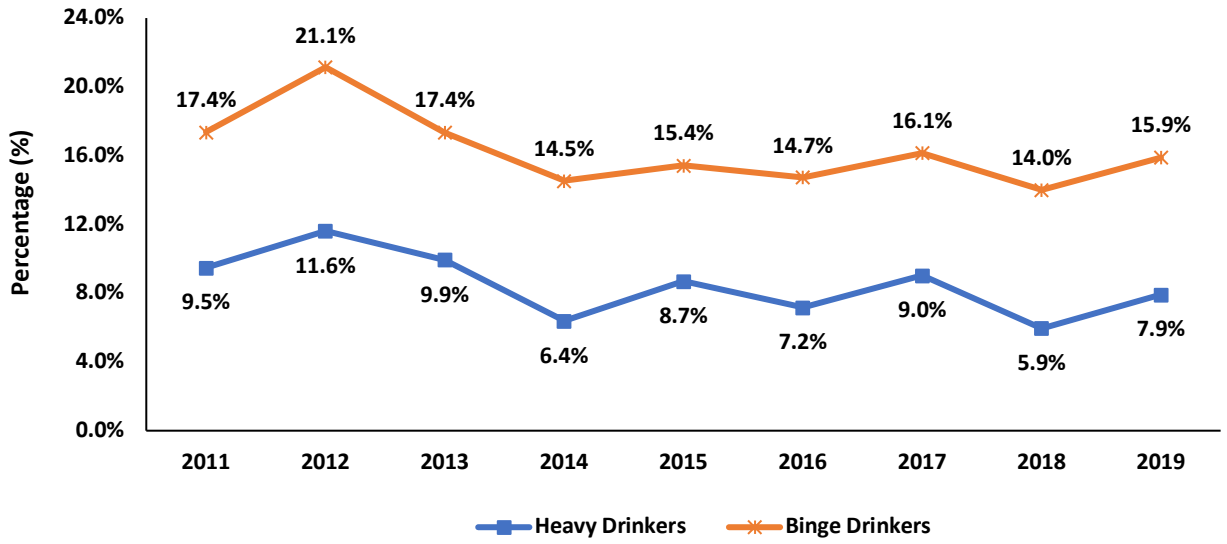
Percentage of Northern Nevada Adults Who Used Marijuana/Hashish, Illegal Drugs, or Painkillers to Get High in the Last 30 Days



Between 2018 and 2019, the number of Northern Nevada adults that reported to using marijuana/hashish to get high in the last 30 days increased 40.9%. In contrast, the number of adults who reported to using illegal drugs to get high in the last 30 days decreased 42.9% and the

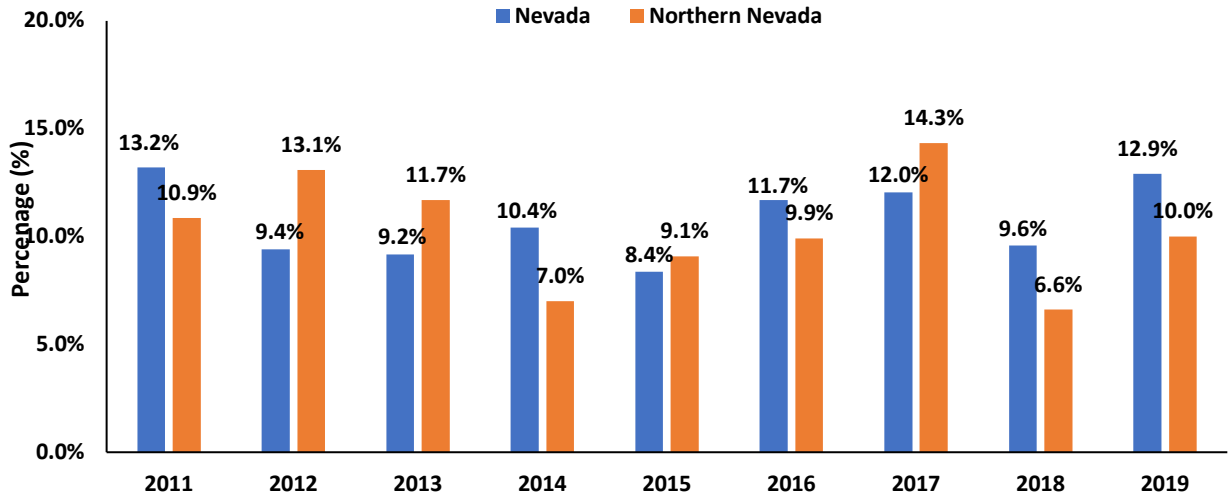
number of adults that reported to using painkillers to get high in the last 30 days decreased 28.6%.

Percentage of Northern Nevada Adults who are considered Heavy or Binge Drinkers



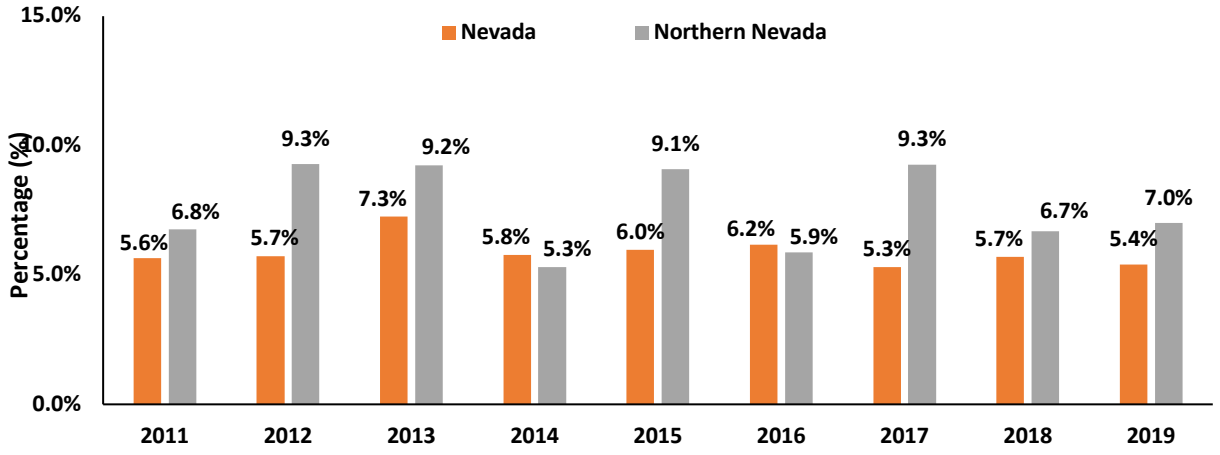
There was an increase in both the number of reported heavy and binge drinking tendencies among adults in Northern Nevada. Between 2018 and 2019, the number of adults reporting to being a binge drinker increased 13.6% and the number of adults reporting to being a heavy drinker increased 33.9%

Percentage of Adult Woman in Nevada Who Are Considered Binge Drinkers



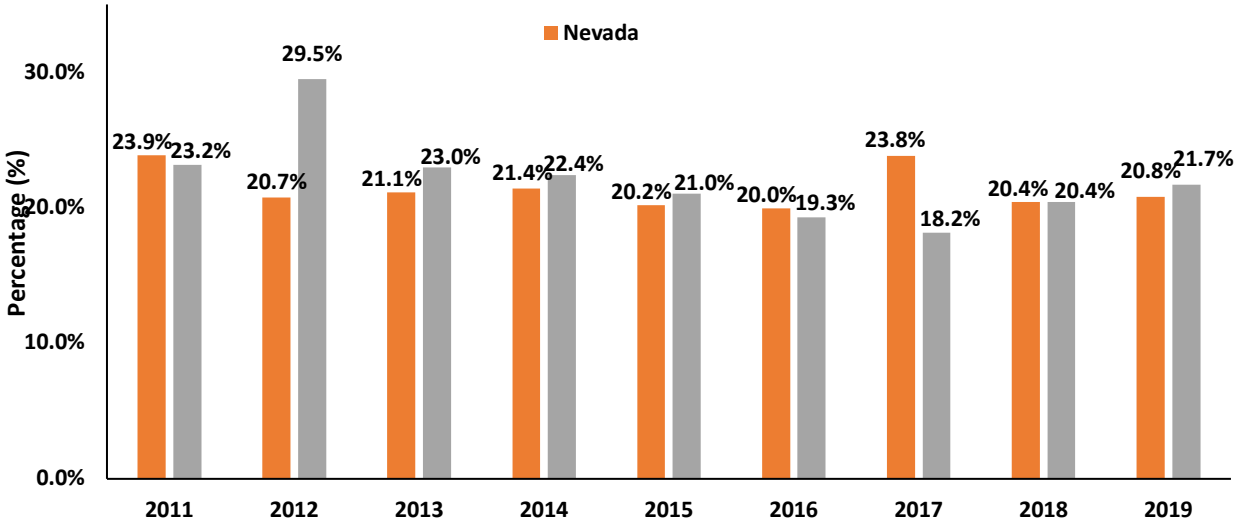
In both Northern Nevada and the state of Nevada as a whole, there has been an increase in the number of adult women who are considered to binge drink alcohol. The number of women in Northern Nevada who reported to binge drinking has increased 51.6% between 2018 and 2019.

Percentage of Adult Women in Nevada Who Are Considered Heavy Drinkers



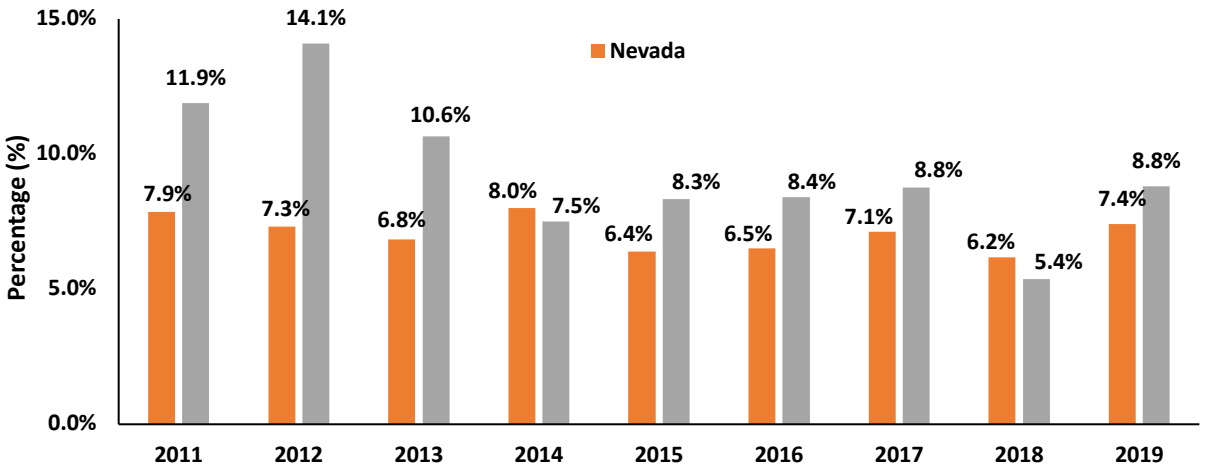
In Northern Nevada there has been an increase in the number of adult women who are considered to be heavy alcoholic drinkers. The number of women in Northern Nevada who reported to heavy drinking has increased 4.5% between 2018 and 2019. Adult women in Nevada state that reported to heavy drinking has decreased 5.7%.

Percentage of Adult Men in Nevada Who are Considered Binge Drinkers



There has been a slight increase in the number of men who reported to binge drinking in both Nevada state and Northern Nevada. Northern Nevada saw a 6.4% increase in men reporting to binge drinking between 2018 and 2019.

Percentage of Adult Men in Nevada Who are Considered Heavy Drinkers



In both Northern Nevada and the state of Nevada as a whole, there has been an increase in the number of adult men who are considered to heavily drink alcohol. The number of men in Northern Nevada who reported to heavily drinking has increased 63% between 2018 and 2019. The number of men in Nevada who reported to heavily drinking has increased 19.3% between 2018 and 2019.

SafeVoice Data Charts

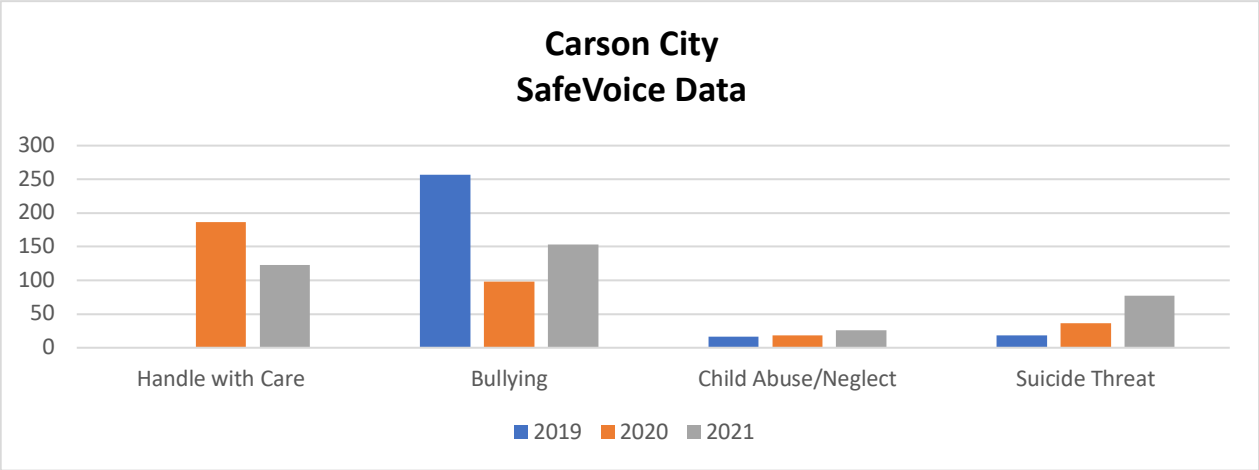
Carson City, Douglas, and Lyon Counties

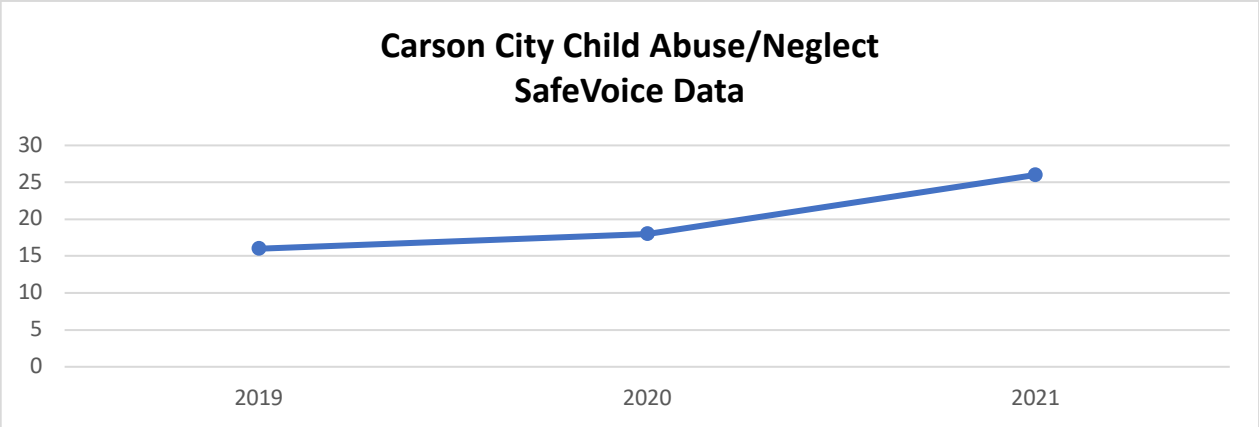
SafeVoice gives students, parents, and faculty access to an anonymous reporting system that prevents violence and saves lives. In partnership with Nevada Department of Public Safety, SafeVoice allows students a safe place to voice their concerns. SafeVoice was established by the Nevada Department of Education under SB 212 in 2017 and provides a team of first responders 24/7/365. SafeVoice protects student's wellness and always stays anonymous.

Please note: Any tips under 10 for each category are not considered in these reports as it is not statistically significant to the data reflection. Churchill did not have enough data to report in 2019 & 2020 and had 29 Handle with Care notifications in 2021. Storey did not have enough data to report as well.

Presented below are a series charts based on data collected between the calendar years 2019 – 2021 for Carson City, Douglas, Lyon, and counties.

Carson City

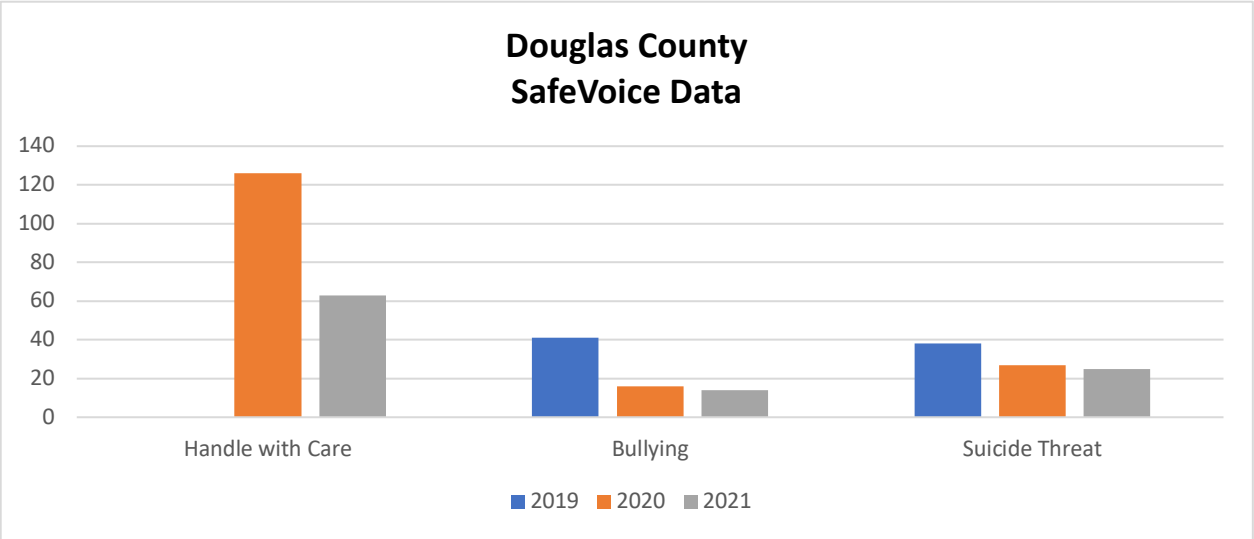




From 2019 to 2021, Carson City saw an increase in suicide threat and child abuse/neglect. The amount of youth at risk for suicide saw a 327.8% increase over the two-year span. The number of children reported to being abused and neglected increased 62.5% from 2019 to 2021.

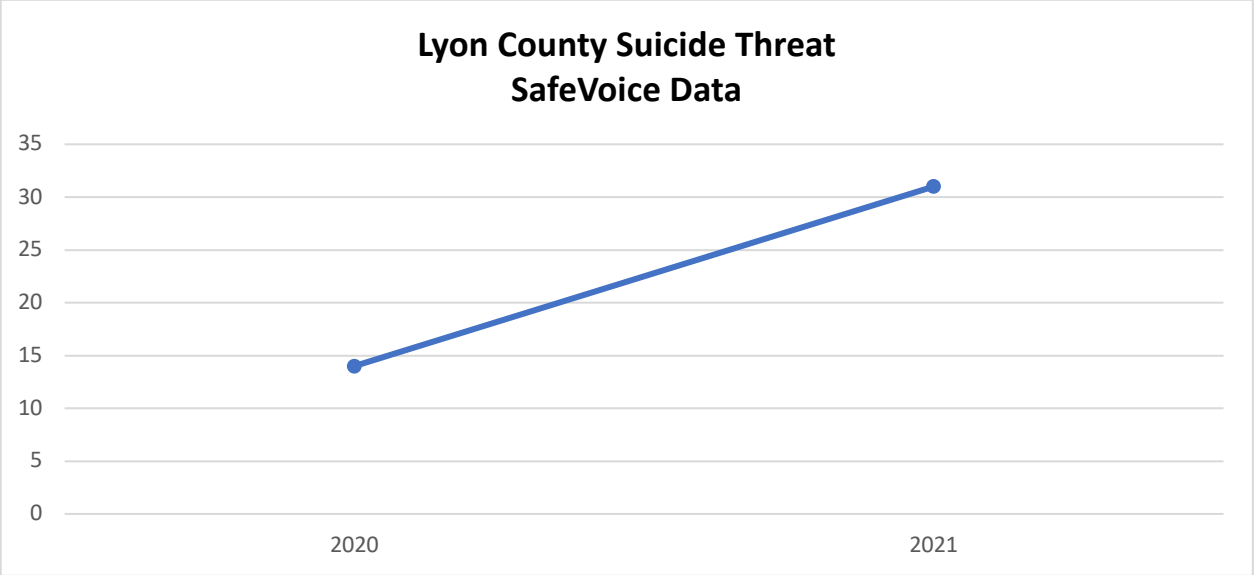
After a sharp decline in the number of reported cases of bullying in 2020, SafeVoice reports an upward trend in bullying 2021. Reports of bullying decreased 61.9% from 2019 to 2020, only to increase 56.1% in 2021.
Handle with Care notifications at schools decreased 33.9% between 2020 and 2021.

Douglas County

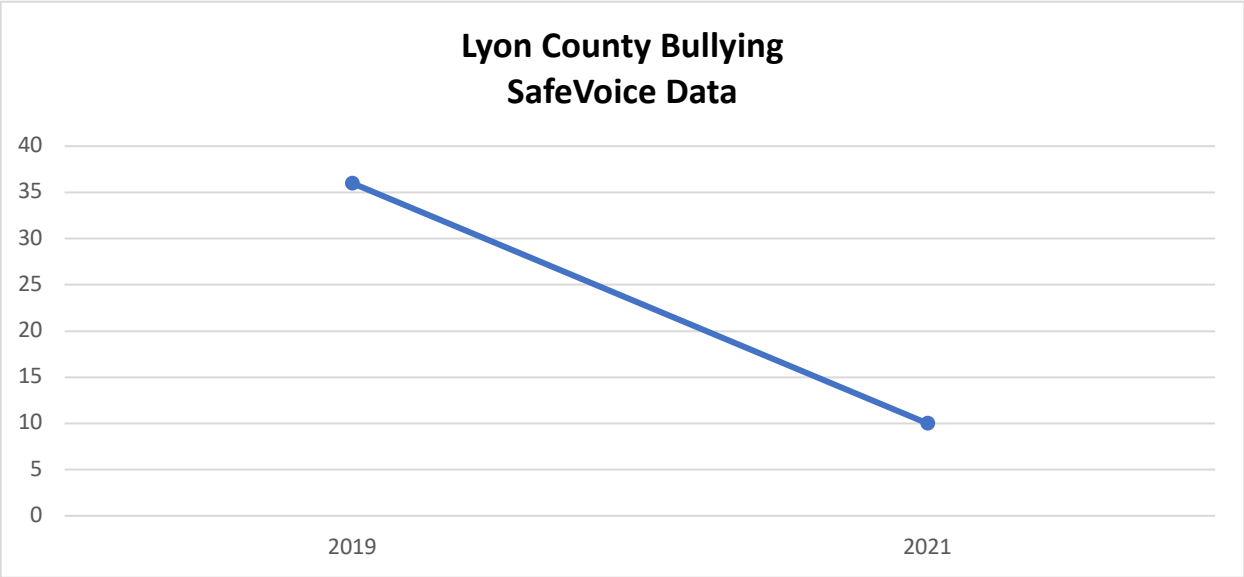


Between 2019 and 2021, SafeVoice reported to Douglas County having a downward trend in handle with care notations, bullying, and suicide threat.

Lyon County

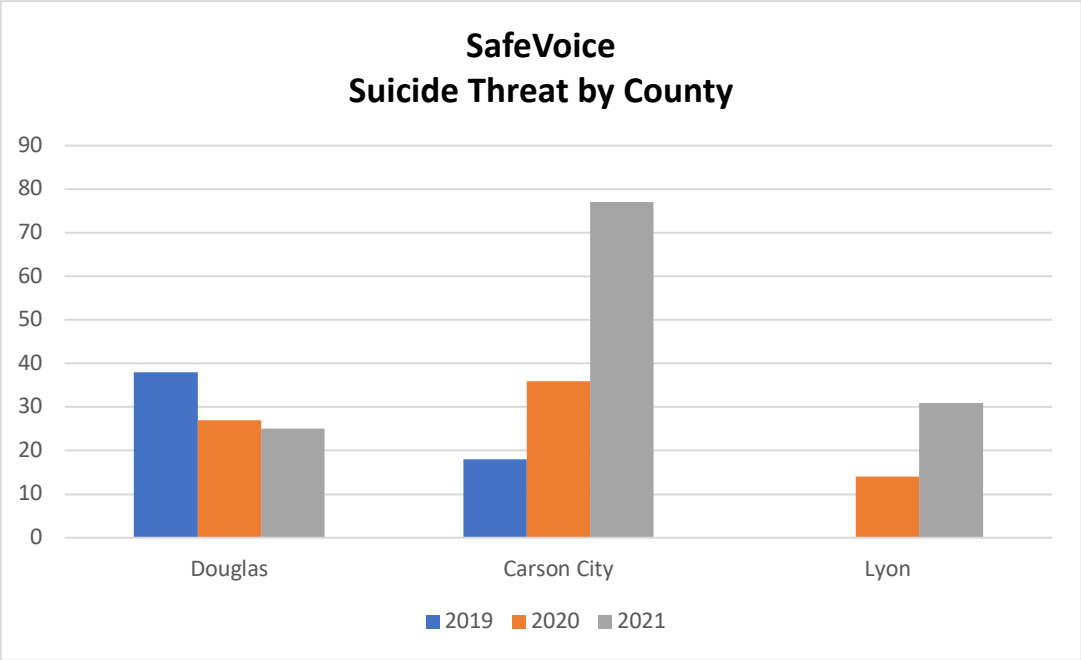


Lyon County saw an exponential increase in youth reported to being at risk for suicide. From 2020 to 2021, the youth suicide threat increased 121.4%.



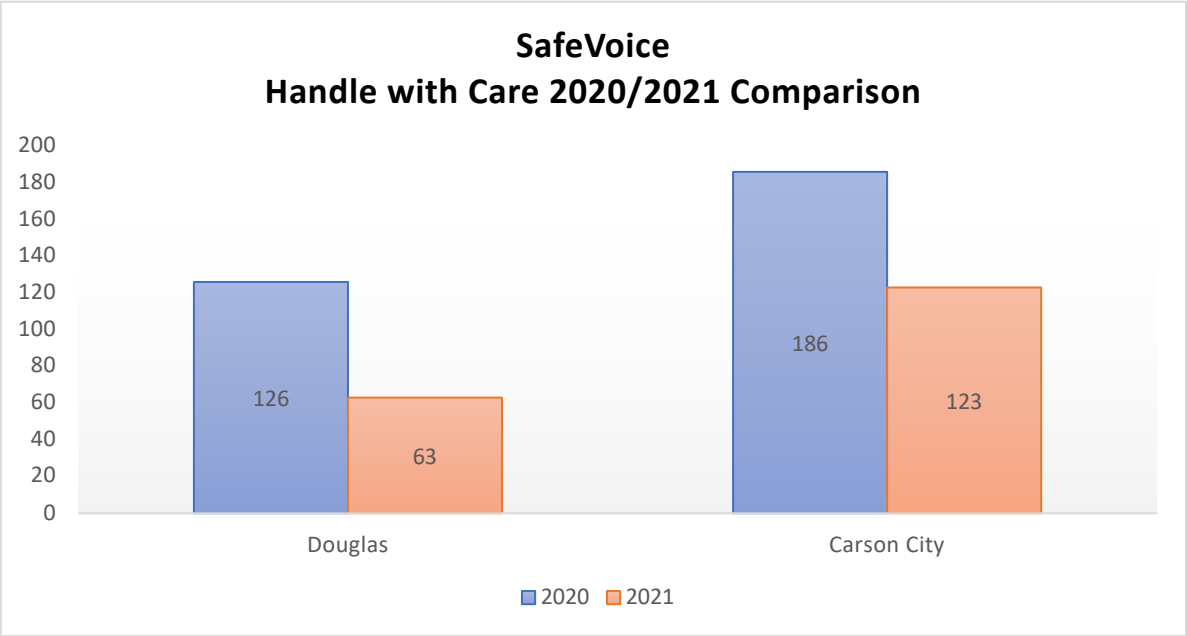
From 2019 to 2021, Lyon County saw a 72.2% decrease of youth bullying reports, in contrast to the rising cases of suicide threats.

Region Comparison Suicide Threat



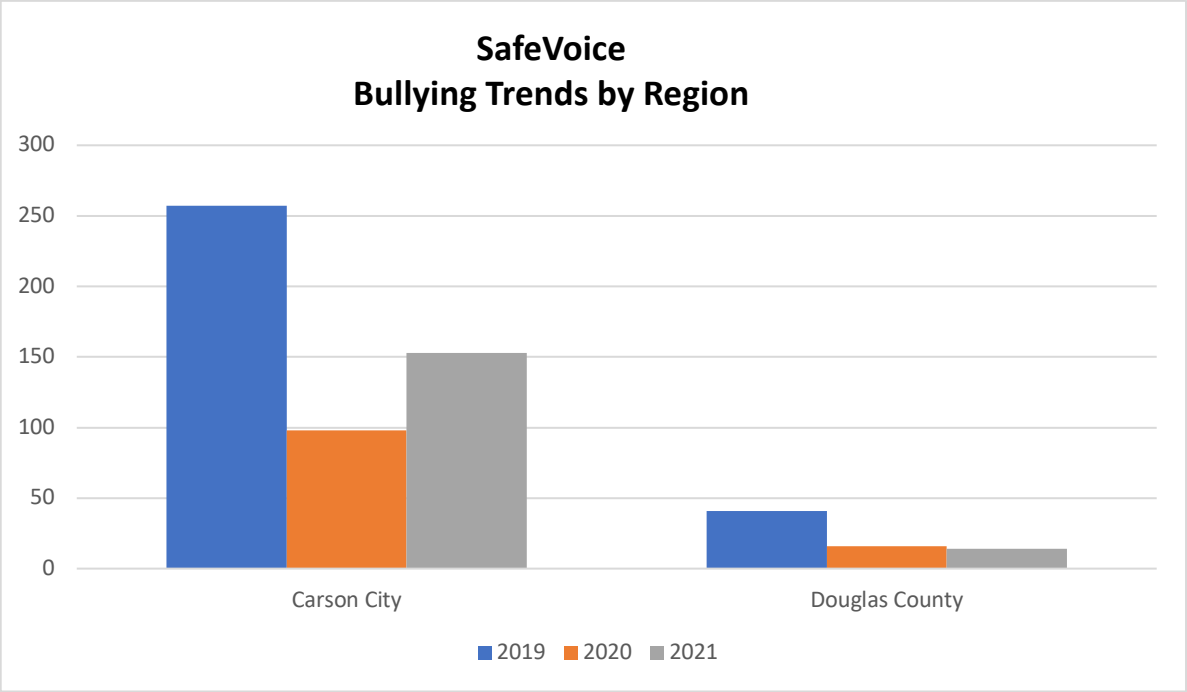
Carson City and Lyon Count experienced an upward trend in youth suicide threat reports, whereas Douglas County saw a decreasing trend.

County Comparison Handle with Care



Between 2020 and 2021, Douglas County and Carson City both saw a decrease in handle with care notifications.

County Comparison Bullying



Carson City saw an increase in SafeVoice bullying reports between 2020 and 2021, after sharp decreases in the trend. Douglas County has experienced a 65.9% decrease in bullying reports between 2019 and 2021.

Data from 2019 Youth Risk Behavior Survey

Youth Mental Health:

- Due to the fact that the questions in the Youth Behavior Risk Survey relating to suicide and feelings of sadness and hopelessness were worded differently in 2019 to past years and should not be compared, there is no data to report on this topic.

Youth Tobacco Use:

- High school students for the Northern Region in 2019, had a significantly higher percent for ever having smoked cigarettes than Nevada at 27.5% and 18.0% respectively. The middle school students in the Northern Region also, had a slightly higher percent for ever trying cigarettes at 14.6% compared to 9.9% Nevada.
- High school students in the Northern Region in 2019 have a significantly higher percent for ever having using an electronic vapor (e-vapor) product than Nevada at 59.9% and 43.5%, respectively. Similarly, middle school students in the Northern Region also have a significantly higher percent for ever using an e-vapor product at 30.6%, 22.4% for Nevada.

Youth Alcohol Use:

- High school students in the Northern Region in 2019 have a significantly higher percent for ever drinking alcohol than Nevada at 66.1% and 56.9%, respectively. The percent from previous years has decreased from 66.4% in 2017. Similarly, middle school students in the Northern Region have a slightly higher percent for ever drinking alcohol at 32.7%, compared 29.2% for Nevada.

Youth Marijuana Use:

- High school students in the Northern Region in 2019 have a significantly higher percent for ever using marijuana than Nevada at 45.4% and 35.4%, respectively. The percent from previous years has increased from 43.6% in 2017. Similarly, middle school students in the Northern Region have a slightly higher percent for ever using marijuana at 16.4%, compared 13.4% for Nevada.

Special Populations- Maternal and Child Health

- Of the self-reported substance use during pregnancy among the Northern Region mothers who gave birth between 2010 and 2019, the highest rate was with marijuana use in 2018, at 18.9 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was at 5.3 per 1,000 births in 2019. Polysubstance use (more than one substance) has decreased from 3.9 per 1,000 live births in 2015 to 2.6 per 1,000 live births in 2019.
- Over the past decade, Inpatient admissions for neonatal abstinence syndrome (NAS) in the Northern Region significantly increased from 2 newborns admitted in 2011 to 13 newborns admitted in 2018. However, there since have been a marked decrease from a high of 9.5 in 2016 to 2.1 in 2019.

Northern Region Behavioral Health Policy Board Annual Report 2021

Nevada Commission on Behavioral Health

March 23rd, 2022

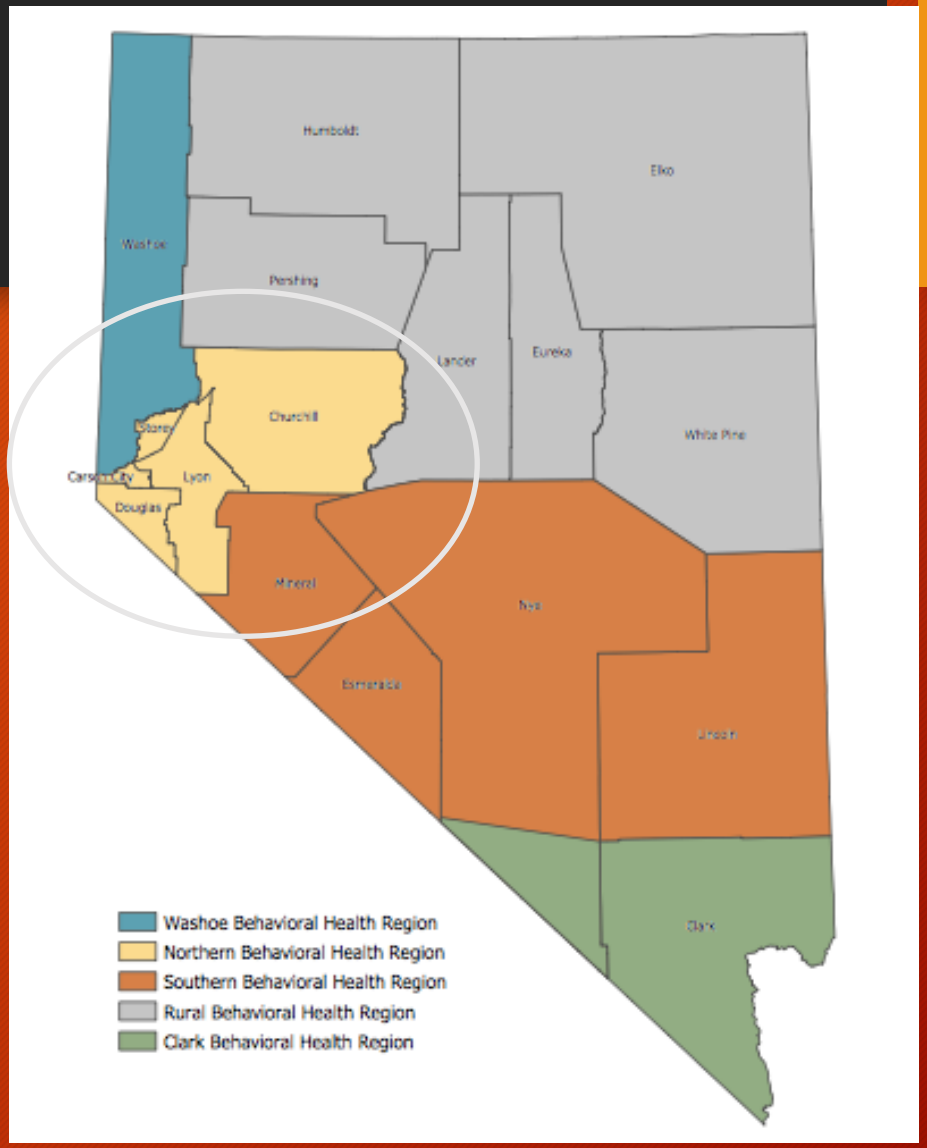
Jessica Flood Abrass, Northern Regional Behavioral Health Coordinator

Northern Regional Behavioral Health Policy Board membership

- **Assemblywoman Dr. Robin Titus**, Nevada State Legislature
- **Dr. Amy Hyne- Sutherland**, Director of Mission Integration, Carson Tahoe Health
- **Nicki Aaker,** RN, Director, Carson City Health and Human Services
- **Taylor Allison,** Executive Director, Douglas County Partnership
- **Erik Schoen,** Executive Director, Community Chest
- **Laura Yanez**, Executive Director, NAMI Western Nevada
- **Sandy Wartgow**, Deputy Chief, Carson City EMS
- **Ken Furlong**, Sheriff, Carson City
- **Lana Robards**, Director, New Frontier Treatment Center, Fallon, Nevada
- **Dr. Daniel Gunnarson**, Psychologist, Aging and Disability Services Rural Regional Center
- **Heather Korbulic**, Executive Director, Silver State Insurance Exchange
- **Dr. Ali Banister**, PhD, Juvenile Probation Chief – First Judicial District
- **Shayla Holmes**, Executive Director of Lyon County Health and Human Services

Northern Region
Carson, Churchill, Douglas, Lyon, & Storey Counties

- 11,976.95 square miles in northwestern Nevada.
- The total population of the Northern Region is estimated to be 194,464 in 2020, slightly up from 192,723 in 2019.
- In terms of ethnicity, 76.5% residents in the Northern Region are White not of Hispanic origin, 16.9% residents are Hispanic, 3.0% of the population are Native American, 2.4%, Asian, and 1.1% of the population are Black.



Trends identified by Stakeholders

Provider staffing shortages and strain leading to reduced availability of behavioral health services

An increase of youth experiencing suicidal thoughts and behaviors

Problems for youth and family accessing outpatient treatment

Increased crisis in older adults leading to increased need for crisis response and hospitalizations

Behavioral health needs caused by COVID induced risk factors

Behavioral health needs caused by socio-economic pressures

Regional Priorities, Gaps, and Strategies

1. Regional Board infrastructure development

- **Need/Gap:** additional infrastructure could lead to greater efficiency as the Northern region works to develop a more sophisticated behavioral health system.
- **Board strategies:**
  - Development of Regional Behavioral Health Authorities
  - Board support positions: Maintaining Regional Behavioral Health Coordinator, addition of data analyst
  - Development and implementation of Northern Region Behavioral Health Emergency Operations Plan (BHEOP)
- **Progress:**
  - Developing concept for Regional Behavioral Health Authorities through updating NRS 433C
  - Obtained full time data analyst position through federal community opioid response grant (COSSAP)
  - Developed and in the process of implementing BHEOP)

2. Affordable and supportive housing and other social determinants of health

- **Need/ Gaps:** Lack of housing options contribute to ongoing homelessness, chronic crisis, and institutionalization
- **Board Strategy:** Northern RRBHPB behavioral health housing subcommittee currently exploring issue

3. Behavioral health workforce with capability to treat adults and youth

Need/Gap: Lack of behavioral health workforce impedes timely access to treatment and prevents providers from expanding quality services.

Board strategies:

- Advocates for a tiered approach to workforce that includes clinicians, community health workers, and peers.

Progress:

- Piloting Community Health Workers (CHWs) in a variety of settings including hospital discharge planning, social services, and jail reentry programming.
- Exploring strategies for implementation of peers, which is currently an underutilized service in the region.

4. Development of a regional crisis response system while obtaining sustainable funding for current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)

Need/ gaps:

- Individuals experiencing crisis in the Northern Region often cannot find the care they need when they need it
- With the implementation of 988 in Nevada, there is a need to coordinate local infrastructure into the state crisis response system.

Board strategies:

- Development of Northern Regional Crisis Response Position Statement with community stakeholder input
- Continued advocacy for sustainable funding of current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)

Progress:

- Engagement of providers to apply for crisis response funding- awaiting state response

5. Increase access to treatment in all levels of care

- **Needs/ Gaps:**
  - Lack of insurance is a barrier for access to behavioral health care.
  - Significant concern about access to care for youth and adults who have insurance.
- **Board strategies:**
  - Exploring opportunities including trauma recovery grant and Certified Community Behavioral Health Centers (CCBHCs)
  - The Northern Board is also interested in exploring other models of care including peer drop-in centers, living room models, and community support centers.
- **Progress:**
  - Continuing to partner with CCBHCs and encouraging community providers to expand services.

6. Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker)

- **Need/ Gap:** There are barriers to continuity of care, that includes lack of formalized referral systems, lack of coordination and communication, and limited provider capacity.
- **Board strategies:**
  - Advocacy for utilization of peers and community health workers to support continuity of care
  - Exploration of structural solutions to strengthen warm hand offs.
- **Progress:**
  - Piloting use of CHWs for discharge planning in Carson and Churchill Counties.

Board Activities

Coordination with county behavioral health taskforces

Participated in development of Regional Behavioral Health Policy Board website: nvbh.org

Adopted Northern BHEOP

Wrote advocacy papers for:

- Funding for additional DWSS Targeted Outreach Program Workers
- Development of Regional Behavioral Health Authorities
- Gap caused by the decrease in funding of the China Spring Youth Camp
- Legislation aligned with board priorities including **SB56, SB69, and SB156 SB44, SB390, and AB154**

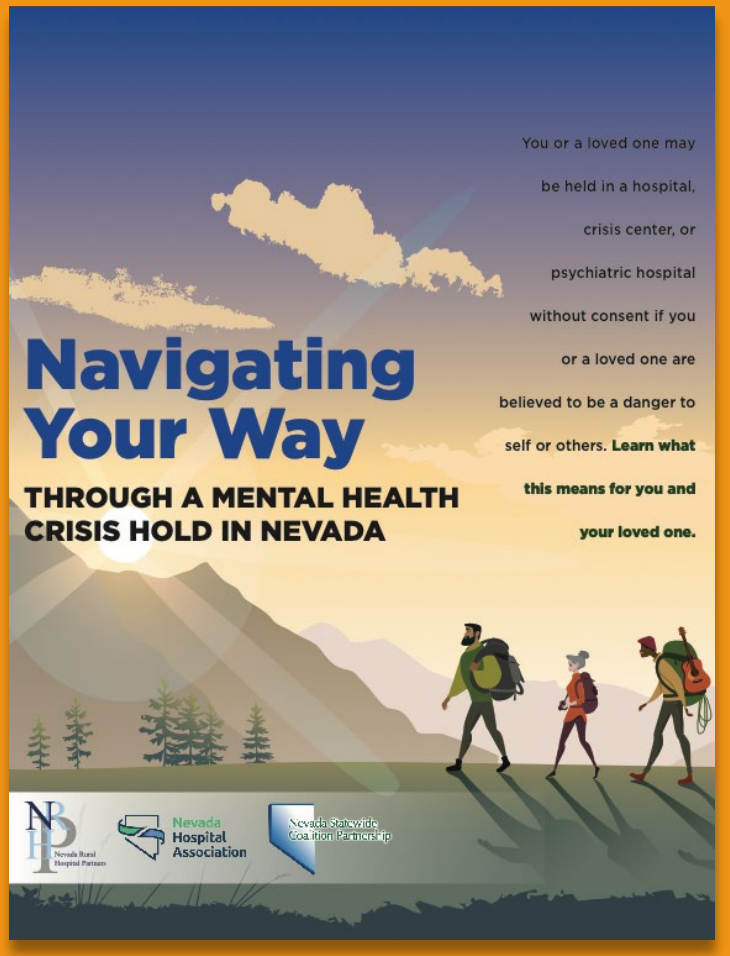
Legislative Activities

- Passage of NRBHPB bill SB70
  - Modernized the mental health crisis hold law
  - Clarified assisted outpatient treatment (AOT) process
  - Updated conditional release
  - Adjusted youth mental health crisis hold process
  - Updated the chemical restraint definition
- Continuing to support implementation for education of mental health crisis hold and involuntary treatment process through Statewide Mental Health Crisis Hold Workgroup

Mental health crisis hold education

- Nvbh.org website
- Adult mental health crisis hold brochure and one pager
- Parent's Guide to Youth Mental Health

- Mental health crisis hold Summit March 7th and 8th



Data highlights

- Suicides have increased in the region 18.8% between 2018 and 2020.
- Mental health related deaths increased 76.47% between 2017 to 2019. There was a slight decrease in mental health deaths in 2020, but the overall there has been a significant increase.
- Northern Nevada has seen an increase in drug and alcohol related deaths. Drug and alcohol related deaths have sharply increased 25.5% from 2018 to 2020.
- Drug related deaths in Northern Nevada have decreased 28% from 2017 to 2020.
- Since 2017, Northern Nevada has seen an increase of 31.7% in the amount of people who have reported to seriously considering committing suicide. There was an increase of 22% from 2017 to 2018, and a 0.4% increase from 2018 to 2019.
- Since 2017, Northern Nevada Adults have reported to experiencing difficulties because of physical, mental, or emotional conditions has increased a considerable amount. The amount of people having difficulty doing errands alone has increased 41.3% between 2017 and 2019. There was a 18.8% increase in the number of adults experiencing difficulty concentrating, remembering, or decision making due to physical, mental, or emotional health conditions.

Conclusion

- The Northern Board is focused on:
  - **Aligning with national best practices while staying true to local values** and resources specific to the region.
  - **Mitigating workforce issues and increase access to care through use of non-clinical roles** such as community health workers, peer support specialists, and family peer advocates.
  - **Gathering more sophisticated and accurate data to better understand trends and the impacts** of significant events such as disasters and the current pandemic.
  - **Exploring innovative solutions to address identified problems** including housing and local/ regional behavioral health infrastructure concepts.
  - **Developing a system that emphasizes person centered and community-based care.**

Contact

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Chief Medical Officer

Washoe Region

Washoe Regional Behavioral Health Policy Board

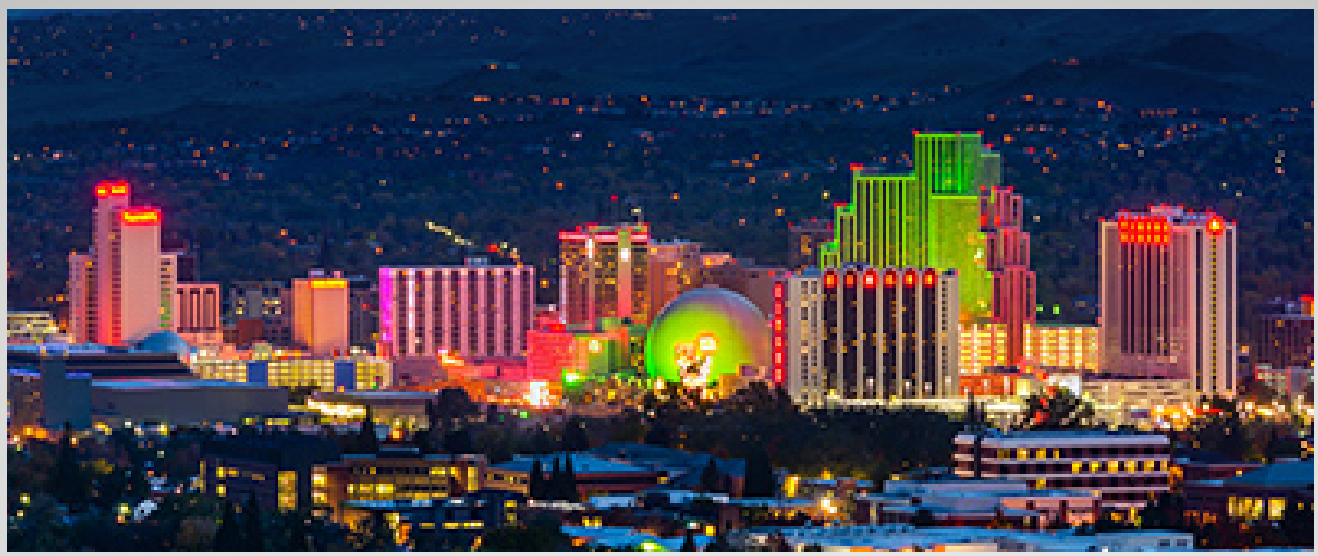
2021 | ANNUAL REPORT

Prepared By

Dorothy Edwards, Regional Behavioral Health Coordinator

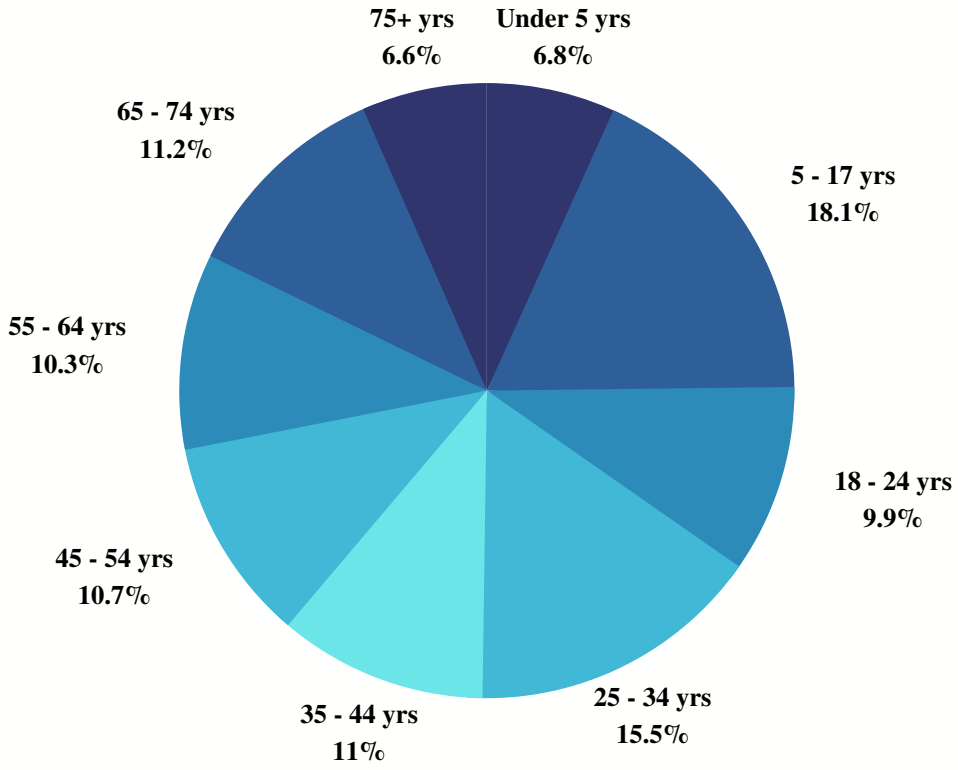
Table of Contents

I. Introduction

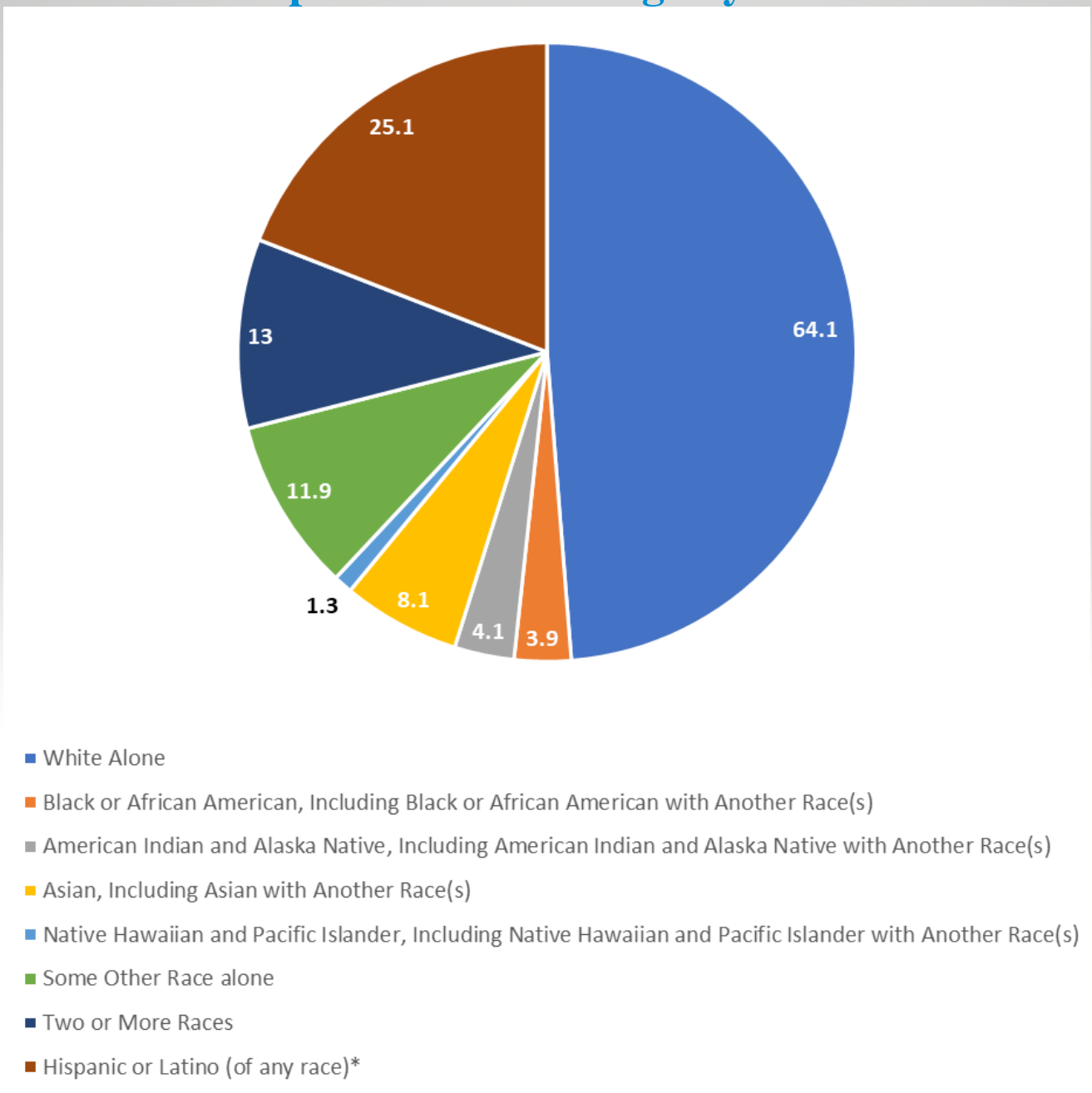


Washoe County is the second most populated county in Nevada with an estimated 486,492 residents in 2020 encompassing 15.7% of Nevada's residents and a growth rate of 1.52% in just the last year and 13.44% since the 2010 census (Census.gov). Washoe County is home to over 6,600 sprawling square miles, bordering both California and Oregon with nearly half a million residents who call our region home. Washoe County's recreation and outdoors experiences are second to none with 49 beautiful parks, 161 miles of trails, and more than 10,000 acres of open space.

Population by Age*



Population Percentage by Race



Note: The population database is derived from the 2020 Census Public Law 94-171 Redistricting Data as provided by the U.S. Census Bureau and validated by the Legislative Counsel Bureau. Compiled by Legislative Counsel Bureau, August, 2021. Racial population data is based on self-identification. Respondents have the option of selecting one or more races. Respondents who self-identify as two or more races are counted in each of the minority race categories they selected, as well as the "Two or More Races" category. Therefore, the seven race categories shown in the table will total to more than 100 percent for each entity.*Hispanic or Latino is reported by the Census Bureau as a language group, separately.Demographic Data | Nevada Reapportionment and Redistricting 2021 (state.nv.us)

US Census Bureau Quick Facts Washoe County, NV

Population	
Population Estimates, July 1 2021, (V2021)	NA
Population estimates base, April 1, 2020, (V2021)	NA
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	NA
Population, Census, April 1, 2020	486,492
Population, Census, April 1, 2010	421,407
Age and Sex	
Persons under 5 years, percent	5.8%
Persons under 18 years, percent	21.3%
Persons 65 years and over, percent	16.8%
Female persons, percent	**49.5%**
Race and Hispanic Origin	
White alone, percent	84.6%
Black or African American alone, percent (a)	2.8%
American Indian and Alaska Native alone, percent (a)	2.2%
Asian alone, percent (a)	5.8%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.7%
Two or More Races, percent	3.9%
Hispanic or Latino, percent (b)	25.0%
White alone, not Hispanic or Latino, percent	62.3%
Population Characteristics	
Veterans, 2015-2019	32,421
Foreign born persons, percent, 2015-2019	14.1%
Housing	
Housing units, July 1, 2019, (V2019)	205,417
Owner-occupied housing unit rate, 2015-2019	58.3%
Median value of owner-occupied housing units, 2015-2019	$334,100
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,663
Median selected monthly owner costs -without a mortgage, 2015-2019	$460
Median gross rent, 2015-2019	$1,074
Building permits, 2020	4,489
Families & Living Arrangements	
Households, 2015-2019	182,180
Persons per household, 2015-2019	2.47
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	81.6%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	23.7%
Computer and Internet Use	
Households with a computer, percent, 2015-2019	93.4%
Households with a broadband Internet subscription, percent, 2015-2019	85.5%
Education	
High school graduate or higher, percent of persons age 25 years+, 2015-2019	88.6%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	30.8%
Health	
With a disability, under age 65 years, percent, 2015-2019	8.5%
Persons without health insurance, under age 65 years, percent	12.5%

Economy	
In civilian labor force, total, percent of population age 16 years+, 2015-2019	66.4%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	61.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	1,860,761
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	D
Total manufacturers shipments, 2012 ($1,000) (c)	6,427,397
Total retail sales, 2012 ($1,000) (c)	6,167,020
Total retail sales per capita, 2012 (c)	$14,345
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	22.1
Income & Poverty	
Median household income (in 2019 dollars), 2015-2019	$64,791
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$36,071
Persons in poverty, percent	⚠ 10.2%

BUSINESSES

Businesses	
Total employer establishments, 2019	12,972
Total employment, 2019	204,608
Total annual payroll, 2019 ($1,000)	10,068,586
Total employment, percent change, 2018-2019	1.0%
Total nonemployer establishments, 2018	33,976
All firms, 2012	37,029
Men-owned firms, 2012	18,503
Women-owned firms, 2012	12,047
Minority-owned firms, 2012	5,881
Nonminority-owned firms, 2012	28,801
Veteran-owned firms, 2012	4,272
Nonveteran-owned firms, 2012	29,568

II. Executive Summary

Behavioral health refers to the promotion of mental health, resilience and wellbeing; the treatment and intervention of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. Individuals suffering with behavioral health issues and disorders are unfortunately all too common in the United States. One in five individuals experience a mental health illness; one in twenty experience a severe mental illness; one in fifteen experience both a mental illness and a substance use disorder; and, one over twelve million individuals report having had thoughts of suicide (NAMI, 2020). Regional behavioral health policy boards in Nevada are only one step towards addressing, supporting, collaborating and educating their respective communities on the behavioral health issues and challenges within their community.

The annual report for the Washoe Regional Behavioral Health Policy Board (WRBHPB) addresses the previous year's activities and available data collection related to the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. In compliance with NRS 433.4295, this report sheds light on the status of behavioral health in our region, and highlights our priorities, strategies and progress. Work began with the 81st legislative session. There were many bill draft requests submitted dealing with behavioral health and the WRBHPB was pleased to have its bill, Senate Bill 69, passed and signed by the Governor. This bill and other related pieces of behavioral health legislation addresses several existing board priorities and opened up new opportunities and areas on which to focus over the biennium.

Collaborative efforts were a high priority during the past year. Supporting and encouraging the maximization of resources among and between public agencies and community-based agencies, as well as the need for information sharing with other behavioral health entities remains a primary objective.

Support of the development of a comprehensive Crisis Response System in Washoe County remains the priority for WRBHPB. Diversity and inclusion; youth mental health; and the behavioral health workforce are issues on which the board hopes to encourage focus and enhancement of services. Those who experience serious and persistent mental illness and/or substance use disorders are overrepresented in the homeless population, criminal justice system, and often have co-occurring substance use disorders and serious mental illness, all of which can have an adverse impact on community health and quality of life. This compounding effect is one reason the WRBHPB seeks to bring awareness to mental health and substance use issues, and supports efforts to address solutions and service enhancements.

Data collection and evaluation is a critical element of behavioral health initiatives. Data analysis helps the policy boards to understand what is working, what needs to change, and which stated outcomes are achieved. We use data to set goals and assess needs, evaluate program outcomes, and make recommendations for program improvement. The WRBHPB continues its goal to obtain the most current, reliable and credible to data to inform its work. While the process is imperfect, we still rely on available data to assist in our focus areas.

Given the historic times we are living in with the COVID-19 pandemic, the coming year may be dramatically different in terms of planning, both programmatic and fiscal. While we don't know what our new normal will be, we will take this opportunity to think about and focus on the strategic priorities that support our responsibilities as a board.

III. Regional Policy Board History

During the 79th session of the Nevada Legislature, testimony was provided to members of the Nevada Legislature and the attending public in support of Assembly Bill (AB) 366. Discussion by a diverse group of legislators, and members of professional and public behavioral health disciplines included the opportunity these boards would provide for improvement in Nevada by giving local leaders a more active voice in the decisions that are made as they pertain to behavioral health. Presenters agreed that all regions of the State face unique challenges especially in behavioral health issues, and generally agreed that each region is best qualified to address their respective issues. By creating four regional behavioral health boards, the Division of Public and Behavioral Health (DPBH) was able to collaborate with local experts for suggestions on policy, funding, and implementation issues.

Subsequent legislation from the 80th session in 2019 added a fifth regional board to Nevada Revised Statutes (NRS)433 which also outlines membership criteria, and board obligations. The five boards represent: Washoe Region which includes all of Washoe County; Clark Region which includes Clark County and part of Nye; Southern Region which includes the counties of Esmeralda, Lincoln, Mineral and a portion of Nye; the Rural Region which includes the counties of Elko, Eureka, Humboldt, Lander, Pershing and White Pine; and, the Northern Region which includes Carson City and the counties of Churchill, Douglas, Lyon and Storey.

The policy boards, each staffed with one behavioral health coordinator, collaborate and share information with the other boards focused on behavioral health issues, the goal of which is to create unified recommendations relating to behavioral health as well as ensuring available resources are maximized to the needs of the communities involved.

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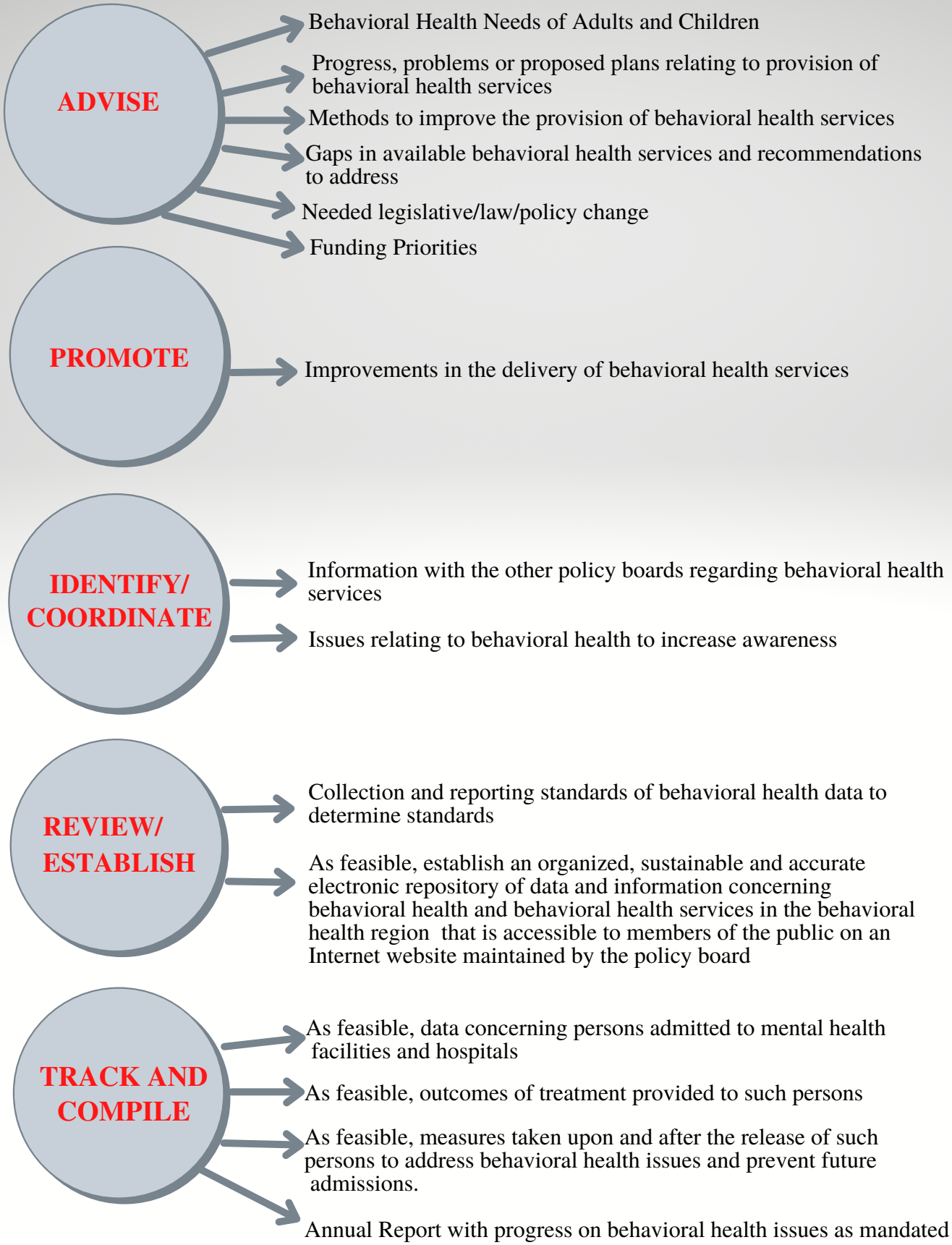
IV. Board Duties and Responsibilities

NRS 433.4295; 433A



V. 2021 WRBHPB MEMBERSHIP

The WRBHPB membership is comprised of individuals who meet the professional criteria outlined in NRS 433.429. Members of the WRBHPB share the same vision and goals as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the recommendations born out of this vision serve to move Nevada closer to achieving these objectives. They strive to increase awareness and understanding of mental health and substance use disorders, promote emotional health and wellness, address prevention of substance use disorders and mental illness, including those with serious mental illness and to increase access to effective treatment and support recovery. They believe it is necessary to always work towards diversity and equitable treatment in both service delivery, resources, and workforce development. Board members are committed to working with State, County, and other professional associations to address training, data, and financing issues through support and advocacy. Members continue to identify important and timely behavioral health issues of concern and to promote recommendations related to improving behavioral health services. As of this writing, there is one vacancy on the board and one pending approval.

2021 Members

JULIA RATTI
Director of Programs and Projects
Washoe County Health District
Policy Board Chair

STEVE SHELL
Vice President of Behavioral Health
Renown Health
Policy Board Vice-Chair

SARAH PETERS
Assemblywoman, District 24
Nevada State Assembly

HENRY SOTELO, Esq.
Reno Municipal Court Specialty Court Attorney
Paralegal/Law Program Director,
Truckee Meadows Community College

JENNIFER DELETT SNYDER
Executive Director
Join Together Northern Nevada
*Resigned in 2021; Vacant

THOMAS ZUMTOBEL
Vice-President, Population Health
Renown Hospital
*Resigned in 2021. New Board Member elected in 2022

SANDRA STAMATES
Community/Family Representative
Behavioral Health Families

WADE CLARK
Lieutenant,
Reno Police Department

CHARMAANE BUEHRLE
Director of Community Programs
WellCare

DR. KRISTEN DAVIS-COELHO
Chief Behavioral Health Officer/Psychologist
Northern Nevada HOPES

FRANKIE LEMUS
Behavioral Health Coordinator Washoe County Human Services Agency

CINDY GREEN
EMS Coordinator
Reno Fire Department

DANI TILLMAN
Executive Director
Ridge House, Inc.
*Resigned in 2022. New member elected in 2022

DOROTHY EDWARDS
Washoe Regional Behavioral Health Coordinator
Washoe County Human Services Agency

Additional Leadership and Participants

Policy Board Appointing Officials for 2020/2021

- Governor Steve Sisolak
- Assemblyman Jason Frierson, Speaker
- Senator Nicole Cannizzaro, Majority Leader
- Richard Whitley, Director, DHHS

State Leadership

- Legislative Commission
- Legislative Committee on Health Care
- Nevada Commission on Behavioral Health
- Nevada Department of Health and Human Services
- Nevada Division of Public and Behavioral Health

Regional Behavioral Health Coordinators

Jessica Abrass, Northern Regional Behavioral Health Coordinator

- Carson City
- Churchill County
- Douglas County
- Lyon County
- Storey County

Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator

- Elko County
- Eureka County
- Humboldt County
- Lander County
- Pershing County
- White Pine County

Kim Donohue, Southern Regional Behavioral Health Coordinator (appointed January, 2022)

- Esmeralda County
- Lincoln County
- Mineral County
- Nye County (Portion)

Michelle Bennett, Clark County Regional Behavioral Health Coordinator

- Clark County
- Nye County (Portion)

Dorothy Edwards, Washoe County Regional Behavioral Health Coordinator

- Washoe County

VI. 2021 Meetings and Presentations

The WRBHPB continues to meet with County leadership, public and private agencies, and stakeholders to assess the needs of the County and how prioritizing and strategizing can not only help meet regional needs but coordinate efforts statewide where resources are limited. During 2021, the WRBHPB exceeded the statutory requirement of quarterly meetings and conducted seven monthly meetings, continuing with virtual meetings in response to the ongoing COVID 19 health crisis. The board invited speakers from a variety of public and private organizations providing and supporting behavioral health services in Washoe County to provide their thoughts on the status of behavioral health services or programs in Washoe County, gaps in services, and resource needs. Meetings included updates on the ongoing 81st legislation in an effort to keep board members aware of pending legislation related to behavioral health. Attachments and minutes from meetings can be found at: Washoe Regional (nv.gov)

VII. Regional Behavioral Health Coordinator Activities

The coordinators each provide a variety of different behavioral health activities and responses to their region, guided by their scope within their agencies. They collaborate and share information with each other, their respective boards, and community partners and stakeholders with the goal of creating unified recommendations relating to behavioral health as well as ensuring available resources are maximized to the needs of the communities involved. Coordinators are responsible for the drafting of an annual report and for ensuring that collaboration between the State and other regions is accomplished.

The Washoe Regional Behavioral Health Coordinator provided presentations, guidance, information, support and/or leadership to the following organizations and agencies. While not all inclusive, the list represents the scope of support and guidance within behavioral health and illustrates the continued work and collaboration that needs to be done. More information is available upon request.

- WC Human Services Agency Senior/Adult Leadership
- Nevada Resilience Project (Washoe Supervision)
- Safe Babies Court
- Join Together Northern Nevada Vice Chair
- Northern Nevada Behavioral Health Coalition
- Senior Covid Vaccination outreach
- Mayor's Mental Health Board
- Community Homeless Advisory Board (CHAB)
- Build For Zero Housing Project Outreach
- Mobile Outreach Support Team: Supervision/Data
- Regional Senior Coalitions/Advisory Boards
- Regional Community Court
- Crisis Response Systems Implementation Project
- Agency Legislation Support

- Workforce Wellness Workgroup
- Nevada Association County Human Services Administrators - Legislative Support
- Community Case Manager Supervision
- WC Sheriff Substance Abuse Task Force
- Senator Cortez Masto - Team presentation/BH meetings
- Commission on Behavioral Health
- Commission on Aging Member
- Community Health Improvement Plan (CHIP) support/
- Additional behavioral health support and education meetings/webinars/trainings

VIII. Regional Priorities and Strategies

Through collaboration and communication with all of the regional behavioral health policy boards, Nevada State leadership can lean on local experts for recommendations and information on policy, funding, and implementation issues. The policy boards are charged with the responsibilities specified in NRS 433.429 as noted in Section IV of this report. Each biennium the board works on establishing priorities and opportunities for support within the behavioral health community. Through review and analysis of behavioral health data, collaboration and outreach with State and County behavioral health partners, and a review of existing behavioral health legislation, board members select subjects or areas that might require policy development, revision and/or enhancement in the field of behavioral health along with programmatic support to behavioral health providers and stakeholders in the region.

The geographic distinctiveness of Nevada provides support for the ultimate decision to regionalize certain behavioral health activities within the State. While each of the annual reports reflect the differences, many of the priorities have remained the same across the regions. Several focus areas have emerged and been identified for board support, influence, and collaboration and an update is also provided on those priorities identified from the previous years. The policy board supports the following identified priorities and strategies for success.

Crisis Response System Implementation Plan (CRSIP)

Regional Gap

People are experiencing challenges to mental and behavioral health on a daily basis. Additionally, COVID-19 has impacted not only the economic and physical wellbeing of communities, but the mental health of individuals and families across the country. Social isolation, physical and mental health conditions, and preexisting illness have been exacerbated across communities, specifically among those that are already most at-risk of experiencing a behavioral health crisis. Individuals and families experiencing a behavioral health crisis need to be supported by a crisis response system that provides a continuum of services to stabilize and engage anyone in crisis and provide them appropriate, integrated treatment to address the problem that led to the crisis. A robust crisis response system ensures that every person in crisis receives the right response in the right place every time. Communities should be empowered to respond to behavioral health crisis in the same way they respond to other emergencies. Residents of Washoe County experiencing suicidality or behavioral health emergencies deserve the same prompt, high-quality care as is delivered to individuals with physical medical emergencies.

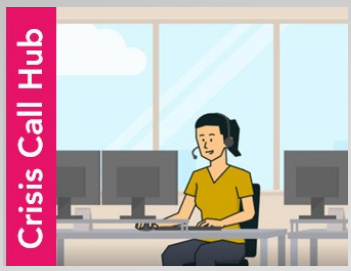
Through its deliberations and briefings by behavioral health experts in 2018/2019, the WRBHPB recognized the need for crisis response/stabilization services in the county. The problem is well known - hospital emergency departments have become the choke point in the current model of crisis care. According to Department of Health and Human Services data, on any given day, Nevada hospital emergency departments can board over 100 individuals waiting for a psychiatric bed to become available. It is not uncommon for patients to wait two or more days before being admitted for behavioral health treatment. Far too often, individuals experiencing a behavioral health crisis are transported to jail – in part due to the likelihood they will receive treatment referral more readily than other methods. That in itself, is also inappropriate and creates an ethical and fiscal issue.

Strategy and Progress

There have been a number of developments at the national level and within Nevada recently that are focused around addressing behavioral health crises and preventing suicide. One is the FCC approving 988 as the three digit call line for experiencing a behavioral health crisis or suicidality. This number will go live across the country on July 16, 2022. There are also state resources, and federal Medicaid dollars to help fund the crisis response system. These efforts are all leading to development of a crisis response system for the Washoe Region.

The goal of a crisis response system is to divert behavioral health and suicidality crises from 911 to 988, save lives, save costs, and ensure that every person in crisis receives the right response in the right place every time. This regional planning project is designing a continuum of services to stabilize and engage anyone experiencing a behavioral health emergency and link them with appropriate interventions to address the crisis. The core elements of this crisis response system are a statewide crisis call center to manage the new 988 behavioral health crisis line, mobile crisis teams, and crisis stabilization programs and policies.

The Washoe County Health District (WCHD) contracted with Social Entrepreneurs, Inc. (SEI) to support the implementation of a behavioral health crisis response system in the Washoe County Region including the City of Reno, City of Sparks, and Washoe County. The project's success depends upon the active involvement of key stakeholders, including those with lived experience, to design the state's first comprehensive crisis response system to address critical behavioral health needs of the residents of Washoe County. Stakeholders have been recruited in six areas, including a Leadership Council of policymakers and a Technical Advisory Committee (TAC) of human services and finance professionals. In addition, four subcommittees composed of subject matter experts have been formed, as recommended by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care. These components are required for a functional, coordinated, and comprehensive response to behavioral health crises and align with the project's subcommittees.



Regional Crisis Call Hub Services – Someone To Talk To

Regional crisis call services offer real-time access to a live person every moment of every day for individuals in crisis. Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Analogous to a 911 call for most emergencies, mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

Mobile Crisis Team Services – Someone To Respond

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or Emergency Department (ED) utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations. It helps individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible; meets individuals in an environment where they are comfortable; and provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

Crisis Receiving and Stabilization Services – A Place to Go

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Equitable Focus on Substance Misuse

Regional Gap

Mental and substance-use problems and illnesses seldom occur in isolation. They frequently accompany each other, as well as a substantial number of general medical illnesses. The term Behavioral Health encompasses mental health and substance misuse, however in the board's contact with community stakeholders during the previous year, some concern was expressed that the focus of programs, funding, and policy might be inequitable between the two. Understanding that the two are often co-occurring, the Board realized a need to work to ensure inclusion and collaboration of all sectors of behavioral health.

Strategy and Progress

Through deliberation during the 2020 meeting year, the WRBHPB agreed that substance misuse should play a role in the Bill Draft Request (BDR) that was crafted for the 81st Legislative Session. As outlined in the 2020 Annual Report, the board's subsequent bill, Senate Bill (SB) 69 incorporated several pieces of legislation around substance misuse. *See Section IX for summary.

The board views the passage of SB69 as successful completion of this priority area, however will continue its support of the inclusion of and focus on substance abuse issues within the region. Improving the quality of mental health and substance use services depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their clients. (National Academy of Sciences)

Behavioral Health Response: Before, During and After A Crisis/Disaster/Health Crisis

Regional Gap

All disasters and emergencies have a behavioral health component. Following disasters, behavioral health problems may range from transitory distress followed by return to pre-exposure levels to the emergence of new disorders including Post Traumatic Stress Disorder (PTSD), anxiety, or depression. The disaster may also lead to the worsening of pre-existing conditions like Serious Mental Illness (SMI) in adults, Severe Emotional Disturbance (SED) in children, and co-occurring Substance Use Disorders (SUD). Awareness has grown in understanding that all who experience a disaster are affected to varying degrees, individually and collectively. It is not uncommon for those affected (both victims and responders) to report disturbing feelings of grief, sadness, anxiety, and anger. The psychological effects of the disaster may be immediate or manifest months or years after the disaster. When a disaster occurs, normal day-to-day behavioral health services must continue in addition to the potential immediate and extended surge demand caused by the disaster. It is helpful if county behavioral health agencies pre-identify behavioral health responders from both the public (directly operated facilities) and private sectors that have disaster behavioral health qualifications, skill sets and training as part of regional health coalition activities. By identifying capabilities in advance, resources may be assigned so that the appropriate level of clinical support or intervention is provided at the incident site or other community setting. (EOM-Disaster-Behavioral-Health-10-26-2018.pdf (ca.gov)

Strategy and Progress

- Discussion continues with the County Emergency Manager's offfice around the inclusion of the draft Washoe County Regional Behavioral Health Emergency Response Plan Annex with the Washoe County Regional Emergency Operations Plan. While the current health crisis provided lessons learned for moving forward in emergency and disaster planning, it also precluded the ability to exercise the plan given the restrictions and prevention strategies in place. We look forward to working with the State and other regions in the exercising of response plans.

- Nevada Resilience Project (NRP): The Crisis Counseling Assistance and Training Program (CCP), rebranded in Nevada as the Resilience Project, is a short-term disaster relief grant for states, U.S. territories, and federally recognized tribes. The Resilience Project serves to provide early and immediate behavioral health support, triage, intervention, and referral of services in response to the impacts of COVID-19 on Nevada's population understanding that early triage, intervention, and referral to services can reduce the risk of mental health disorders for those impacted by COVID-19. The WRBH Coordinator currently provides high-level supervision and oversight to the Washoe team of Nevada Resilience Ambassadors (NRP). Resilience Ambassadors provide education, information, counseling, and resource navigation while promoting healthy coping, empowerment, and resilience. Resilience Ambassadors can provide support and connection to resources over the phone, through text and video-chat, or face to face. They are able to offer bi-lingual access to services; assistance navigating to needed resources in your community; help to reduce stress, build coping skills, and develop a resilience plan. The effort is a collaboration between the State of Nevada (providing the current funding), the WCHD (providing daily Covid "positive" lists), and Washoe County HSA/Regional Coordinator providing high level supervision of ambassadors.

  The success of this project is substantial. The fact that every individual who is testing positive for COVID-19 has or will be offerered an opportunity to speak to a crisis counselor and obtain referrals for services as needed, is not only significant but potentially unprecedented for a disaster/event of this magnitude.

- The Community Health Improvement Plan (CHIP), developed by the Washoe County Health District is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. Behavioral health was seen as a top concern cited by the community and is one that greatly suffers from lack of adequate resources and available workforce. The Board supports the efforts taken for the successful implementation of the CHIP.

Additional Areas of Discussion

Diversity and Inclusion

The behavioral health needs of minority communities have been historically and disproportionately underserved. Providers need to be sensitive to cultural issues and equipped with the necessary language skills that facilitate and promote effective service delivery. The proportion of behavioral health providers from diverse groups generally does not represent the proportion of those various diverse groups in the United States. Following SAMHSA's commitment to addressing these behavioral health workforce disparities, WRBHPB, seeks to identify and promote the effective retention strategies for prevention, treatment, and recovery support providers and providers who are or who serve members of racial, gender, and ethnic minority populations or other minority groups such as military members, veterans, and their families; lesbian, gay, bisexual, and transgender (LGBT) individuals; and American Indian/Alaska Native tribal members. WRBHPB will continue to welcome presentations and education, studying the cultural attributes that affect our ability to reach and serve our community members.

Mental and Behavioral Health Needs of Children

During the last two years of the pandemic, children experienced greater rates of anxiety, depression, and suicidality as they have been impacted by grief, economic instability, and isolation from friends and social supports. Children with disabilities have seen their challenges compound. According to the National Center for Education Statistics, seven million (14 percent) of public school students receive special education services. Of children with behavioral and mental health needs, 80 percent rely on school-based services. When schools shut down, many students were left without the lifelines they so desperately needed and at a time when mental health professionals were already in short supply. The lack of early mental health services creates tragic and expensive consequences when youth with emerging mental health issues have difficulty finding timely treatment and a service system that can respond quickly and confidentially (NASHP,2021). The WRBHPB continues to support those regional partners that are working towards the enhancement and improvement of access to mental health care for families and children.

Behavioral Health Workforce

Nationally, there is more demand for behavioral health (mental health and substance use) treatment than workforce capacity to deliver services which impacts timely access to treatment and prevents providers from expanding quality services. Regionally, the pandemic stressed an already overwhelmed behavioral health workforce. The region is fortunate to have many highly competent and committed professionals working hard to deliver behavioral health services, but barriers to educational attainment, professional recruitment, and long-term retention have been included in discussions around workforce development. The WRBHPB continues to support the study and discussion on how Nevada, and Washoe County can affect change to this growing need. The passage of SB69, which acknowledges the role peers can play in the workforce was a positive step.

IX. Legislative Update

While the focus of the WRBHPB is on behavioral health issues in Washoe County, the goal will always remain a collaboration with other regional boards to mitigate duplication of effort and affect positive change for all of Nevada. It is only through working together that we can accomplish goals that might not be obtainable in isolation. One method to affect change in regional behavioral health is the unique opportunity that the regional behavioral health policy boards are afforded to develop and present a Bill Draft Request (BDR) each legislative session. As reported in the 2020 annual report, the WRBHPB was pleased to submit SB69 for consideration in the 81st legislation session. The bill passed and was signed by Governor Steve Sisolak.

Below is a summary of the four regional behavioral health policy board bills introduced in the 81st legislative session as well those bills for which the WRBHPB submitted letters of support. **Several of the pieces of legislation positively impacted the forward momentum of crisis response systems implementation.**

Senate Bill 69

Washoe Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

Peer Recovery Support

Legislative Intent: Require certification for Peer Recovery Support Specialists and Peer Recovery Support Specialists Supervisors.

Benefits to Nevada:

- Clearly defines peer recovery support services and Peer Recovery Support Specialists.
- Establishes a required certification process to ensure minimum standards are met before using the title Peer Recovery Support Specialist.
- Establishes requirements governing the supervision of Peer Recovery Support Specialists.

Youth Risk Behavior Survey (YRBS) Passive Consent

Legislative Intent: Increase survey response rates through a uniform passive (opt out) consent process in all school districts.

Benefits to Nevada:

- Cost savings as there is less administrative burdens with passive consent vs. active consent.
- Supports the only common data source related to youth behaviors available to Nevada's 17 counties.
- Eliminates the loss of federal funding due to not having core measure data.
- Greater participation among students ensures reliable data, and less chance of biases and underrepresentation of certain groups.

Substance Misuse K-12 Prevention Education Curriculum

Legislative Intent: Support the move to evidence-based substance misuse prevention programming to meet current standards.

Benefits to Nevada:

- Provides teachers a link to nationally recognized evidence-based substance misuse prevention programs.
- Compiles a list of current curricula and/or programs being implemented in grades K-12.
- Allows partnering community organizations to fund more school-based prevention programs.

Establish Substance Misuse Prevention Coalitions in NRS

Legislative Intent: Legitimize the substance misuse prevention coalitions legal status in statute.

Benefits to Nevada:

- Ensures Nevada is in alignment with national best practice standards as established by the Community Anti-Drug Coalitions of America (CADCA).
- Urban, rural, and frontier communities are equally represented in the coalition model, recognizing the importance of community level decision making.
- The coalition model is science driven, evidence-based, and has been operating as the prevention model in Nevada for 20 years.
- Coalitions have secured $11,864,320 for FY20-21 to support local-level behavioral health issues.

Senate Bill 70

Northern Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

- Clarifies the distinction between mental health crisis hold and the court-ordered involuntary admission process.
- Clarifies the process for family members to request the court to have a family member be picked up and transported for an evaluation, which is different than a court-ordered involuntary admission.
- Updates the law as to current practices for both conditional release and chemical restraint.
- Separates and clarifies the Assisted Outpatient Treatment program

Senate Bill 44

Rural Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

- Revises provisions concerning the administration and licensure of certain behavioral health professions.
- Authorizes certain behavioral health licensing boards to issue a temporary provisional license to an applicant who meets certain requirements.
- Requires the Legislative Committee on Health Care (LCHC) to study the licensing practices of behavioral health licensing boards and identify barriers to licensure.
- Requires behavioral health licensing boards to implement strategies to eliminate each barrier identified, unless a barrier is deemed necessary to maintain the quality of services
- Makes various changes to the Board of Examiners for Social Workers

Senate Bill 56

Clark Regional Behavioral HealthPolicy Board
Status: Failed. No Action Taken

- Required health insurance policies to include coverage for behavioral health services provided through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means.
- Prohibited health insurance coverage for behavioral health services provided in the home of an insured to be dependent on the geographic location of such home
- Required the Division of Health Care Financing and Policy of the Department of Health and Human Services to apply for a waiver from the federal centers for Medicare and Medicaid services to approve matching funds for coverage for standard telephone behavioral health services.

Senate Bill 156

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Expands the authority of the Division of Public and Behavioral Health of the Department of Health and Human Services (DHHS) to issue an endorsement as a crisis stabilization center to any licensed hospital that meets certain requirements.
- Expands the list of organizations by which a hospital may be accredited to qualify for renewal of an endorsement, and exempts rural hospitals from the accreditation requirement.
- Expands the existing requirement that DHHS take any action necessary to ensure crisis stabilization services provided at a psychiatric hospital with a crisis stabilization center endorsement are reimbursable under Medicaid to include such services provided at any hospital with endorsement.
- Makes changes to existing law requiring health maintenance organizations or managed care organizations that provide services through Medicaid or the Children's Health Insurance Program to negotiate in good faith to include a hospital with an endorsement as a crisis stabilization center in their provider network

Senate Bill 390

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Provides for the establishment of a suicide prevention and behavioral health crisis hotline;
- Exempts a telecommunications provider from certain damages relating to the hotline; requiring the imposition of a surcharge on certain communications services to support the hotline;
- Creates funding mechanism deposited into a Fund
- Authorizes the use the money in the Fund for certain statewide projects and to award grants to various public and private entities to address the impact of opioid use disorder and other substance use disorders

Senate Bill 154

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Requires DHHS to apply for a waiver from the federal government to receive federal funding to include in the State Plan for Medicaid coverage for substance use disorder treatment for individuals in an institution for mental diseases.
- Authorizes DHHS to apply for a similar waiver to treat adults with serious mental illness or children with severe emotional disturbance in an institution for mental disease.

Assembly Bill 181

Assesmblywoman Peters
Status: Passed and Signed by Governor

- Requires certain health insurers that provide health coverage for their employees to comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which prohibits group health plans and health insurance issuers that provide benefits for mental health or substance use disorders from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits.
- Requires each insurer or other organization subject to those requirements to submit to the commissioner of insurance certain information that demonstrates compliance with the Act. The commissioner may adopt regulations to carry out the provisions of this bill, shall keep certain information confidential, and must submit annually a report to various entities.
- Requires certain providers of health care to report information relating to suicide to the chief medical officer pursuant to regulations adopted by the State Board of Health

X. Behavioral Health Data

Washoe Behavioral Health Profile

The Washoe Regional Behavioral Health Policy Board operates with the intention of addressing the importance and necessity of substance use, mental health, and behavioral health services for Washoe County residents.

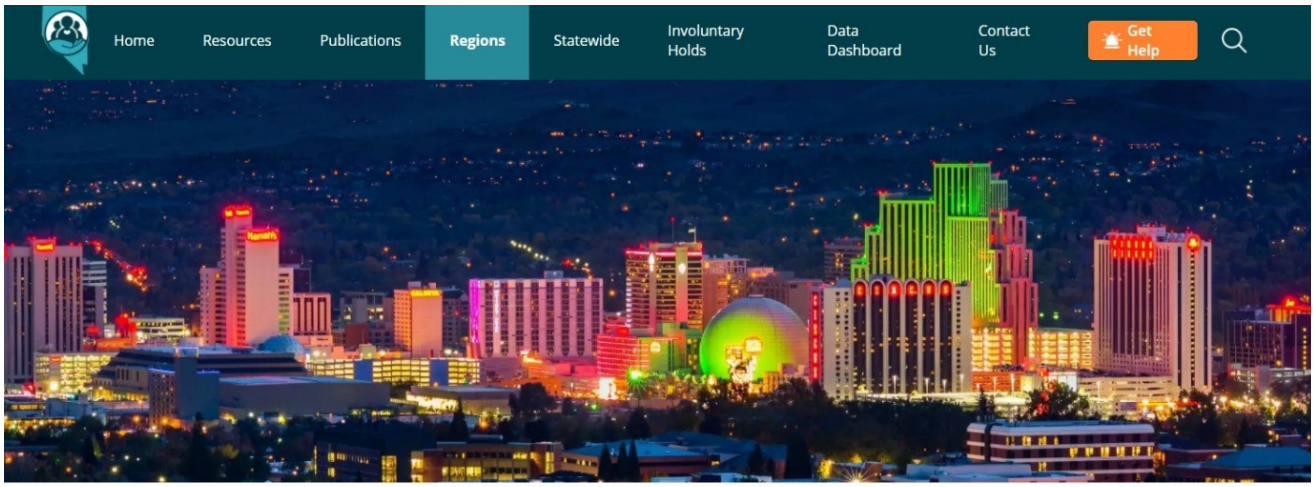
For several years, the board has supported the development of a county specific behavioral health profile. This profile aims to outline key behavioral health indicators associated with Washoe County residents, and to identify trends in available data. By using a wide range of data sources, we can identify key problem areas within Washoe County, and use this information to help guide the policy board towards focusing on the areas deemed to be the most at-risk. This report is shared widely with internal and external stakeholders to provide an overview of how the County compares nationally and statewide in areas of behavioral health.

One of the significant sources of data is the Nevada Regional Behavioral Health Epi Profiles, provided by the Nevada State Office of Analytics. This valuable report combined other state and federal data (CDC) and along with data collected by the Regional Behavioral Health Coordinator from other sources, provided a regionalized lens from which to view Washoe County against the State and Nation in certain behavioral health data points.

The majority of sources of data for these reports are reported biennially and, based on this availability, the Nevada Office of Analytics will begin providing these reports every other year. To avoid unnecessary duplication, the Washoe Regional Behavioral Health Profile will follow this reporting timeline as well. The link for the 2020 Washoe Behavioral Heath Profile as well as additional data resources, is provided in the Appendix A. **While there is no Washoe Behavioral Health Profile this year, there are several data points that have been updated and these are included in sections that follow.**

Nevada Regional Behavioral Health Policy Board Data Website (https://nvbh.org)

Pursuant to requirements outlined in NRS 433.4295, the Regional Behavioral Health Coordinators began discussions with the State around funding for a data repository, and with the assistance of the Northern Behavioral Health Region and the State of Nevada DPBH, a Behavioral Health Website was developed late in 2021. It is still in the piloting stage, as coordinators seek to determine the most efficacious way to include current and accurate behavioral health resources, however it is open for the public to view and utilize.



The Washoe Behavioral Health Region

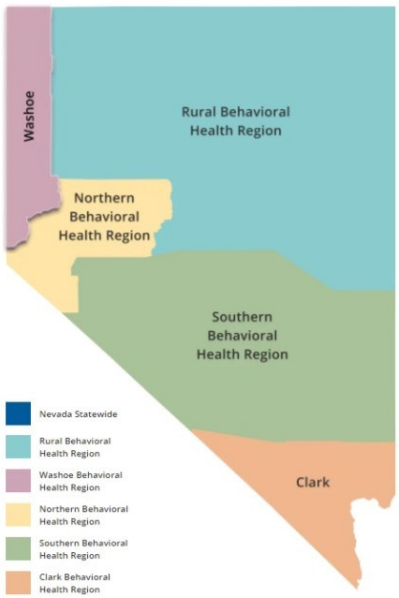
Washoe County is home to over 6,600 sprawling square miles, bordering both California and Oregon with nearly half a million residents who call our region home. Washoe County's recreation and outdoors experiences are second to none with 49 beautiful parks, 161 miles of trails, and more than 10,000 acres of open space. Washoe County's 24 departments are managed by the county's top executive, the Washoe County Manager, and governed by five elected County Commissioners, who also serve as the Board of Fire Commissioners for the Truckee Meadows Fire & Rescue.

In 2019, the estimated population for Washoe County was 469,963, a 10.3% increase from the 2010 estimated population. With 15.2% of Nevada's population living in Washoe County, it is the second most populous area in the state, with an approximately equal percentage of females and males.

More demographic information can be found on the County's home page at Washoe County, NV.

- Members +
- Board Priorities +
- Gaps & Needs +
- Initiatives and Strategies for Success +
- Recommendations +
- Featured Resources +

Click to select Behavioral Health Region



FEBRUARY, 2022

CALENDAR OF EVENTS

NO EVENTS

Mental Health America 2022 Report

While the WRBHPB Annual Report emphasizes Washoe County data, it is important to include State and National data to provide comparisons and identify trends. The Mental Health America annual report identifies a set of common data indicators for mental health that gives a complete picture of mental health status in America. The report provides data on prevalence rates of mental health problems for youth and adults and data on access to care with goals being to provide a snapshot of mental health status for program and policy planning, analysis and evaluation; to track changes in prevalence of mental health issues and access to care; to understand how changes in national data can affect legislation; and, to increase dialogue and improve outcomes. It should be noted that as with many behavioral health data reports, while this data is reported annually, it is taken from previous year or two in some surveys. Key findings related to Nevada are listed below; the entire report can be found at the link provided in Appendix A.

Adults: States that are ranked 1-13 have lower prevalence of mental illness and higher rates of access to care for adults. States that are ranked 39-51 indicate that adults have higher prevalence of mental illness and lower rates of access to care. ***Nevada's ranking overall is 40th, improving by 2 from last year's report.***

Adult Ranking Adults with Any Mental Illness (AMI): According to SAMHSA, Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Any mental illness includes persons who have mild mental illness, moderate mental illness, and serious mental illness.

- **United States:** 19.86% of adults are experiencing a mental illness; equivalent to nearly 50 million Americans. 4.91% are experiencing a severe mental illness which is up from last year.
- **Nevada:** Ranks 34th with 21.97%, a slight improvement from last year

Adults with Substance Use Disorder in the Past Year

- **United States:** 7.74% of adults in America reported having a substance use disorder in the past year. 2.97% of adults in America reported having an illicit drug use disorder in the past year. 5.71% of adults in America reported having an alcohol use disorder in the past year.
- **Nevada:** Ranks 45th, with 9.32%. This is a regression from 40th in the previous year.

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Adults with Serious Thoughts of Suicide

- **United States:** The percentage of adults reporting serious thoughts of suicide is 4.58%. The estimated number of adults with serious suicidal thoughts is over 11.4 million - an increase of over 664,000 people from last year's data set. The national rate of adults experiencing suicidal ideation has increased every year since 2011-2012.
- **Nevada:** Ranks 34th with 4.94% which demonstrates another regression from last reporting period (31st).

Adults with AMI who are Uninsured

- **United States:** 11.1% (over 5.5 million) of adults with a mental illness remain uninsured. The rankings for this indicator used data from the 2017-2018 NSDUH. In December 2017, Congress passed the Tax Cuts and Jobs Act, which eliminated the individual mandate penalty from the ACA. There was a 0.5% increase from last year's dataset, the first time this indicator has increased since the passage of the ACA. The increase in this indicator is consistent with data from the U.S. Census Bureau, which found that in 2018, the rate of uninsured Americans rose for the first time since the ACA took effect. Only twenty states saw a reduction in Adults with AMI who are uninsured in this year's dataset.
- **Nevada:** Ranks 30th with 11.5%, an improvement from 31st in the previous reporting period

Adults with AMI who Did Not Receive Treatment

- **United States:** Over half (56%) of adults with a mental illness receive no treatment. Over 27 million individuals experiencing a mental illness are going untreated.
- **Nevada:** Ranks 41st with 58%, improving from being 44th in the last reporting period.

Adults with AMI Reporting Unmet Need

- **United States:** Almost a quarter (24.7%) of all adults with a mental illness reported that they were not able to receive the treatment they needed. This number has not declined since 2011. Individuals seeking treatment but still not receiving needed services face the same barriers that contribute to the number of individuals not receiving treatment: No insurance or limited coverage of services; shortfall in psychiatrists, and an overall undersized mental health workforce; lack of available treatment types (inpatient treatment, individual therapy, intensive community services); disconnect between primary care systems and behavioral health systems; and, insufficient finances to cover costs in including copays, uncovered treatment types, or when providers do not take insurance.
- **Nevada:** Ranks 45th with 29.50% which is a significant decline from the previous reporting rank of 39th with 26.1%.

Adults with Disability Who Could Not See a Doctor Due to Costs

- **United States:** 29.67% of adults with a cognitive disability were not able to see a doctor due to costs. According to the Centers for Disease Control (CDC), 12% of people in the U.S. had a cognitive disability, even when adjusted for age. The percentage of people with cognitive disability ranged from 8.9% in some states to 19.6%. The prevalence of adults with cognitive disability who couldn't see a MD due to cost ranges from 18.48% in Rhode Island to 40.65% in Texas.
- **Nevada:** Ranks 15th with 24.51%, which ticks up from last year when Nevada ranked 18th.

Youth: States with rankings 1-10 have lower prevalence of mental illness and higher rates of access to care for youth. States with rankings 39-51 indicate that youth have higher prevalence of mental illness and lower rates of access to care. ***Nevada's overall ranking is 51st which remains the same from last year's reporting.***

Youth with At Least One Major Depressive Episode (MDE) in the Past Year

- **United States:** 15.08% of youth (age 12-17) report suffering from at least one major depressive episode (MDE) in the past year. Childhood depression is more likely to persist into adulthood if gone untreated. The number of youth experiencing MDE increased by 306,000 from last year's dataset.
- **Nevada**: Ranks 47th with 17.93%, a decline from previous reporting ranking of 39th.

Youth with Substance Use Disorder in the Past Year

- **United States:** 4.08% of youth in the U.S. reported having a substance use disorder in the past year. 1.64% had an alcohol use disorder in the past year, while 3.16% had an illicit drug use disorder.
- **Nevada:** Ranks 49th with 5.59%, a decline from previous reporting ranking of 47th.

Youth with Severe MDE

- **United States:** 10.6% of youth (or over 2.5 million youth) cope with severe major depression. The number of youths experiencing Severe MDE increased by 197,000 from last year's dataset.
- **Nevada:** Ranks 38th with 13.2%, a slight improvement from last year's ranking of 39th.

Youth with MDE who Did Not Receive Mental Health Services

- **United States:** 60.3% of youth with major depression do not receive any mental health treatment. Youth experiencing MDE continue to go untreated. Even among the states with greatest access for youth, 1 in 3 youth are still not receiving the mental health services they need. The state prevalence of untreated youth with depression ranges from 30.0% in Maine to 73.1% in Texas.
- **Nevada:** Ranks 40th with 65.2%, a significant improvement from last year's ranking of 51st.

Youth with Severe MDE who Received Some Consistent Treatment

- **United States:** Nationally, only 27.3% of youth with severe depression receive some consistent treatment (7-25+ visits in a year). Late recognition in primary care settings and limited coverage of mental health services often prevent youth from receiving timely and effective treatment.
- **Nevada:** Ranks 45th with 18.70%, an improvement from last year's ranking of 51st.

Children with Private Insurance that Did Not Cover Mental or Emotional Problems

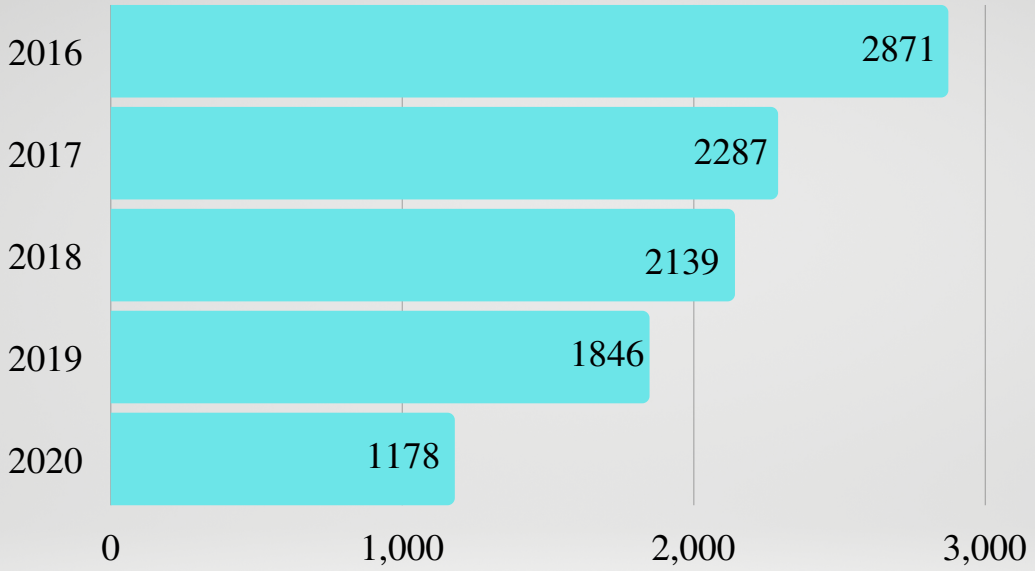
- **United States**: The Mental Health Parity and Addiction Equity law (MHPAE) was enacted in 2008 and promised the equal coverage of mental health and substance use services. However, the rate of children with private insurance that does not cover mental or emotional problems increased 0.3 percent from last year's dataset, and there are still 950,000 youth without coverage for their behavioral health. The state prevalence of children lacking mental health coverage ranges from 1.9% in Massachusetts to 17.7% in Arkansas.
- **Nevada:** Ranks 24th with 7.10%, a significant improvement from previous ranking of 45th.

Students Identified with Emotional Disturbance for an Individualized Education Program

- **United States:** Only .759% of students are identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).The rate for this measure is shown as a rate per 1,000 students. The calculation was made this way for ease of reading. Unfortunately, doing so hides the fact that the percentages are significantly lower. If states were doing a better job of identifying whether youth had emotional difficulties that could be better supported through an IEP the rates would be closer to 8% instead of .8 percent.
- **Nevada:** Ranks 42nd with 4.64%; previous ranking was 43rd.

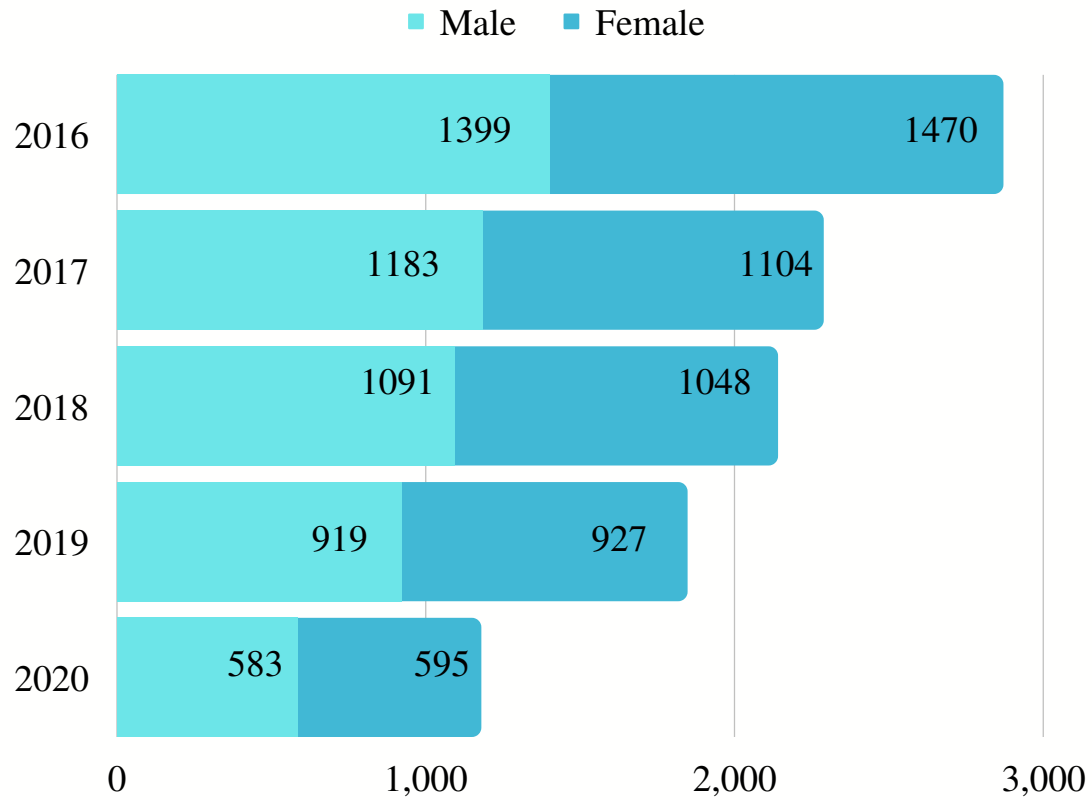
Mental Health Clinic Utilization Data: Washoe County

Unique Clients Served at State-Funded Mental Health Clinics in the Washoe Region 2016-2020



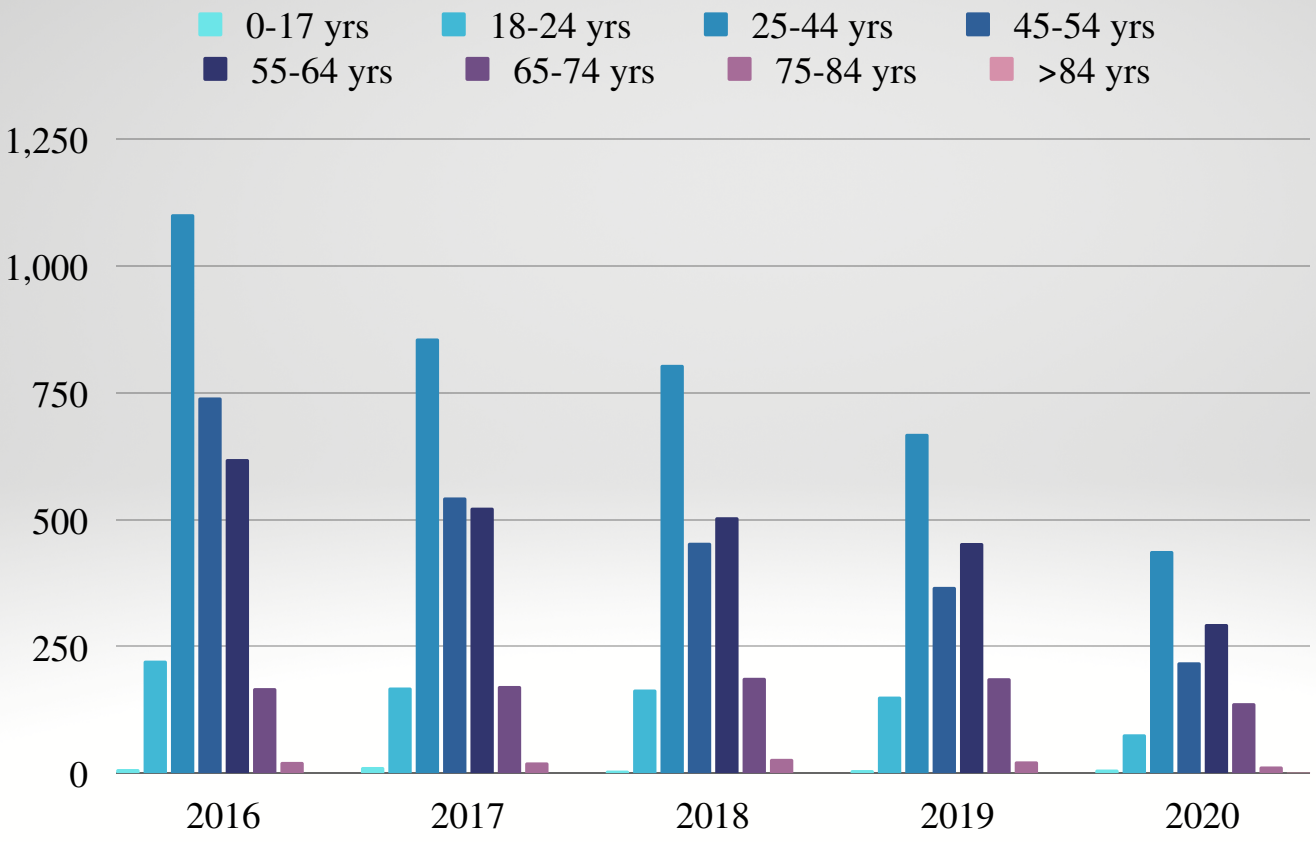
Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

Unique Clients Served at State-Funded Mental Health Clinics in the Washoe County Region: Gender 2016-2020



Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

State-Funded Mental Health Clinics Utilization in the Washoe County Region: Age-Group, 2016-2020

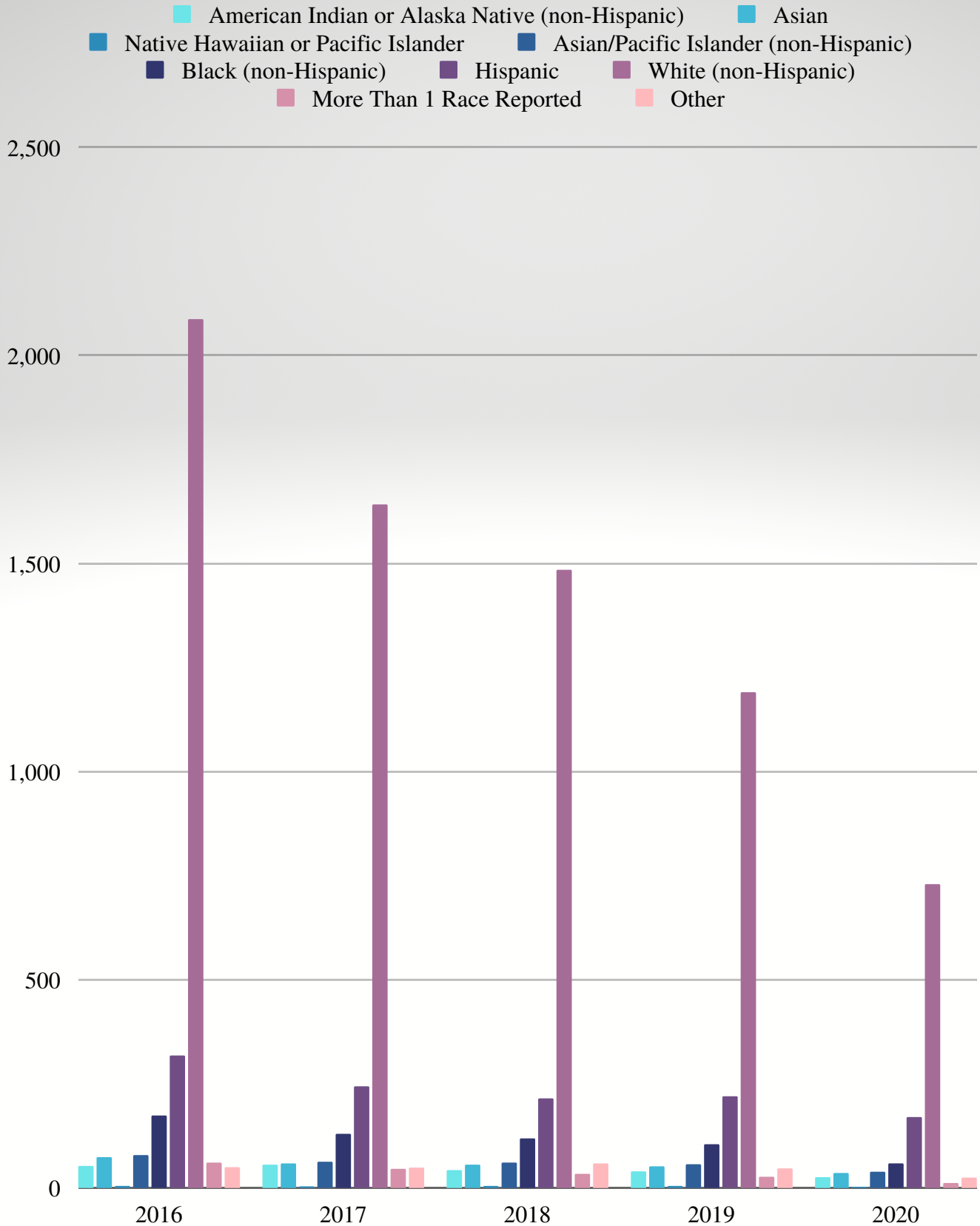


Percentages for 2020

0-17	0.79%
18-24	6.45%
25-34	17.83%
35-44	19.10%
45-54	18.42%
55-64	24.79%
65-74	11.63%
75-84	1.10%
>84	0.08%

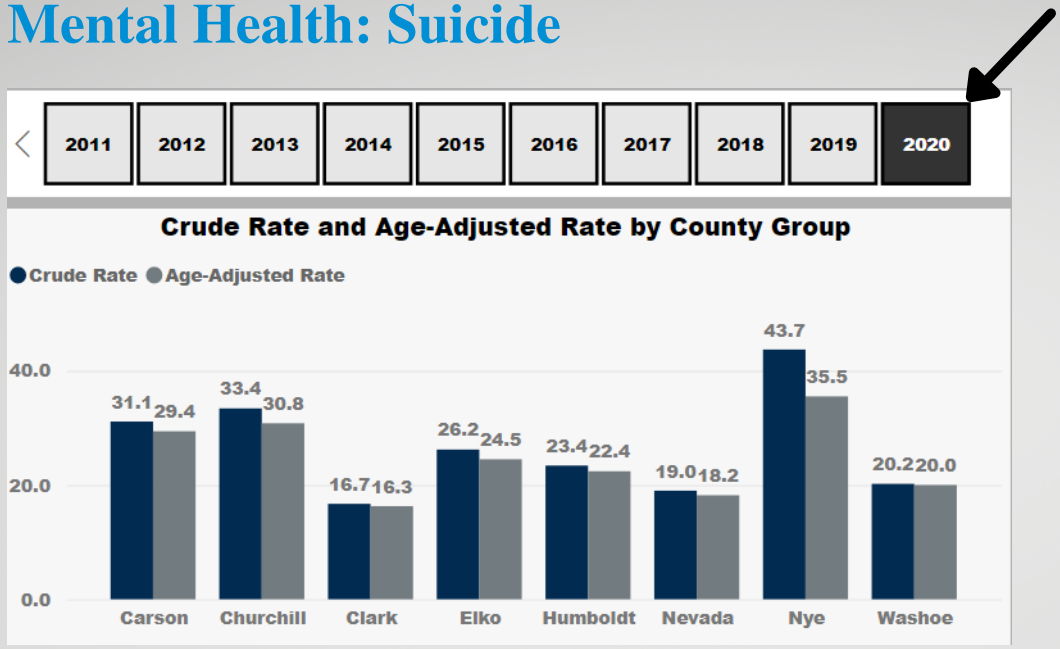
Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

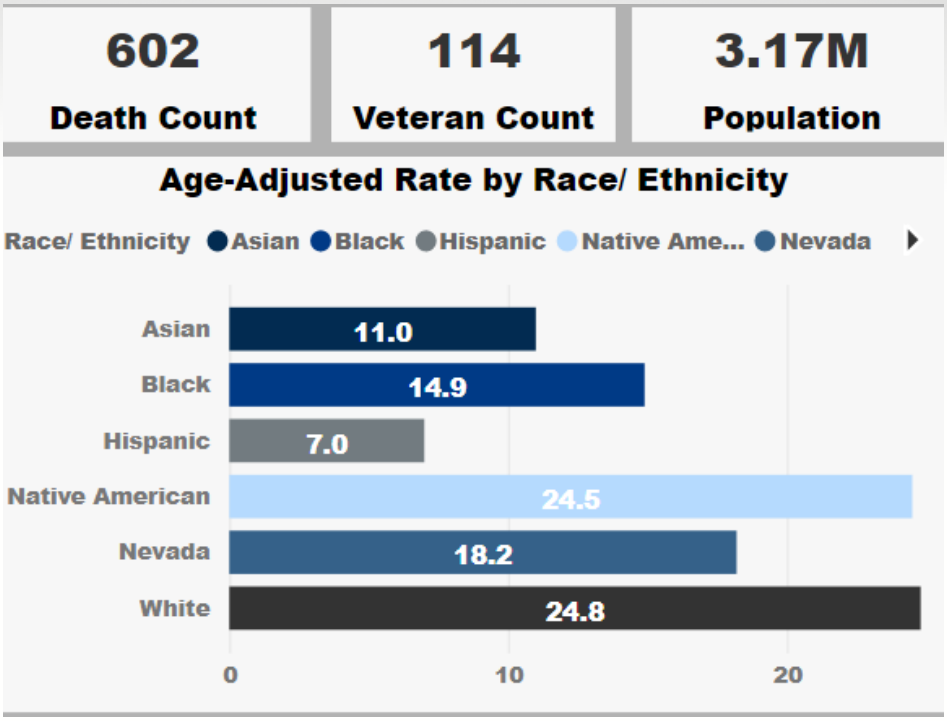
State-Funded Mental Health Clinics Utilization by Washoe County Region and Race/Ethnicity, 2016-2020



Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

Mental Health: Suicide





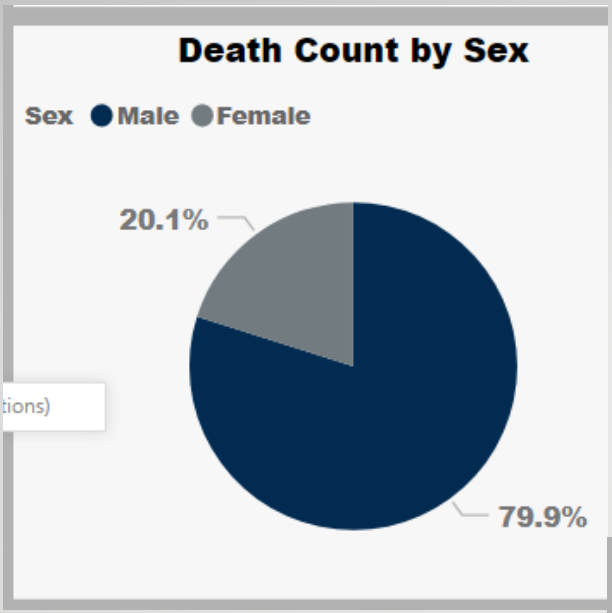
Data Definition

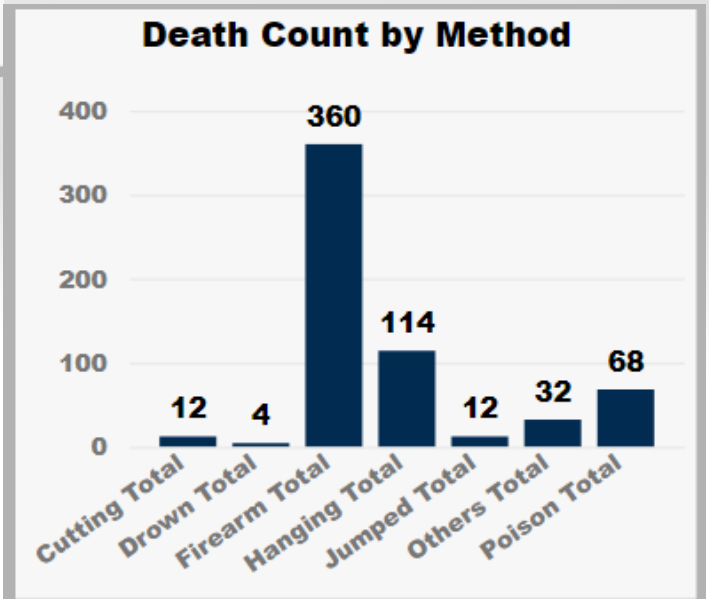
Suicide: The act of intentionally causing one's own death; Mortality Rate: The count of deaths per one hundred thousand population for a specific cause (also called crude rate) Population: Estimated population from the Nevada State Demographer including prisoner population Nevada Resident: Any person with a residence address within the State of Nevada which includes counts outside of the State Age-Adjusted Rate: A modified crude rate to account for changes in age between populations

County Groups: Churchill: Churchill, Lyon, Mineral, Storey; Nye: Nye, Esmeralda; Elko: Elko, Eureka, Lincoln, White Pine; Humboldt: Humboldt, Lander, Pershing

Data Source

Data has been pulled from the Electronic Death Registry System, State Demographer Population Estimates
Provided by Department of health and Human Services, Office of Analytics





Year	County Group	Death Count	Crude Rate	Age-Adjusted Rate
2020	Carson	33	31.0	29.3
2020	Churchill	31	33.4	30.9
2020	Clark	391	16.8	16.3
2020	Elko	19	26.2	24.5
2020	Humboldt	7	23.3	22.3
2020	Nye	22	43.8	35.5
2020	Unknown	3	0.0	0.0
2020	Washoe	96	20.1	19.9

Suicide Counts and Rates by Age Group by County by Year
Nevada Residents, 2010-2020

Year	County Group	Age Groups							
		Age 0-17		Age 18-24		Age 25-64		Age 65+	
		Count	Crude Rate	Count	Crude Rate	Count	Crude Rate	Count	Crude Rate
2010	Clark	7	1.4	25	13.8	277	26.1	64	28.2
2010	Washoe	0	0.0	8	19.2	73	32.8	13	25.2
2010	Balance	1	1.3	8	24.0	47	28.6	25	44.5
2011	Clark	15	3.1	25	13.8	229	21.6	57	24.3
2011	Washoe	4	3.9	14	33.7	55	24.5	13	24.3
2011	Balance	3	4.0	7	20.4	66	39.8	21	36.4
2012	Clark	4	0.8	22	12.0	274	25.6	56	22.9
2012	Washoe	2	2.0	5	11.9	57	25.1	14	25.0
2012	Balance	0	0.0	5	13.8	53	32.0	14	23.6
2013	Clark	6	1.2	19	10.0	253	23.2	66	25.9
2013	Washoe	4	3.9	9	21.4	58	25.3	24	41.2
2013	Balance	3	4.1	7	18.9	59	35.6	21	34.2
2014	Clark	7	1.4	29	15.0	242	21.8	81	30.8
2014	Washoe	2	1.9	6	14.3	63	27.3	21	34.7
2014	Balance	2	2.8	9	25.1	67	40.4	29	45.9
2015	Clark	10	1.9	35	17.9	256	22.7	69	25.6
2015	Washoe	4	3.8	4	9.5	69	29.7	23	36.6
2015	Balance	3	4.3	7	20.5	56	33.4	17	26.2
2016	Clark	12	2.2	31	15.5	278	24.1	90	32.3
2016	Washoe	3	2.9	3	6.9	77	32.8	41	62.8
2016	Balance	4	5.8	9	27.1	58	34.2	32	48.1
2017	Clark	11	2.0	42	20.8	288	24.7	86	29.9
2017	Washoe	3	2.8	13	30.0	56	23.8	22	32.5
2017	Balance	2	2.9	7	22.8	56	32.4	33	48.7
2018	Clark	20	3.7	40	19.2	317	26.5	83	27.8
2018	Washoe	2	1.9	6	13.5	56	23.5	24	34.0
2018	Balance	6	8.7	5	16.4	65	37.1	37	52.0
2019	Clark	10	1.8	32	14.9	275	22.6	100	32.4
2019	Washoe	5	4.6	10	21.5	72	29.7	26	35.7
2019	Balance	1	1.4	11	36.7	66	37.3	34	46.4
2020	Clark	16	2.9	40	18.2	236	19.1	99	31.0
2020	Washoe	1	0.9	10	20.9	63	25.8	22	29.1
2020	Balance	2	2.8	12	42.4	72	40.5	29	38.4

Balance includes: Carson, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine counties.

Washoe County Methamphetamine and Stimulant Surveillance 2020*

Summary

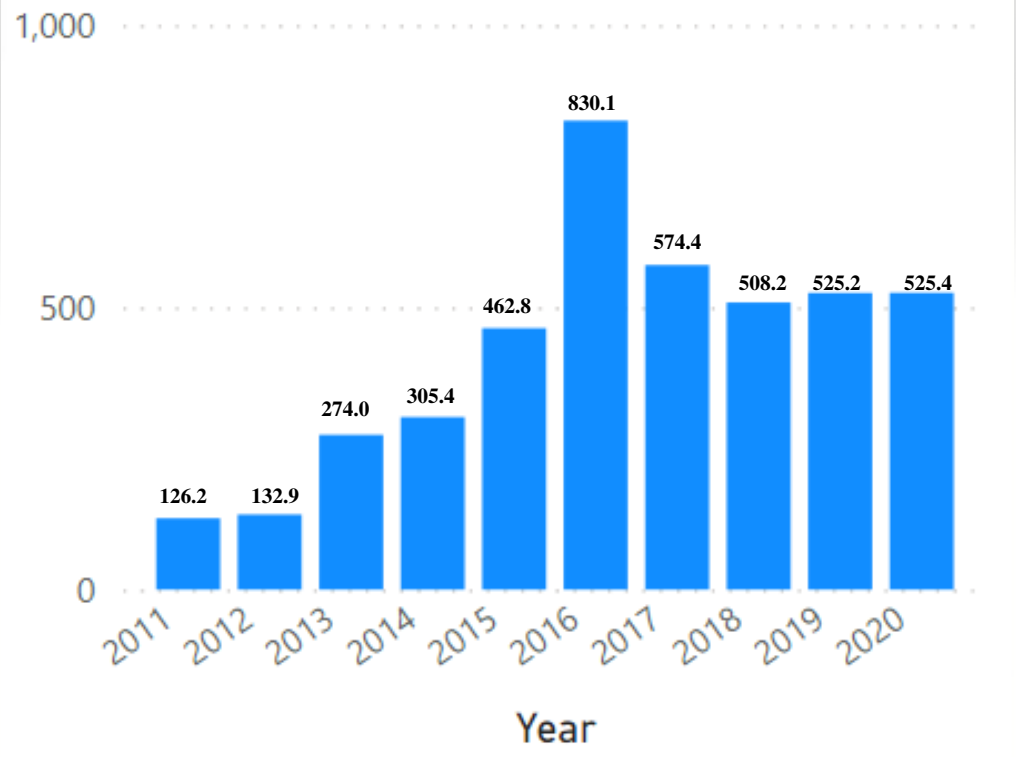
- From 2011 to 2020, methamphetamine-related emergency department (ED) visits increased per 100,000 residents from 115.7 to 512.7 in Nevada and in Washoe County from 126.2 to 525.4
- In 2020, ED visits were most prevalent among Nevada and Washoe County residents 30 -39 years old
- From 2011 to 2020, methamphetamine-related inpatient admissions increased per 100,000 Nevada residents from 88.6 to 402.4 and in Washoe County from 153.1 to 410.0.
- In 2020, methamphetamine-related inpatient admissions were most prevalent among Washoe residents 30-39
- From 2011 to 2020, methamphetamine-related deaths increased per 100,000 residents from 4.4 to 13.7 in Nevada and from 4.4 to 14.7 in Washoe County
- In 2020, methamphetamine-related deaths were most prevalent among Washoe County residents 50 - 59 years of age.
- In 2020, Washoe County methamphetamine-related deaths were most prevalent among Black, non-hispanic residents (40.27)

*Age-Adjusted Rates

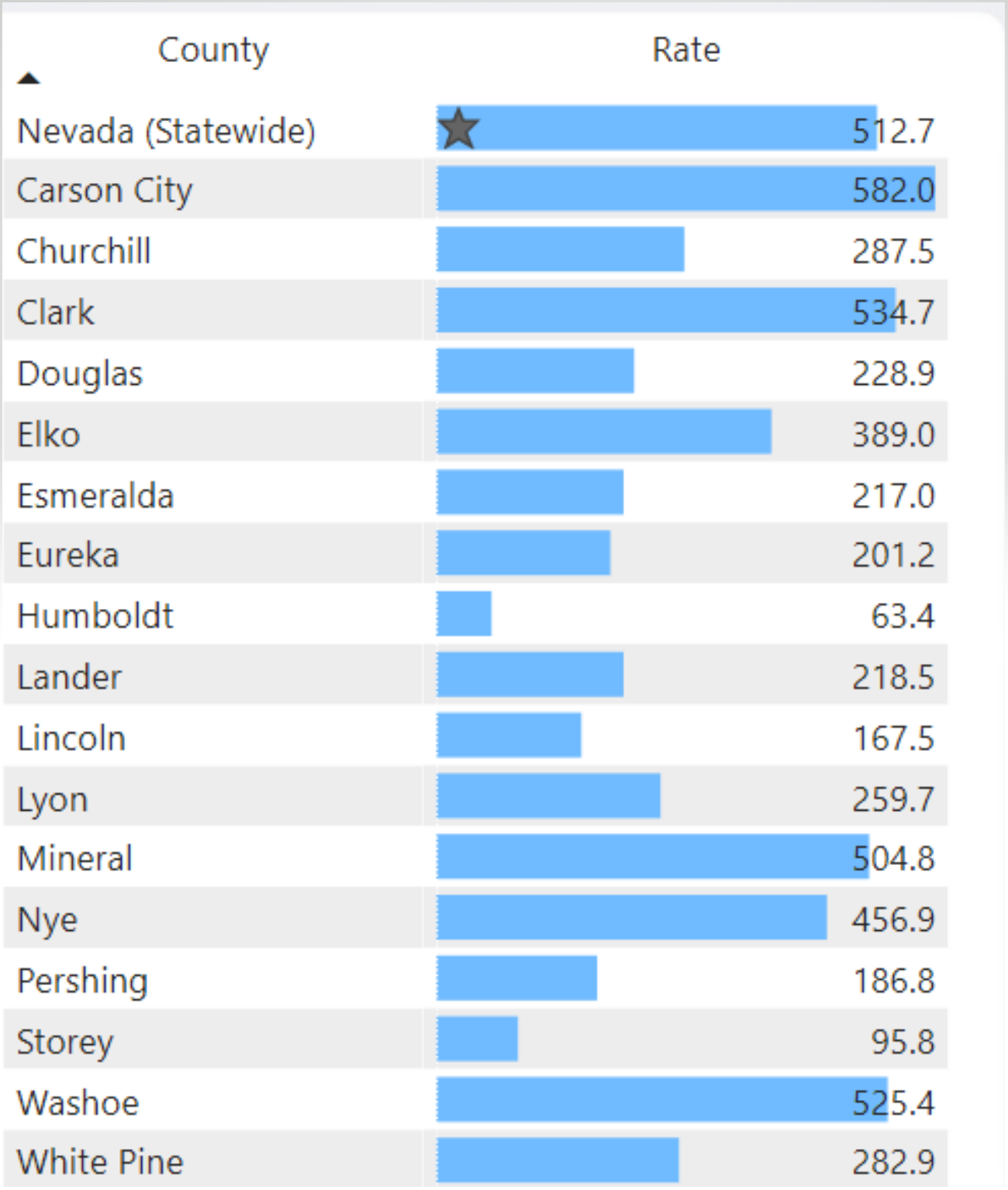
Methamphetamine/Stimulant Related Emergency Department Visits
Washoe County

525.4

Rate per 100,000 Nevada Residents

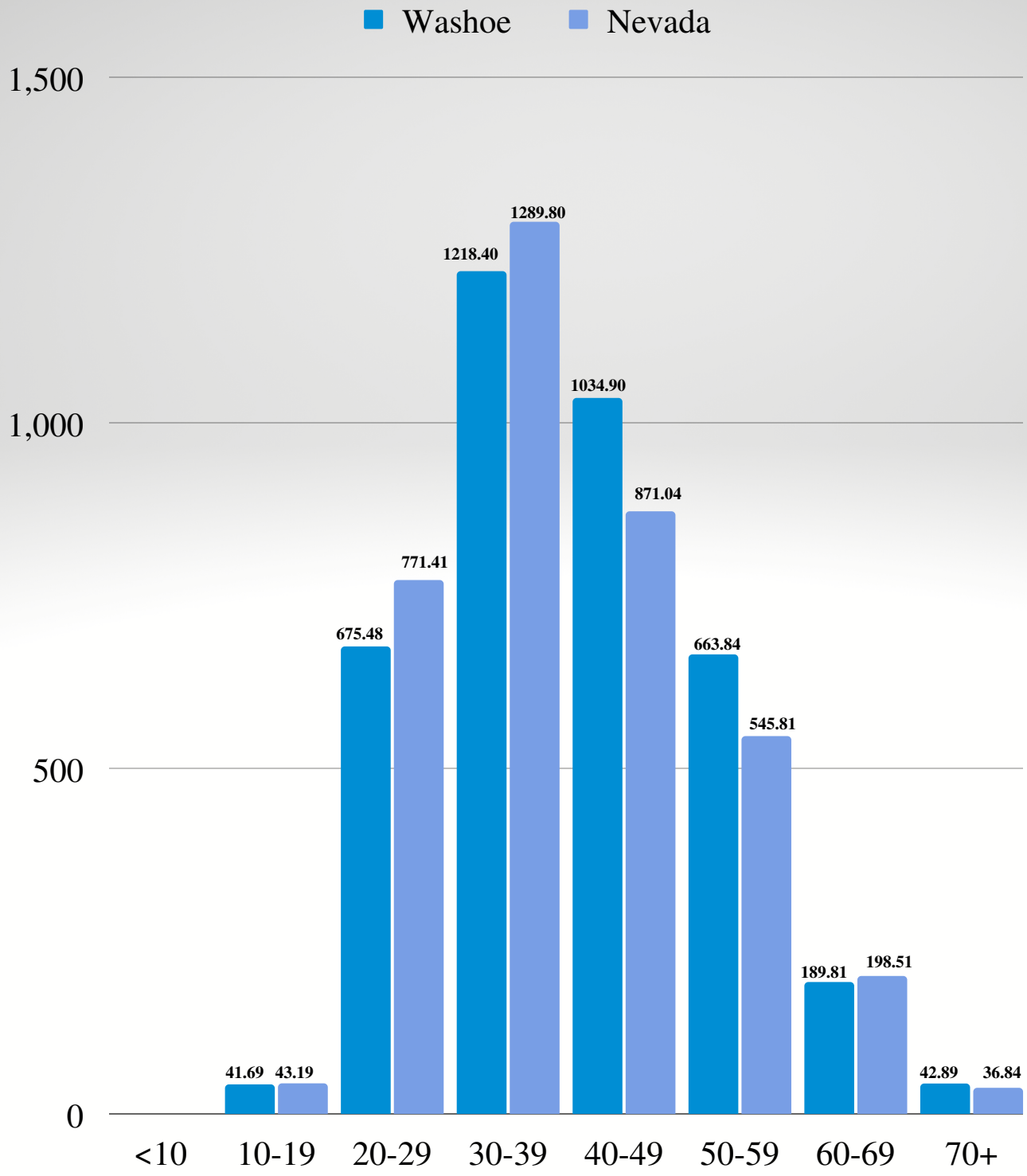


2020 Methamphetamine/Stimulant Related Emergency Department Visits: County (per 100,000)

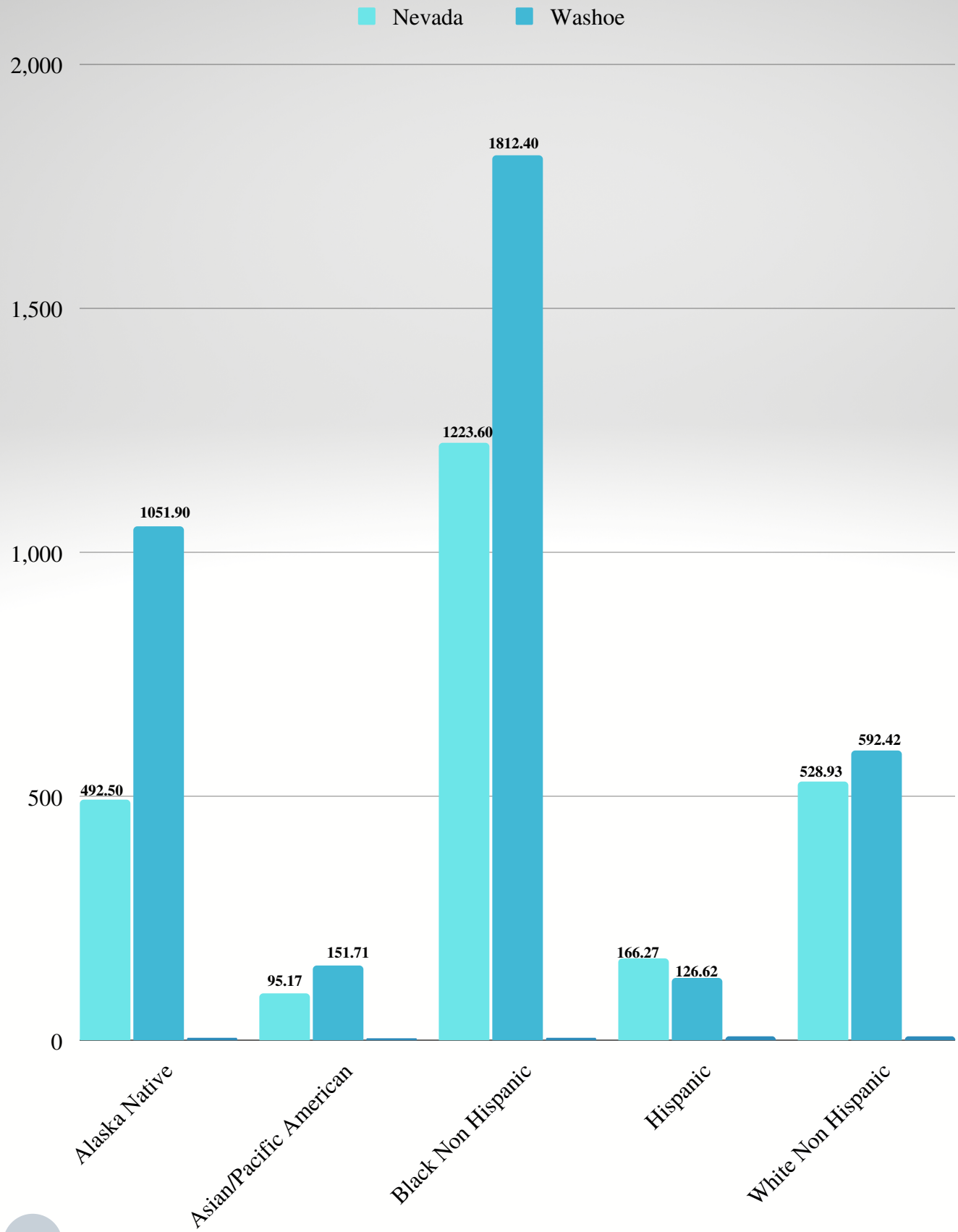


County	Rate
Nevada (Statewide)	512.7
Carson City	582.0
Churchill	287.5
Clark	534.7
Douglas	228.9
Elko	389.0
Esmeralda	217.0
Eureka	201.2
Humboldt	63.4
Lander	218.5
Lincoln	167.5
Lyon	259.7
Mineral	504.8
Nye	456.9
Pershing	186.8
Storey	95.8
Washoe	525.4
White Pine	282.9

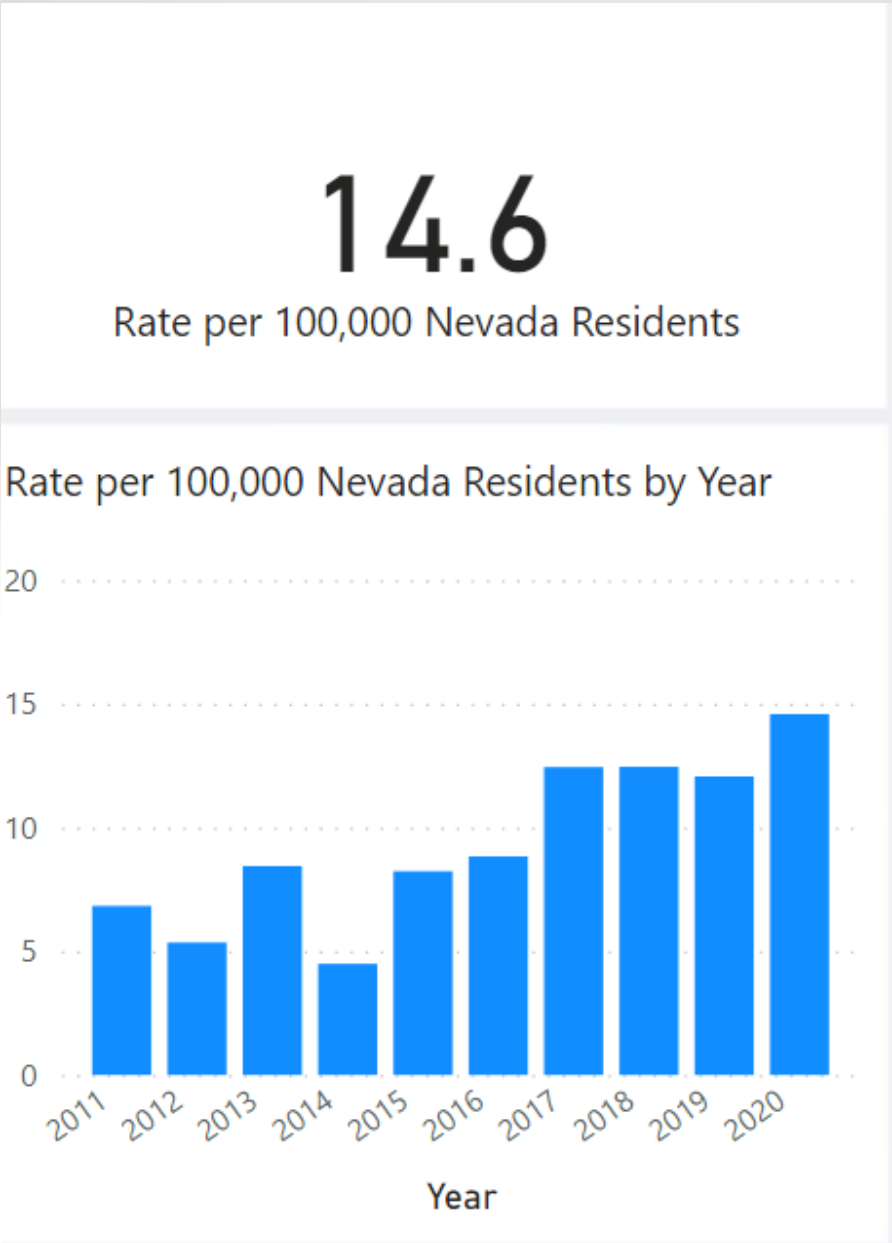
2020 Methamphetamine/Stimulant Related Emergency Department Visits: Age (per 100,000 Nevada Residents)



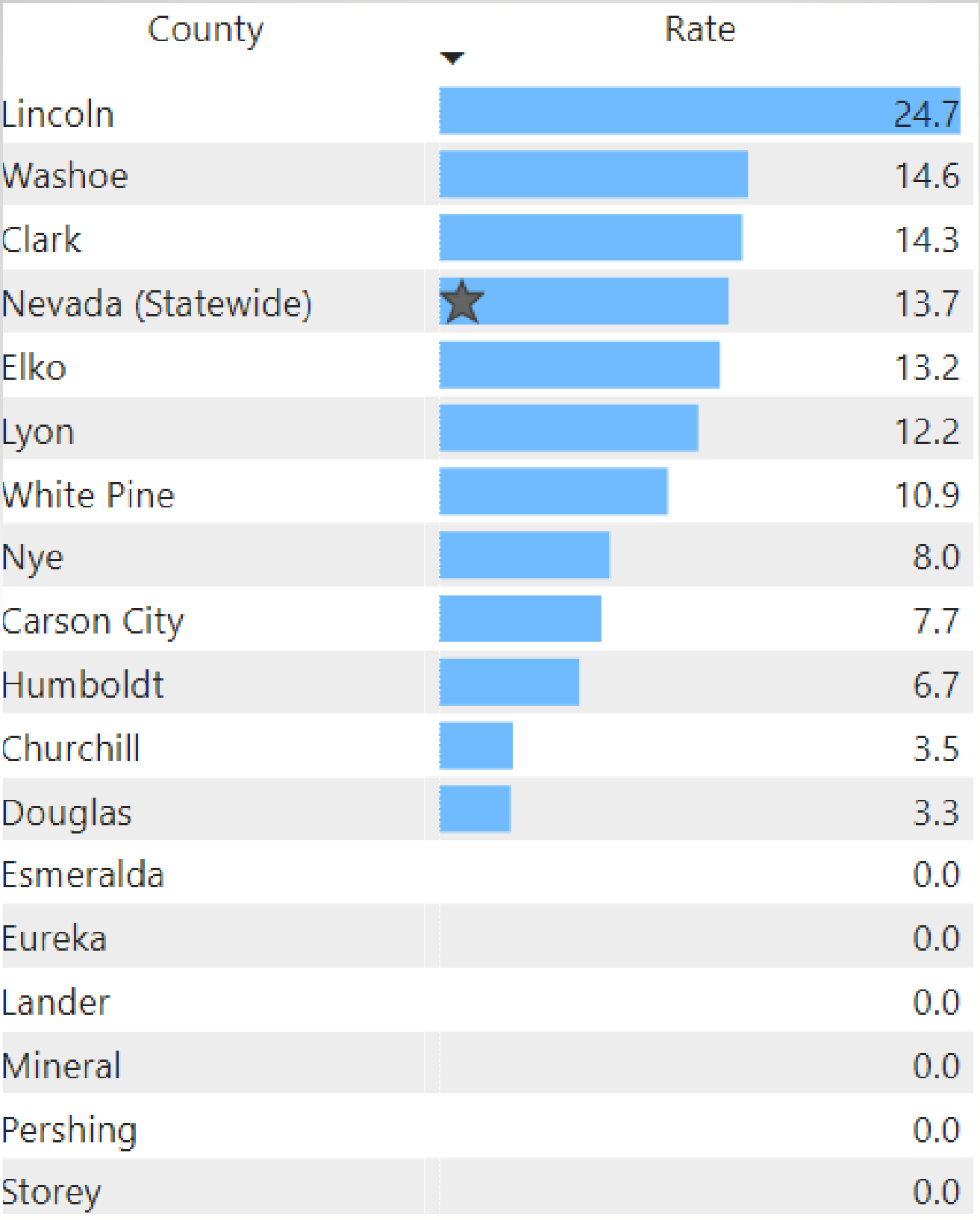
2020 Methamphetamine/Stimulant Related Emergency Department Visits: Race/Ethnicity (Per 100,000 Nevada Residents)



Methamphetamine Deaths

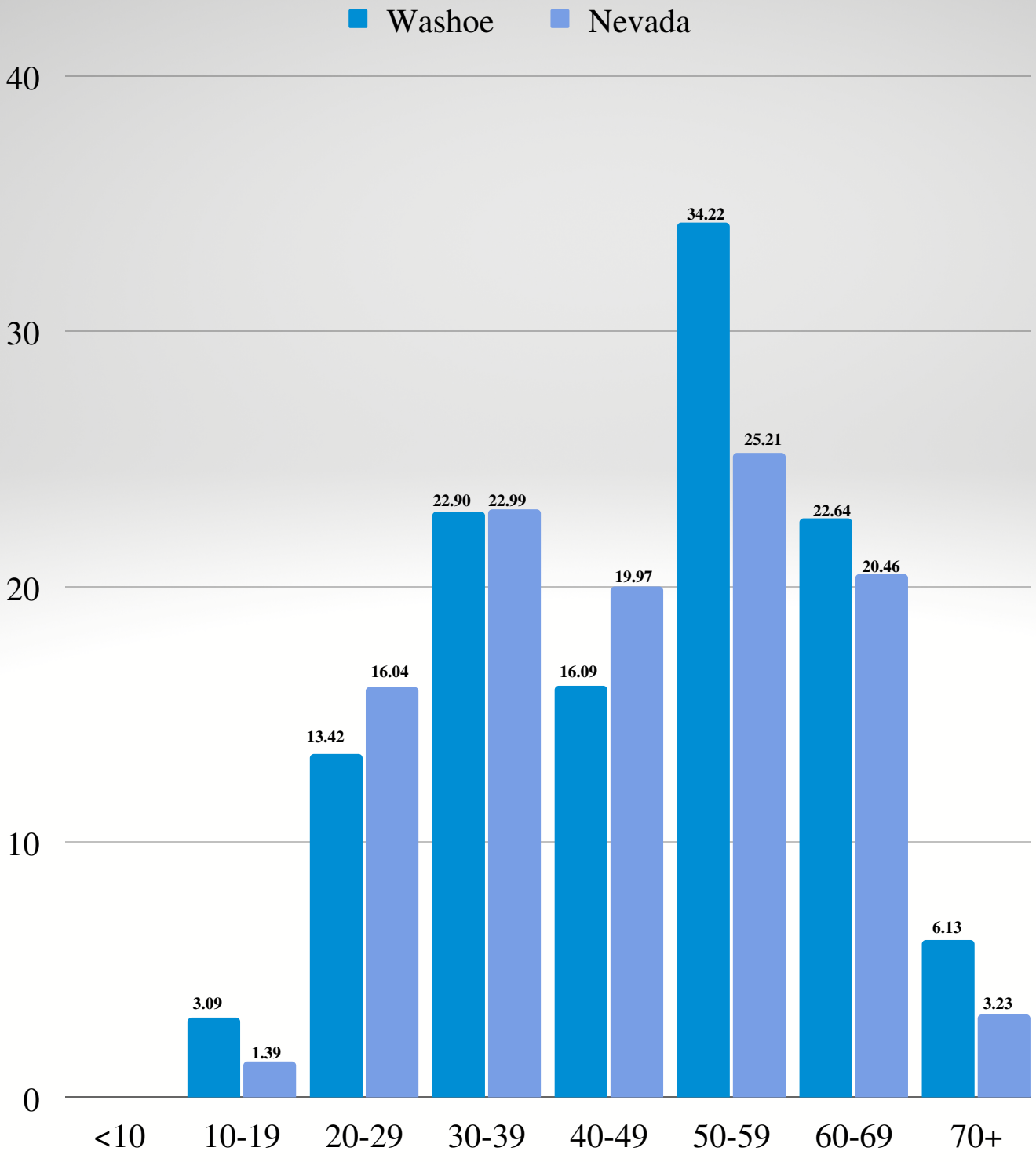


2020 Methamphetamine Deaths: County

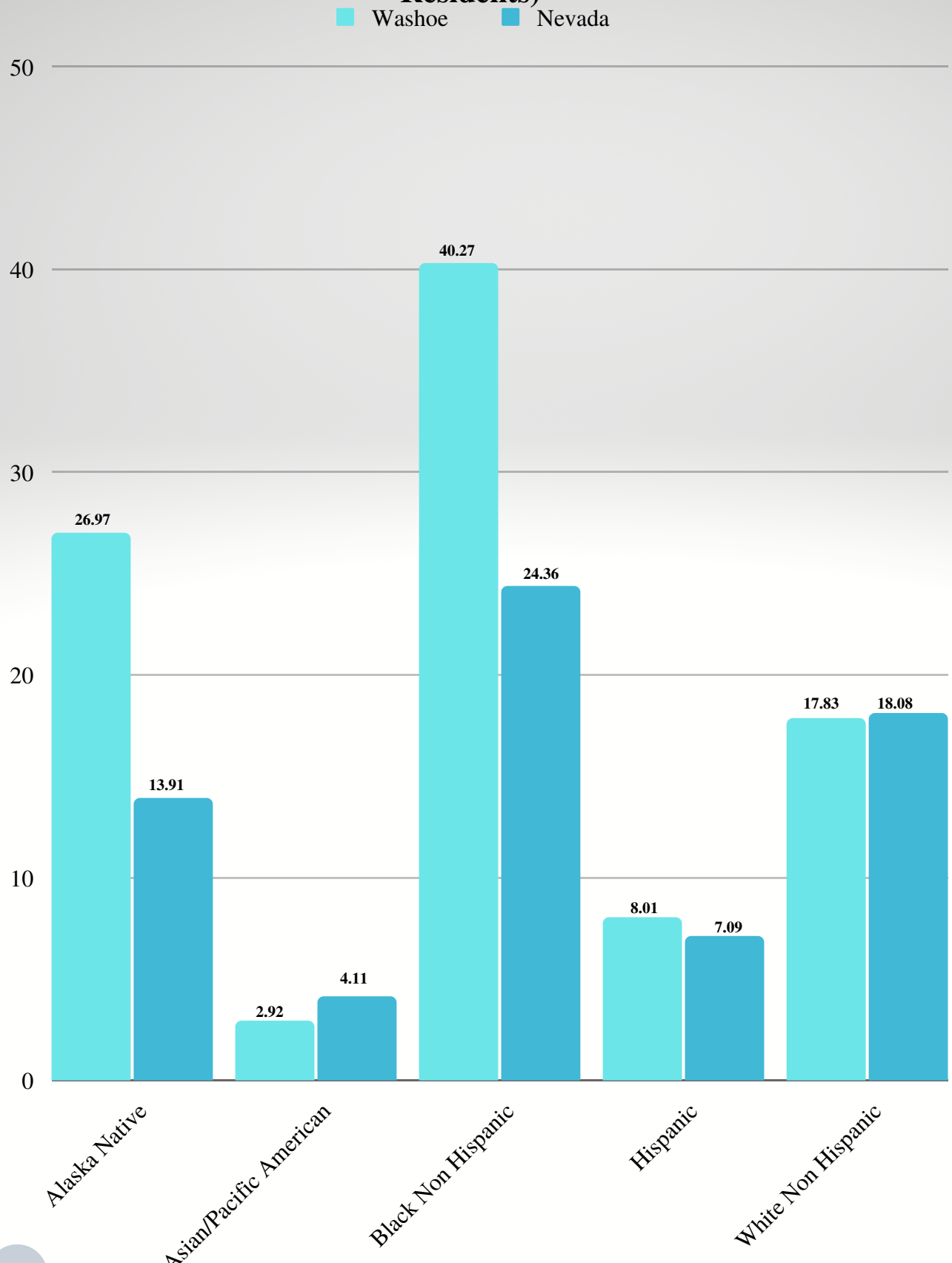


County	Rate
Lincoln	24.7
Washoe	14.6
Clark	14.3
Nevada (Statewide)	13.7
Elko	13.2
Lyon	12.2
White Pine	10.9
Nye	8.0
Carson City	7.7
Humboldt	6.7
Churchill	3.5
Douglas	3.3
Esmeralda	0.0
Eureka	0.0
Lander	0.0
Mineral	0.0
Pershing	0.0
Storey	0.0

2020 Methamphetamine Deaths: Age (Per 100,000 Nevada Residents



2020 Methamphetamine Deaths: Race/Ethnicity (Per 100,000 Nevada Residents)



Opioid Surveillance 2020/2021

- From 2010 to 2020, opioid-related emergency department (ED) encounters increased by 96%
- In terms of demographics, in 2021 the rate of opioid-related ED encounters was highest among Black Non-Hispanics at 234.2 per 100,000 Nevada residents.
- In 2021, inpatient admissions were highest among White Non-Hispanics at 244.7 per 100,000 Nevada residents and were most prevalent among Nevada residents ages 24-34 (24%)
- From 2010 to 2020, the number of opioid-related overdose deaths increased by 24%
- In terms of demographics, in 2021 the rate of opioid-related overdose deaths was highest among Black Non-Hispanics and 25-34 year old Nevada residents.
- Nevada has had 587 opioid-related suicide deaths between 2010 and 2020.

Source: Nevada State Office of Analytics; **County specific data not available**

Opioid-Related Overdose Deaths by Drug Category, Nevada Residents

Year	Heroin	Natural and Semi-Synthetic	Methadone	Synthetic Opioids	Unspecified Narcotic
2013	48	241	70	25	39
2014	61	218	63	32	37
2015	82	260	57	33	37
2016	87	235	53	53	29
2017	97	239	46	67	20
2018	106	212	33	83	11
2019	122	168	29	115	12
2020	127	215	30	276	9
2021	96	180	17	288	9

Opioid-Related Deaths, Nevada Residents

Race/Ethnicity	%	Crude Rates
Non-Hispanic American Indian or Alaska Native	0%	11.1
Non-Hispanic Asian/Pacific Islander	1%	3.1
Non-Hispanic Black	7%	22.7
Non-Hispanic White	33%	20.4
Hispanic	9%	9.0
Non-Hispanic Other Race	50%	
Unknown	0%	

Opioid-Related Deaths by Age, Nevada Residents

Year	0-14	15-24	25-34	35-44	45-54	55-64	65+
2013	0	33	76	65	112	80	30
2014	1	33	62	62	95	74	38
2015	3	31	81	75	97	94	38
2016	1	37	72	71	98	97	30
2017	0	40	73	75	103	77	43
2018	0	16	78	64	83	80	49
2019	1	34	71	76	76	75	41
2020	1	98	126	109	83	82	42
2021	1	63	125	100	83	67	49

Opioid-Related Deaths by Intent, Nevada Residents

Cause of Death	N	%
Accidents	4,390	86%
Assault (Homicide)	5	0%
Events Of Undetermined Intent	131	3%
Intentional Self-Harm (Suicide)	587	11%
Total	5,113	100%

XI. SUMMARY

The WRBHPB appreciates the opportunity to discuss current and future activities and values the participation of State legislators as well as State and County leadership in our joint pursuit of improving behavioral health for all Nevadans. The board emphasizes the importance of the provision of the highest quality of behavioral health care to patients and their families; the development and enhancement of acute, residential, and outpatient services; and, the provision of services to children and adults in need of mental health and substance abuse care. In the accomplishment of those goals, the WRBHPB strives to serve with compassion, empathy, and perseverance for those who are dealing with behavioral health issues; encourage and participate in open communication and to research and encourage sound fiscal management with resources. It is important that we advocate for prevention services for all, for early identification and intervention for those at risk, integrated and efficient access to care and behavioral services for all with recovery as a goal. We believe that gathering and providing current data and information about disparities faced by individuals with mental health challenges/problems is a tool for change.

As behavioral health continues to emerge as a critical community concern across the nation, so too do the options for data resources. Statewide, there is some impressive and comprehensive research which makes the decision around inclusion in this report, challenging. As with most extensive data reports, the results are not always the most current year and often a year or two behind. This ensures the accuracy and fidelity to the data as it takes time to correlate but can sometimes present the impression of a report that is not "current". The data included in this report is the most current available in most subjects and has been selected to provide a picture of areas that emerge in Washoe County as notable. Certain state and national data are also included to provide comparison and trends. Additionally, in the interest of length, certain repetitive data from previous reports was omitted unless it was for annual comparison. There are a myriad of references and links for readers to access at the end of the report for further information. The intention of data analyses most often reflects correlation and not causation. Readers can clearly see trends and patterns but not necessarily explanations. It is the task of all of us to take the next steps in exploring causation and moving towards solutions. Data collection and review is the first step. We look forward to the completion of the Washoe County Behavioral Health Profile next year, when CDC has released 2020/2021 data.

The WRBHPB is pleased to present priorities, strategies and recommendations that are based on what has been learned through a careful examination of programmatic research, Nevada and Washoe specific data, national best practices and the experience of many regional experts in the field of behavioral health. The WRBHPB recognizes that many of the recommendations and strategies proposed may present fiscal, programmatic and logistical challenges in implementation. While recognizing these challenges, we must remember that Nevada remains at the bottom of many national indices for behavioral health issues and how they are addressed. For many other health issues, resources are allocated for their eradication and/or research. It is unacceptable for Washoe County or the State of Nevada to fail to move forward as a leader in our commitment to protect and provide services to those in our communities that are suffering from behavioral health issues. It is with the hope for a positive, productive and secure future for all of Nevada's citizens that this report is respectfully submitted.

This report is respectfully submitted to:

DHHS Commission on Behavioral Health

Cc: Chair, Legislative Committee on Health Care
Richard Whitley, Director, Nevada Department of Health and Human Services
Eric Brown, Washoe County Manager
Amber Howell, Director, Washoe County Health and Human Services
Members, Washoe Regional Behavioral Health Policy Board

APPENDIX A

References/Links

National Center for Education Statistics; NCES.ed.gov

National Alliance On Mental Illness (Nami); Mental Health By The Numbers:
Https://Www.Nami.Org/Learn-More/Mental-Health-By-The-Numbers

Nevada Legislature, 79th Session, Ab366:
Https://Www.Leg.State.Nv.Us/Session/79th2017/Bills/Ab/Ab366_En.Pdf

Nevada Legislature, 81st Session,
Sb69 Overview (State.Nv.Us)

State Strategies to Increase Diversity in the Behavioral Health Workforce - The National Academy for State Health Policy (nashp.org)

U.S. Department Of Health And Human Services Substance Abuse And Mental Health Services Administration (SAMHSA): Https://Www.Samhsa.Gov/About-Us/Who-We-Are

Washoe Regional Behavioral Health Policy Board Meetings And Presentations:
Http://Dpbh.Nv.Gov/Boards/Rbhpb/Board_Meetings/2018/Washoe_Regional/

Substance Abuse Prevention And Treatment Agency 2020 Epidemiologic Profile Washoe
Office Of Analytics - Data & Reports (Nv.Gov)

Washoe County Behavioral Health Profile (Board Meeting 3/8/21 Attachment):
Http://Dpbh.Nv.Gov/Boards/Rbhpb/Board_Meetings/2018/Washoe_Regional/

Nevada Office Of Suicide Prevention
Http://Suicideprevention.Nv.Gov/

Public Health Assessment And Wellness
Http://Washoe.Nv.Networkofcare.Org/Ph/Healthindicatorslist.Aspx?Cid=12

Washoe County Health District Community Health Improvement Plan.
Chip-2021-Final.Pdf (Washoecounty.Us)

Mental Health America 2022 State of Mental Health in America Report | Mental Health America (mhanational.org)
ttps://dhhs.nv.gov/Programs/Office_of_Analytics/DHHS_Office_of_Analytics/

Washoe Regional Behavioral Health Annual Report Summary

Demographics

(2020 Census Results)

- Washoe County second most populated county in Nevada
  - 486,492 estimate according to 2020 census
  - 15.7% of Nevada residents
- Age Group from 55 years and up compose nearly 30% of population
- 64.1% White alone 25.1%Hispanic or Latino

Washoe Regional Behavioral Health Policy Board

2022 Membership
NRS 433.4295

JULIA RATTI
Director of Programs and Projects
Washoe County Health District
Policy Board Chair

STEVE SHELL
Vice President of Behavioral Health
Renown Health
Policy Board Vice-Chair

SARAH PETERS
Assemblywoman
District 24 Nevada State Assembly

HENRY SOTELO, Esq.
Reno Municipal Court
Specialty Court Attorney
Paralegal/Law Program Director,
Truckee Meadows Community College

DR. TRACI BIONDI
Chief Medical Officer
Prominence Health

PETER OTT
Executive Director
Bristlecone Recovery Center

SANDRA STAMATES
Community/Family Representative
Behavioral Health Families

WADE CLARK
Lieutenant
Reno Police Department

CHARMAANE BUEHRLE
Director of Community Programs
WellCare

DR. KRISTEN DAVIS-COELHO
Chief Behavioral Health Officer/Psychologist
Northern Nevada HOPES

FRANKIE LEMUS
Behavioral Health Coordinator
Washoe County
Human Services Agency

CINDY GREEN
EMS Coordinator Reno Fire
Department

Regional Behavioral Health Coordinator Activities

- WC Human Services Agency Senior/Adult Leadership
- Nevada Resilience Project (Washoe Supervision)
- Safe Babies Court
- Join Together Northern Nevada Vice Chair
- Northern Nevada Behavioral Health Coalition
- Senior Covid Vaccination Outreach
- Mayor's Mental Health Board
- Community Homeless Advisory Board (CHAB)
- Build For Zero Housing Project Outreach
- Mobile Outreach Support Team: Supervision/Data
- Regional Senior Coalitions/Advisory Boards
- Regional Community Court
- Crisis Response Systems Implementation Project
- Agency Legislation Support
- Workforce Wellness Workgroup
- BHCI Workgroup
- 988 Implementation Workgroup
- Nevada Association County Human
- Services Administrators - Legislative Support
- Community Case Manager Supervision
- WC Sheriff Substance Abuse Task Force
- Senator Cortez Masto - Team presentation/BH meetings
- Commission on Behavioral Health
- Commission on Aging Member
- Community Health Improvement
- Plan (CHIP) support
- Additional behavioral health support and education, meetings/webinars/trainings

Regional Priorities and Strategies

- Crisis Response System Implementation Plan (CRSIP)

  - Gap: Individuals in crisis need an integrated, appropriate response with a continuum of services
  - Strategy: Regional Crisis Stabilization Center – Someone to talk to; Someone to Respond; A Place to Go
  - Progress: Implementation Plan designing services to stabilize, engage and link to services. Great collaboration and support from County and City leadership; SMEs. Legislation from 81st session
  - Core Elements: Statewide Crisis Call Center to manage the 988 crisis line; mobile crisis teams; physical crisis stabilization center.
  - Challenges: Still waiting to see who applied and awarded under NOFO for elements of system

Regional Priorities and Strategies, cont.

- Equitable Focus on Substance Misuse
  - Gap: Focus more on mental health vs substance abuse
  - Strategy: Education, information and SB69
  - Progress: Bill passage; continue focus but no longer on priority list
- Behavioral Health Response
  - Gap: Lack of coordinated BH response in crisis; trained providers
  - Strategy: Integration of BH Response Annex into Regional Emergency Plan; Training in PFA; COVID Ambassadors (Resilience Project)
  - Progress: Post Covid meeting with DEM, County EM to discuss plan, schedule exercise. Continue to explore PFA training opportunities. Continue to focus but no longer on priority list
- Additional Areas of Discussion to Move to Priority List
  - Diversity and Inclusion
  - Mental and Behavioral Health Needs of Children
  - Behavioral Health Workforce
  - Support of the BH focus area of the Community Health Improvement Plan (CHIP)

Legislative Activities

- Passage of WRBHPB Bill SB69 (81st session)
- Support letters and testimony for SB70, SB44, SB56, SB156, SB390, SB154 and AB181
- Beginning presentations and outreach for 82nd session BDR. Presented so far or scheduled:
  - Continued Crisis Stabilization/Response
  - Children's Mental Health
  - Behavioral Health Workforce
  - Housing for individuals with BH issues and VL/EL income
  - Senior Emergency Response Times

Data

Data Sources

- Behavioral Health Profile (biennial)
- YBRS (biennial)
- BRFSS (annual for some/biennial for others)
- Nevada Office of Analytics Epidemiology Report (biennial)
- Mental Health America (annual)
- Nevada Regional Behavioral Health Policy Board Data Website(ongoing) (https://nvbh.org)
  - *Thank you, Northern Board!!*

Data Challenges

- Different sources, not consistent or accurate
- Intention of data analyses often reflects correlation and not causation
- Results often several years behind giving impression of info that is not current

*Correlation takes time to ensures accuracy and fidelity to data

Significant Regional Data Points

Substance Misuse:

- Since 2017, use of alcohol among adults has remained higher in Washoe County compared to Nevada and the US, both for binge drinking and heavy drinking
- From 2011 to 2020, methamphetamine related emergency department visits per 100,000 residents increased in Washoe County from 126.2 to 525.4 (exceeding statewide percentage)
- From 2011 to 2020, methamphetamine related deaths per 100,000 residents increased in Washoe County from 4.4 to 14.7 and most prevalent in the age group 50-59.

Mental Health/Suicide:

- In 2020, the age group of 55 and above represented nearly 38% of state funded mental health clinic utilization
- In 2019, the percent of adults in Washoe County who experience poor mental health or physical health preventing them from doing their usual activities more than 10 days in a month increased from 19.4% (2018) to 20.3% (2019).
- The percent of Washoe County high students who attempted suicide has continued to exceed those numbers for the State as well as nationally. 2019 reflects a slight uptick for state and county numbers.
- In 2019, those individuals from age 75 – 84 continue to lead in suicide completions. Those numbers are expected to trend the same way
- Among the veteran population from 2015 to 2019, the highest percentage of suicides occurred in the 65-74 age group, accounting for 23% of the 603 suicide-related deaths.

SUMMARY

Contact: Dorothy Edwards

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam,
Ph.D., M.D.
Chief Medical Officer

Rural Region

RURAL REGIONAL
BEHAVIORAL HEALTH POLICY BOARD

2021 Annual Report

March 2022

PREPARED BY
VALERIE M. C. HASKIN, MA, MPH
RURAL REGIONAL BEHAVIORAL HEALTH COORDINATOR

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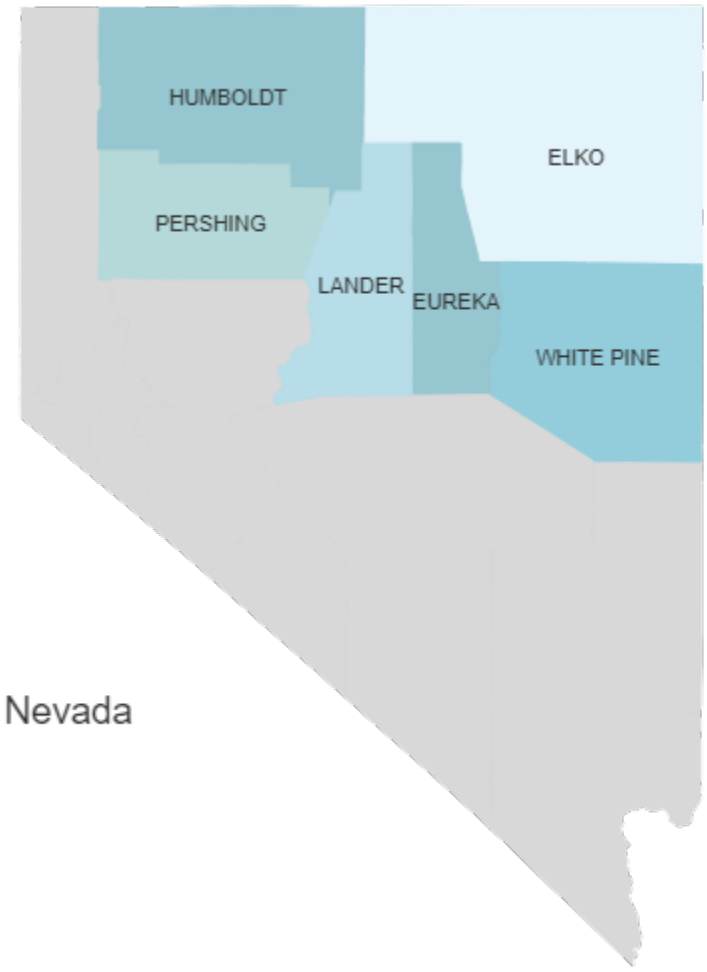


The Counties Included in the Rural Region

served by the Rural Regional Behavioral Health Policy Board:

Elko

Eureka

Humboldt

Lander

Pershing

White Pine

Board Members

2021 Board Members

Fergus Laughridge
Board Chair
EMS Representative
Humboldt County

Amy Adams
Drug and Alcohol Counselor
White Pine County

Senator Pete Goicoechea
Elko, Eureka, White Pine Counties

Matt Walker
CEO, William Bee Ririe Hospital
White Pine County

Bryce Shields
Pershing County District Attorney
Pershing County

Jeri Sanders
Peace Officer, Eureka County District Court
Eureka County

Dr. Erika Ryst
Psychologist
Remote

Amanda Osborne
Director of Human Services and Human Resources
Elko County

Brooke O'Byrne
Family Member Representative
Remote

Board Member Changes as of March 2022

(Date of Publication)

Fergus Laughridge
Board Chair
Now Health Officer Representative
Humboldt County

Amanda Osborne
Now Elko County Manager
Elko County

Sean Burke
Director of Lander County EMS
Lander County

Steven Brotman
Director of Behavioral Health at Nevada Health Centers
Remote

Sarah Dearborn
Nevada Medicaid
Remote

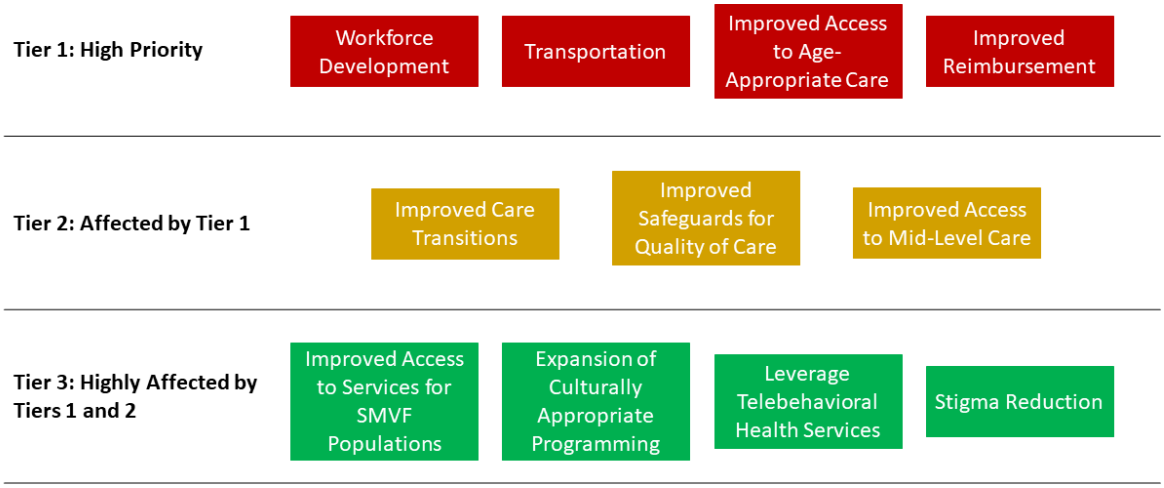
Rural Regional Behavioral Health Coordinator:

Valerie Cauhape Haskin, MA, MPH

Executive Summary

The Rural Regional Behavioral Health Policy Board (Rural RBHPB, or "the Board") was successful during the 81st Session of the Nevada Legislature with the passing of SB 44, aimed to improve paths to licensure for behavioral health providers. The purpose for this bill was to attempt to address the chronic provider shortages experienced by rural communities.

Through the exploration of data and feedback from stakeholders across the region, the Board developed the following priorities for 2022:



By taking a tiered approach in its priority setting, the Board has identified priorities upon which to focus that may affect and improve other issues identified. For further explanation of these priorities, please see page 15.

The Board has made recommendations to the Governor's Commission on Behavioral Health (page 19) that align with these priorities and aim to resolve some of these issues to the extent possible at the state level.

The Board will continue to learn how to best address its priority issues and will be working throughout 2022 to advocate for programs and services to fill gaps, and to identify potential topics to address with its BDR for the 2023 legislative session.

Data Highlights

In previous annual reports of the Board, the DHHS Division of Public and Behavioral Health (DPBH), Substance Abuse Prevention and Technical Assistance (SAPTA) and Office of Analytics branches provided each region with a comprehensive epidemiological report. Due to the staffing and data reporting needs required of DPBH to complete accurate data reporting for the COVID-19 pandemic, each Regional Behavioral Health Coordinator (RBHC) was instead provided with data sets for their own use.

The Rural RBHC also collected data as available from local sources, providing more timely understanding of community behavioral health needs. Northeastern Nevada Regional Hospital (NNRH, located in Elko, NV) and SafeVoice (administered by the Nevada Department of Education) were included in the data set, but truly only show the scope of behavioral health problems in Elko County. This and other data were visualized by the Rural RBHC for the purpose of informing the Rural Regional Behavioral Health Policy Board (or simply, the "Board") of the current behavioral health status of the communities it serves, as well as for planning purposes, has been provided in Appendix A.

Highlights from the data provided in Appendix A include:

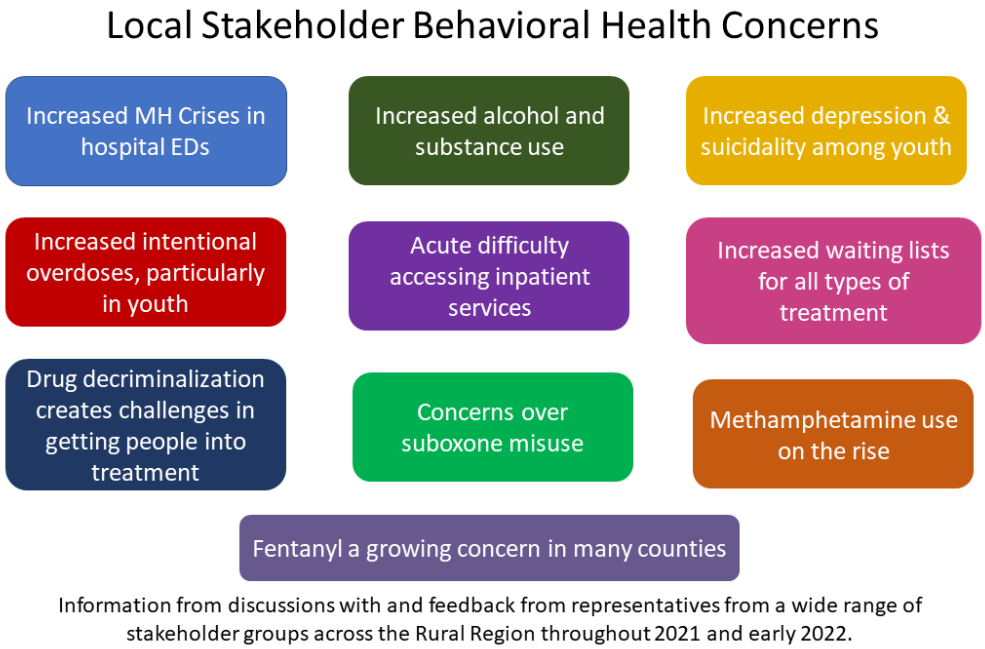
- Data from SaveVoice and NNRH indicates a higher incidence of suicidal ideation among youth in Elko County than in other counties within the Rural Region.
- People of color in the Rural Region are disproportionately affected by death from alcohol and substance use.
- Marijuana and hashish use continues to be more highly utilized than other substances, the rates of which have been increasing in a curvilinear manner since legalization.
- Adult binge drinking and heavy drinking remains higher in the Rural Region than the state taken as a whole.
- Alcohol abuse and substance use disorder is still on the rise in most counties.
- Youth overdose and substance misuse remains an issue across the region.

Additionally, anecdotal information from conversations and interviews between the Rural RBHC and stakeholders throughout 2021 proved fruitful in identifying patterns of new or persistent issues of which to be aware, which may not be reflected by the data available from DPBH yet. In previous years, this anecdotal information was later reflected in data published by DPBH, so while not all of the concerns reported by local-level stakeholders can be considered "proven true" yet, they should be taken into consideration. Concerns from stakeholders included:

- Inability to find placement for patients needing crisis stabilization or inpatient care in a timely manner. Upon further investigation, this appears to be caused by a combination of outbreaks of COVID-19 within facilities and/or high staff attrition as uncompetitive wages at state facilities and long working hours affect the appeal of working within these facilities.
- Difficulty in enrolling high-risk community members in specialty court programs as laws regarding the criminalization of some substances have changed. The communities within the rural region generally have special courts programs to assist persons who have been

arrested with either mental illness and/or substance use disorder, but the movement of possession of smaller amounts of substances to the misdemeanor level has created issues. Ideally, these community members might be a better fit for an ACT, AOT, or other treatment program, but such programs do not yet exist in the region, and deficits such as funding and staffing may make it difficult to get such programs up and running in the near future within our rural communities.

- Transportation to both crisis and outpatient services continues to be a challenge in all of the communities in the region.
- Lack of mid-level services is another persistent issue. Communities are working towards improved access to crisis care, but the availability of treatment services that fit between crisis and weekly outpatient treatment is virtually non-existent within the region at the time of this report. This gap in treatment for both mental illness and substance use disorder is felt to contribute the rising incidence of persons presenting to hospitals and encountered by law enforcement needing crisis or other inpatient care.
- Increased concerns for the mental health of youth and young adults, including concerns over increased suicidality and intentional overdoses among youth as young as those who are junior high/middle school-aged.
- Both law enforcement and hospitals have reported concerns over rising methamphetamine use within their communities.
- Law enforcement has reported concerns regarding the misuse and trafficking of suboxone among high-risk populations.
- As most communities within the region sit along major interstate highways, there is concern over increased fentanyl and fentanyl-laced substances circulating within rural communities.



Information from discussions with and feedback from representatives from a wide range of stakeholder groups across the Rural Region throughout 2021 and early 2022.

Both the data presented, as well as the anecdotal concerns from stakeholders, were taken into consideration by the Board when building its 2022 priorities and recommendations to the Governor's Commission on Behavioral Health (CBH).

2021 Rural Regional Behavioral Health Policy Board Activities

The following sections cover the activities of the Rural RBHPB and the Rural RBHC throughout 2021. While the COVID-19 pandemic ebbed and surged throughout the year, efforts continued to address persistent problems experienced both within the region and across the state.

Senate Bill 44 in the 81st Session of the Nevada Legislature

As discussed in the 2020 Annual Report, the Rural RBHPB developed SB 44 to affect the processes required for licensure by endorsement and the oversight of interns as regulated by the four main licensing boards for behavioral health providers:

- Board of Examiners for Social Workers
- Board of Psychological Examiners
- Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors
- Board of Examiners for Alcohol, Drug, and Gambling Counselors

SB 44 aimed to change regulations to streamline the processes required for licensure of experienced professionals “by endorsement”. Professionals who would qualify for this licensure type are experienced providers who have been licensed out of state, are currently in good standing, and who are looking to begin practicing in Nevada. As many of the organizations in the Rural Region who hire new providers must recruit from out of state, a quick and streamlined process is necessary to increasing the number of providers available to rural communities.

Additionally, the bill required the licensing boards to add or solidify regulations that would allow for the remote supervision of interns, much like those currently in place under the Governor’s emergency directives related to the COVID-19 response. This shift would allow more interns to practice within the rural region, many of whom either are current residents who have been able to complete their coursework online, or may be originally from the region and wish to practice in their home communities. Additionally, this aids in addressing issues regarding the need for practitioners who have experience or direction in working with clients of color or who associate with various minority groups by allowing the interns to seek oversight from supervisors who may have clinical experience working with special populations, regardless of their location within the state.

The bill also added a fourth licensure type to the offerings of the Board of Examiners for Social Workers, the Licensed Master of Social Work (LMSW) type. LMSW licensure is available in most states and the addition of this licensure type aids the Board of Examiners for Social Workers in developing interstate compacts for licensure reciprocity, which is ultimately the gold standard for enabling licensees to practice across multiple states.

The bill passed towards the end of the regular session, and its full text as enrolled can be found at the following link: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7221/Text#

Board Meetings and Presentations

Unfortunately, the Rural RBHPB was only able to meet three times in 2021; once each in January, February, and March. Meetings in April and July were canceled due to lack of quorum. The May meeting was canceled due to technical issues. After the July meeting, it came to the attention of the Board and the Rural RBHC that appointments were expiring and arrangements for new appointments needed to be made.

The three meetings that were held focused on refining SB 44 and the progress of the bill through the legislative session.

All meeting notes, presentations, and other materials can be found at: https://dpbh.nv.gov/Boards/RBHPB/Board_Meetings/2018/Rural_Regional/

Rural Regional Behavioral Health Coordinator (Rural RBHC) Activities

While the COVID-19 pandemic continued to create some challenges to the functioning of some activities, such as restricted access to the building during the legislative session, most efforts continued apace via Zoom or other online platforms. While travel restrictions were lifted during 2021, the Rural RBHC was unable to travel for the first half of the year due to personal medical reasons. However, regional travel continued during the summer of 2021 and into the rest of the year, better facilitating face-to-face connections and relationship building with local stakeholders.

The following sections outline some of the major projects and activities engaged in by the Rural RBHC throughout 2021.

SB 44 and the 81st Session of the Nevada Legislature

During legislative sessions, each RBHC works to ensure their respective bills are appropriately understood by stakeholders, legislators, and the other policy boards. The Rural RBHC worked with the Chair of the Rural RBHPB to ensure that comprehensive feedback from all of these groups was garnered and taken into consideration during the development and amendment of SB 44. The Rural RBHC was responsible for crafting and submitting proposed amendments, meeting with legislators and/or their staff to hear their concerns, presenting the status and current components of the bill to local groups during meetings throughout the region, and presenting the bill and answering questions during legislative committee meetings and work sessions.

Community Outreach Project

It became clear early in the year that the Rural RBHC would need to take a period of time off for maternity leave during the late spring and summer of 2021. As there would be substantial savings in grant monies from the lack of salary and travel for a period of weeks, the Rural RBHC worked with grant program officers at DPBH to ensure that funds within the grant were re-allocated appropriately.

In the end, the Rural RBHC, in conjunction with the Northern RBHC and other stakeholders, put together a community engagement project that included the following components:

- A survey of community members to better understand their perspectives on behavioral health within their communities, and moreover, how they would like local and state-level government agencies to be involved (implemented in all counties within the Rural and Northern Behavioral Health Regions);
- A behavioral health system assessment survey to engage members of the system to identify their perspectives on system gaps and how they could best be filled (implemented only in the Rural Region);
- An event to present the data from the abovementioned assessments and other sources in a town-hall format focusing on one community, and to then lead attendees through community strategic planning processes.

The community survey was available online via Survey Monkey and in hardcopy, distributed by participating coalitions and social service agencies. The electronic survey was shared and boosted via Facebook, and received well over 200 answers across the two regions. The hardcopies were then hand entered into the Survey Monkey survey for ease of reporting. In the end, well over 400 responses from across the two regions were collected.

The Stakeholder Assessment was modeled after the Local Public Health System Assessment, available through the National Association of City and County Health Officials (NACCHO). However, the assessment was cut to a series of ten questions, rather than hundreds, as it was designed to be administered within other standing meetings. Assessments were completed in Winnemucca, Lovelock, Ely, West Wendover, and Elko. The data assessment was completed for Winnemucca, and all other communities are still in progress.

The" Town Hall" event was held in Winnemucca on September 29, 2021 at the local Boys and Girls Club facility. There were well over 50 individuals in attendance, and other ten who attended via Zoom. Stakeholders represented treatment agencies, the local hospital (Humboldt General Hospital), tribal groups within Humboldt County, law enforcement, courts systems and the criminal justice system, social services agencies, and advocates and peers representing the needs of persons using the behavioral health system. The group prioritized the need for stigma reduction, affordable housing, prevention activities, youth mental health and substance use prevention, and mid-level treatment for both mental illness and substance abuse disorder/substance misuse.

Overdose Data to Action (OD2A) Program – Substance Misuse Specialists (SMS)

In 2021, work continued with the Rural RBHC acting as a team lead to collaborate with the SMS' seated within the Rural Region. Gains were made in the gathering of data from local dispatch and law enforcement, and SMART Recovery programming was implemented by the SMS located in White Pine County both in Ely and Eureka. The SMART Recovery model is evidence-based and better serves persons who may not be a fit for religious-based programs such as AA or NA. There are plans to further expand the SMART Recovery model through the SMS program in 2021. Additionally, several Naloxone trainings were scheduled and coordinated by SMS' in Humboldt County, and more scheduled through 2022.

The team also built a brief resource sheet for stakeholders and community members wanting to learn more about program planning and evaluation, as strong skills in these areas can improve

not only programs developed at the local level, but may also help in writing competitive grant applications. This resource sheet was shared widely in spring of 2021.

Collaboration with Other Regional Behavioral Health Coordinators

The Rural RBHC continued to work collaboratively with the other RBHCs across the state, but specifically focused on building a partnership with the Northern RBHC, as she was the only other RBHC that served rural counties while the Southern RBHC position remained vacant. Projects worked on collaboratively include the Community Outreach program discussed above, the development of an all-board website (nvbh.org), communication regarding bills during the legislative session, and many others.

Governor's Challenge Team and Expansion Teams

Unfortunately, there was little progress in the development and launch of the Expansion Teams to address suicide prevention among service members, veterans, and their families (SMVF) in the designated sites of Elko and Winnemucca. Much of this resulted from staffing turnover at local and state levels, which creates periods of pause. However, the Rural RBHC and a representative from the expansion team in Elko were invited to speak at the Nevada Suicide Prevention Conference in Las Vegas in November 2021.

Evidence-Based Practices and Programs

To improve access to reputable programs and communicate them to larger populations, the Rural RBHC began compiling EBPs into an online guide page in 2020 and into 2021. Resources included in this guide include those from SAMHSA, Federal DHHS, CIT International, KnowCrisis.org, University of Columbia's Lighthouse Project, the VA, USDA, PsychHub, Zero Suicides, and many others. The EBPs are organized by target audience to assist users in selecting the practice that works best for their proposed grant program or project. The project was completed in April of 2021.

Engagement with Prevention Coalitions

Engagement and relationship building with the two prevention coalitions within the region, PACE and Frontier Community Coalition (FCC) expanded throughout 2021. In the last quarter of the calendar year, the Rural RBHC worked with both groups and various other stakeholders to build an application for funding to build a region-wide prevention initiative, heavily involving both coalitions.

Task Forces and Multi-Disciplinary Teams

Work continued through 2021 with local task forces and coalition groups acting as task forces. The Humboldt County Behavioral Health Task Force, facilitated by the pre-trail services coordinator for the 6th Judicial Court carried forward with the most momentum. Coalition groups in White Pine and Pershing Counties were re-engaged in 2021 and hold great potential to make progress to address behavioral health in their respective communities.

As a new member of the Rural RBHPB represents Lander County, efforts to connect with local stakeholders and create movement to address behavioral health in that county will be renewed in 2022.

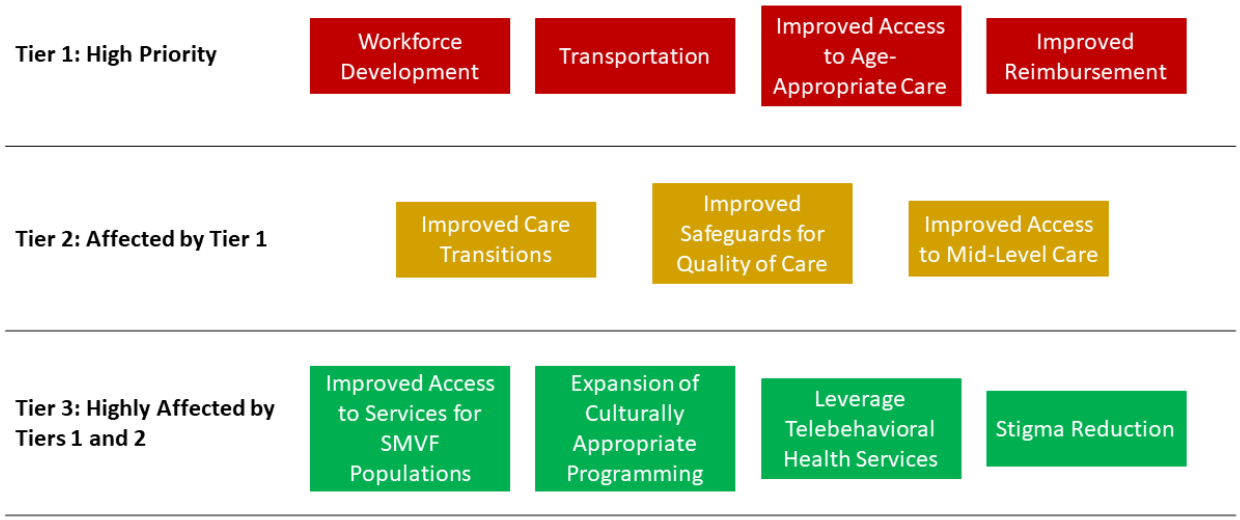
County	Task Force and MDT Status
Humboldt County	Humboldt County Task Force – Undergoing strategic planning. Currently exploring various options to develop and pilot MDTs for high-risk community members.
Elko County	Multiple community groups which complete the activities of a Task Force.
Eureka County	Interest in MDT-like programming; very few potential participants. Existing coalition meetings fill role of a Task Force.
White Pine County	
Pershing County	Pershing FCC meeting designated as Task Force.
Lander County	Outreach difficult; efforts to be renewed in 2022.

Closing

The sections above highlight the larger projects undertaken by the Rural RBHC during 2021. However, for the sake of brevity, this description is not completely exhaustive and there were many smaller projects and activities undertaken to support the improvement of the behavioral health system in the Rural Region not listed here.

2022 Rural Regional Behavioral Health Policy Board Priorities

In previous years, the priorities of the Rural RBHPB did not include any sort of hierarchy of needs. However, as the Board set its priorities for 2022, the need to focus on specific priority topics surfaced, and it is hoped that making strides in these areas will lead to improvements in priority areas that fall into subsequent tiers.



Tier 1: High Priority

Workforce Development	While the availability of funding for treatment providers and other programs is improving as federal funding trickles down to the state and county levels, a persistent lack of workforce to staff new programs has become a challenge that creates roadblocks to systemwide efforts to improve treatment options. Without qualified providers and allied staff to fill positions, access to badly-needed treatment and services will remain poor for all rural residents.
Transportation	While transportation to and from all types of treatment has been a priority of the Rural RBHPB in previous years, the situation has remained dire for many communities. Unfortunately, other efforts to improve transportation to and home from services has largely proved fruitless; these options are either cost prohibitive or not realistic for consumers, or are cost prohibitive for potential transportation providers. The Rural RBHPB prioritizes both novel and evidence-

	based practices in resolving transportation challenges, so long as proposed solutions are centered around the needs of user.
Improved Access to Age-Appropriate Care	While providers and treatment programs remain few in the region, those who specialize in caring for special populations such as children and the elderly are rare at best. As the communities the Rural RBHPB have not been immune to the children's mental health crisis, there is a poignant need for providers who serve children and teens at all levels of care, including crisis care and stabilization.
Improved Reimbursement	While real estate costs may be comparatively smaller, the overall cost of living and running treatment facilities is often higher in rural communities than in urban Nevada. Oftentimes treatment agencies must offer higher salaries in rural Nevada than in urban communities to recruit high-quality staff. Labor and supply costs for building new facilities or remodeling existing structures may also be higher, as well as other general costs of doing business. Given that the majority of clients requiring intensive treatment options tend to be covered by Nevada Medicaid and/or CMS, chronically low reimbursement rates may hamstring the ability of treatment organizations to expand existing services, and there is little incentive for new agencies or providers to begin practices that serve our communities. It is theorized by the Board that increasing the reimbursement rates for behavioral health services from Nevada Medicaid and CMS (if possible), even if these increases are specific to services within rural Nevada, will facilitate the expansion of services that are available to the community members the Board serves.

Tier 2: Affected by Tier 1

Improved Care Transitions	A common problem across all communities within the Rural Region and the agencies outside the region that serve community members seeking treatment is a lack of communication and warm hand-offs. These cold, unclear, or sometimes incomplete transitions of patient care create opportunities for patients to fall out of treatment at best, but more affect patient safety and well-being. Oftentimes, patients who are transported to inpatient and/or crisis care outside of the region are discharged with little to no plan to continue appropriate care upon returning to their home community, and their specific needs regarding

	medication or other issues are not communicated to providers from whom they may seek further assistance. These transitions need to be improved in order to support improved outcomes for the patients. This may include altering the accessibility of information through the state's health information exchange or use of another platform to not only create the opportunity for appropriate referrals, but for providers to communicate patient progress as a care team.
Improved Safeguards for Quality of Care	While filling gaps in provider shortages is an urgent priority, the Board wishes to be sure that creating safeguards to protect the quality of the services provided to rural community members is also taken into consideration. While having more options for care may assist in "weeding out" agencies or providers who give sub-quality care, it will be necessary to create additional safeguards or complaint options as providers are added to the regional behavioral health system.
Improved Access to Mid-Level Care	Currently, mid-level care options for persons with mental illness or substance use disorder are rare or non-existing in most communities in the region. Having access to intensive outpatient treatment or other options throughout the continuum of care is an imperative component to helping community members with behavioral health challenges get into and remain in a state of recovery. Most of these services cannot be provided via telebehavioral health means and require a higher level of expertise from providers; both of these issues create further challenges to creating a treatment system that assists persons in need of these levels of treatment.

Tier 3: Highly Affected by Tier 1 and Tier 2

Increased Access to Services for SMVF Populations	As in previous years, the Rural RBHPB prioritizes improving the access to high-quality care for service members, veterans, and their families (SMVF) across the state, but particularly those who live within the Rural Region. Many persons within this population in the Rural Region must travel to either Las Vegas or Reno to receive covered services, but many must travel out of state to Utah or Idaho for services. Increasing the number of providers that accept Tricare insurance, work with VA benefit organizations, and have staff who are trained in culturally appropriate means of discussing and treating behavioral health among this population may improve their outcomes.

Expansion of Culturally Appropriate Programming	While there are programs within the region that specialize in serving persons of color, particularly indigenous and Hispanic communities, these are few. The Board acknowledges that the number of programs and services that at the least maintain culturally appropriate services must be expanded to ensure high-quality care for all members of our communities.
Leverage Telebehavioral Health Services	During the COVID-19 pandemic, telebehavioral health services became the primary source of treatment for many individuals and treatment providers, some who had previously resisted engaging in any sort of telehealth services. With telebehavioral health practices now becoming more commonplace, the Board acknowledges that leveraging this technology for appropriate levels of care may help increase access for many rural residents, and should be leveraged for various programs and services to the extent that it fits within the service or treatment type while maintaining quality.
Stigma Reduction	The stigma surrounding both mental illness and substance misuse and/or substance use disorder remains prevalent in the communities served by the Board. Stigma continues to create a barrier to the implementation of badly-needed programming, particularly for youth, and similarly acts as a barrier for persons of all groups to seeking care. Strategies to reduce the stigma surrounding these conditions and seeking care should be implemented across the region, with special focus on higher need populations, including youth, the elderly, and persons identifying as BIPOC.

Current Recommendations to the Governor's Commission on Behavioral Health

After reviewing the most updated data related to behavioral health in the region it serves, the Rural Regional Behavioral Health Policy Board would like to make the following recommendations to the Governor's Commission on Behavioral Health:

1. The Board recommends increased investments in programs to bolster the workforce of behavioral health providers and related staff across Nevada. This might include programs that address:
    a. Tuition reimbursement for providers serving within designated provider shortage areas;
    b. Tuition reimbursement or scholarship opportunities for new providers serving disadvantaged populations, including persons of lower socio-economic status and/or persons of color who are underserved in their respective communities;
    c. Increased reimbursement for behavioral health services, particularly for persons covered by Nevada Medicaid in Fee-For-Service areas, specifically rural and frontier Nevada;
    d. incentives for providers specializing in the treatment of children, the elderly, and other high-risk populations;
    e. And support policy changes that expand the ability of interns to access completely remote supervision, expansion of the number of internship sites available, and to expedite licensure processes.
2. The Board recommends investments in both evidence-based and novel transportation solutions for persons across the state needing to access emergency and non-emergency behavioral health services. Transportation needs to be affordable, reliable, easy to book (if necessary), easy to access within short timeframes, and must enable an individual to get to and from their services in a manner that causes minimal impact to their daily lives. Some services for rural residents have been increased in recent years for this purpose, but unfortunately, the hours of operation, required lead time for booking, insurance accepted, and/or expenses related to utilizing these services creates further challenges to using them to access behavioral health treatment in "neighboring" communities.
3. The Board recognizes that the communities within the region it serves have not been immune to the mental health crisis experienced by children nationwide. As such, the Board recommends policies and investments that increase the availability of services across the behavioral health continuum of care for children and adolescents struggling with mental illness, substance misuse, or dual diagnoses.
4. The Board also recognizes there are breakdowns in communication among providers within the spectrum of behavioral health care, and recommends policies to ensure warm hand-offs and clear, open communication regarding patient needs, referrals, and preferred care throughout the system. This may include policy changes regarding the sharing of information, creation of referrals, and requirements for warm hand-offs, but may also include funding for patient care coordination that is not limited to one institution (such as community-based patient navigator), and vastly improved utility/accessibility of state's health information exchange.

5. As workforce shortages for behavioral health professionals persists, the need to hire paraprofessionals within communities becomes more vital. The Board recommends supporting policy shifts that would enable the services of trained and certified Community Health Workers (CHWs) operating within the behavioral health field to be reimbursable by Nevada Medicaid. CHWs could play a vital role in connecting with community members throughout rural and urban communities in the state to act as navigators, trainers for evidence-based programs to recognize and respond to persons with mental illness or substance use disorder, or even as care coordinators after specialized training.

These recommendations will be submitted to the CBH in March 2022 for consideration for its recommendations to the Governor. The Board hopes that together, we can improve the lives of those suffering with behavioral health challenges across the state.

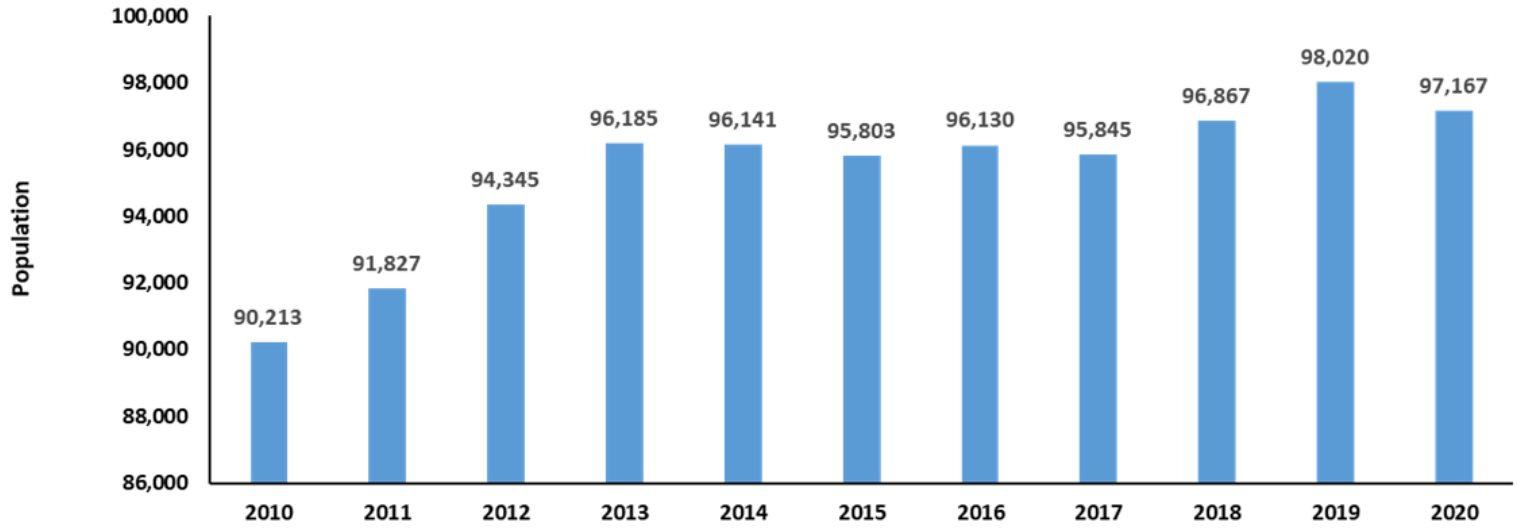
Appendix A: Behavioral Health Data Presented to the Rural RBHPB During its February 2022 Meeting

This Presentation

- Review of available data
- Anecdotal information from stakeholders
- Review of 2021 Priorities
- Discussion and Development of 2022 Board Priorities

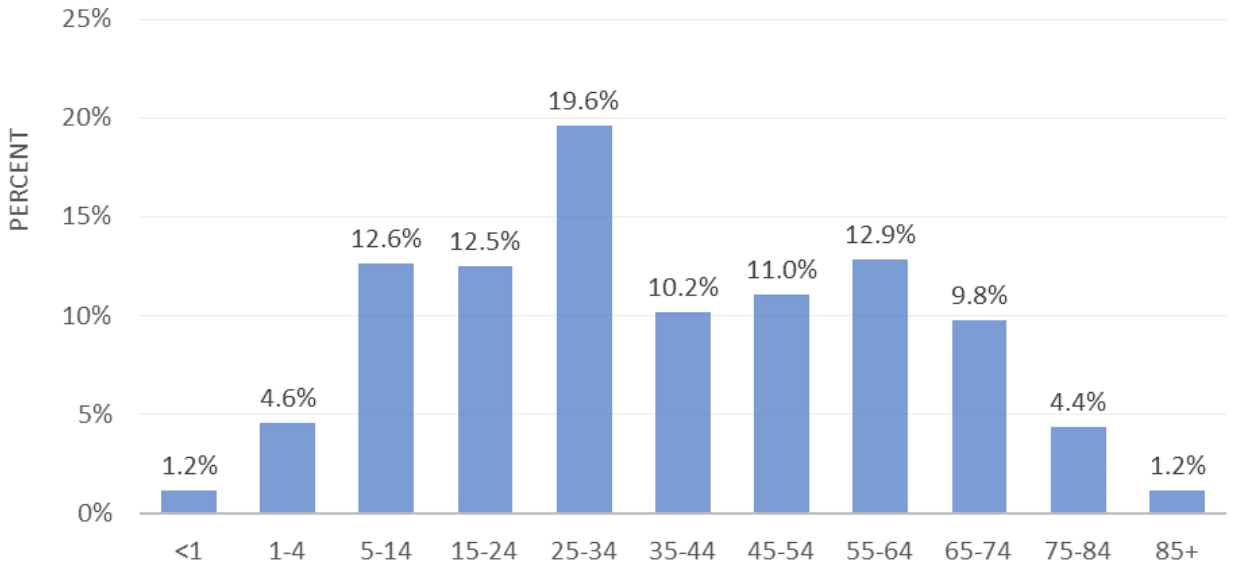
Review of Behavioral Health Data for Rural Region

Annual Est. of Total Population of the Rural Region
Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties



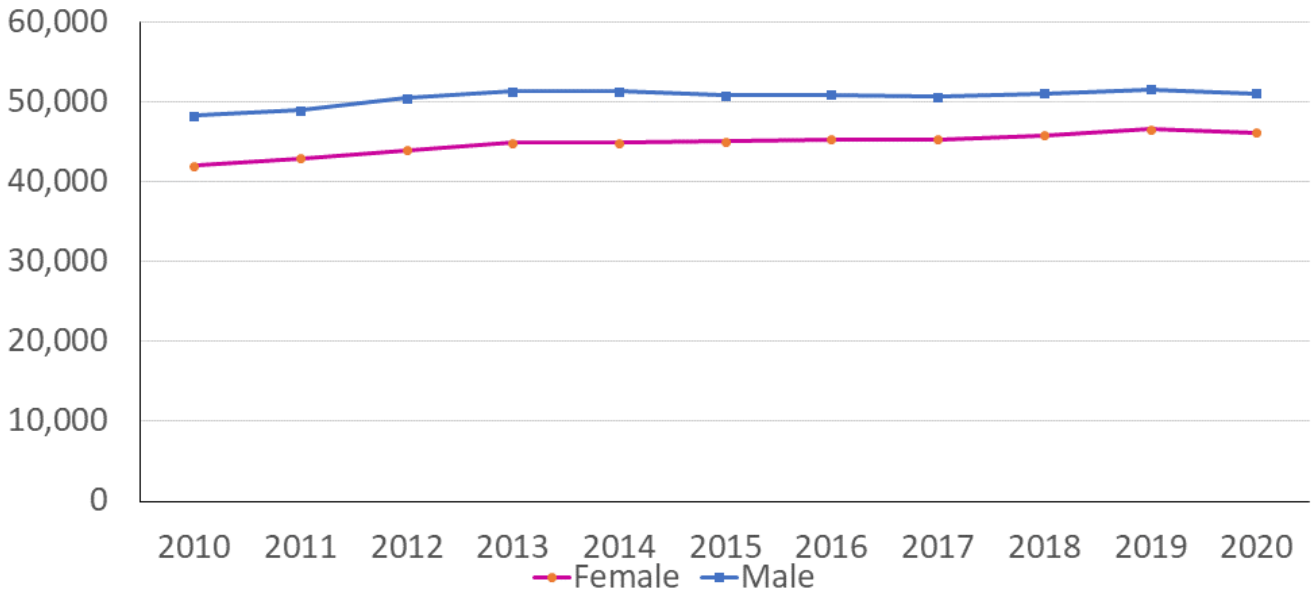
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Age Groups as %age of Total Population of the Rural Region, 2020



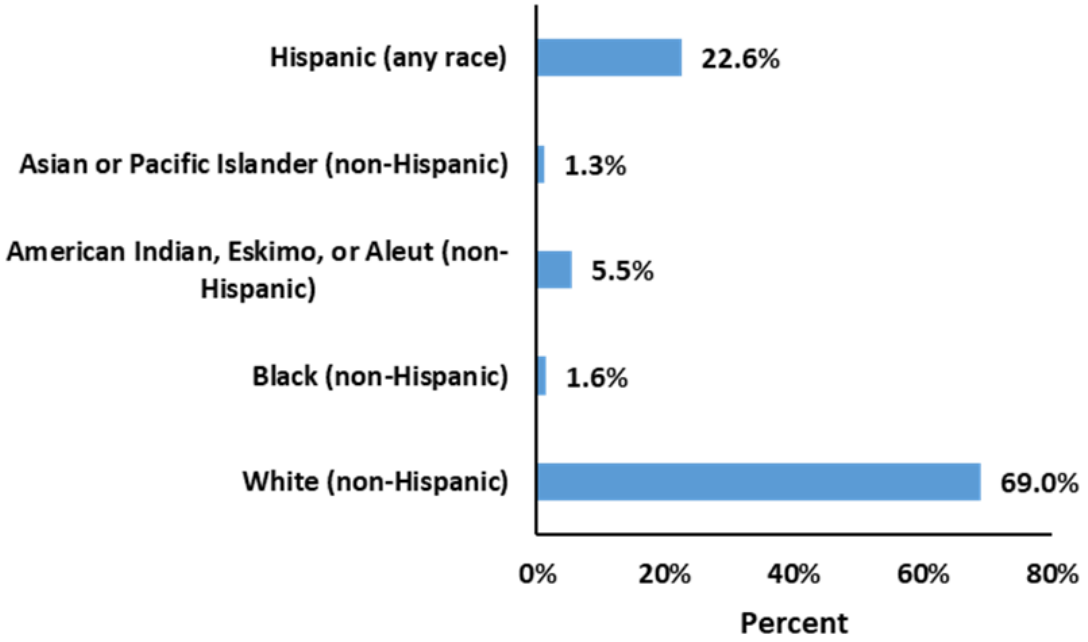
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Total Annual Male and Female Populations of the Rural Region

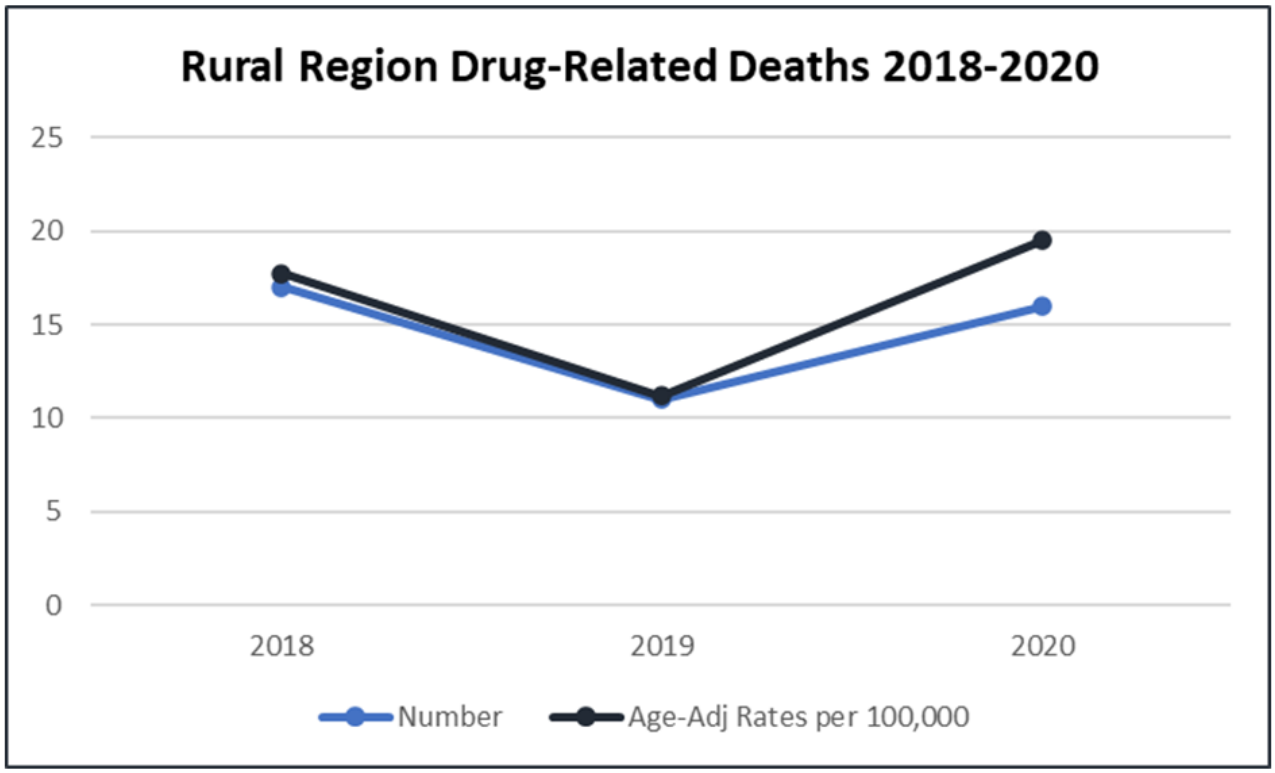


Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

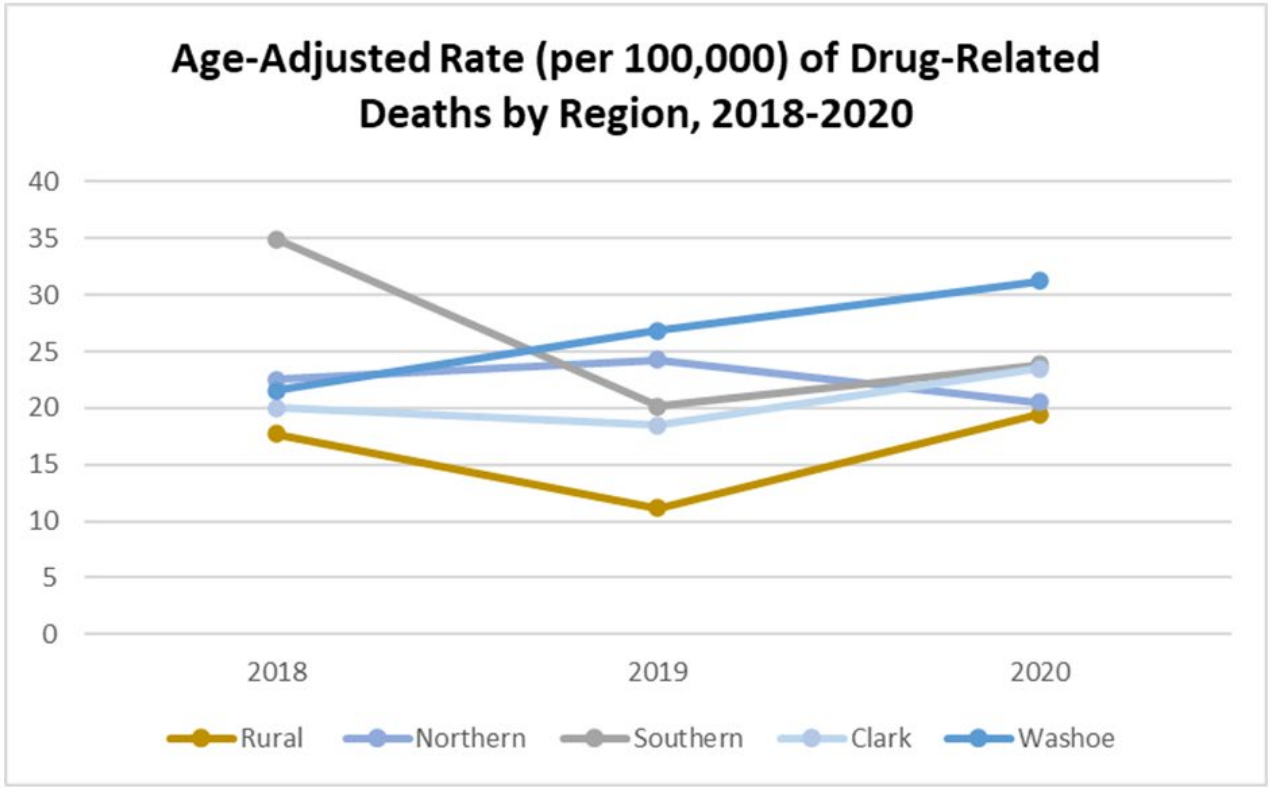
2020 Total Population of the Rural Region, by Race/Ethnicity



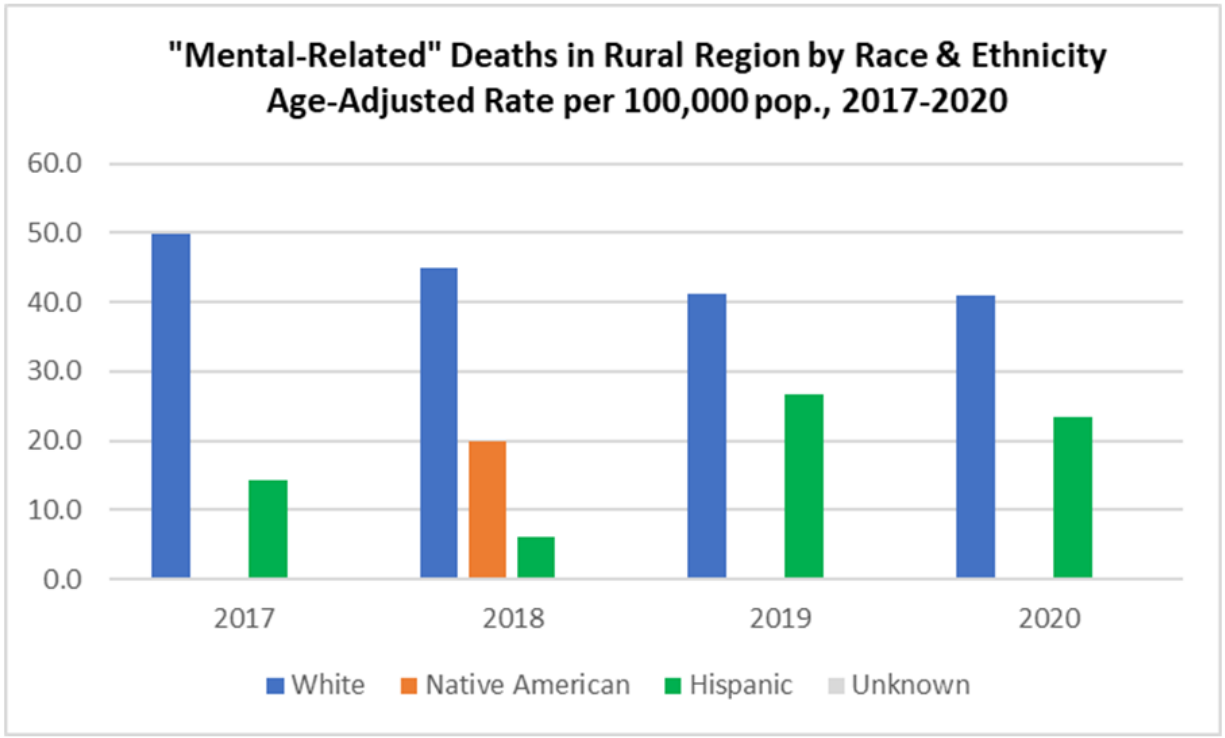
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022



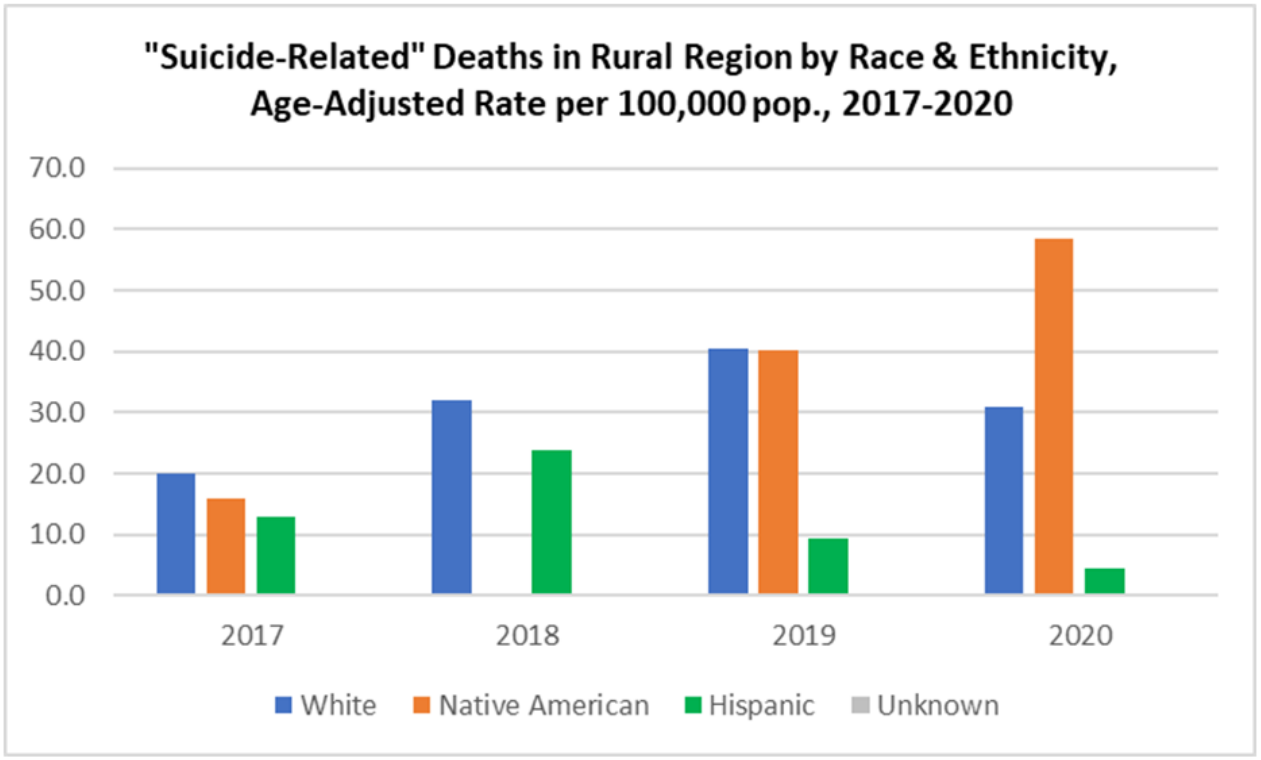
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022



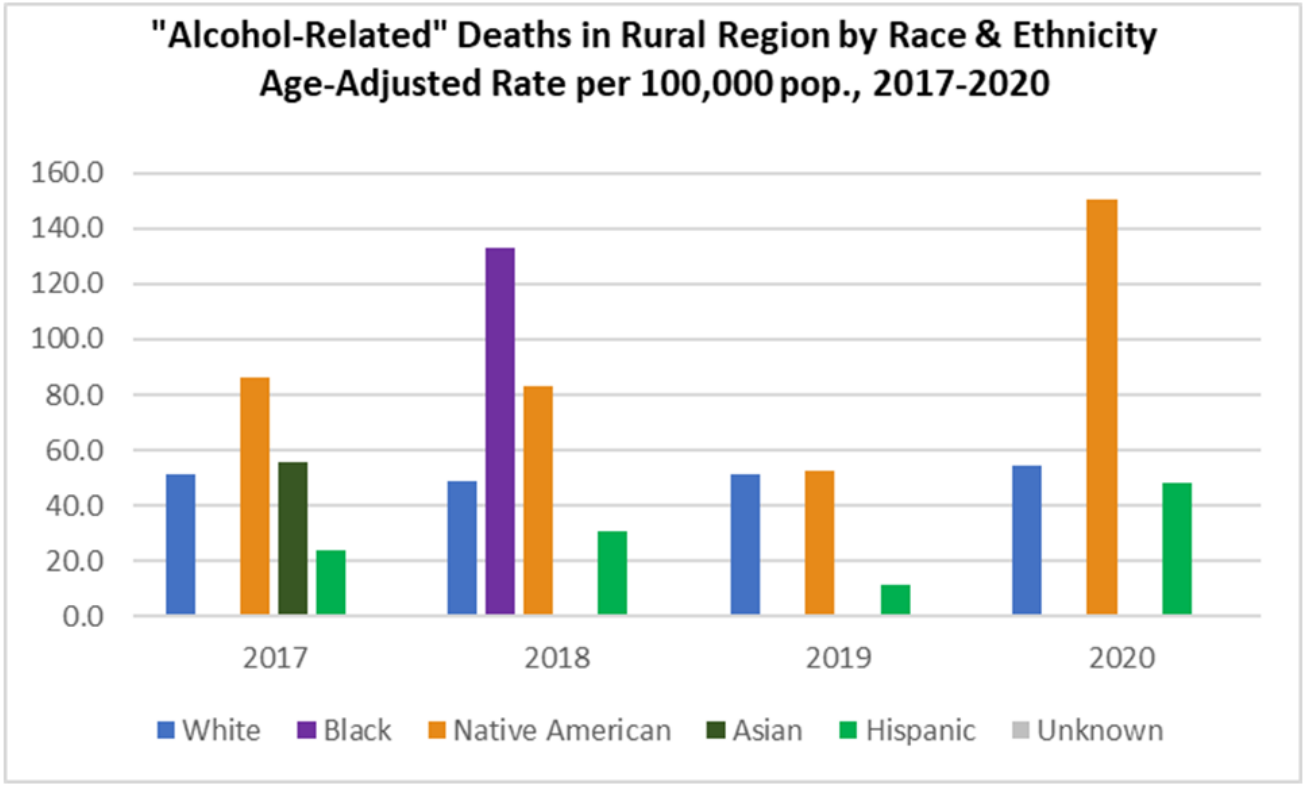
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022



Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

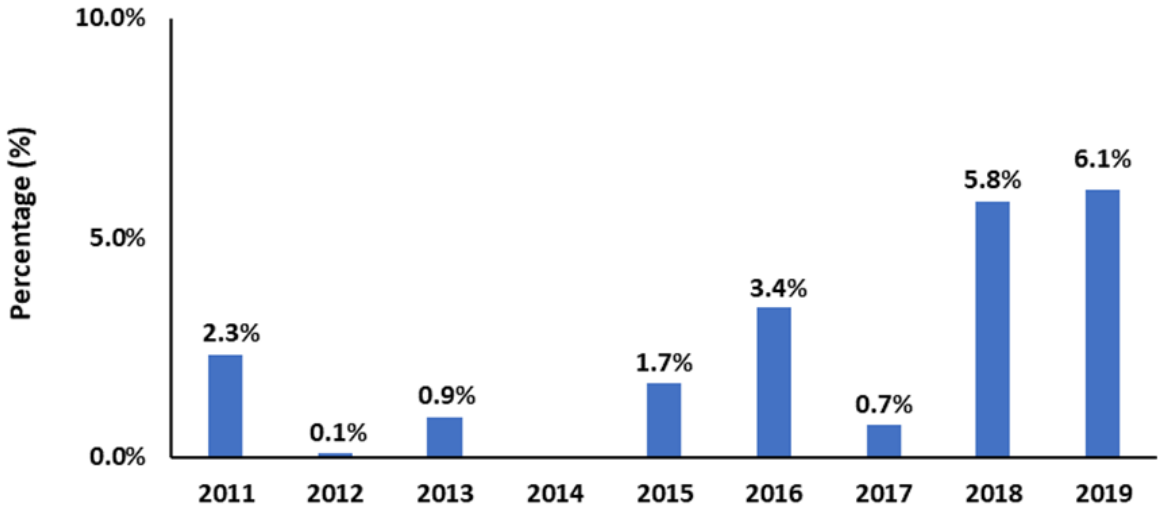


Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022



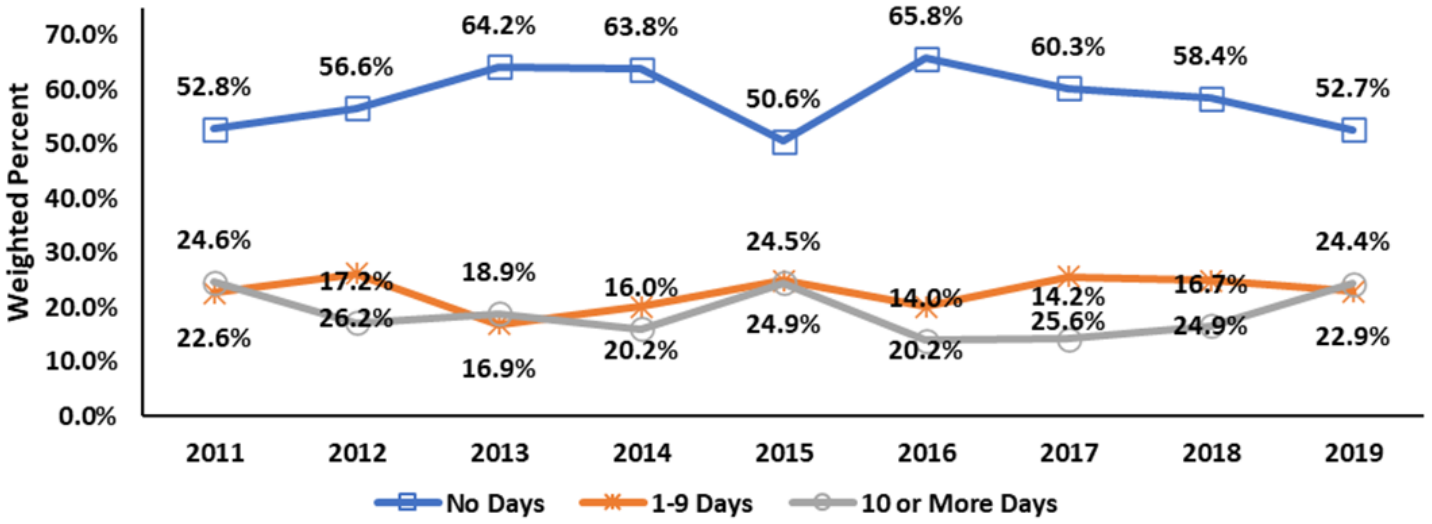
Source: Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Behavioral Region Who Have Seriously Considered Suicide, 2011-2019



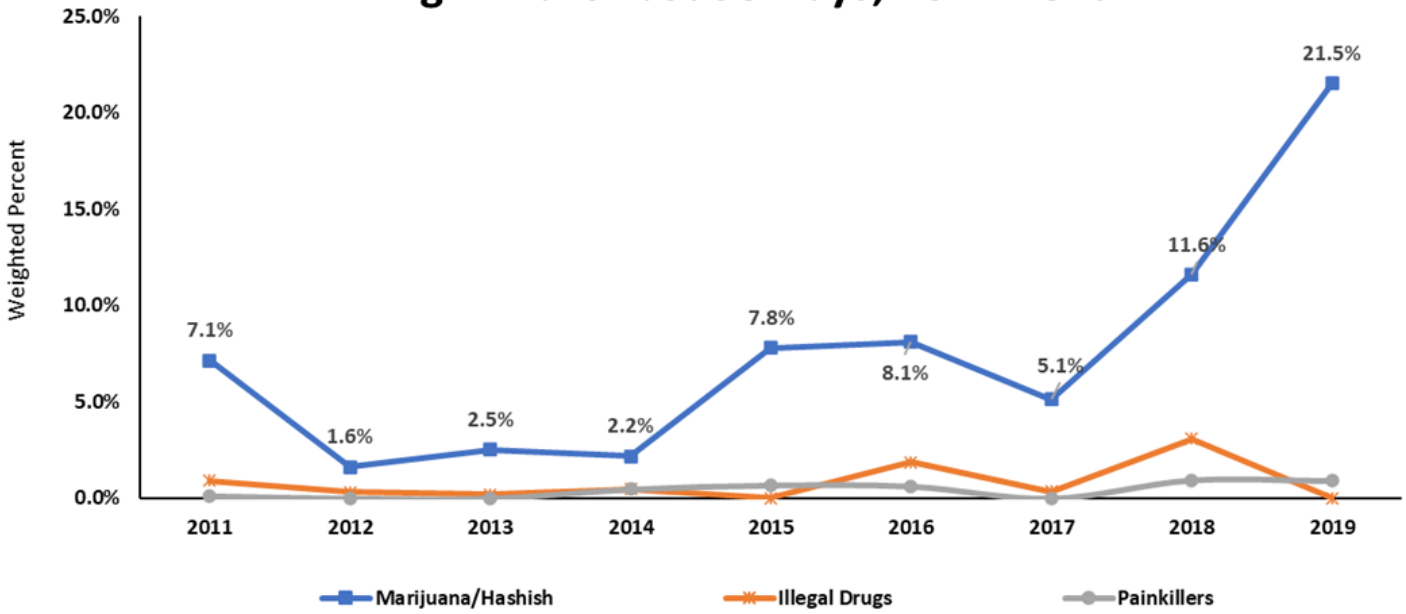
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Behavioral Region Who Experienced Poor Mental or Physical Health that Prevented Them From Doing Usual Activities, 2011-2019



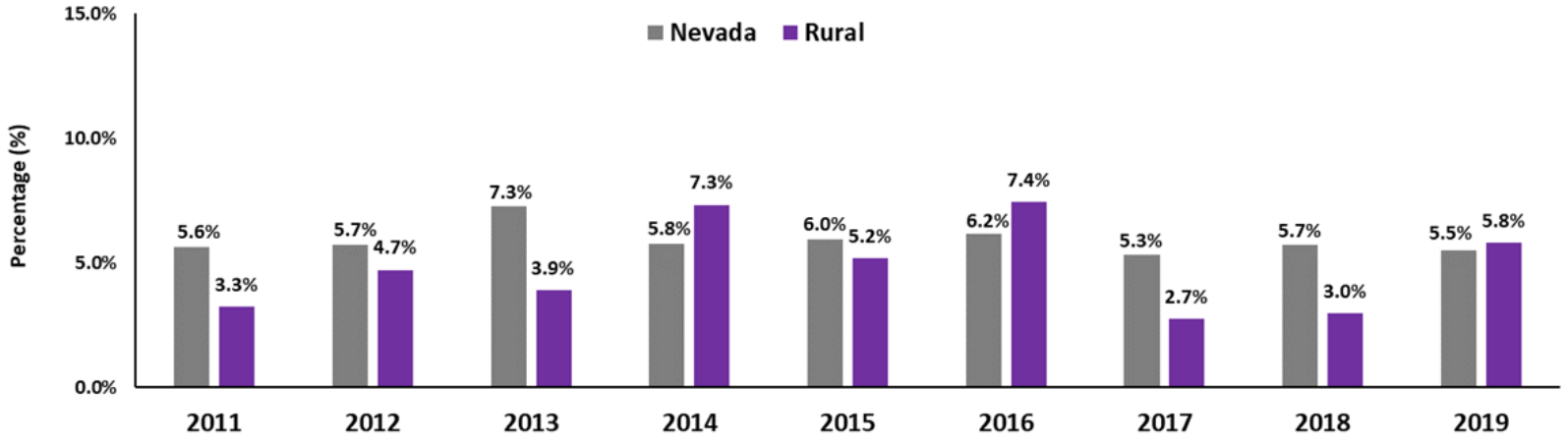
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Behavioral Region Who Used Marijuana/Hashish, Illegal Drugs, or Painkillers to Get High in the Last 30 Days, 2011-2019



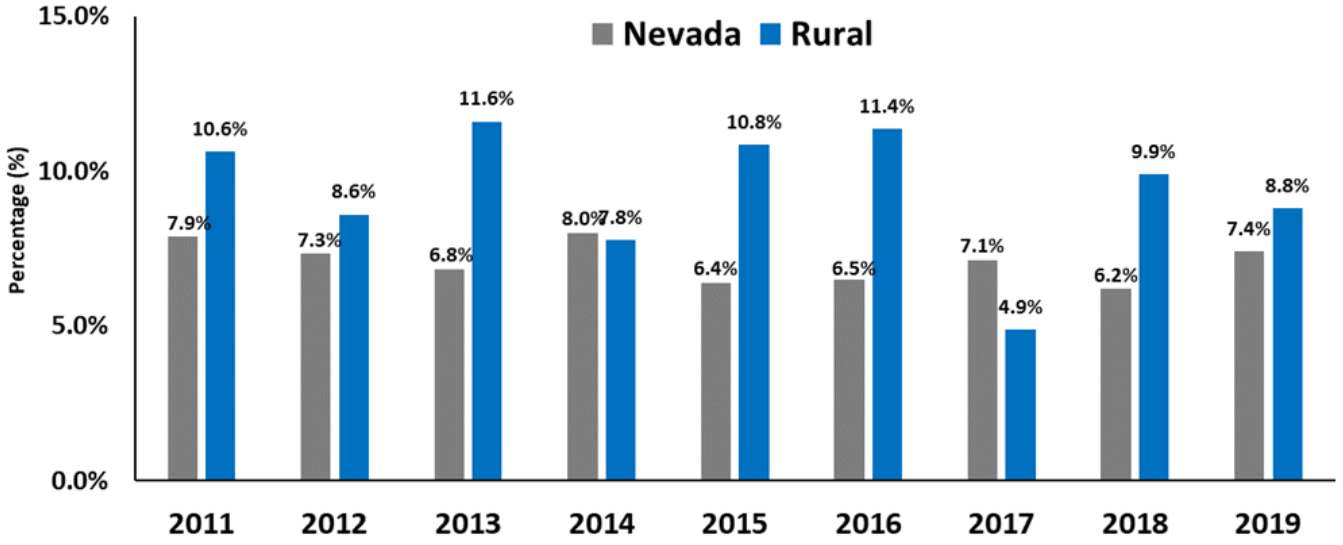
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adult Women in Rural Region Who Are Considered Heavy Drinkers, 2011-2019



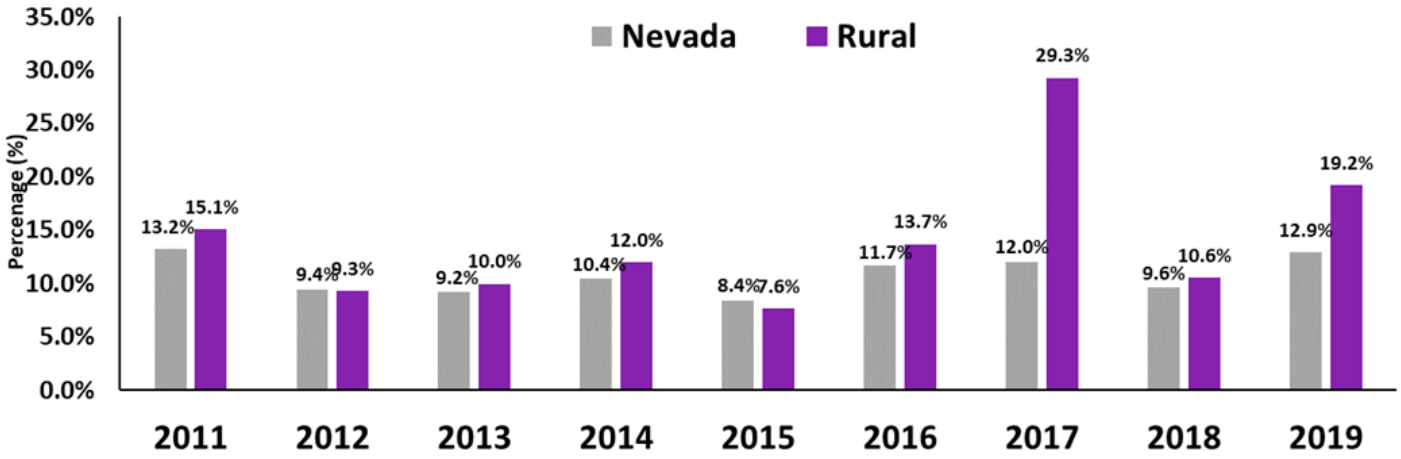
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adult Men in Rural Region Who Are Considered Heavy Drinkers, 2011-2019



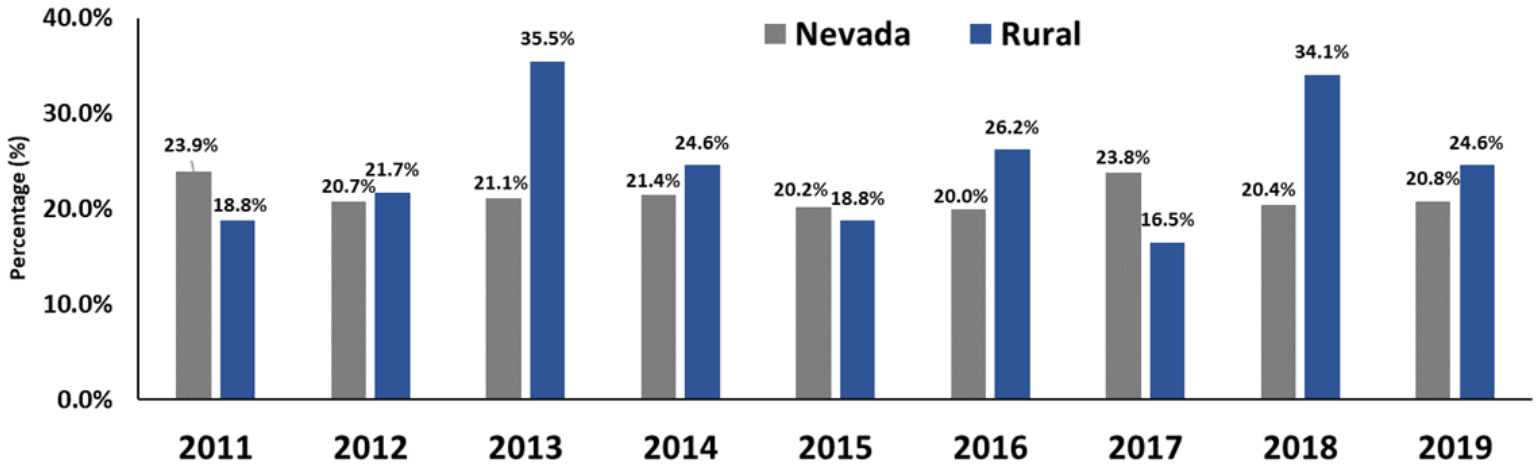
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adult Women in Rural Behavioral Region Who Are Considered Binge Drinkers, 2011-2019



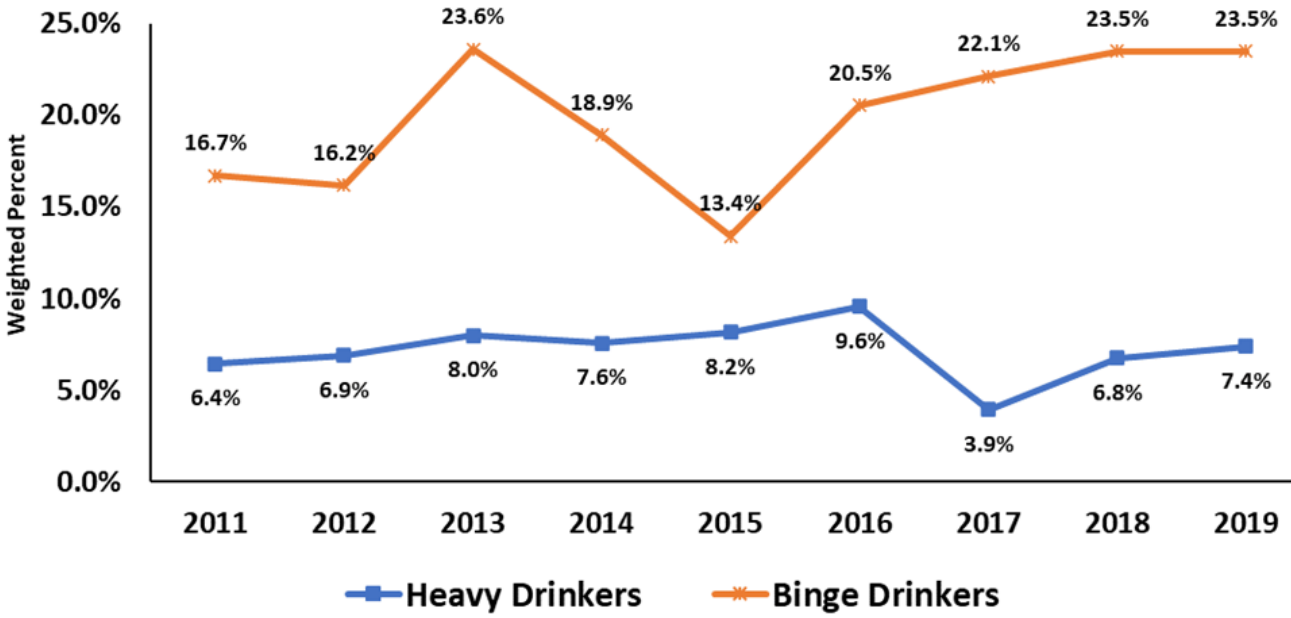
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adult Men in Rural Region Who Are Considered Binge Drinkers, 2011-2019



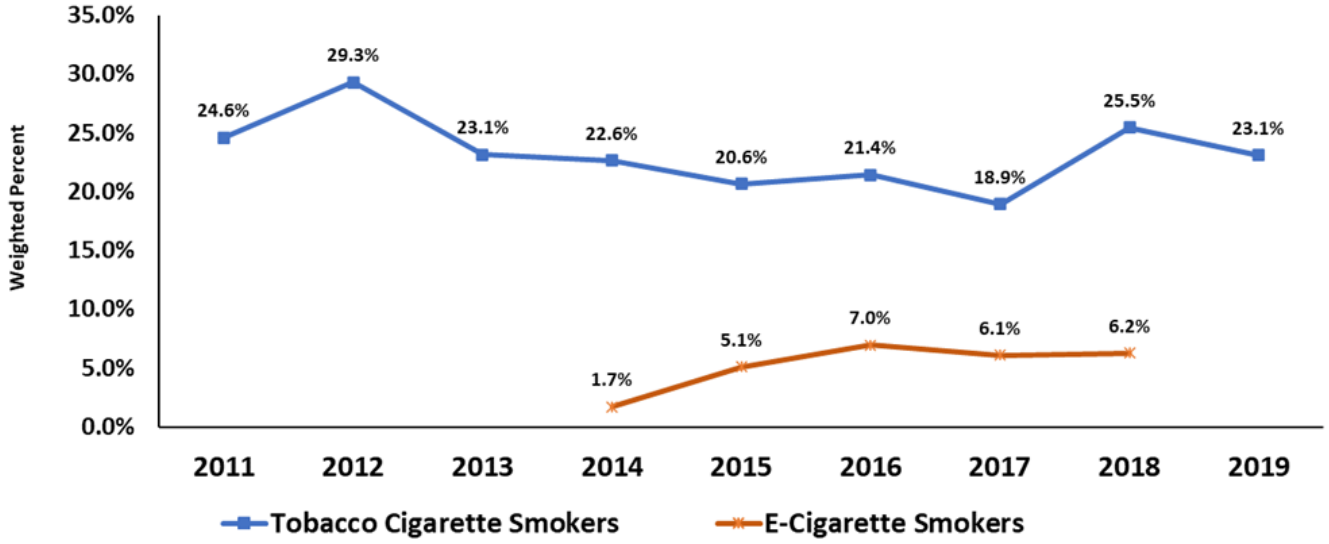
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentages of Nevada Adults considered Heavy or Binge Drinkers 2011-2019



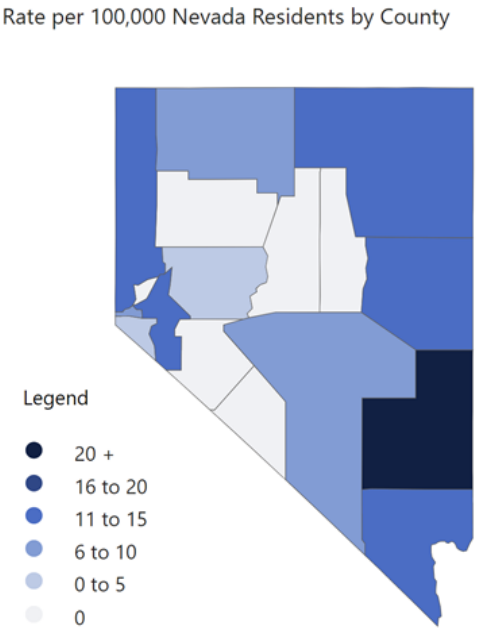
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Region Who Are Current Tobacco Cigarette or E-Cigarette Smokers, 2011-2019



Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Rate of Nevada Methamphetamine-Related Deaths 2020, per 100,000 population, all counties

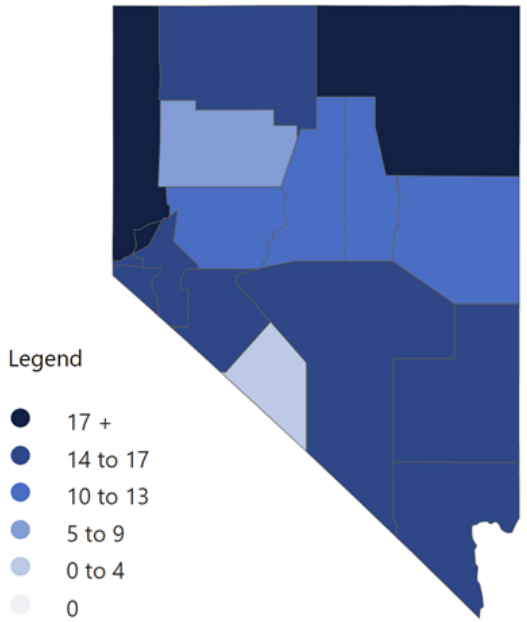


County	Rate
Lincoln	24.7
Washoe	14.6
Clark	14.3
Nevada (Statewide)	13.7
Elko	13.2
Lyon	12.2
White Pine	10.9
Nye	8.0
Carson City	7.7
Humboldt	6.7
Churchill	3.5
Douglas	3.3
Esmeralda	0.0
Eureka	0.0
Lander	0.0
Mineral	0.0
Pershing	0.0
Storey	0.0

Source: Nevada DHHS, Methamphetamine and Stimulant Surveillance Dashboard, February 22, 2022

Rate of Nevada Stimulant Rx, per 100 population, all counties

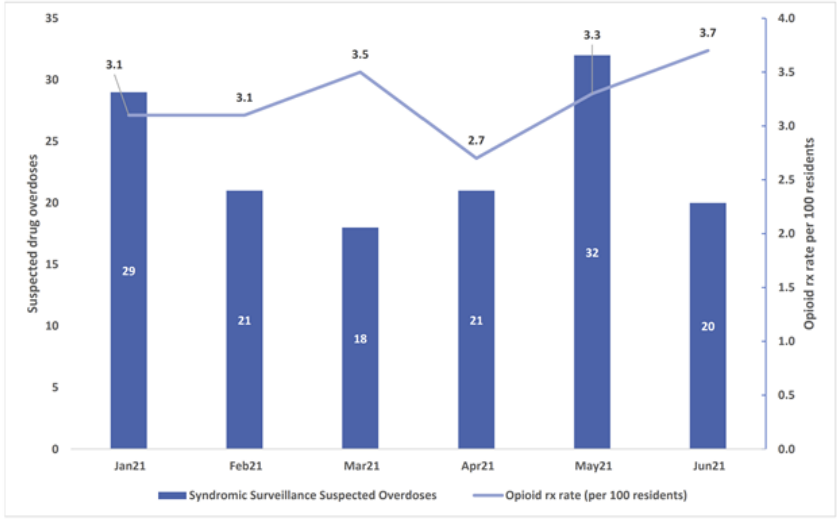
Rate per 100 Nevada Residents by County

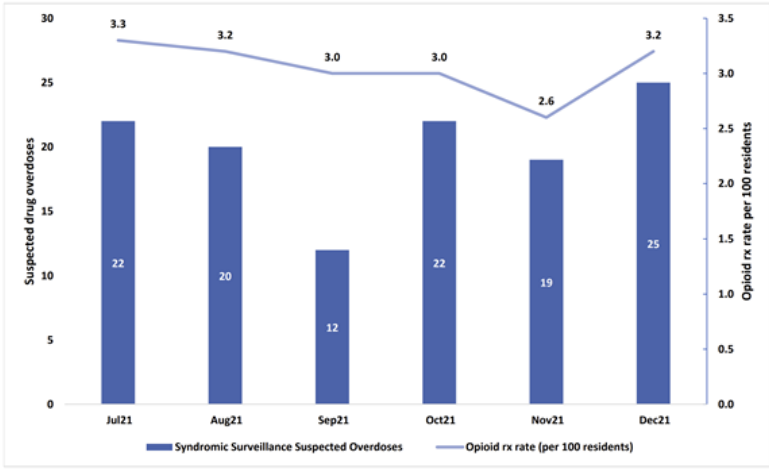


County	Rate
Storey	21.8
Elko	19.1
Washoe	17.7
Douglas	15.8
Nye	15.5
Carson City	15.4
Nevada (Statewide)	14.7
Mineral	14.7
Lyon	14.5
Clark	14.2
Lincoln	13.2
Humboldt	12.6
Churchill	11.3
Lander	10.7
Eureka	9.7
White Pine	8.9
Pershing	7.9
Esmeralda	3.3

Source: Nevada DHHS, Methamphetamine and Stimulant Surveillance Dashboard, February 22, 2022

Suspected drug overdoses from Syndromic Surveillance and prescription (Rx) opioid rates (per 100 residents) in the Rural Region, January 2021 – December 2021





Source: Nevada Drug Overdose Surveillance Monthly Reports, July 2021 and January 2022: Rural Region
Available at nvopioidresponse.org

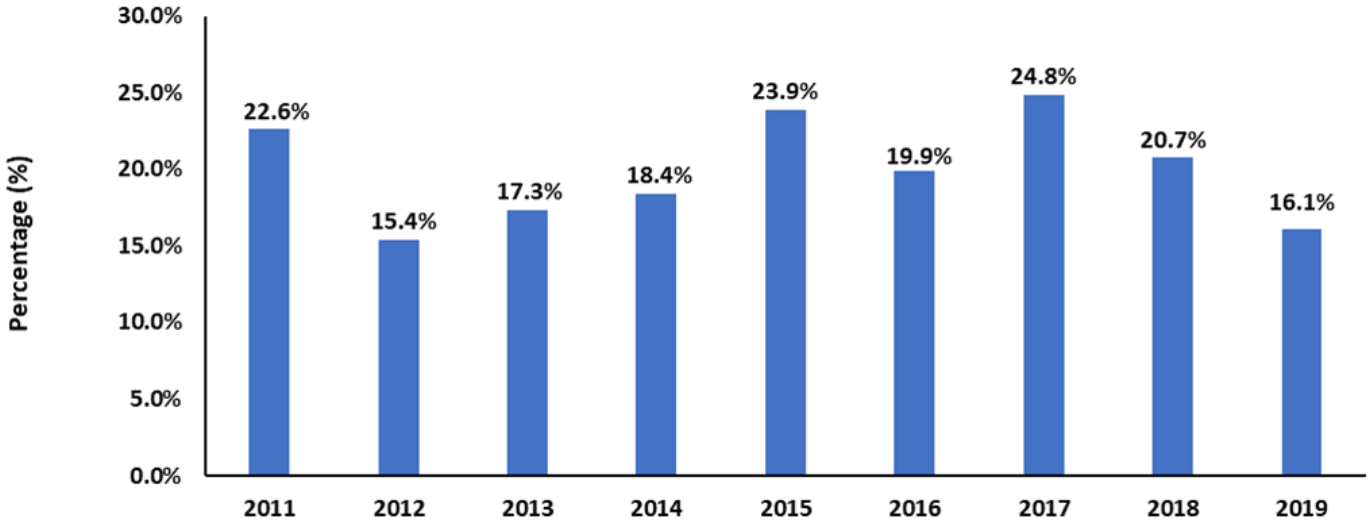
Opioid-Related Overdose Deaths by Drug Category, Nevada Residents

Year	Heroin	Natural and Semi-Synthetic	Methadone	Synthetic Opioids	Unspecified Narcotic
2013	48	241	70	25	39
2014	61	218	63	32	37
2015	82	260	57	33	37
2016	87	235	53	53	29
2017	97	239	46	67	20
2018	106	212	33	83	11
2019	122	168	29	115	12
2020	127	215	30	276	9
2021*	96	180	17	288	9

*2021 data are preliminary

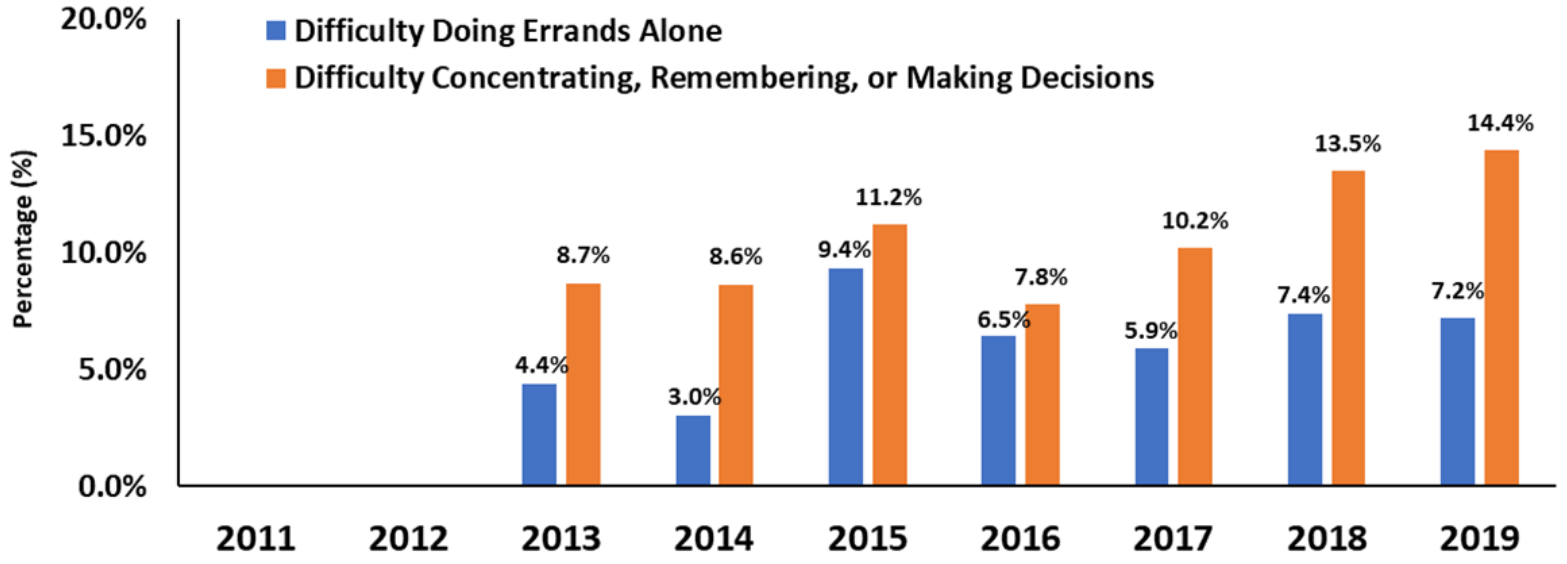
Source: Nevada DHHS, Opioid Surveillance Dashboard, accessed 2.22.22

Percentage of Nevada Adults in Rural Region Who Rated Their General Health As Poor or Fair, 2011-2019



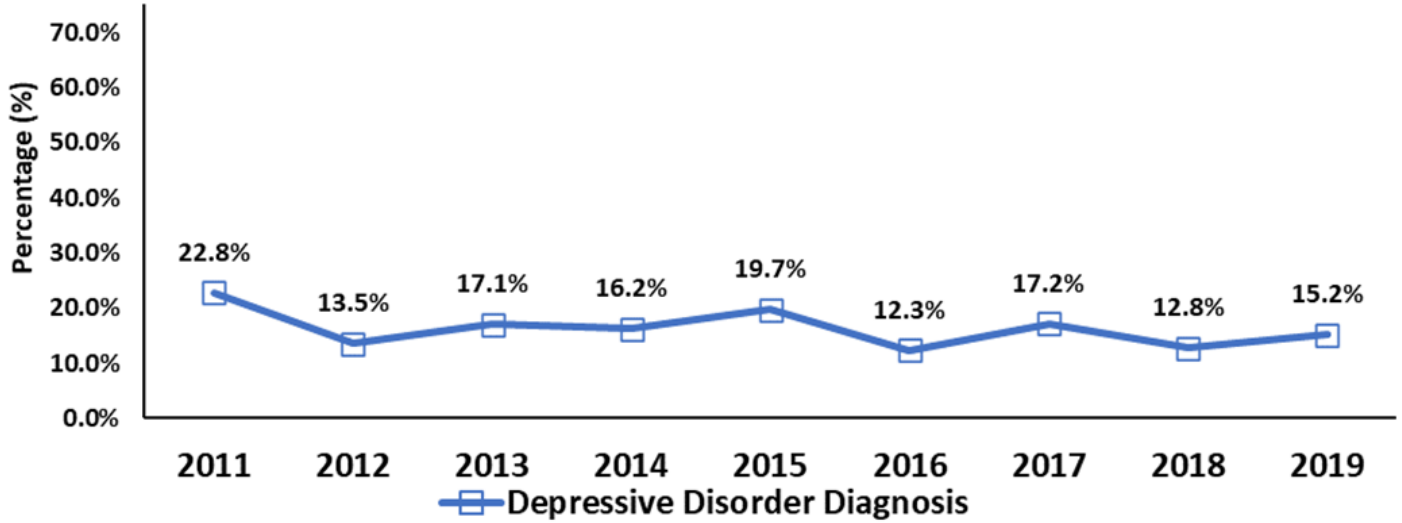
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Region Who Experience Difficulties Because of Physical, Mental, or Emotional Conditions, 2011-2019



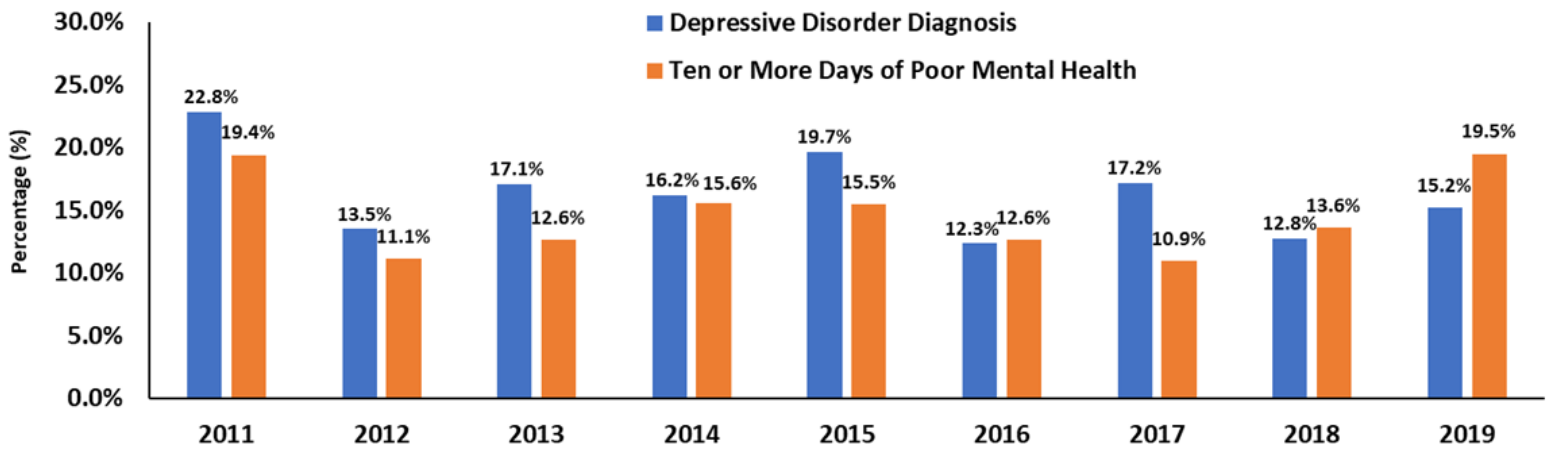
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults who have a Depressive Diagnosis 2011-2019



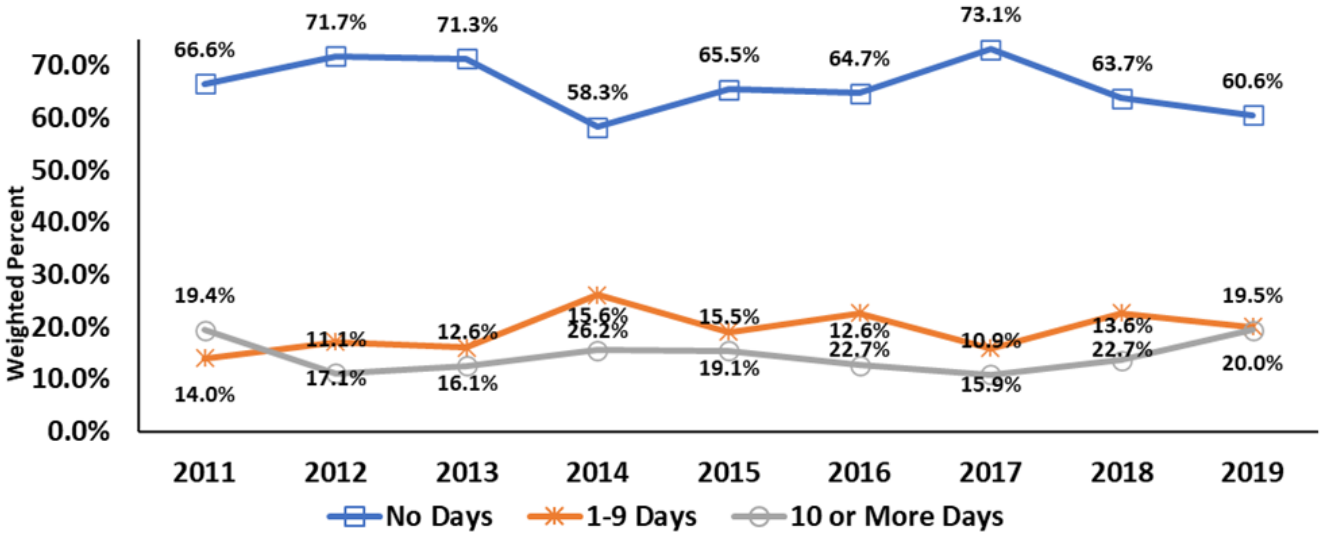
Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentage of Nevada Adults in Rural Region Who Reported Unfavorable Mental Health, 2011-2019

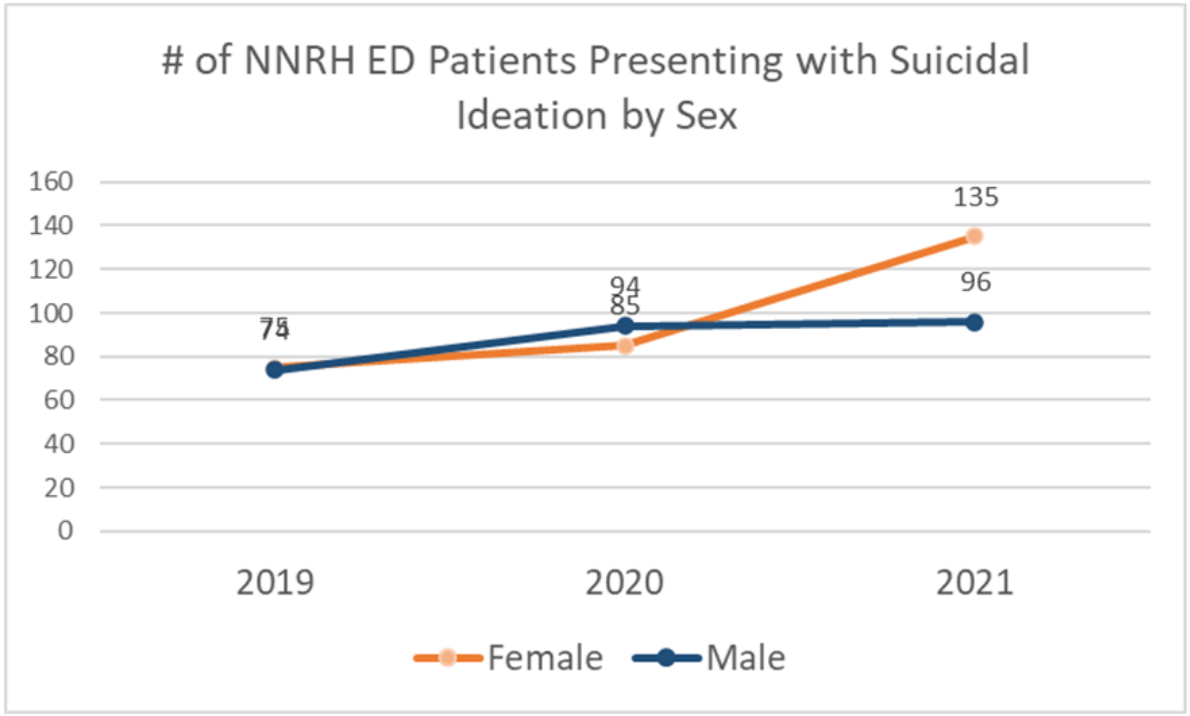


Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022

Percentages of Nevada Adults Whose Mental Health was Not Good by Days Affected



Source: BRFSS data as reported by Nevada DHHS, Division of Public and Behavioral Health, Office of Analytics, 2022



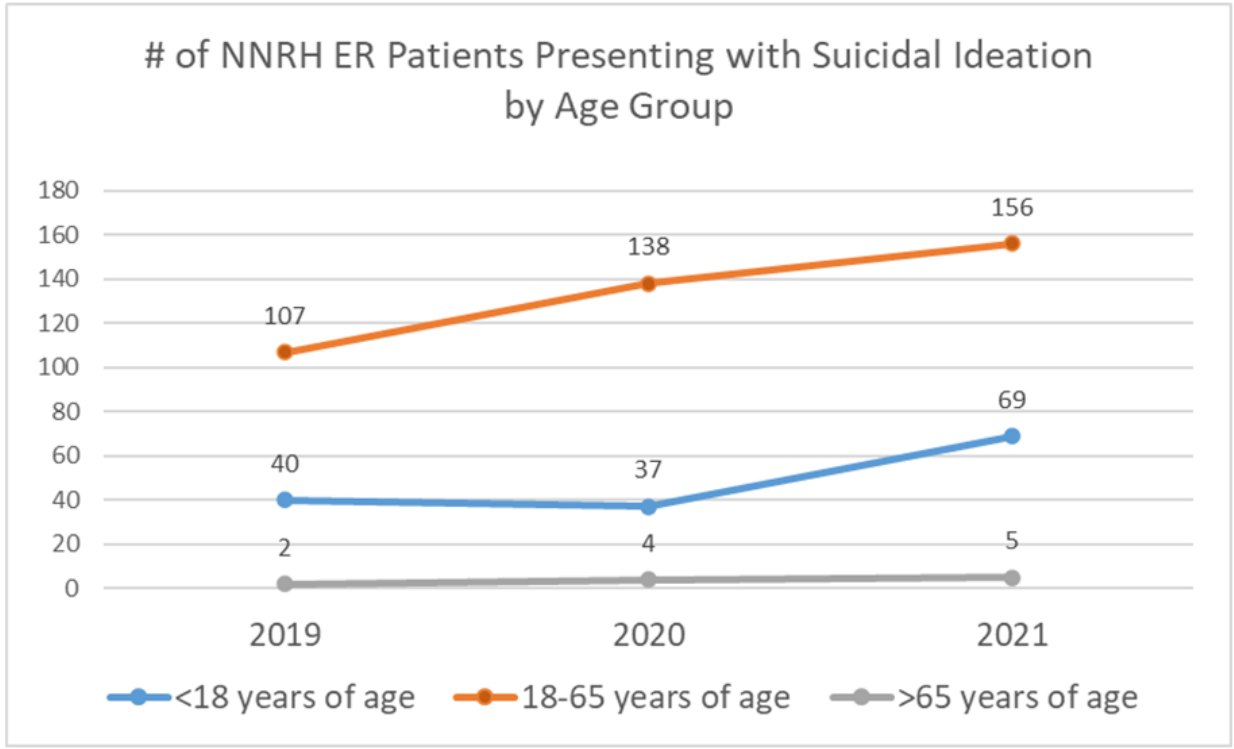
Annual Totals

2019: 149

2020: 179

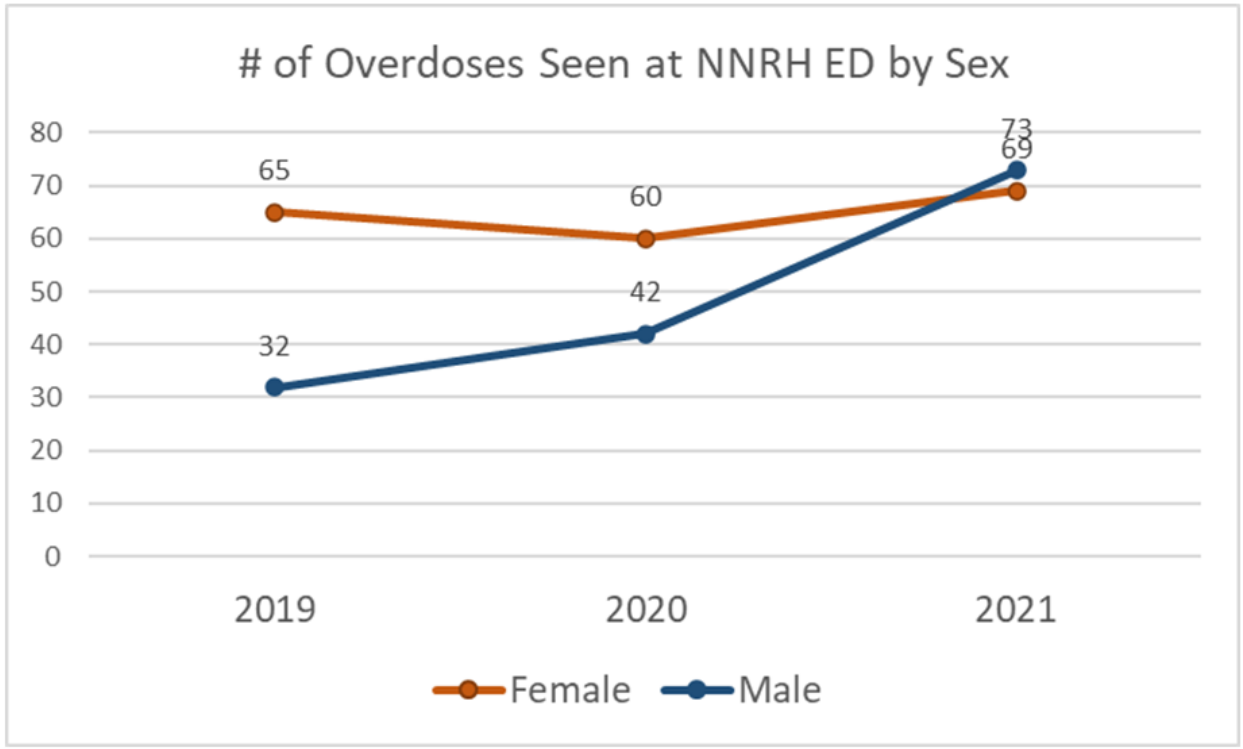
2021: 231

Source: Monthly Report from Northeastern Nevada Regional Hospital to Elko County Zero Suicides, January 2022



Percent of patients **under 18** presenting to the NNRH ED with Suicidal Ideation

Source: Monthly Report from Northeastern Nevada Regional Hospital to Elko County Zero Suicides, January 2022



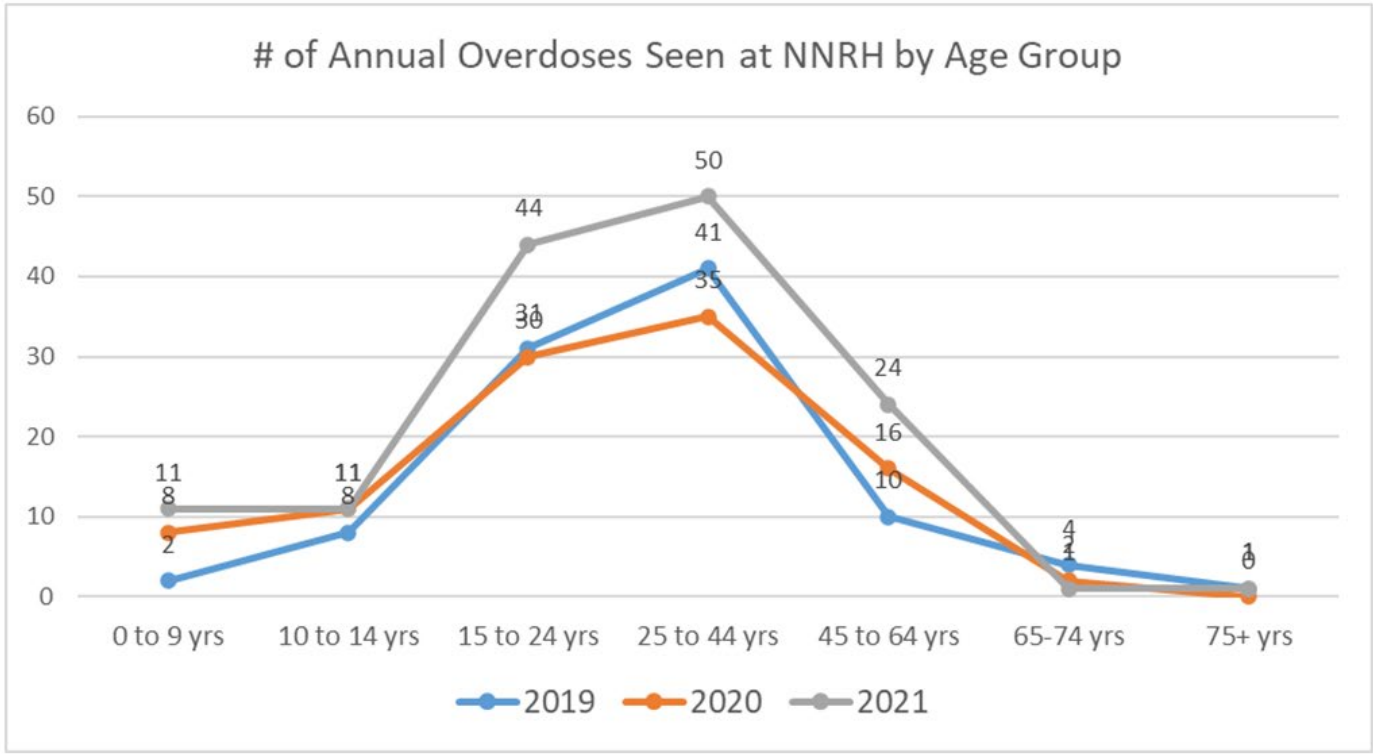
Annual Total ODs

2019: 97

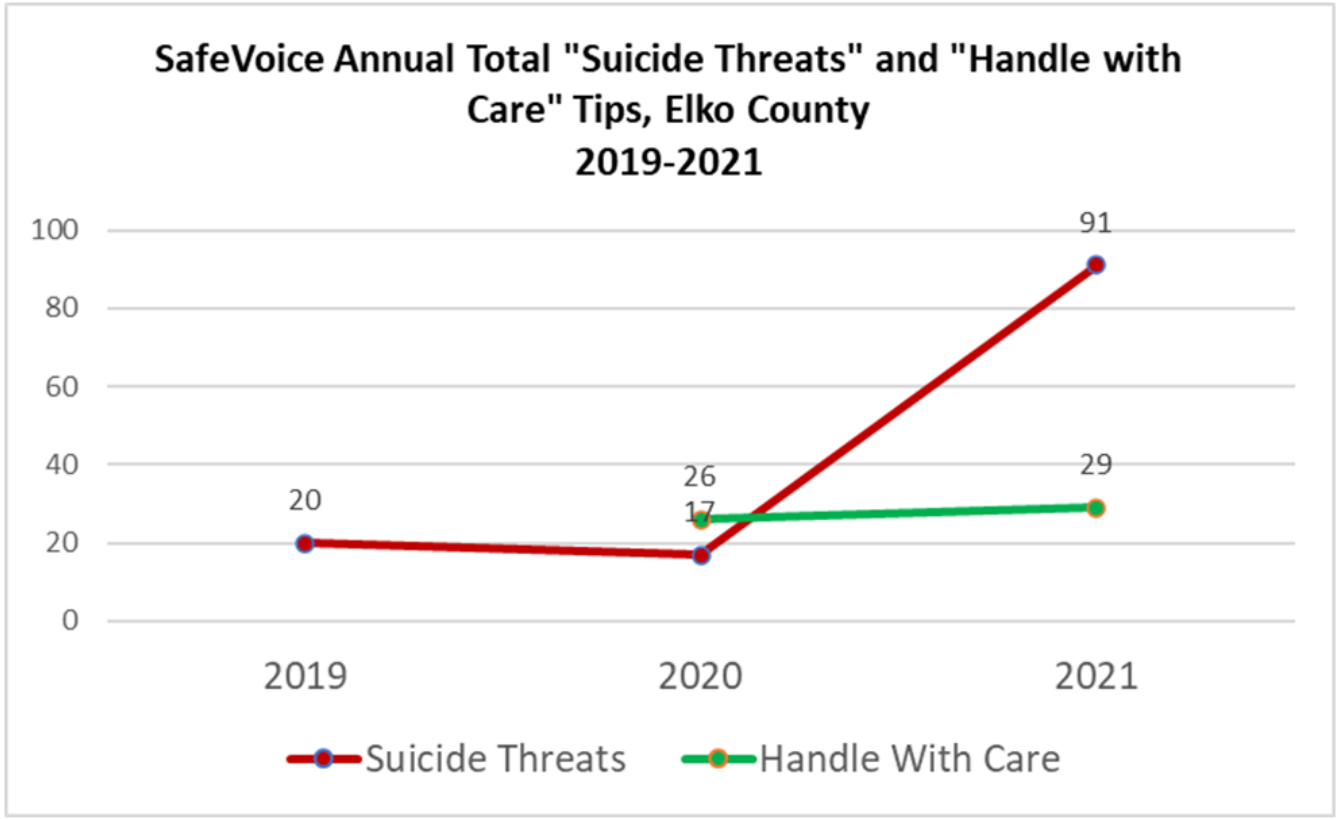
2020: 102

2021: 142

Source: Monthly Report from Northeastern Nevada Regional Hospital to Elko County Zero Suicides, January 2022



Source: Monthly Report from Northeastern Nevada Regional Hospital to Elko County Zero Suicides, January 2022



Source: Nevada Department of Education, special query January 2022

*SafeVoice Tips, Other Counties in the Rural Region, 2019-2021

Eureka: 2019-2021 all tips were below the 10 threshold

Humboldt: 2019 had bullying at 13 total; 2020-2021 below the 10 threshold

Lander: 2020 and 2021 both years with 13 Handle with Care notifications; all other tips below 10 threshold

Pershing: 2019-2021 all tips were below the 10 threshold

White Pine: 2019-2021 all tips were below the 10 threshold

Source: Nevada Department of Education, special query January 2022

2021 Rural Children's Mobile Crisis Team Calls and Responses, All Rural Counties

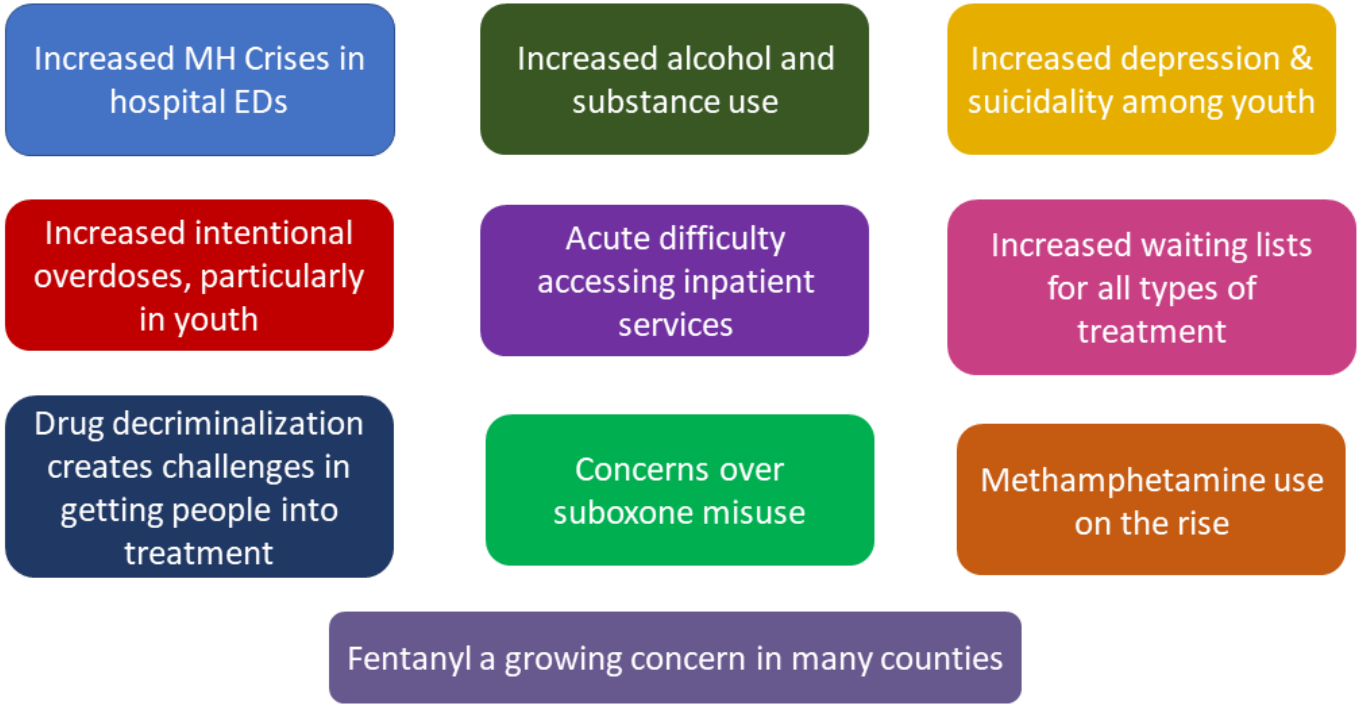
Month	Total Calls	Clients Served (Team Responded)	Hospitalization	Hospital Diversion	Stabilization Recommended	Hospital Diversion Rate
January	26	16	3	13	11	81%
February	35	11	0	11	6	100%
March	42	22	4	18	9	82%
April	36	22	4	18	7	82%
May	42	18	4	14	6	78%
June	22	5	1	4	5	80%
July	15	6	2	4	3	67%
August	18	6	1	5	4	83%
September	55	29	6	23	13	79%
October	38	21	2	19	10	90%
November	27	9	2	7	3	78%
December						

Source: Nevada DHHS, Nevada Behavioral Health Caseloads Dashboard, Mobile Crisis – Children, Rural Children, 2021; Accessed 2.22.22

Data Takeaways:

- Youth mental health is a major concern, particularly in Elko County
- Adult binge drinking and heavy drinking remains higher in the Rural Region than the state taken as a whole.
- Alcohol abuse and substance use disorder is still on the rise in most counties
- Youth overdose and substance misuse remains an issue across the region

Local Stakeholder Behavioral Health Concerns



Information from discussions with and feedback from representatives from a wide range of stakeholder groups across the Rural Region throughout 2021 and early 2022.

Rural Regional Behavioral Health Policy Board 2021 Priorities

Increase Accessibility of Transportation to Crisis and Non-Crisis Behavioral Health Services

Medicaid/CMS Reimbursement for Behavioral Health Services

Behavioral Health Workforce Development

Improve Behavioral Health Data Quality

Increased Interagency Communication and Partnership

Improved Access to Appropriate Youth, Elder, and Minority Services

Improved Quality and Accessibility of Services for Service Members, Veterans, and Their Families

Next Steps

- What priorities from 2021 should be carried over? Should the intent be changed in any way?
- Are there new priorities that should be added for 2022? What is their intent?

PRESENTATION TO THE NEVADA GOVERNOR'S COMMISSION ON BEHAVIORAL HEALTH
MARCH 24, 2022

RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

2021 Annual Report

Approved March 23, 2022

PREPARED BY
VALERIE M. C. HASKIN, MA, MPH
RURAL REGIONAL BEHAVIORAL HEALTH COORDINATOR

Today's Presentation

- Brief review of sections content
  - Data highlights
  - SB 44
  - Board Meetings and Presentations
  - Rural RBHC Activities
  - 2022 Board Priorities
  - Board's Recommendations to the Commission on Behavioral Health

Data Highlights

- Data used was presented to the Rural RBHPB during its meeting on February 23, 2022
- Highlights Include:
  - Data from SaveVoice and NNRH indicates a higher incidence of suicidal ideation among youth in Elko County than in other counties within the Rural Region.
  - People of color in the Rural Region are disproportionately affected by death from alcohol and substance use.

Data Highlights, cont'd

- Marijuana and hashish use continues to be more highly utilized than other substances, the rates of which have been increasing in a curvilinear manner since legalization.
- Adult binge drinking and heavy drinking remains higher in the Rural Region than the state taken as a whole.
- Alcohol abuse and substance use disorder is still on the rise in most counties.
- Youth overdose and substance misuse remains an issue across the region.

Data Highlights, cont'd

- Anecdotal Data From Stakeholders:
  - Inability to find placement for patients needing crisis stabilization or inpatient care in a timely manner.
  - Difficulty in enrolling high-risk community members in specialty court programs as laws regarding the criminalization of some substances have changed.
  - Transportation to both crisis and outpatient services continues to be a challenge in all of the communities in the region.

Data Highlights, cont'd

- Anecdotal Data From Stakeholders:
  - Lack of mid-level services is another persistent issue.
  - Increased concerns for the mental health of youth and young adults, including concerns over increased suicidality and intentional overdoses among youth as young as those who are junior high/middle school-aged.

Data Highlights, cont'd

- Anecdotal Data From Stakeholders:
  - Both law enforcement and hospitals have reported concerns over rising methamphetamine use within their communities.
  - Law enforcement has reported concerns regarding the misuse and trafficking of suboxone among high-risk populations.
  - As most communities within the region sit along major interstate highways, there is concern over increased fentanyl and fentanyl-laced substances circulating within rural communities.

Senate Bill (SB) 44

- SB 44 to affect the processes required for licensure by endorsement and the oversight of interns as regulated by the four main licensing boards for behavioral health providers:
  - Board of Examiners for Social Workers
  - Board of Psychological Examiners
  - Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors
  - Board of Examiners for Alcohol, Drug, and Gambling Counselors
- Bill as enrolled: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7221/Text#

Board Meetings and Presentations

- Only three meetings in 2021
  - January 27, 2021
  - February 24, 2021
  - March 24, 2021
- Issues with making quorum and ensuring appointments were completed
- Meetings focused on refining SB 44

Rural Regional Behavioral Health Coordinator (Rural RBHC) Activities

- Assistance with SB 44
- Community Outreach Project
- OD2A Program Participation
- Collaboration with other RBHCs
- Evidence-Based Practices and Programs Listing
- Engagement with Prevention Coalitions
- Task Forces and Multidisciplinary Teams (MDTs)

2022 Rural Regional Behavioral Health Policy Board Priorities

Tier 1: High Priority	Workforce Development	Transportation	Improved Access to Age-Appropriate Care	Improved Reimbursement
Tier 2: Affected by Tier 1	Improved Care Transitions	Improved Safeguards for Quality of Care	Improved Access to Mid-Level Care	
Tier 3: Highly Affected by Tiers 1 and 2	Improved Access to Services for SMVF Populations	Expansion of Culturally Appropriate Programming	Leverage Telebehavioral Health Services	Stigma Reduction

Current Recommendations to the Governor's Commission on Behavioral Health

1. The Board recommends increased investments in programs to bolster the workforce of behavioral health providers and related staff across Nevada. This might include programs that address:
    a. Tuition reimbursement for providers serving within designated provider shortage areas;
    b. Tuition reimbursement or scholarship opportunities for new providers serving disadvantaged populations, including persons of lower socio-economic status and/or persons of color who are underserved in their respective communities;

Current Recommendations to the Governor's Commission on Behavioral Health

c. Increased reimbursement for behavioral health services, particularly for persons covered by Nevada Medicaid in Fee-For-Service areas, specifically rural and frontier Nevada;
d. Incentives for providers specializing in the treatment of children, the elderly, and other high-risk populations;
e. And Support policy changes that expand the ability of interns to access completely remote supervision, expansion of the number of internship sites available, and to expedite licensure processes.

Current Recommendations to the Governor's Commission on Behavioral Health

2. The Board recommends investments in both evidence-based and novel transportation solutions for persons across the state needing to access emergency and non-emergency behavioral health services. Transportation needs to be affordable, reliable, easy to book (if necessary), easy to access within short timeframes, and must enable an individual to get to and from their services in a manner that causes minimal impact to their daily lives. Some services for rural residents have been increased in recent years for this purpose, but unfortunately, the hours of operation, required lead time for booking, insurance accepted, and/or expenses related to utilizing these services creates further challenges to using them to access behavioral health treatment in "neighboring" communities.

Current Recommendations to the Governor's Commission on Behavioral Health

3. The Board recognizes that the communities within the region it serves have not been immune to the mental health crisis experienced by children nationwide. As such, the Board recommends policies and investments that increase the availability of services across the behavioral health continuum of care for children and adolescents struggling with mental illness, substance misuse, or dual diagnoses.

Current Recommendations to the Governor's Commission on Behavioral Health

4. The Board also recognizes there are breakdowns in communication among providers within the spectrum of behavioral health care, and recommends policies to ensure warm hand-offs and clear, open communication regarding patient needs, referrals, and preferred care throughout the system. This may include policy changes regarding the sharing of information, creation of referrals, and requirements for warm hand-offs, but may also include funding for patient care coordination that is not limited to one institution (such as community-based patient navigator), and vastly improved utility/accessibility of state's health information exchange.

Current Recommendations to the Governor's Commission on Behavioral Health

5. As workforce shortages for behavioral health professionals persists, the need to hire paraprofessionals within communities becomes more vital. The Board recommends supporting policy shifts that would enable the services of trained and certified Community Health Workers (CHWs) operating within the behavioral health field to be reimbursable by Nevada Medicaid. CHWs could play a vital role in connecting with community members throughout rural and urban communities in the state to act as navigators, trainers for evidence-based programs to recognize and respond to persons with mental illness or substance use disorder, or even as care coordinators after specialized training.

Contact

Valerie M.C. Haskin, MA, MPH
Rural Regional Behavioral Health Coordinator

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam,
Ph.D., M.D.
Chief Medical Officer

Clark Region

ANNUAL REPORT 2021

Prepared by
Michelle Bennett
Clark County Regional Behavioral Health Coordinator

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CLARK COUNTY AND SOUTHERN NYE COUNTY

Clark County:
2020 Population = 2,315,963
2020 Percent of State = 73.8%

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BOARD MEMBERS

Char Frost
Board Chair/Clark County Children's Mental Health Consortium

Jamie Ross
Vice Chair/PACT Coalition

Senator Fabian Donate
Legislator, Nevada Senate District 10

Dr. Lesley Dickson
Center for Behavioral Health/Nevada Psychiatric Association

Michelle Guerra
Director Of Health Equity and Cultural Competency - Molina Healthcare of Nevada, Inc

Jacqueline Harris
Licensed Marriage and Family Therapist

Dan Musgrove
Nevada Strategies 360

Justine Perez
Compassion Community Care Clinic

Ariana Saunders
Corporation for Supportive Housing Southwest

Captain Nita Schmidt
Las Vegas Metropolitan Police Department

Cory Whitlock
Las Vegas Fire and Rescue

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EXECUTIVE SUMMARY

The public health emergency Coronavirus Disease 2019 (Covid-19) has brought doubt and fear. This has created the unexpected opportunity to develop innovative approaches to support individuals with behavioral health needs. During this time, adults and children have experienced behavioral health challenges that may not have existed pre-pandemic. The challenges of mandatory isolation have disrupted support systems and presented barriers to accessing care. According to the American Psychological Associations' 2020 report on Stress in America, 34 percent of young adults ages 18 to 23 stated their mental health has deteriorated. The compounded stress of previous stressors in conjunction with current pandemic stress can lead to long-term behavioral health needs.

The unparalleled federal and State investments to improve behavioral health care, treatment/prevention for drug and alcohol misuse, racial inequalities, building behavioral health workforces, and addressing the need for housing to reduce homelessness are all critical to successful policymaking. These investments are also necessary for improving the delivery system infrastructure that serves the whole community. In order to maximize services, there is great need to improve multi-system collaboration and engagement effectively at the local, state, and federal level. The Clark Regional Behavioral Health Policy Board (CRBHPB) is committed to advocate for the Clark Region to fill gaps and identify important topics for the upcoming 2023 bill draft request (BDR.)

Throughout 2021, the Clark Regional Behavioral Health Policy Board (CRBHPB) continued to follow its purpose to address behavioral health issues, endorse improvements in the delivery of behavioral health services, coordinate with other regional policy boards, and identify gaps in the Clark region. The impact of the pandemic has been greatly considered along with any necessary federal and State investments made to assist the populations served. CRBHPB meetings prioritized the needs of adults and children experiences various behavioral health issues in the community. This community includes the metropolitan and rural areas of Clark County and Southern Nye County.

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2021 CLARK REGIONAL BEHAVIORAL HEALTH PRIORITIES

The Clark Regional Policy Board continues to embrace a data-driven approach to identifying the behavioral health needs and system gaps of the region with an emphasis on recovery efforts. The success of a data-driven approach depends on the existence of data, the quality of the data gathered, as well as the rigor and pertinence of its analysis and interpretation. Detailed recommendations for board priorities can be found throughout this report, main points are highlighted as follows:

- Mental health oversight agency and workforce development issues
- Dedicated funding for crisis services for children and adults
- Residential treatment services for youth
- Increasing collaboration on the spectrum of substance misuse and its relation to mental health and integrating behavioral health and substance misuse

Recovery and Recovery Support

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

- Health—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- Home—having a stable and safe place to live
- Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society
- Community—having relationships and social networks that provide support, friendship, love, and hope

The board has approved the same priorities from 2021 to continue the ongoing work of addressing and removing barriers with an emphasis on recovery efforts which are a priority for behavioral health services. In January 2022 through the exploration of data and stakeholder feedback the board voted and approved to add an additional priority:

- Identify wrap-around services for individuals experiencing homelessness and mental health crisis.

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Priorities and Recommendations

The Clark Regional Policy Board continues to embrace a data-driven approach to identifying the behavioral health needs and system gaps of the region. That said, the success of a data-driven approach depends on the existence of data, the quality of the data gathered, as well as the rigor and pertinence of its analysis and interpretation. What follows is a description of the Clark Regional Policy Board's methods of gathering data and information, a summary of that data, and a brief description of the data's limitations.

Mental Health: Oversight Agency and Workforce Development Issues (to include licensing boards)

The Board recognizes that workforce and the availability of qualified behavioral health providers have troubled Southern Nevada for many years. While the region has seen steady growth, the community falls well below the average of providers per capita. The Board wants to further investigate what measures can be taken to improve the Behavioral Health Workforce supply in Nevada. All publicly funded substance abuse treatment providers are certified by SAPTA. Additionally, all mental health providers of all types including Psychiatrist, Psychologist, Advanced Practice Registered Nurses, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Professional Counselors, are licensed by the State licensing boards for each of the disciplines.

Recommendation: The board would like to recommend that DHHS and DPBH review the allocation of funds to meet the identified needs for the Clark Region. Address the region's counselor to patient ratio by attracting counselors from out of state. As well as mainstream the application process for behavioral health professional to become licensed. Review the Medicaid reimbursement rate and processing time to align with more competitive states. Add incentives for providers who serve high risk populations and utilize peer support specialists.

Dedicated Funding for Crisis Services

The Clark Regional Behavioral Health Policy Board supports efforts to increase the community's access to crisis intervention. Currently, in Clark County, there is one mobile crisis team for adults that serves only one zip code located in Downtown Las Vegas. The Crisis Response Team in this one area responded to thousands of calls in one year. The Nevada Department of Health & Human Services Division of Child & Family Services provides a mobile crisis response team (MCRT) for youth and families in crisis.

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Recommendation: The Board, DHHS, and DPBH to review and develop a plan for working with community partners to model Crisis Now services. Crisis services with adequately trained staff and good options for behavioral health treatment and follow-up can reduce the number of emergency room visits. The average number of patients waiting in emergency rooms for Behavioral Health Services continues to rise yearly. In 2021 data from the U.S. Labor Statistics rated Nevada second in the nation for the highest number of workers quitting jobs. Many health care professionals are experiencing high burnout and long hours with little incentives. Other professions have offered remote working, but this is not the case for in-person medical staff. The shortage of staff and increase of emergency rooms can leave a patient not receiving adequate behavioral health care or limited options for follow-up. Crisis care can help an individual get on the right track while in crisis.

Residential Treatment Services for Youth

The Clark Behavioral Health Policy Board relies on the Clark County Children's Mental Health Consortium for recommendations related to children's mental health due to their focus solely on children, youth and transition age youth and their families. Part of their 10-year plan calls for reducing the reliance on out-of-state and out-of-community placements for services or treatment of youth with Serious Emotional Disturbance (SED).

The Clark County Department of Family Services has reported staff shortages. More children are coming through the system with a higher need for care, but the DCFS staff are unable to meet the needs of these children. This has resulted in children not being accepted for services and caregivers left desperate for help. Data for 2021 reflects the significant decrease to service Desert Willow Treatment Center - Acute Care served four children in May 2021 but decreased to one by November. The residential services served twenty-two children in March 2021, but only six were receiving services by December.

Recommendation: The Clark Regional Behavioral Health Policy Board and the Clark County Children's Mental Health Consortium think of creating more intensive community-based services to enhance the existing system of care. While the ideal situation is for a child(ren) to remain with families and caregivers, increased collaboration and funding options for local and state services will need to align with the severe needs of children who need a higher level of care to stay safe to themselves and within their community.

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Increasing Collaboration on the Spectrum of Substance Misuse and its Relation to Mental Health

The Policy Board needs to effectively address behavioral health in our community, we must recognize the role of substance misuse and mental health. The National Institute on Drug Abuse recognizes that "many (about half of) individuals who develop substance use disorders (SUD) are also diagnosed with mental disorders, and vice versa." To create change around behavioral health and improve the lives of Clark County residents. substance misuse and abuse must be part of the discussion. The Clark Regional Behavioral Health Policy Board must work to build a bridge that connects prevention, treatment, and recovery providers to mental health professionals to create innovative solutions and systems change. We know that mental health and substance use disorders are co-occurring, and we must work to join resources and direct them to raise the health equity in Clark County.

Recommendation: The Clark Regional Behavioral Health Policy Board supports efforts to improve public education and awareness for substance misuse and prevention. Due to prejudice or discrimination, many individuals are unwilling to seek mental health and substance misuse treatment. Breaking down biases through education encourages individuals to meet with health care professionals and openly discuss treatment options, recovery support, and connections to services. In addition to a treatment option, prevention has long-lasting economic benefits and averts injuries, disabilities, and deaths caused by misuse. The Surgeon General's office reports that evidence-based intervention returns $58 for every $1 spent.

The return on investment could have significant implications for public safety and criminal justice system costs. In a 2021 study by Applied Analysis, the increased demands of the growing community and the lack of available beds for both substance abuse and mental health issues are bombarding the system. On average, the Clark County Detention Center (CCDC) processes 70,000 inmates yearly, with 30 percent of that population experiencing a mental health need. In conjunction with substance misuse, the large volume of inmates makes it nearly impossible to provide comprehensive treatment while in custody. Identifying issues while in custody may be the only opportunity for linking someone to a diversion program that would better suit their needs versus imprisonment. Often, individuals serve their time and are released with little understanding of an action plan, therefore having a higher likelihood of repeating the cycle. The board will continue to monitor public health trends like this one to make current and relevant recommendations effectively.

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Important considerations

In addition to serving all individuals in the Clark region, significant consideration is taken to help vulnerable populations. The Board recognizes that many successful behavioral health outcomes are closely impacted by the Social Determinants of Health (SDOH), including access to food, transportation, income levels, and social support. Desired health can be achieved by providing equal access to services and meeting individuals where they are physically, emotionally, and economically. The Nevada Minority Health and Equity Coalition explains that health equity is attained with every person can reach full health potential. They encourage policymakers to develop and support efforts to reduce disparities in healthcare provisions and increase access.

To be effective and reduce disparities, it is essential to consider racial and cultural identities that impact the actions that influence behavioral health. When discussing the priorities previously listed, the Board examines how the SDOH affects longevity and quality of life for behavioral health across the region's diverse population.

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2021 CLARK REGIONAL BEHAVIORAL HEALTH POLICY BOARD ACTIVITIES

As the world continued to meet the challenges of the Covid-19 crisis, CRBHPB met with stakeholders and held full Board Meetings virtually. Board members, guests, and the public met in accordance with NRS. 433.429 relating to mental health. The virtual public meetings were held through teleconferencing and allowed the meetings to be accessible telephonically to all members and the public interested in observing or addressing the Board. All board meetings are subject to specific notice and accessibility requirements. The CRBHPB will continue to meet virtually until further notice.

2021 Board Meetings

During the 2021-year January through December, the Board met on five occasions. All presentations, materials, and minutes provided to the Clark Regional Behavioral Health Policy Board can be found at: https://dpbh.nv.gov/Boards/RBHPB/Board_Meetings/2018/Clark_Regional/ The list below provides an overview of notable presentations, initiatives, and actions initiated by the Board in 2021.

January 28, 2021

- Discussion and approval of 2020 Clark Annual Report
- Discussion and approval for letters of support for the other regional policy boards

March 11, 2021

- Update on other Regional Behavioral Health Policy Boards' bills
- Discussion and vote to allow Chair Char Frost to represent the interests of the Board as they relate to SB56
- Discussion and approval to support other Policy Board's bill by writing letters of support to submit as testimony
- Presentation on the Olmstead Decision by Nevada Legal Services

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May 12, 2021

- Presentation on the Healthy People 2030- data-driven national initiative to improve health and well-being over the next decade. It is a framework to promote and educate people on their well-being. It uses national data from a social determinates of health perspective.
- Discussion- Senate Bill 56 Revises provisions governing insurance coverage of behavioral health services to include telephonic behavioral health services

July 28, 2021

- Presentation on Legal 2000 data collection and outcomes
- Presentation on American Rescue Plan Act of 2021 (ARPA)
- Discuss and Approve Board Recommendations to be sent to the State regarding allocation of ARPA funding
- Presentation on Regional Coordinators work with a regional website

November 1, 2021

- Presentation by University of Nevada, Reno on Open Beds, an electronic behavioral health and social service treatment referral system and collection of Legal 2000 (L2K) data
- Update Clark County Children's Mental Health Consortium
- Update Prevention Coalition future updates to board (Senate Bill 69 regarding peer recovery support services) Senate Bill (SB) 69 institutionalized peer recovery support specialists, changed from passive to active consent for the youth risk behavioral survey, and institutionalized prevention coalitions
- Discussion and vote of Board membership of Appointments and Reappointments of Board Positions
- Update discussion and vote on updated Bylaws for the Board

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DATA HIGHLIGHTS

Traditionally the epidemiological report provided data from the Department of Human and Health Services Division of Public and Behavioral Health (DPBH), Substance Abuse Prevention and Technical Assistance (SAPTA), and Office of Analytics yearly. However, staffing challenges due to the epidemic have resulted in the epidemiological report will be given every other year. Therefore, for 2021 each Regional Behavioral Health Coordinator was given a set of raw data to pull as information from and help compose each annual report.

In order to gain a better representation with a more robust data collection other sources were added to this report. Data from the Center for Disease Control and Prevention; U.S Department of Labor Statistics, Healthy Southern Nevada; Department of Human and Health Services Chart Pack; UNLV Center of Business and Economic Research; and Applied Analysis: Behavioral Health Services in Southern Nevada have all been instrumental in showcasing the behavioral health challenges for the Clark Region.

Key Findings

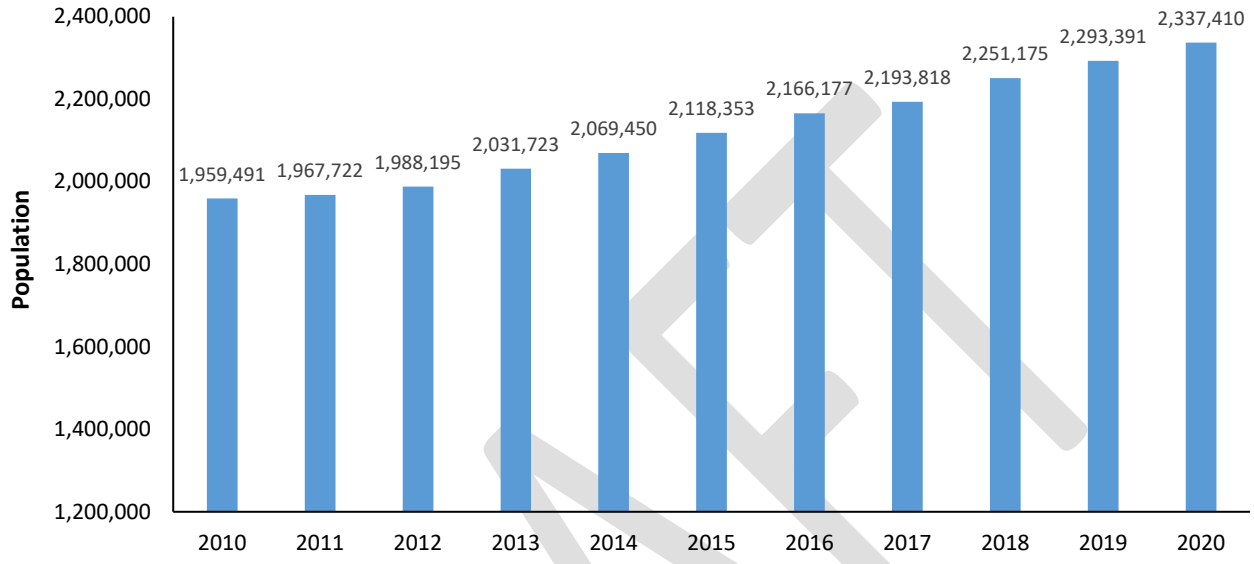
- Clark county population 2,226,715
- Approximately 73% of the whole state of Nevada
- 15.1% of the population is 65 and over
- 56% of the population is an ethnic minority
- Young adults and children make up almost half the entire population
- An estimated 20% of the population experience 10 or more poor mental health day and categorize themselves as having unfavorable mental health.
- Significant increase to unintentional or undetermined overdose related deaths for youth under eighteen followed closely by young adults.
- Significant need for inpatient and outpatient bed that are left unmet
- Clark County on average has 21 child and adolescent psychiatrist per 100,00; national average is 89.
- Alcohol and substance misuse continue to rise
- Clark County coroner data attributes 219 deaths for fentanyl overdose

DRAFT

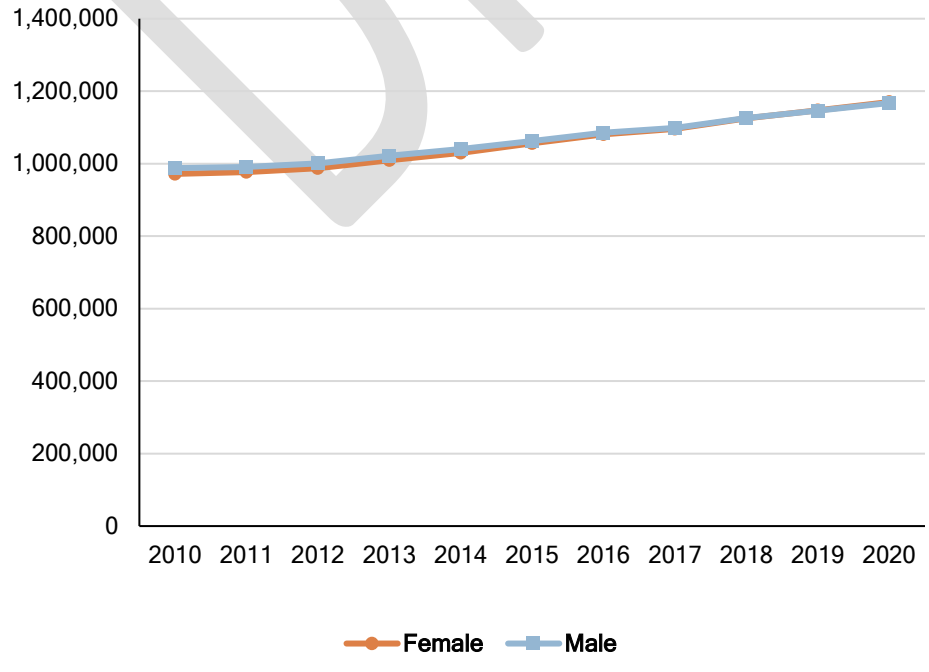
APPENDICES

Appendix A

Clark population growth 2010-2020

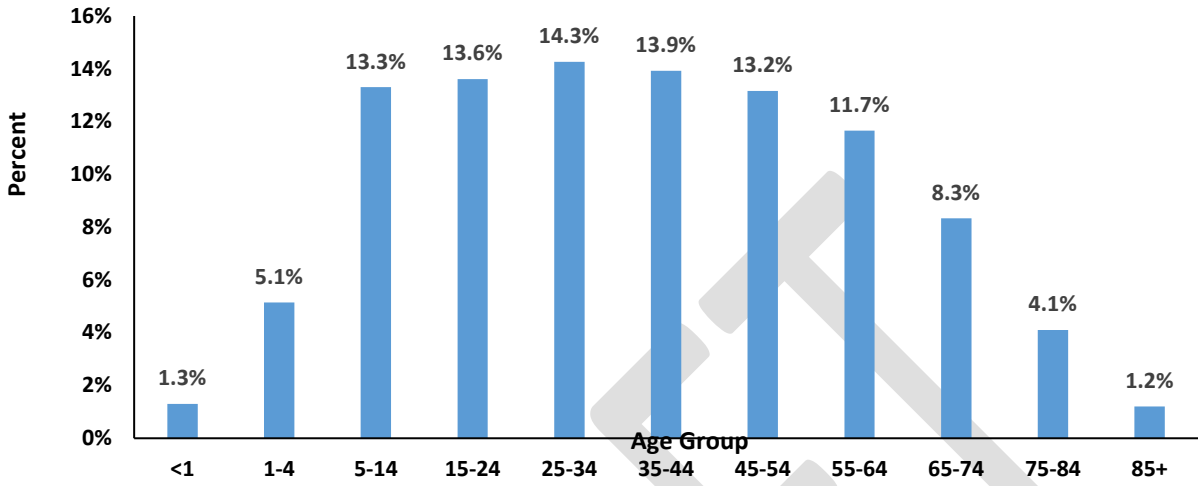


Clark County 2020: Total Man and Female Populations



DRAFT

Clark County 2020: Percentage of Total Population by Age Group



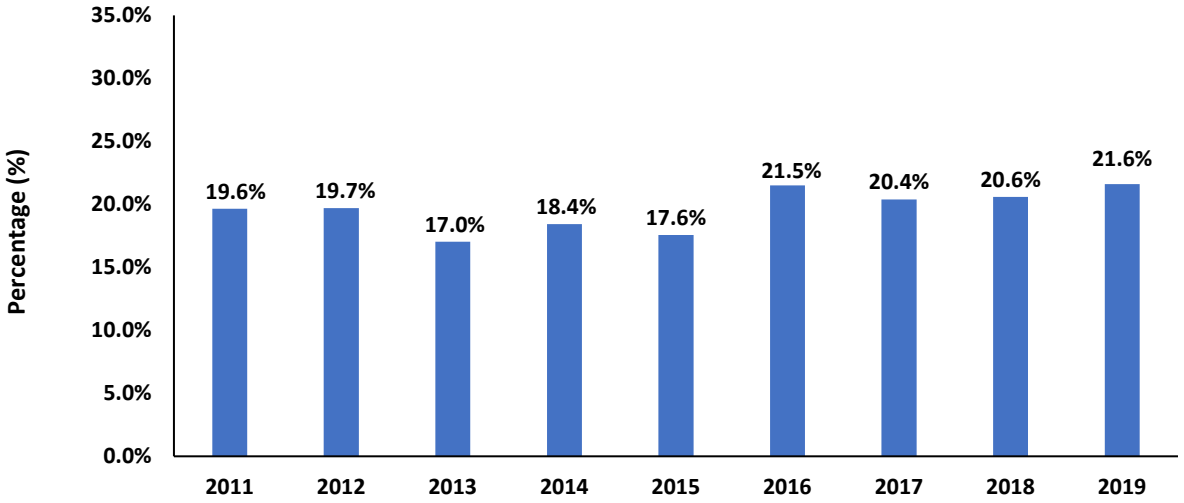
AFT

County Demographics –

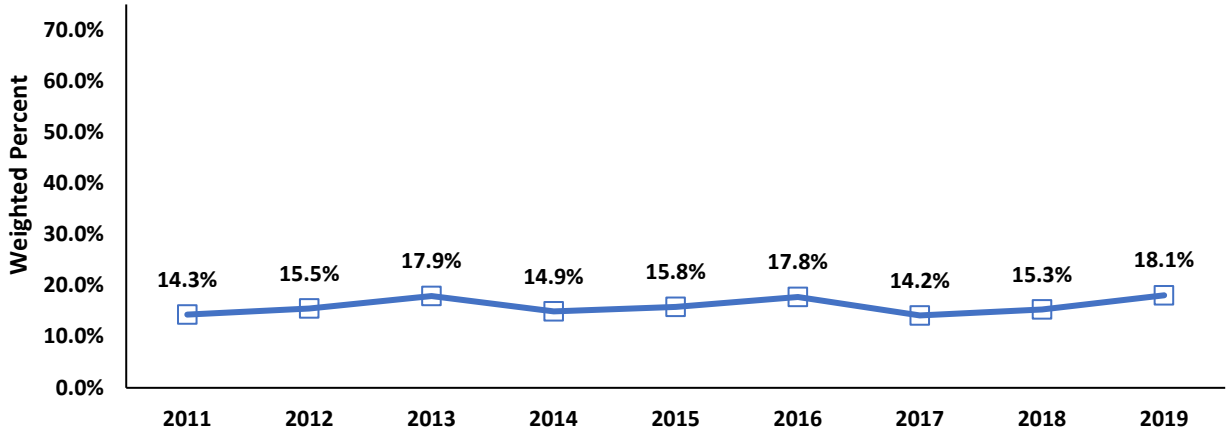
	County	State
Population	2,266,715	3,080,156
% below 18 years of age	23.0%	22.5%
% 65 and older	15.1%	16.1%
% Non-Hispanic Black	11.9%	9.3%
% American Indian & Alaska Native	1.2%	1.7%
% Asian	10.4%	8.7%
% Native Hawaiian/Other Pacific Islander	0.9%	0.8%
% Hispanic	31.6%	29.2%
% Non-Hispanic White	41.7%	48.2%
% not proficient in English	7%	6%
% Females	50.1%	49.8%
% Rural	1.3%	5.8%

Clark (CL) County | Trend | Error Margin | Top U.S. Performers | Nevada

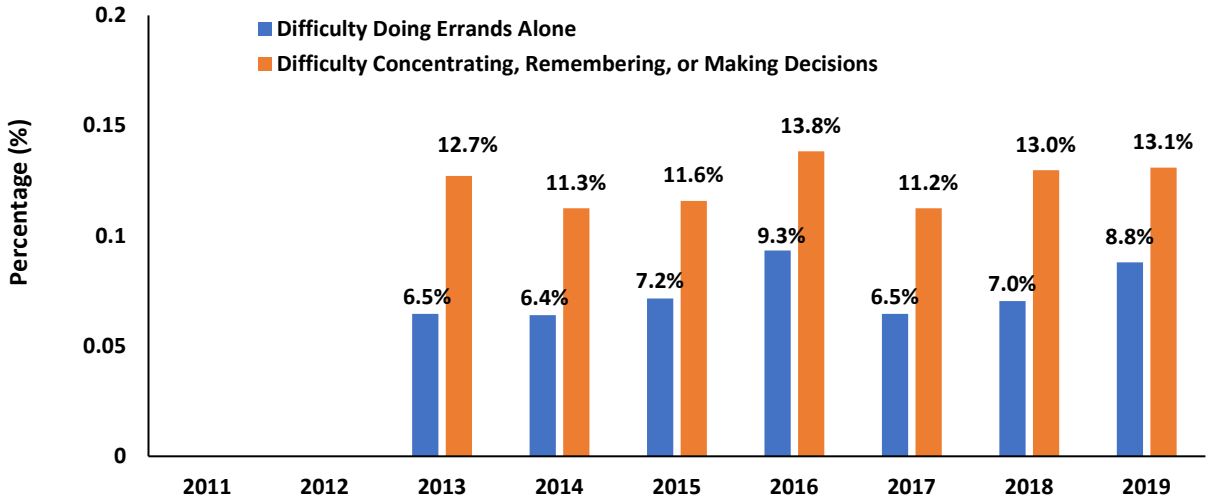
Percentage of Nevada Adults in Clark County Who Rated Their General Health As Poor or Fair, 2011-2019



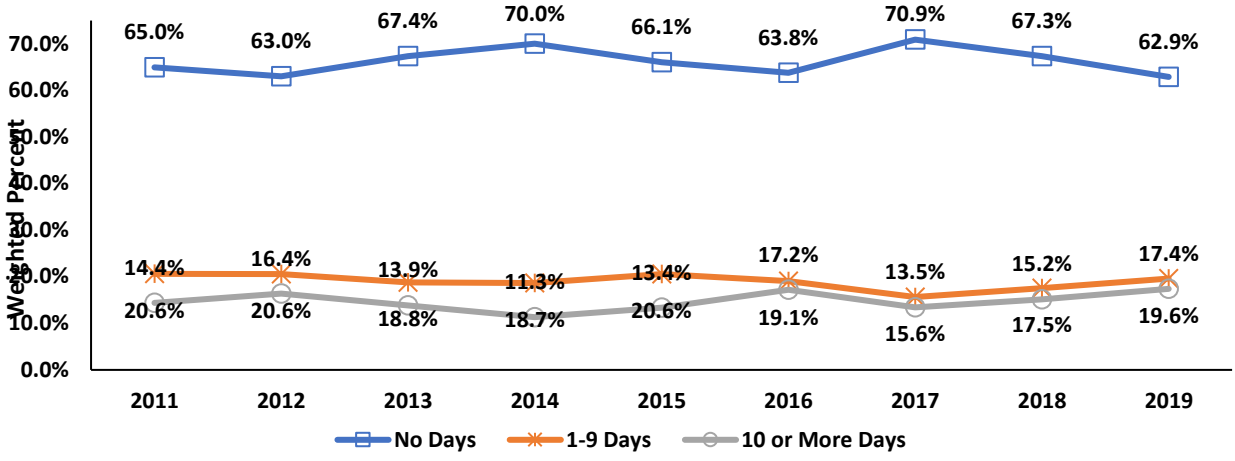
Percentage of Nevada Adults in Clark County Who Reported Unfavorable Mental Health, 2011-2019



Percentage of Nevada Adults in Clark County Who Experience Difficulties Because of Physical, Mental, or Emotional Conditions, 2011-2019



Percentage of Nevada Adults in Clark County Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities, 2011-2019

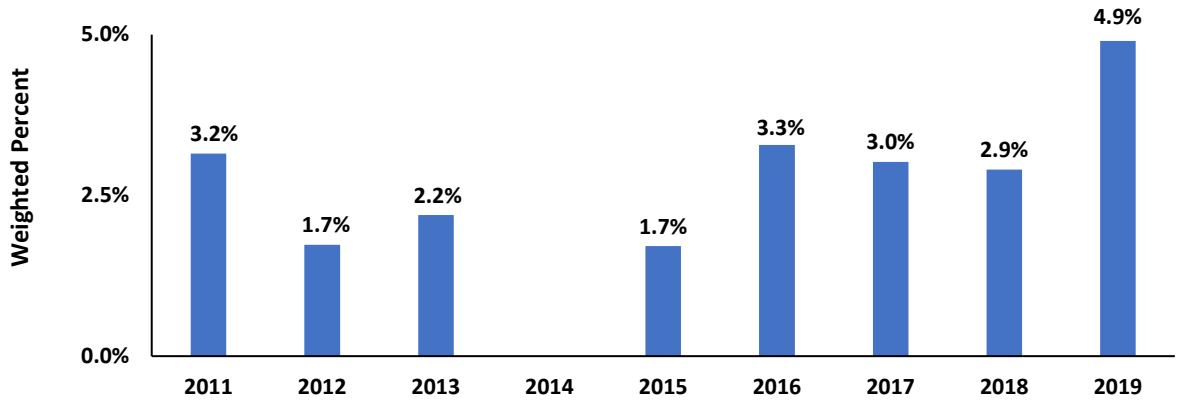


Nevada 2019 - 2020: Unintentional or undetermined overdose-related deaths in

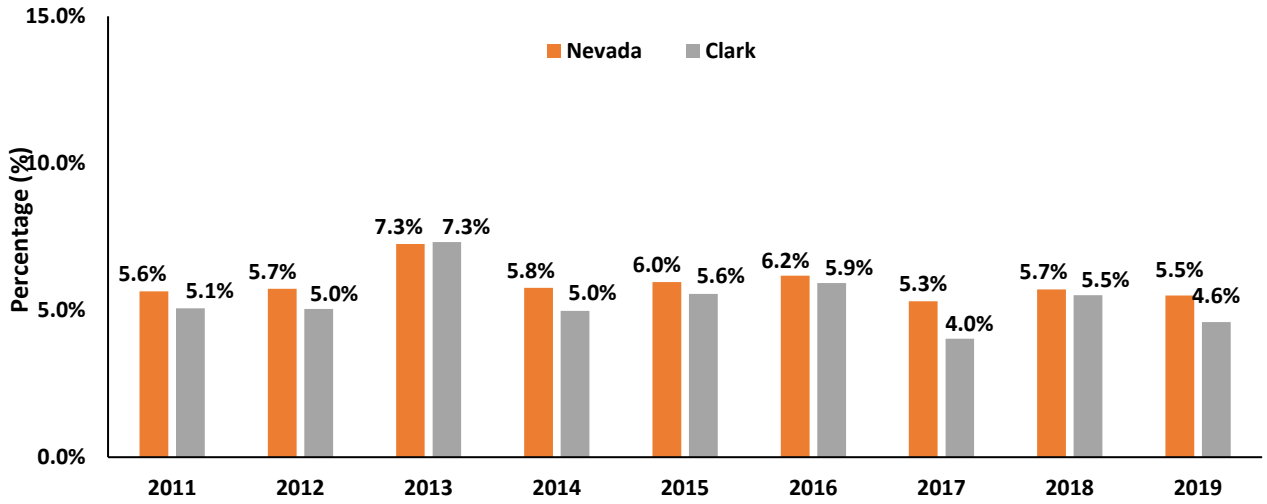
Region: Clark 328 (64.3%) 542 (68.8%) 65.2% No significant change

Characteristic	2019 N[a]=510 (%)	2020 N[a]=788 (%)	Relative % Change[b]	Trend[c]
Age				
<18 years	2 (0.4%)	13 (1.6%)	550.0%	Significant Increase
18-24 years	36 (7.1%)	93 (11.8%)	158.3%	Significant Increase
25-34 years	83 (16.3%)	149 (18.9%)	79.5%	No significant change
35-44 years	99 (19.4%)	144 (18.3%)	45.5%	No significant change
45-54 years	120 (23.5%)	158 (20.1%)	31.7%	No significant change
55-64 years	126 (24.7%)	162 (20.6%)	28.6%	No significant change
65+ years	44 (8.6%)	69 (8.8%)	56.8%	No significant change

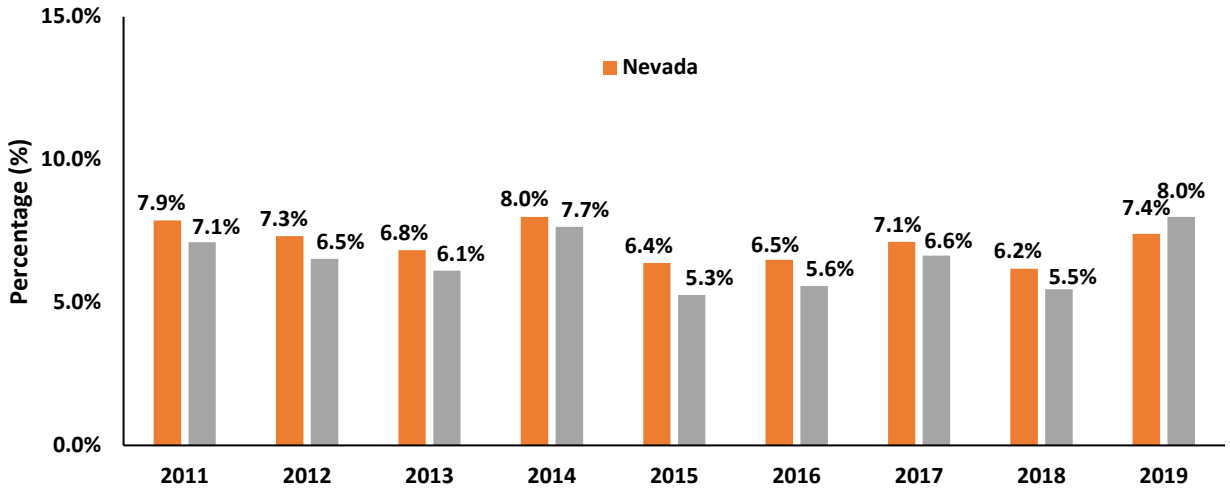
Percentage of Nevada Adults in Clark County Who Have Seriously Considered Suicide, 2011-2019



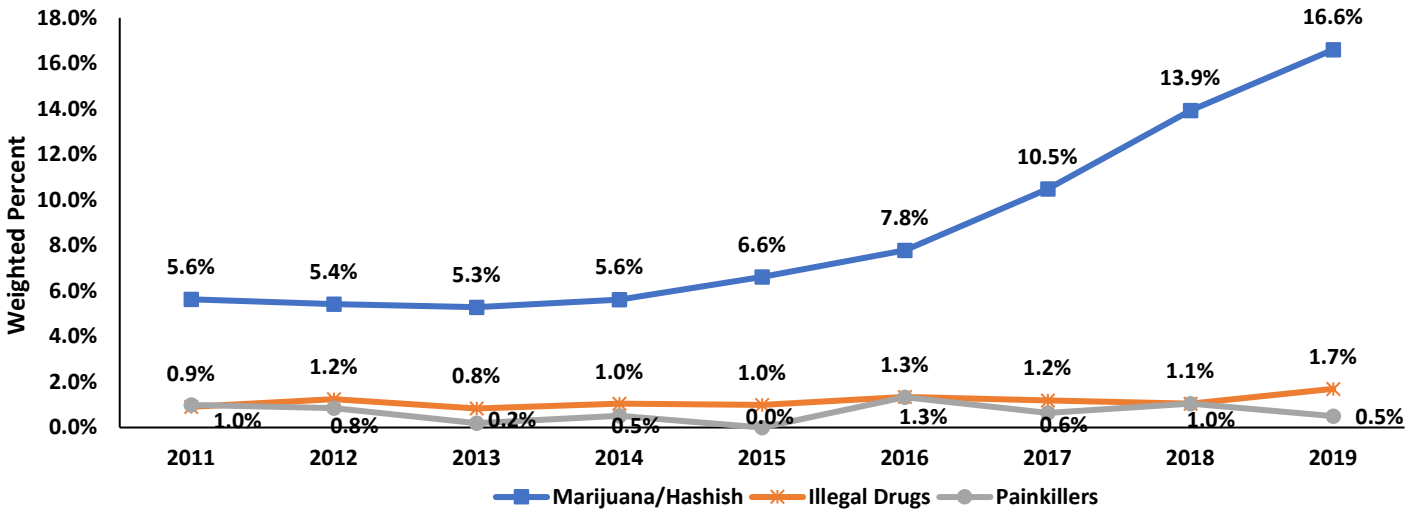
Percentage of Nevada Adult Women in Clark County Who Are Considered Heavy Drinkers, 2011-2019



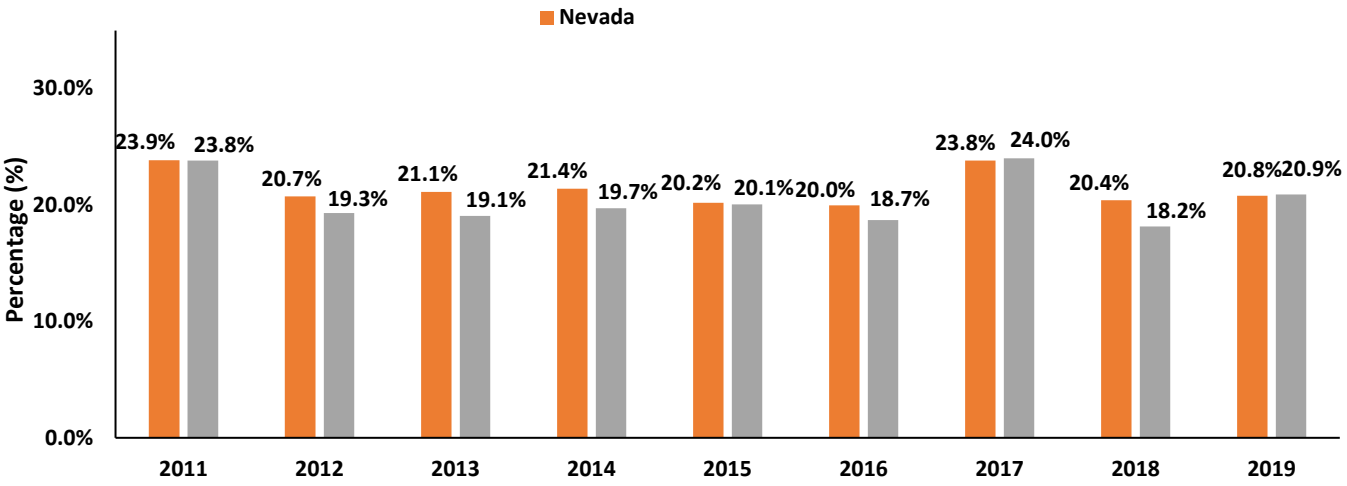
Percentage of Nevada Adult Men in Clark County Who Are Considered Heavy Drinkers, 2011-2019



Percentage of Nevada Adults in Clark County Who Used Marijuana/Hashish, Illegal Drugs, or Painkillers to Get High in the Last 30 Days, 2011-2019



Percentage of Nevada Adult Men in Clark County Who Are Considered Binge Drinkers, 2011-2019



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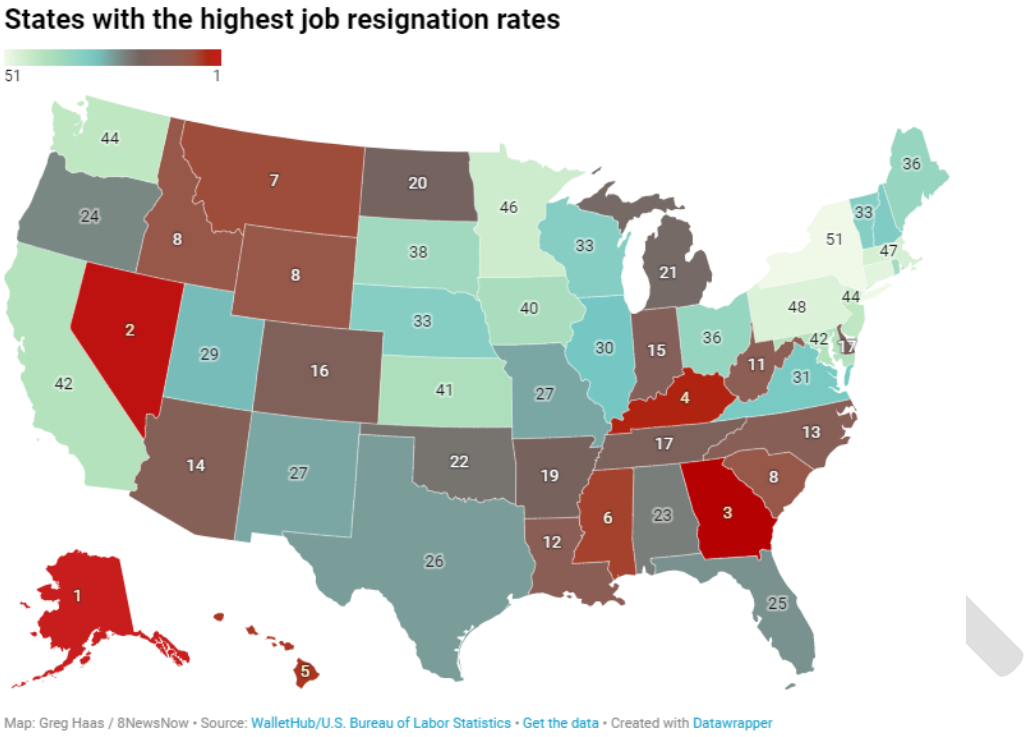
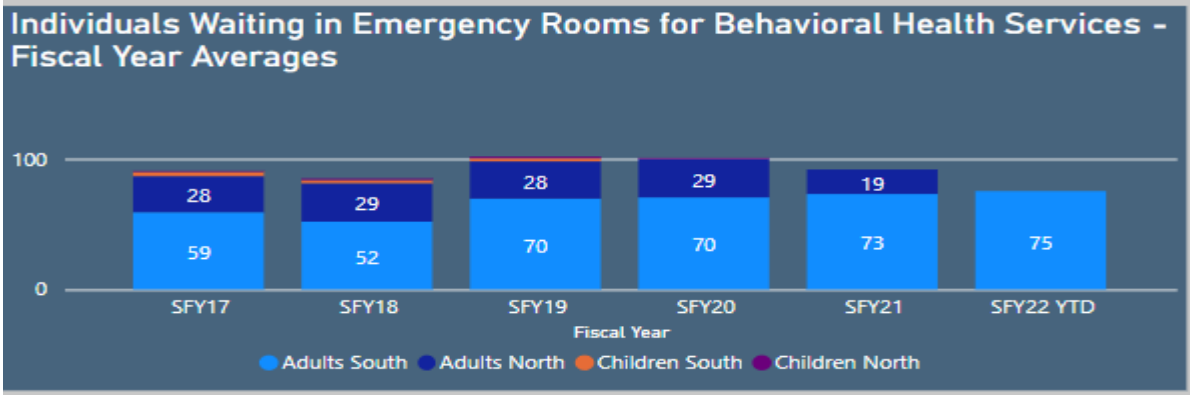
Appendix B



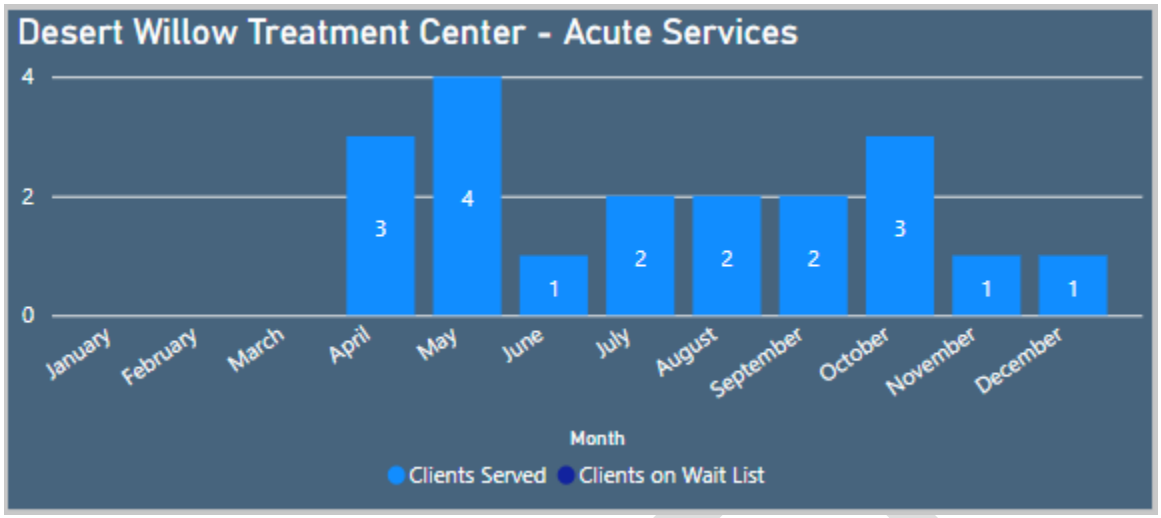
Fiscal Year Averages

Fiscal Year	Adults South	Adults North	Children South	Children North	Total	Percent Change
SFY17	59	28	3	1	91	
SFY18	52	29	2	1	85	-6%
SFY19	70	28	2	1	101	20%
SFY20	70	29		1	100	-2%
SFY21	73	19			90	-10%
SFY22 YTD	75				75	-17%



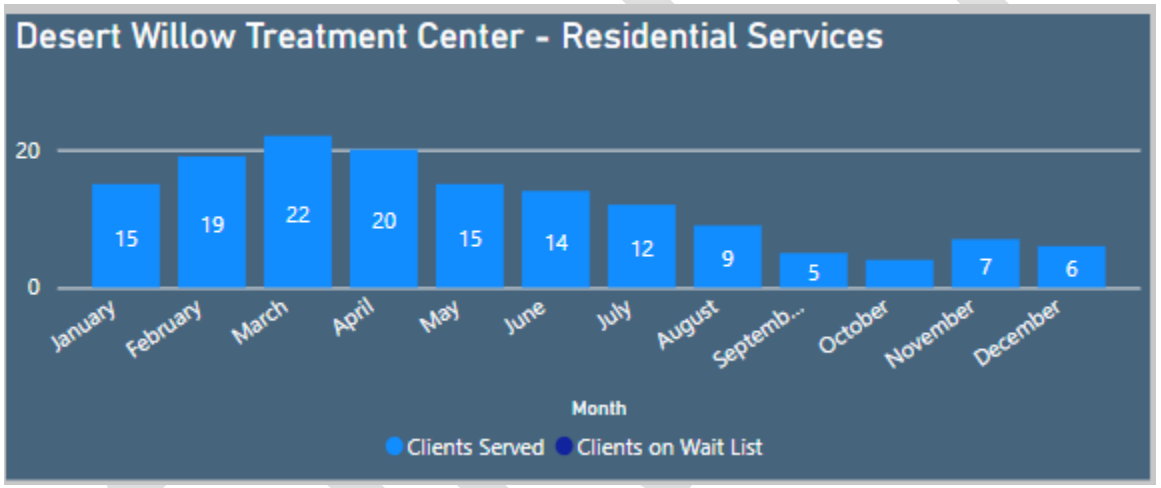
Source: DHHS Behavioral Health Chart Pack

Children's Mental Health - South



Desert Willow Treatment Center- Acute Services was undergoing renovations from July 2020 to March 2021

Source: DHHS Behavioral Health Chart Pack



Source: DHHS Behavioral Health Chart Pack

Source: DHHS Behavioral Health Chart Pack

Appendix C

6385 S. RAINBOW BLVD., SUITE 105
LAS VEGAS, NEVADA 89118
T: 702.967.3333
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APPLIEDANALYSIS.COM

APPLIED ANALYSIS

September 29, 2021

Ms. Teresa Etcheberry
Assistant Manager
Clark County Department of Social Service
1600 Pinto Lane
Las Vegas, NV 89106

RE: Behavioral Health Services in Southern Nevada 2021

Dear Ms. Etcheberry:

In accordance with your request, Applied Analysis ("AA") is pleased to submit this review and analysis of the state of behavioral health services in Southern Nevada. AA was retained by the Clark County Department of Social Service to assist in evaluating the region's mental and behavioral healthcare system. In addition, AA was retained to focus its efforts on a number of key areas of analysis, including the following: (1) the specific mental and behavioral health needs of the Clark County community; (2) the effectiveness of the system in treating those needs; (3) identifying areas of the system that are in particular need of improvement in order to meet those needs; and (4) comparing how these results have changed since the 2016 evaluation of the behavioral health system.

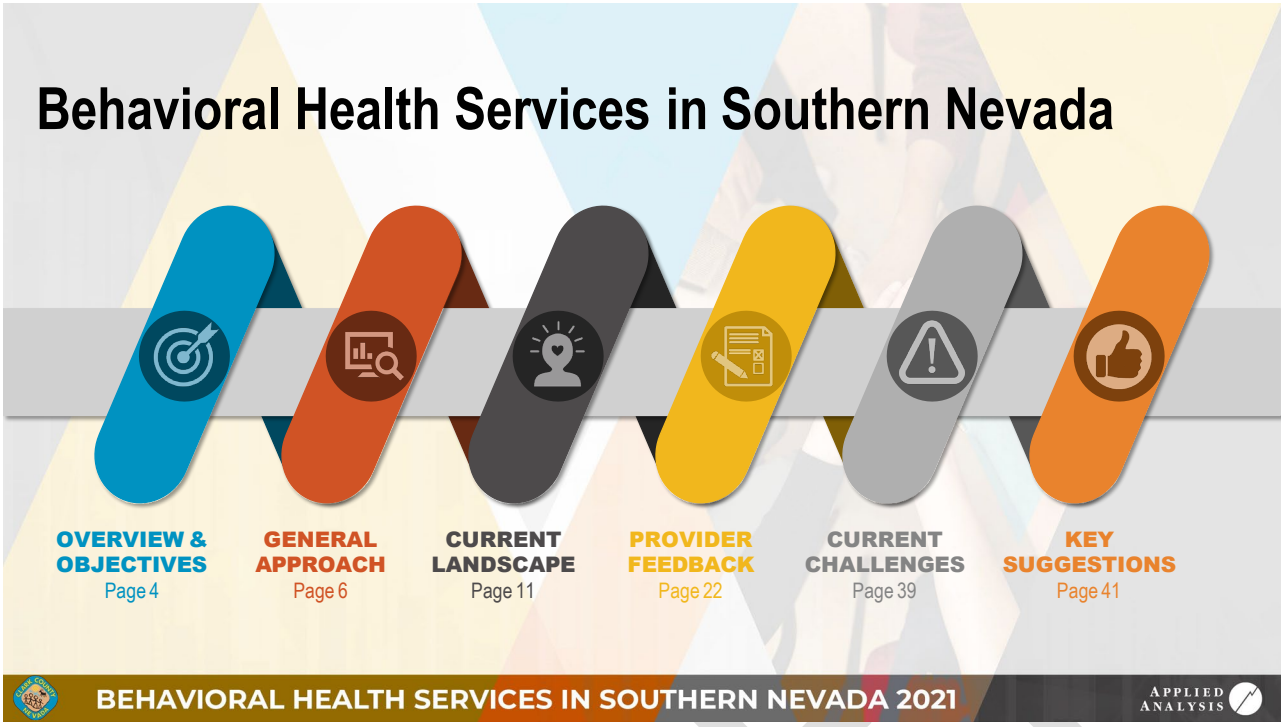
This report was designed by AA in response to your request. However, we make no representations as to the adequacy of these procedures for all purposes. Generally speaking, our findings and estimates are as of the date of this letter and utilize the most recent data available. This report contains economic, demographic, and other predominant market data. This information was collected from our internal databases and various third parties, including the Nevada Department of Health and Human Services and other public data providers. The data were assembled by AA. While we have no reason to doubt its accuracy, the information collected was not subjected to any auditing or review procedures by AA; therefore, we can offer no representations or assurances as to its completeness.

This report is an executive summary. It is intended to provide an overview of the analyses conducted and a summary of our salient findings. AA will retain additional working papers relevant to this study. If you reproduce this report, it must be done so in its entirety. We welcome the opportunity to discuss this report with you at any time. Should you have any questions, please contact Jeremy Aguero or Brian Gordon at (702) 967-3333.

Sincerely,

Applied Analysis

Applied Analysis


Behavioral Health Services in Southern Nevada
OVERVIEW & OBJECTIVES
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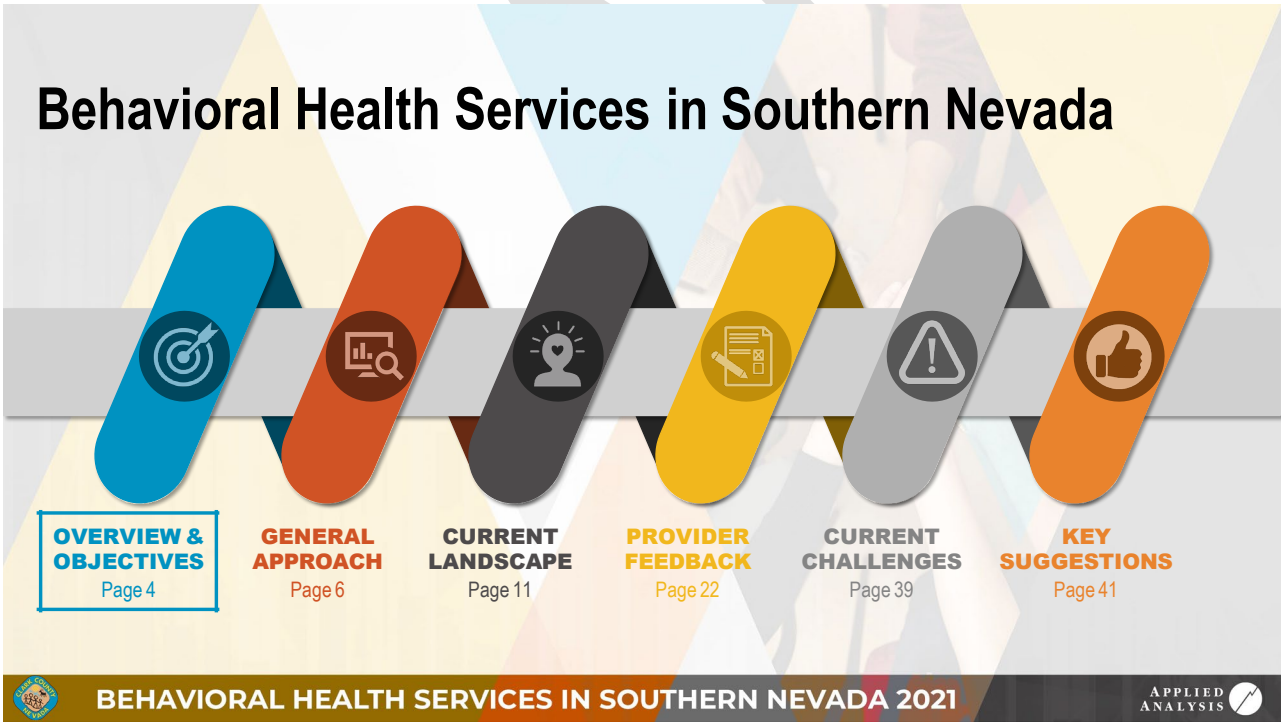
GENERAL APPROACH
Page 6
CURRENT LANDSCAPE
Page 11
PROVIDER FEEDBACK
Page 22
CURRENT CHALLENGES
Page 39
KEY SUGGESTIONS
Page 41
BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021
APPLIED ANALYSIS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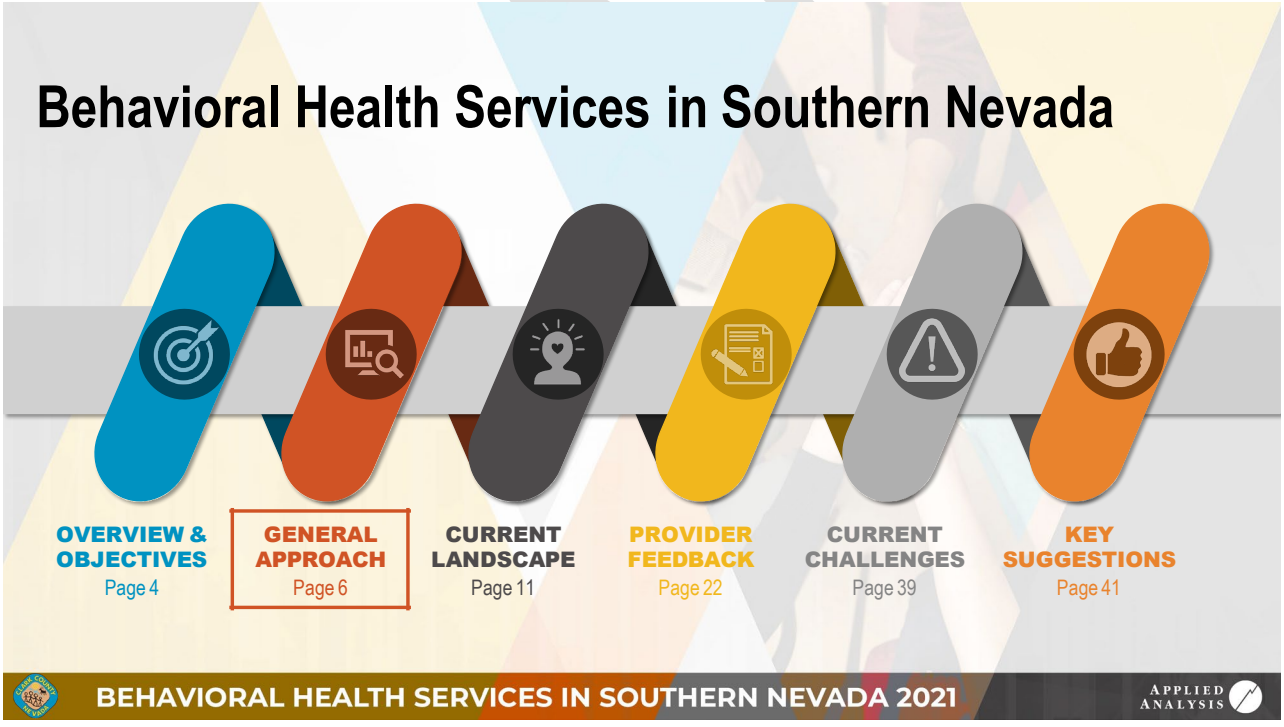
BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021
APPLIED ANALYSIS

Project Overview and Objectives

Assignment:	Clark County Department of Social Services ("CCSS") provides a variety of services for needy residents within Clark County who are not assisted by other state, federal or local programs. One area of focus that has been a challenge is meeting the needs of individuals requiring mental health assistance. CCSS seeks to improve awareness and effectiveness of the system. Applied Analysis ("AA") previously conducted a similarly study in the 2016 timeframe. This analysis was designed to provide an update to the original 2016 analysis, including the identification of specific mental and behavioral health needs of the Clark County community; consideration of the effectiveness of the system in treating those needs; and identifying areas of the system that are in particular need of improvement in order to meet those needs.
Approach:	AA conducted surveys of community providers and stakeholders to identify current challenges in the mental health system and compare these results to needs identified in 2016.
Limitations:	Although we have no reason to doubt the accuracy of any information obtained and utilized, the information was not subjected to any auditing or review procedures by AA; therefore, we make no representations or assurances as to its completeness.



Research Approach & Methodology
Multi-Faceted Approach

Research Approach & Methodology
Develop Provider Database

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Care Financing and Policy

NEVADA STATE BOARD
Medical Examiners & Osteopathic Medicine

NEVADA DETR
Department of Employment, Training & Rehabilitation

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Provider Identification (NPI) Registry

Research Approach & Methodology
Conduct Provider Survey

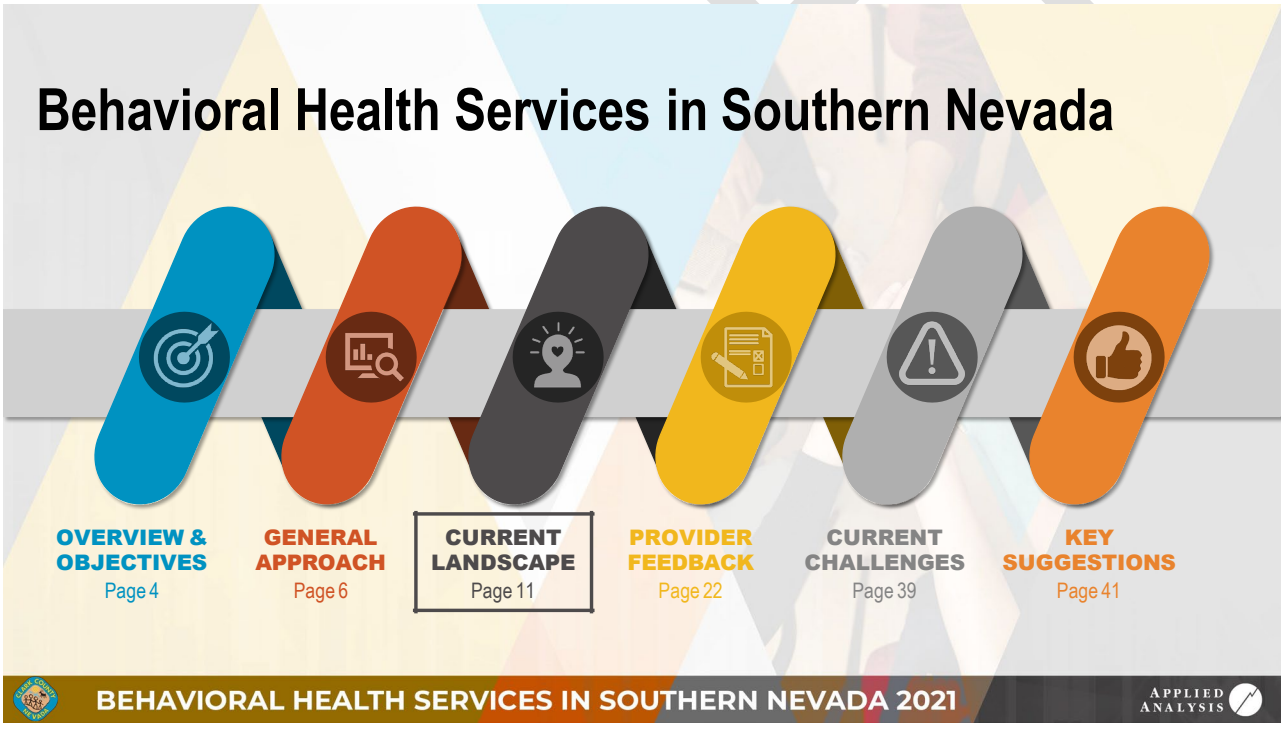
Information contained within this report relates to the current state of Clark County's behavioral and mental health system. The compiled database of service providers was utilized as a baseline for research in evaluating the current system and opportunities for improvement. To administer the survey, the representative list of providers in the region was developed. In its final form, this provider database included nearly 6,300 individuals and organizations. All survey data was acquired through a telephonic survey. During the survey period, roughly 14,900 phone calls were made to providers in the database. By exhausting the database (many providers declined to participate), a total of 122 providers of relevant services located in Clark County completed the survey.

6,300
TOTAL PROVIDERS IN DATABASE

14,900
TOTAL PHONE CALLS (INCL. CALLBACKS)

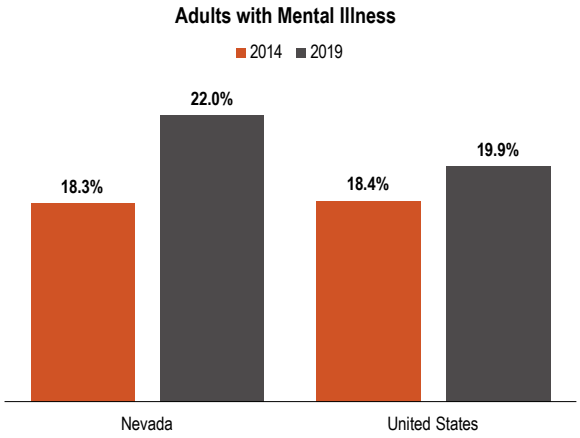
122
PROVIDERS COMPLETING THE SURVEY

Note: Additional details and parameters of the survey are contained later in this analysis.



Mental and Behavioral Health Landscape
Prevalence of Mental Illness

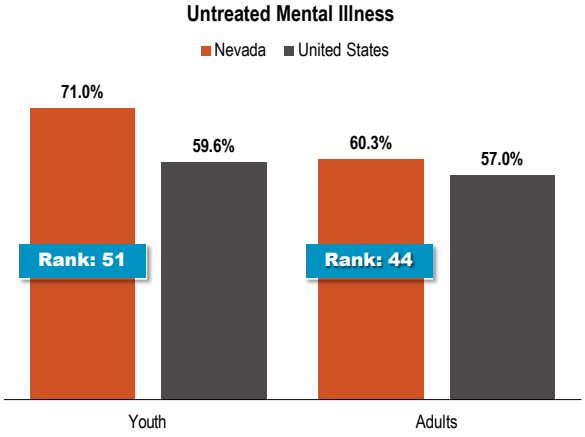
Comparing Nevada to the rest of the nation regarding the prevalence of mental illnesses is imperative to evaluating the effectiveness of the current behavioral and mental health system and identifying target areas for improvement. According to the latest data (2018-2019) from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), about 19.9 percent of Americans over age 18 have some type of mental illness, and about 7.4 percent of Americans over the age of 12 have an alcohol or drug dependence. For the state of Nevada, SAMHSA estimates that 22.0 percent of adults have some sort of mental illness, similar to the national average. Nevada has a higher-than-average prevalence of drug and alcohol dependence, with 9.0 percent of residents over 12 years of age dealing with substance abuse. As compared to 2014, mental illness prevalence has increased, while alcohol and drug dependence have decreased nationwide. However, in Nevada, while prevalence has followed a similar trend to the nation, substance abuse dependence has stayed relatively constant as opposed to decreasing.



Source: SAMHSA.

Mental and Behavioral Health Landscape
State Comparisons

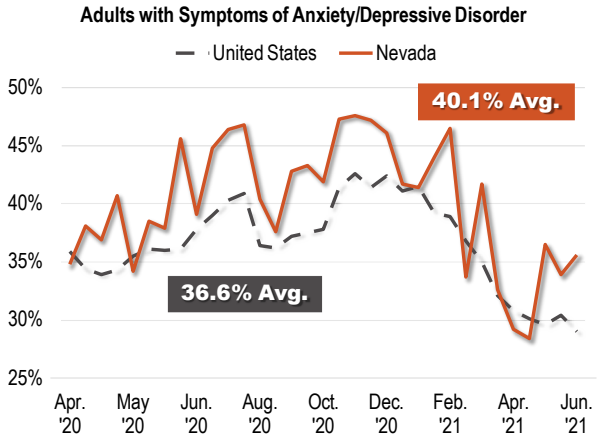
Mental Health America (MHA) publishes an annual report titled "The State of Mental Health in America," which compiles data from SAMHSA, the U.S. Centers for Disease Control and Prevention, and various state organizations to compare states in a variety of measures. An overall state ranking is compiled based on 15 different measures covering prevalence and accessibility factors among youth and adults. According to the 2021 report, which is largely based on 2018 data as the latest year available for all states, Nevada varied significantly from the national average in a number of categories. Notably, Nevada is ranked last in the nation overall, indicating a high prevalence of mental illness and low access to care. Of particular concern were Nevada's youth rankings, where the state placed last for three different measures including overall youth care and youth access to care. For youth with depression in the past year, 71.0 percent did not receive treatment as compared with the national average of 59.6 percent. Although not ranked last, a similarly concerning trend was seen in adults, where 60.3 percent of people in Nevada reported not receiving treatment for any mental illness compared to 57.0 percent nationally.



Source: Mental Health America.

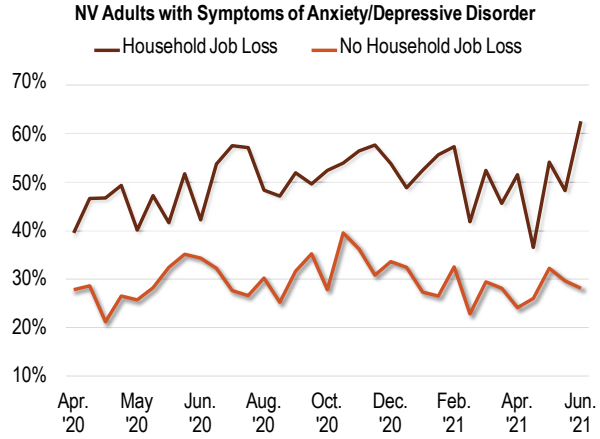
Mental and Behavioral Health Landscape
Impact of COVID-19

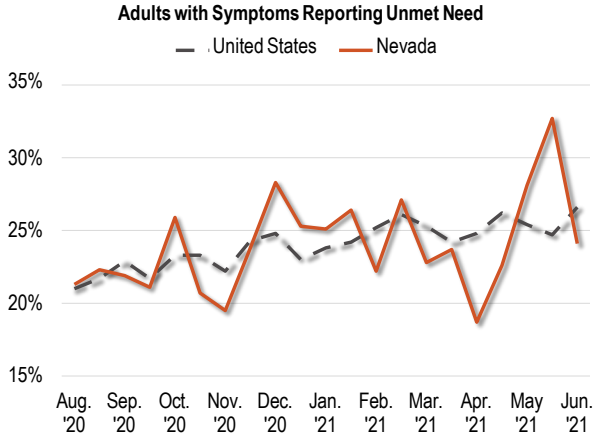
The COVID-19 pandemic had a significant impact on mental health around the country. According to data from the Kaiser Family Foundation (KFF), between April 2020 and June 2021, 36.6 percent of the adult population experienced symptoms of anxiety or depressive disorder. In Nevada, more than 40.0 percent of the population experienced these symptoms over the same time period. There was a sharp divide in reported symptoms for Nevadans that had experienced job loss, with 50.0 percent reporting anxiety or depressive disorder symptoms as compared to 29.6 percent in people that had not experienced job loss. Further, for those people that did experience negative symptoms, nearly one-quarter reported needing, but not receiving, mental health treatment.



Source: Kaiser Family Foundation. Note: These adults, ages 18+, reported experience symptoms of anxiety and/or depressive disorder during the majority of the past 7 days.

Mental and Behavioral Health Landscape
Impact of COVID-19



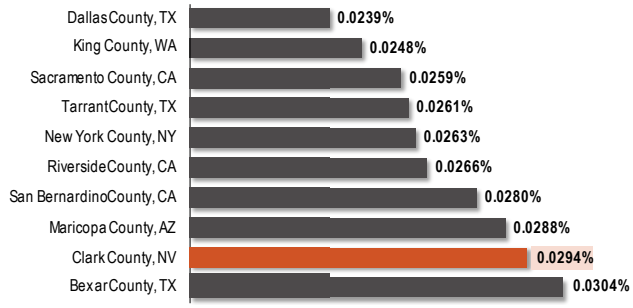


Source: Kaiser Family Foundation. Note: These adults, ages 18+, reported experience symptoms of anxiety and/or depressive disorder during the majority of the past 7 days. For those with unmet needs, they also reported needing but not receiving counseling in the past four weeks.

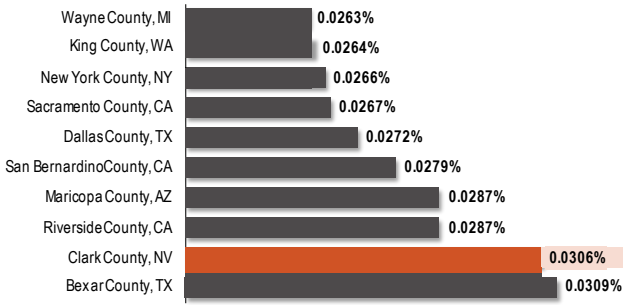
Mental and Behavioral Health Landscape
Impact of COVID-19

Similar impacts have been found by Mental Health America, which has released two spotlight reports on COVID-19 related to severe depression and suicide at the county level. Clark County had the second largest percentage of population with severe depression and frequent suicidal ideation among the large counties in the United States. In both cases, however, Clark County fared better than Nevada overall, which had 0.034 percent of the population reporting severe depression and 0.035 percent reporting frequent suicidal ideation*.

Top 10 Large Counties with Severe Depression



Top 10 Large Counties with Suicidal Ideation



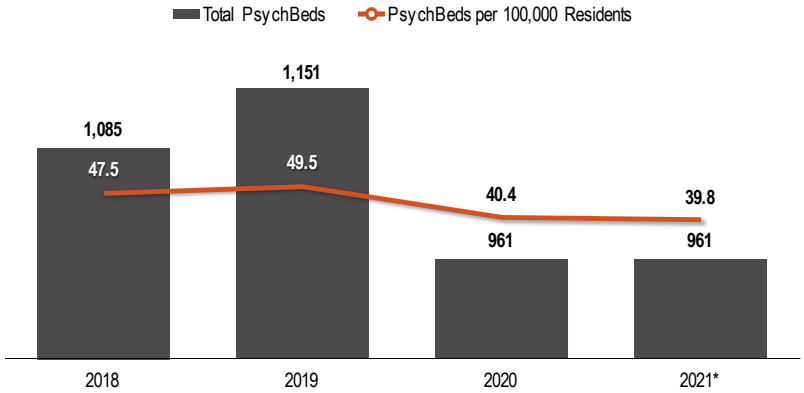
Source: Mental Health America. *Note Data has been weighted to account for the higher likelihood of those aged 11-17 and female to take the MHA Screening used to collect results.

Mental and Behavioral Health Landscape
Accessibility

The Nevada Healthcare Quarterly Reports (NHQR) compiled by the UNLV Center for Health Information Analysis tracks usage statistics at hospitals throughout the state. The graph to the right combines statistics for specialty hospitals and acute care hospitals, with specialty hospitals providing the vast majority of services in each case.

The largest provider in terms of available psychiatric beds is Southern Nevada Adult Mental Health Services (SNAMHS), the state-funded psychiatric care provider. The second largest provider, Montevista Hospital, shut down its 202-bed facility in Q1 of 2020, contributing to the large drop-off in beds experienced during subsequent years.

Hospital Supply of Psychiatric Beds
Clark County

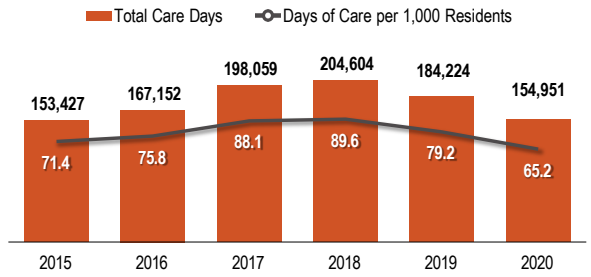


Source: Nevada Healthcare Quarterly Report; Clark County Comprehensive Planning; Applied Analysis. Note: NHQR reporting system changed in Q4 2017, which altered the way data was reported. Data before 2018 may not be comparable. Final bed count from Q4 of each year, except 2021 2021 population is projected. *Only accounts for Q1-Q2 of 2021.

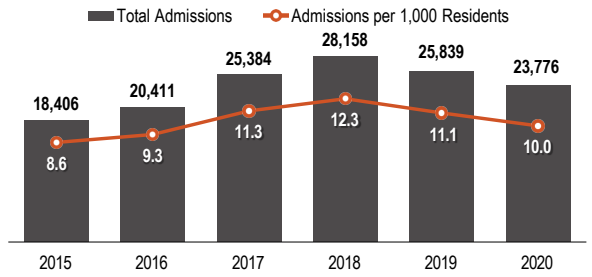
Mental and Behavioral Health Landscape
Accessibility

Nevada Compare Care publishes quarterly reports that identify the number of admissions (cases) and inpatient days that hospitals report, broken down by Diagnosis Related Group (DRG). The graphs below provide key statistics related to mental health and substance abuse DRG codes. To maintain consistency, only hospitals who reported psychiatric beds in the NHQR were included. Also note that several mental health providers from the NHQR reports (including Southern Nevada Adult Mental Health Services) were not included in the Nevada Compare Care reports.

Total Days of Inpatient Care
Clark County Hospitals with Identified Psychiatric Beds



Inpatient Psychiatric Admissions
Clark County Hospitals with Identified Psychiatric Beds

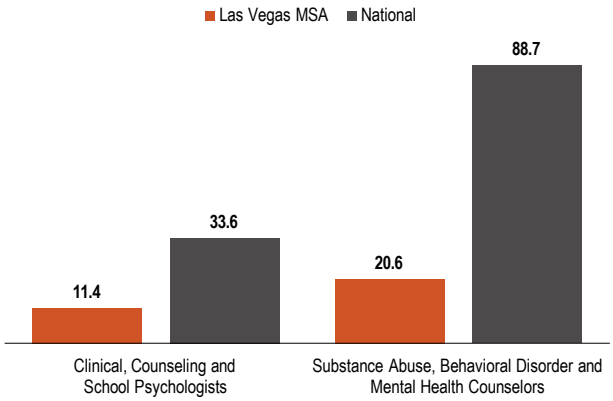


Source: Nevada Compare Care; Clark County Comprehensive Planning; Applied Analysis. Note: There are other sources, such as the Nevada Healthcare Quarterly Reports, that report similar information. However, due to differences in reporting requirements, categorization of information and which entities contribute, the data is not directly comparable to Nevada Compare Care or past versions of this report. Caution should be taken in interpreting these results, as some larger providers such as Southern Nevada Adult Mental Services, did not have available data.

Mental and Behavioral Health Landscape
Provider Shortages

According to the Bureau of Health Workforce Health Resources and Services Administration (HRSA), as of June 30, 2021, 2.4 million residents, or 77.9 percent of the total population (as of 2020) in Nevada, are living in a designated mental health professional shortage area. A comparison of total employment for selected mental health professions further illustrates the shortages Nevada faces. For example, the Las Vegas MSA has 20.6 substance abuse, behavioral disorder and mental health counselors per 100,000 people (based on 2020 data). This is 4.3 times less than the national average of 88.7. Similarly, there are 11.4 clinical, counseling and school psychologists per 100,000 people in Clark County as compared to 33.6 nationally. Data released by the American Academy of Child and Adolescent Psychiatry in 2018 estimated that Clark County faced a severe shortage of child and adolescent psychiatrists (CAPs), with only 21 psychiatrists per 100,000 children aged 0-17. A "mostly sufficient supply" was estimated to be 47 CAPs per 100,000.

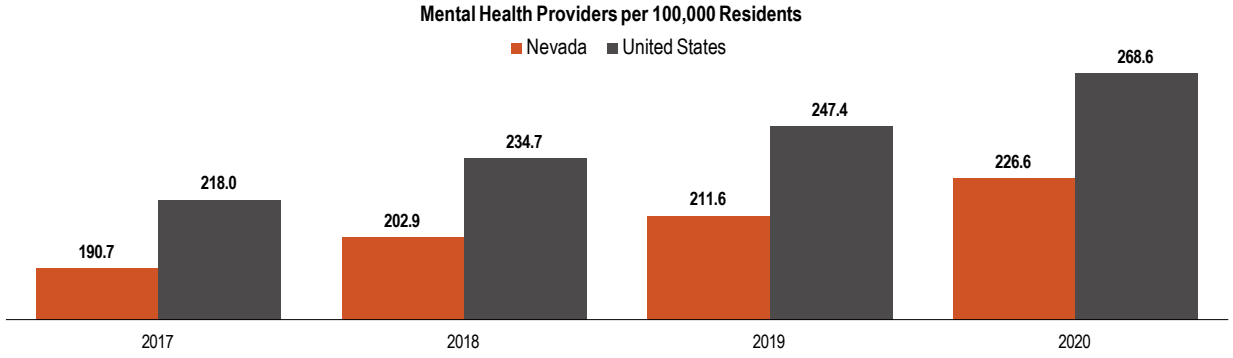
Mental Health Employment Per 100,000 Residents



Source: American Academy of Child and Adolescent Psychiatry; Bureau of Health Workforce Health Resources and Services Administration; Bureau of Labor Statistics; U.S. Census Bureau; Clark County Comprehensive Planning; Applied Analysis. Note: BLS OEWS data as of May 2020 (most recent available).

Mental and Behavioral Health Landscape
Provider Shortages

The UnitedHealth Foundation annually releases statistics on the number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, advanced practice nurses (specializing in mental health care) and providers that treat alcohol and other drug abuse per 100,000 population per state. Nevada's mental health practitioners per 100,000 residents has remained well below the average in the last 5 years.



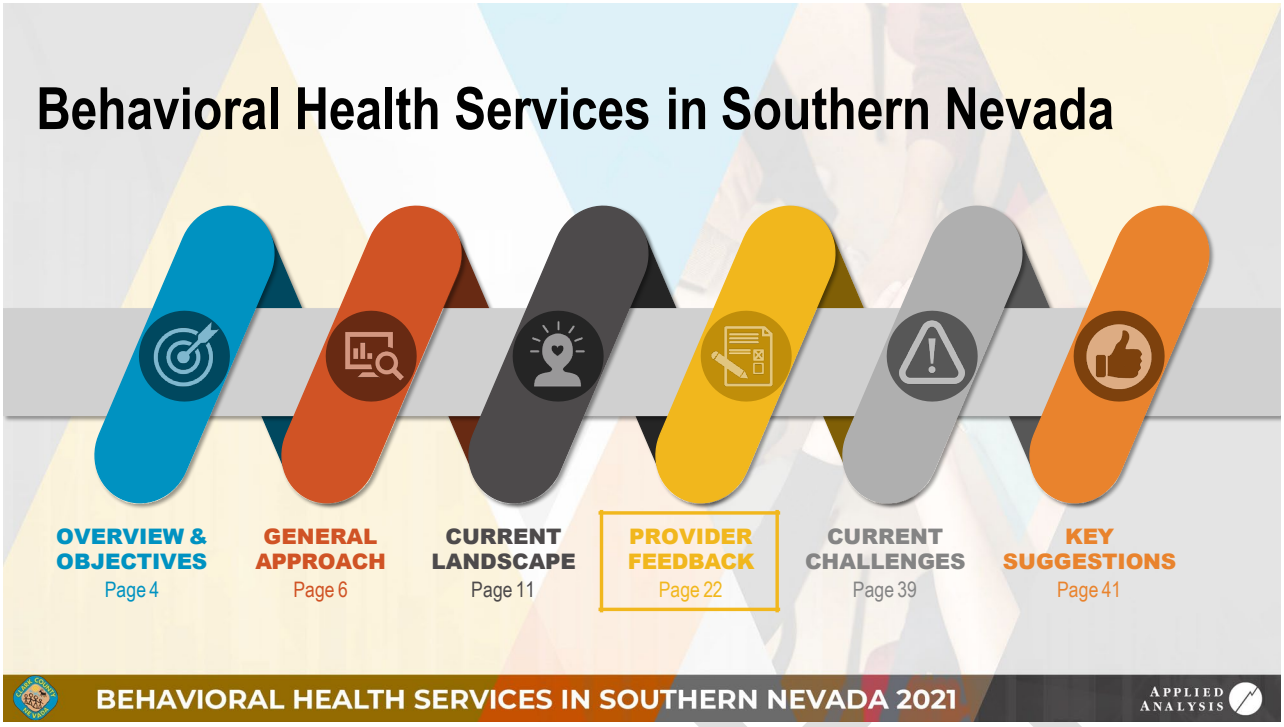
Source: United Health Foundation.

Mental and Behavioral Health Landscape

During an interview with Clark County Detention Center (CCDC), the largest mental health provider in Clark County by patient volume, representatives of law enforcement described many challenges and how these compared to what was experienced in 2016. In many ways, the challenges from five years ago are still present today. There were two issues identified as most pressing to the system today:

1) Somewhere between 85-90 percent of inmates at CCDC are awaiting trial rather than serving a sentence, which makes the length of stay at the detention center oftentimes uncertain. When the CCDC has notice of at least 30 days, social workers within the system can help inmates go through a discharge planning process. However, many clients, including those with chronic mental health conditions, are often released too quickly to provide anything more than triage and emergency care, which perpetuates a process whereby individuals consistently cycle through the system. Even when inmates complete the discharge planning process and other programs CCDC offers, they are still responsible for making the plan actionable. CCDC cites a lack of community resources and shortage of providers (especially those that treat youthful offenders) in barriers to achieving "warm" hand offs upon release – that is, the transfer of patient care from CCDC to providers within the community. As such, it can be difficult to ensure that inmates continue treatment after release since there is little to no follow up procedures in place, which limits CCDC's impact.

2) CCDC faces an imbalance between available resources and the needs of the population. An estimated 25 to 30 percent of the inmate population has mental health needs. Given the large amount of inmates that cycle through the system in a calendar year (70,000), the detention center does not have the resources to provide comprehensive treatment to everyone and oftentimes can only administer emergency care for emergent needs. As such, CCDC recognizes that one challenge is to identify opportunities for diversion before inmates even reach booking. Diversion relates to identifying whether someone would be better suited to getting care for mental health issues as opposed to going to jail.



Provider Feedback

Summary of Biggest Challenges Facing the System

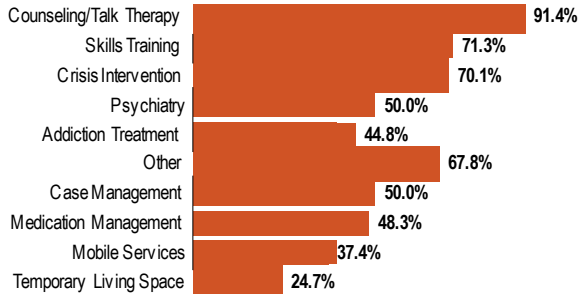
The following provides a brief summary of the major challenges facing the behavioral health community in Southern Nevada, which are very similar to the challenges encountered in 2016:

- Deficiency of providers to meet the sizeable demand in Southern Nevada, including lack of diversification to address cultural needs of the community
- Limited access to care and affordability of services/insurance copays
- Inadequate insurance reimbursement and difficult treatment approval processes
- Lack of funding and resources
- Limited affordable housing for people with severe illness and/or homeless
- Education, awareness and getting children care early

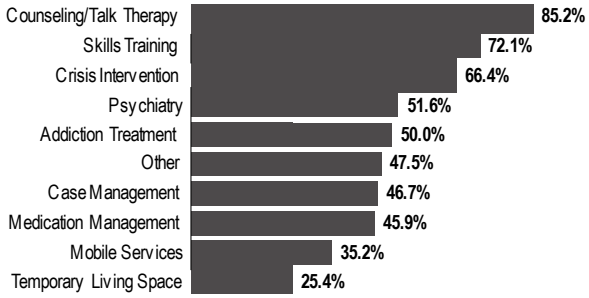
Provider Feedback
Community Behavioral Health Needs

The top three services that providers in Southern Nevada offer have remained the same between 2016 and 2021, with counseling and talk therapy comprising the majority of provided services (85.2 percent). The next most commonly offered services were skills training (72.1 percent) and crisis intervention (66.4 percent). Skills training includes social, academic, workplace, and other skills to help patients cope with their disorders while maintaining productive lives. Some commonly cited additional offerings included group therapy, family therapy and therapy related to autism/applied behavior analysis..

Proportion of Providers Offering Services
2016 Provider Survey



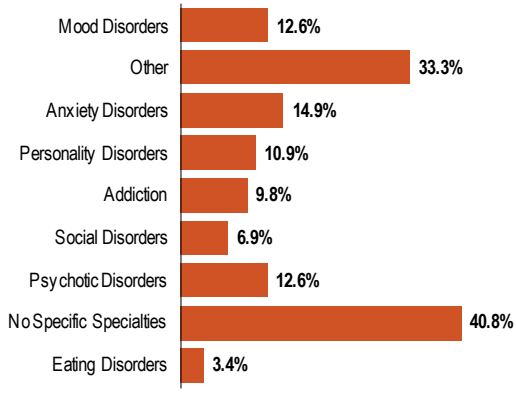
Proportion of Providers Offering Services
2021 Provider Survey



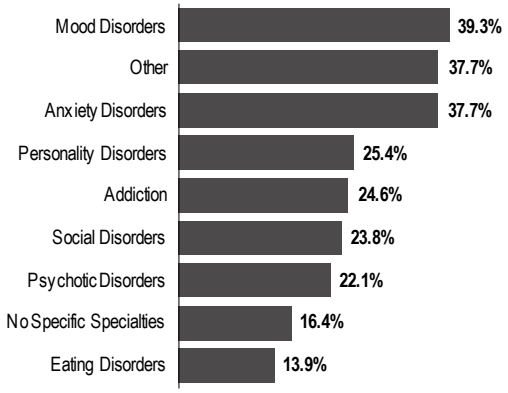
Source: Applied Analysis. N=122 Note: Multiple responses allowed, percentages reflect proportion of providers giving each response.

Provider Feedback
Community Behavioral Health Needs

Proportion of Providers Specializing in Disorder Types
2016 Provider Survey



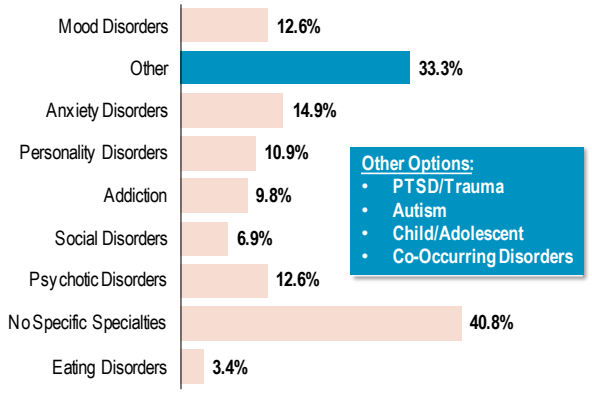
Proportion of Providers Specializing in Disorder Types
2021 Provider Survey



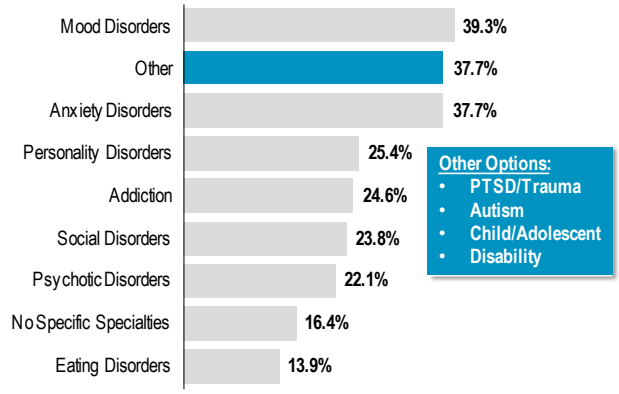
Source: Applied Analysis. N=122 Note: Multiple responses allowed, percentages reflect proportion of providers giving each response.

Provider Feedback
Community Behavioral Health Needs

Proportion of Providers Specializing in Disorder Types
2016 Provider Survey



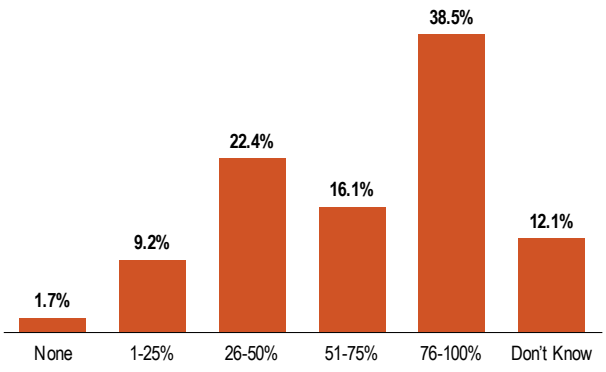
Proportion of Providers Specializing in Disorder Types
2021 Provider Survey



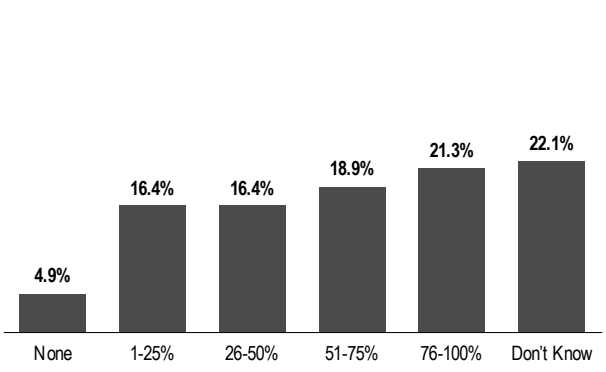
Source: Applied Analysis. N=122 Note: Multiple responses allowed, percentages reflect proportion of providers giving each response.

Provider Feedback
Community Behavioral Health Needs

Proportion of Patients on Medication
2016 Provider Survey



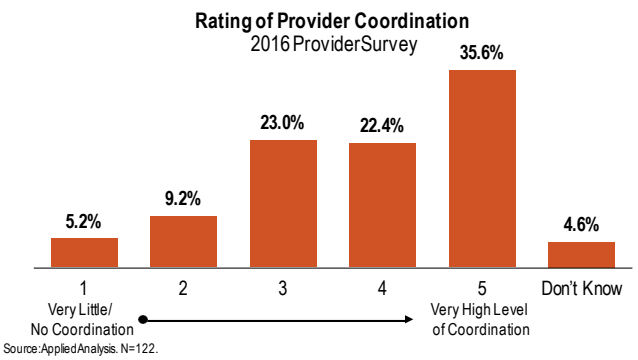
Proportion of Patients on Medication
2021 Provider Survey

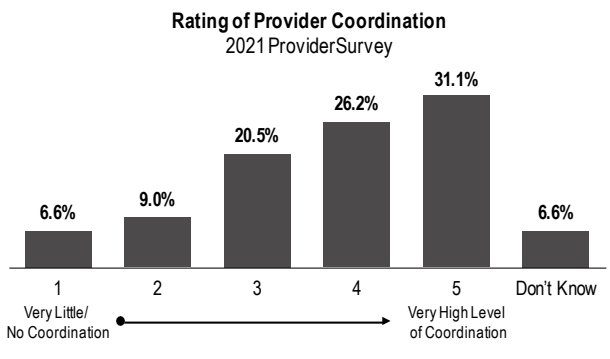


Source: Applied Analysis. N=122.

Provider Feedback
Coordination Between Providers

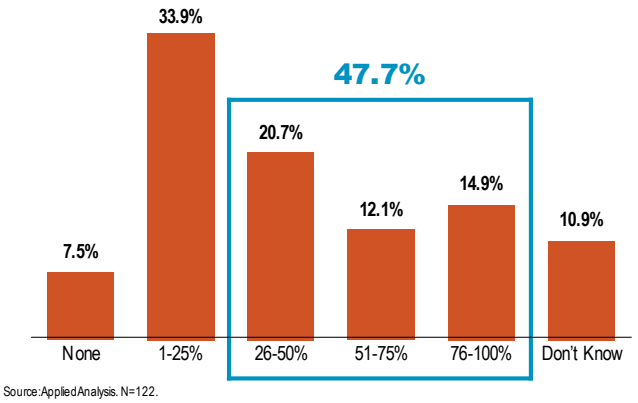
In both 2016 and 2021, providers rated care coordination in Southern Nevada as high, with 77.9 percent rating it at 3 or better. It is important to note that interviews with key stakeholders revealed that care coordination is still a major challenge in Nevada's mental health system. Certain measures have been introduced to try to improve coordination. For example, SB146, passed during the 2021 legislative session, requires inpatient psychiatric treatment facilities treating children to coordinate care with the child's health care provider. However, a significant barrier relates to billing, as care coordination (such as phone calls between providers) are not billable services, which deters some from the process.

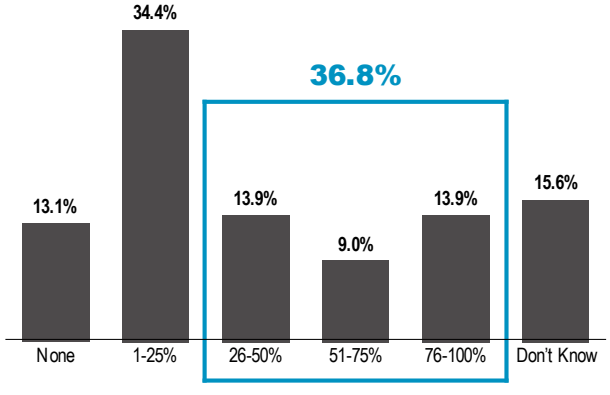




Source: Applied Analysis. N=122.

Provider Feedback
Co-Occurring Disorders



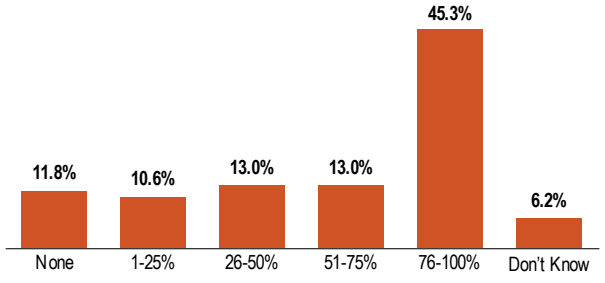


Source: Applied Analysis. N=122.

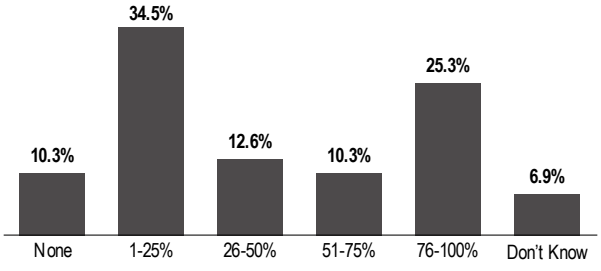
Provider Feedback
Co-Occurring Disorders

For providers that had patients with co-occurring disorders, treatment remained relatively dispersed. Approximately 25 percent of respondents indicated they treat 75 to 100 percent of patients with a co-occurring disorder for both issues. However, 34.5 percent of providers indicated that only 1-25 percent of these patients receive care from one provider. An additional 10.3 percent stated that they treat none of those patients for both their substance abuse issues and mental health disorders. This shift may be the result of providers becoming more specialized, necessitating a greater need for care coordination across providers.

Proportion Receiving Care for Co-Occurring Disorder at a Single Provider
2016 Provider Survey



Proportion Receiving Care for Co-Occurring Disorder at a Single Provider
2021 Provider Survey

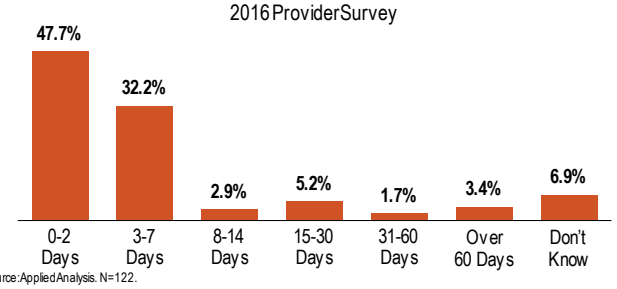


Source: Applied Analysis. N=87.

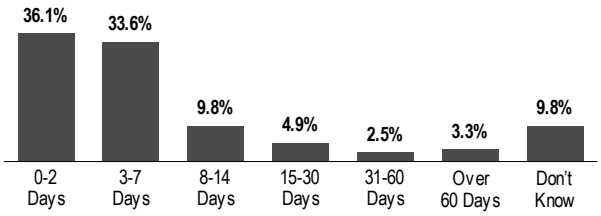
Provider Feedback
Responsiveness of the System

Almost 70 percent of survey respondents indicated that the wait time between a patient calling to make an appoint and the availability of one was within a week. However, a smaller portion of providers have immediate appointments available. Note, for example, that only 36.1 percent of respondents in 2021 had openings within 2 days, a nearly 12 percent decrease from 2016. Further, interviews with NAMI and the Behavioral Health Commission revealed that long wait times have been a chronic problem within the mental health system. Wait times were cited anywhere between 2-6 months pre-COVID (with longer times associated with psychiatrists) and 9-12 weeks for youth. Commonly cited barriers include insurance reimbursement rates and a lack of providers available to meet the demand. Specifically, variance in reimbursement rates among different insurance providers likely contribute to certain populations ability to quickly get appointments while other populations face greater difficulties and longer wait times.

Wait Time Between Call and Appointment Availability
2016 Provider Survey



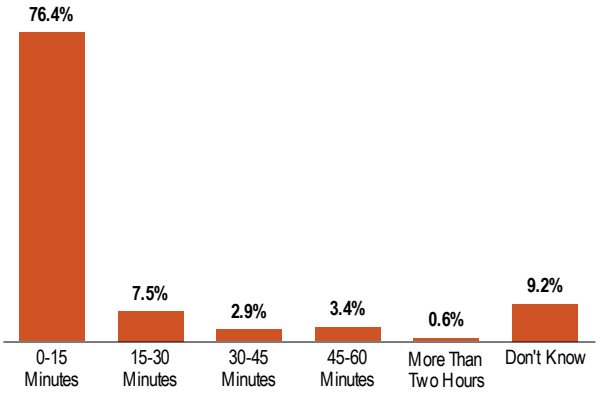
Wait Time Between Call and Appointment Availability
2021 Provider Survey



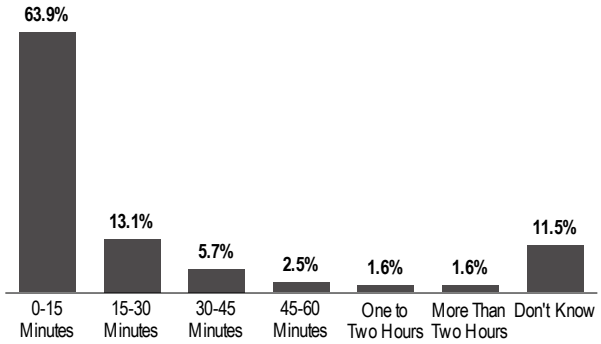
Source: Applied Analysis. N=122.

Provider Feedback
Responsiveness of the System

Wait Time Between Office Arrival & Treatment
2016 Provider Survey



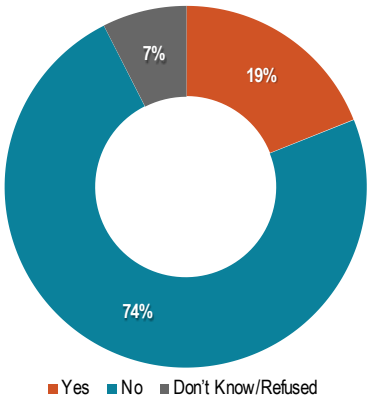
Wait Time Between Office Arrival & Treatment
2021 Provider Survey



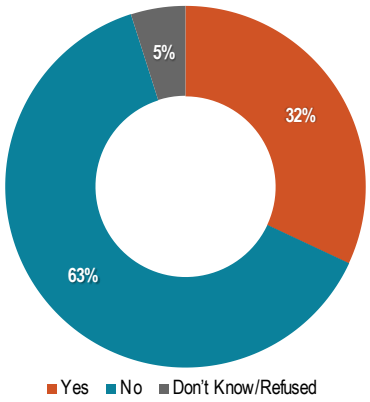
Source: Applied Analysis. N=122.

Provider Feedback
Funding Considerations

Funding Sources Beyond Patient Fees
2016 Provider Survey



Funding Sources Beyond Patient Fees
2021 Provider Survey

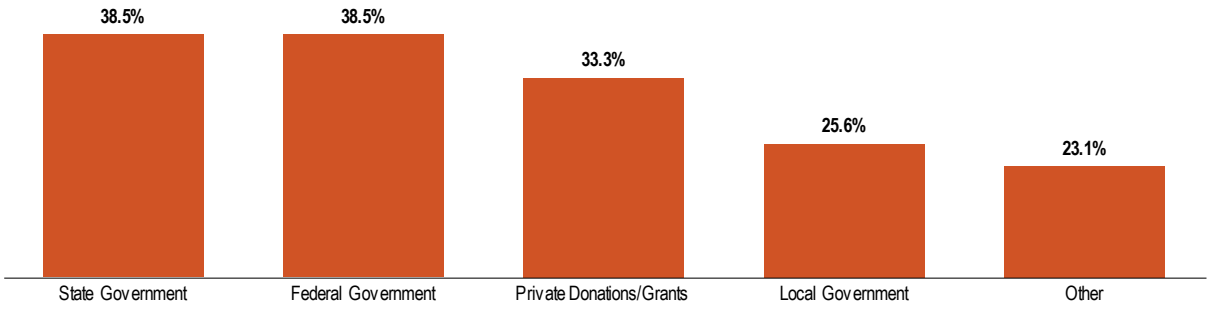


Source: Applied Analysis. N=122.

Provider Feedback
Funding Considerations

A greater portion of providers receive funding beyond patient fees (which includes insurance billing) than in 2016, with 32 percent indicating that other sources act as revenue sources. Unlike in 2016, where the majority of other funding came from private donations, providers in 2021 appear to receive revenue from a variety of sources outside of private donations including local, state and federal government.

Other Funding Sources
2021 Provider Survey

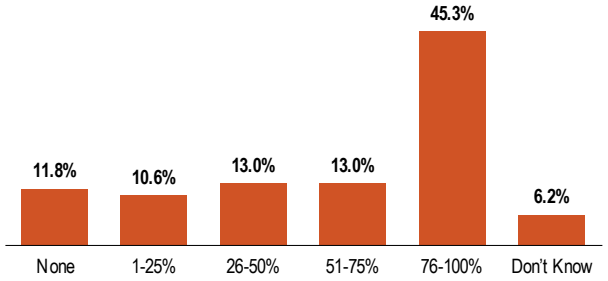


Source: Applied Analysis. N=39 Note: Multiple responses allowed.

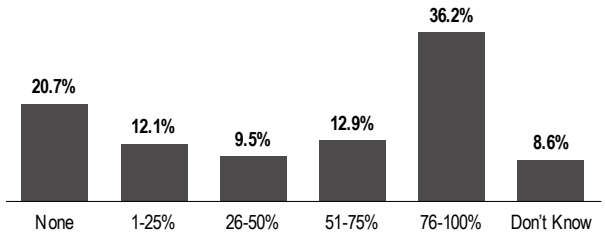
Provider Feedback
Funding Considerations

While some providers receive direct government funding or private donations to help pay for their services, the vast majority rely on patient fees for most of their revenue. However, indirect government funding through programs such as Medicaid allow large numbers of people to access care. Over 36 percent of providers who responded stated that between 75 percent and 100 percent of their patients pay for services through Medicaid, while 71 percent of providers responded that at least some of their patients are covered by Medicaid. Notably, more than 1 out of 5 providers indicated that none of their patients were on Medicaid, a much greater share than what was seen in 2016, where only a little more than 1 out of 10 providers had no Medicaid patients.

Proportion of Patients on Medicaid
2016 Provider Survey



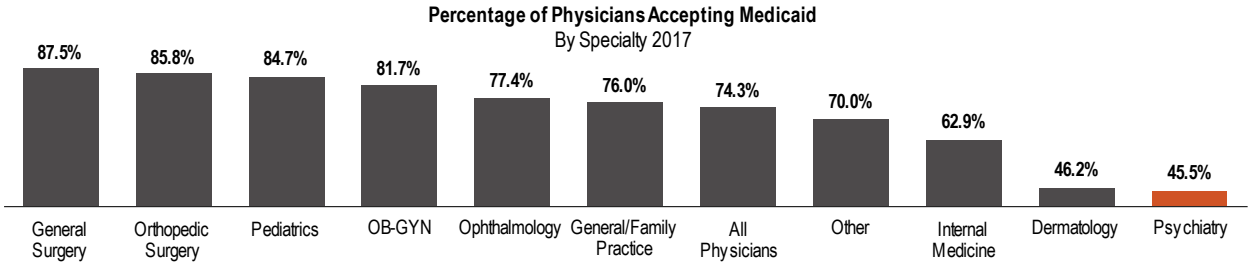
Proportion of Patients on Medicaid
2021 Provider Survey



Source: Applied Analysis. N=122.

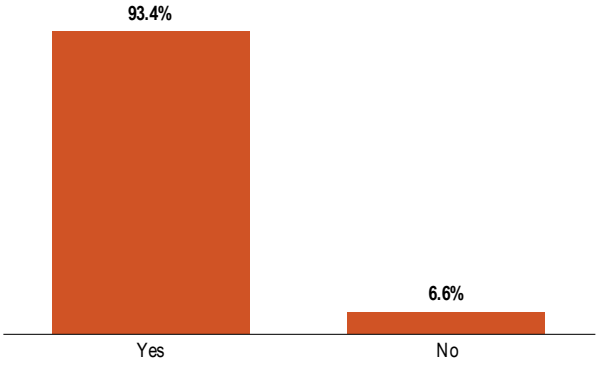
Provider Feedback
Funding Considerations

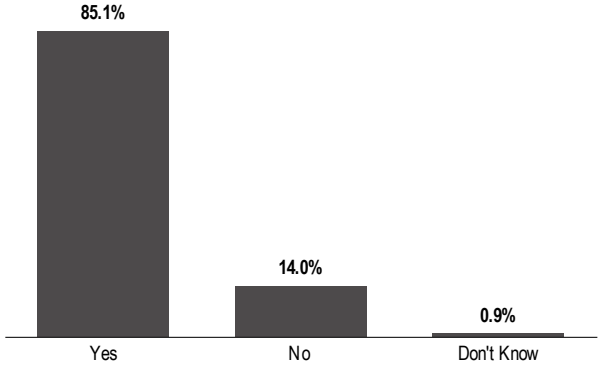
Although the Medicaid expansionallowed a greater proportion of individuals to receive insurance coverage,the Southern Nevadamental health industry has encountered a separate, butrelated challenge.As indicated by the provider surveya larger proportion ofproviders haveno Medicaid patients. One reason forthis stems from reimbursement rates, which have been commonly cited as low in Nevada.As a result, many providershave simply stopped accepting Medicaid as a form of payment, which leaves marginalized patients without adequate care options. This problem appearsto be widespreadacross the United States. A study by the Medicaid and CHIP Payment and Access Commission (MACPAC)in 2021 found that all types of providers wereless likely to accept new patients covered byMedicaid than those covered byother insurance types(private,Medicare,etc.). Psychiatrists accepted new Medicaid patients at a rate almost two times lower than the average across all physicians. However,it is also worth noting that for all physicians, Nevadaaccepted Medicaid patients at a higher rate than the average (79.9percent in Nevadaversus74.0 percent United States average).



Source:MACPAC. Note:2017wasmost recentavailabledata.

Provider Feedback
Impact of COVID-19



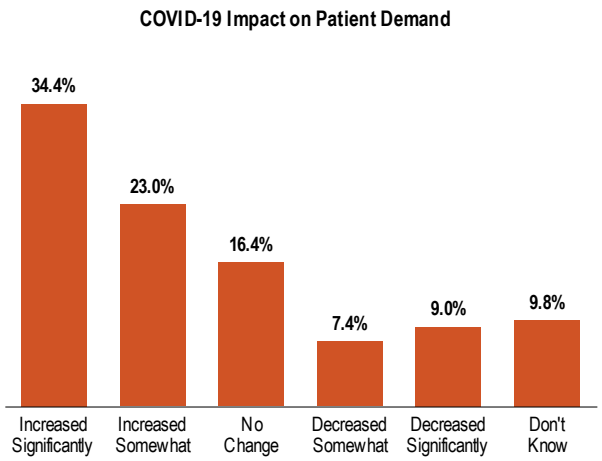


Source:Applied Analysis. N=122fortelehealthavailability andN=114foroffered because ofCOVID-19.

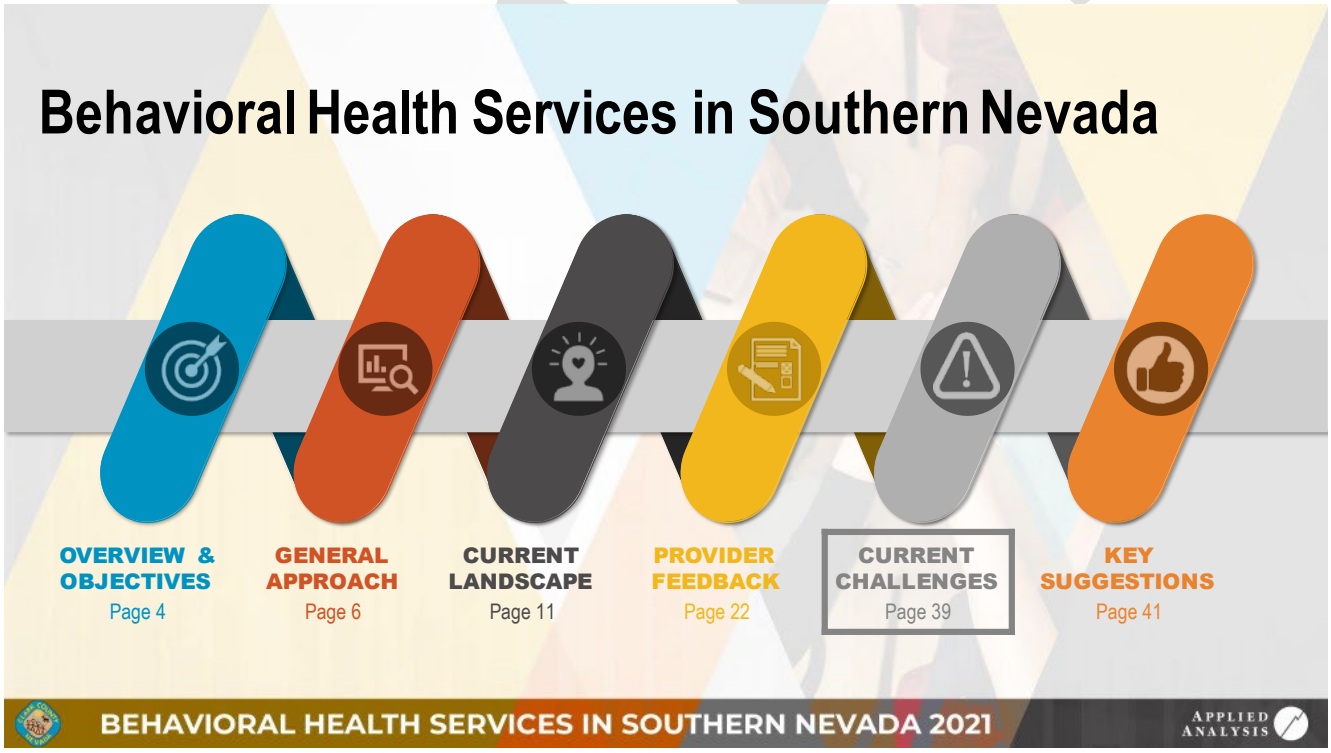
Provider Feedback
Impact of COVID-19

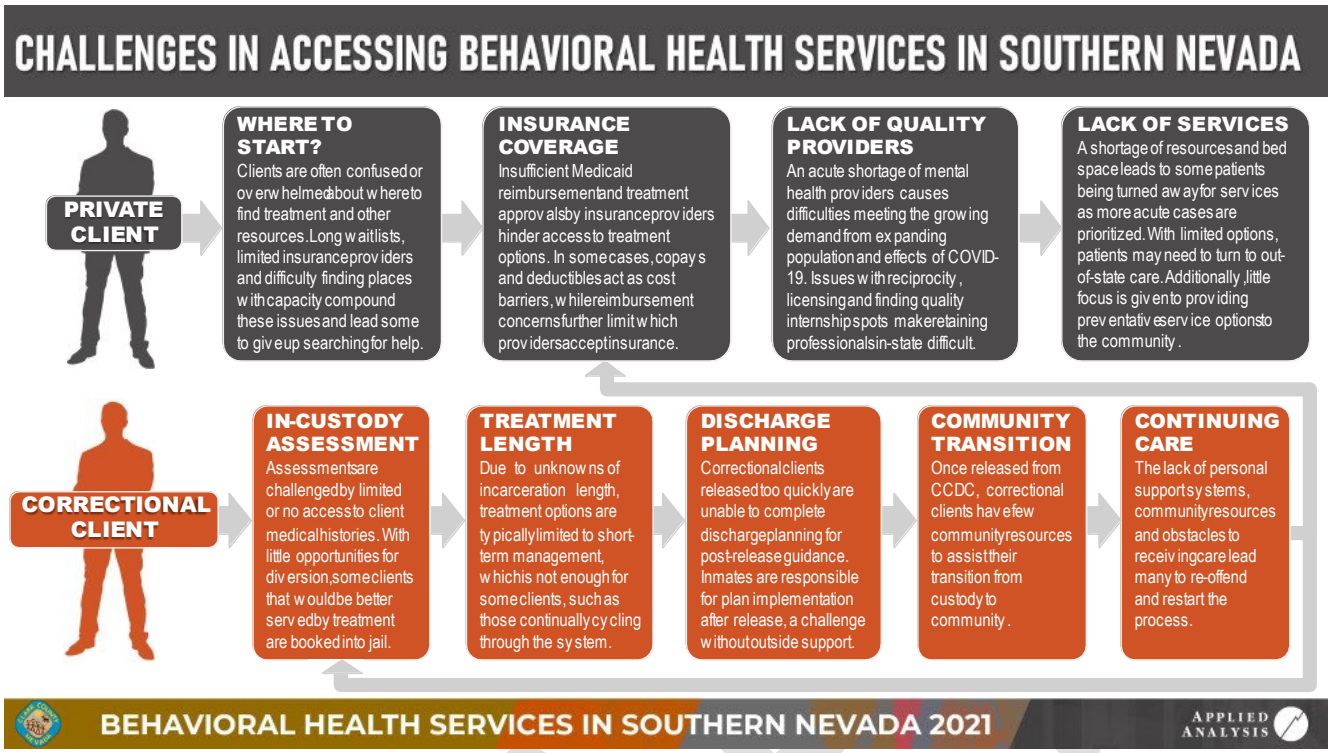
The COVID19 pandemic has increased the demand for mental health services in Southern Nevada. Nearly 60 percent of respondents indicated that demand had increased and 34.4 percent indicated that demand increased significantly. Along with increasing demand, numerous other impacts of the pandemic were relayed during interviews. One unexpected consequence related to accessibility. The rise of telehealth as a result of lockdowns helped improve access to care issues for rural areas and other vulnerable populations (such as those with transportation issues). However,technological access, availability of internet and decreased privacy during at-home treatment for both adults and children were also identified as downsides to increasing telehealth services. Moving forward, expanded service options that include both in-person and telehealth will be important to continue addressing historic access issues.

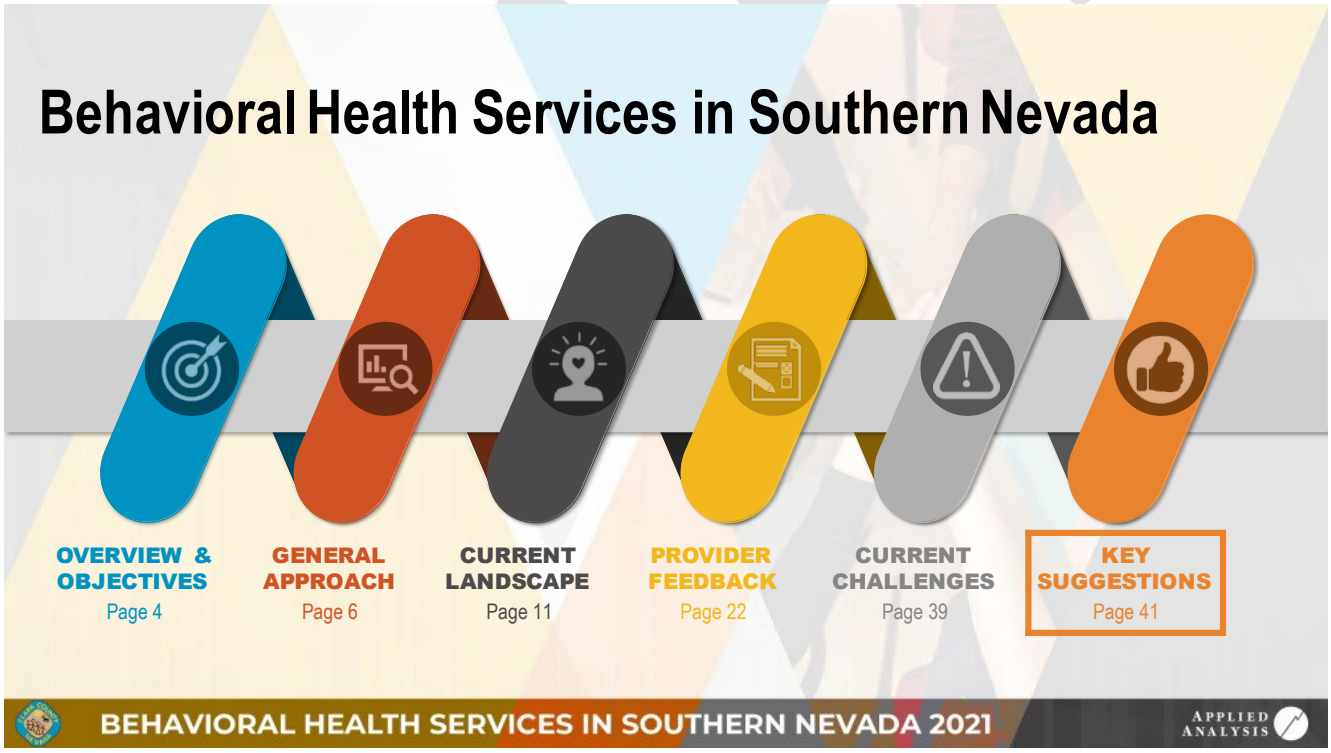
Specifically for children and adolescents, providers recognized that large cohorts of historically disadvantaged patients (those struggling the most, with the least access and without adequate support systems) were "lost in the system" during the pandemic. When schools closed, not only were the main source for reports/suspicions of abuse/neglect impacted, but children were considered withdrawn after failing to log into virtual classrooms for 10 days. The combination of these two factors posed and continue to pose challenges for child and adolescent providers.



Source: Applied Analysis. N=122.




CHALLENGES IN ACCESSING BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA
PRIVATE CLIENT
WHERE TO START?
Clients are often confused or overwhelmed about where to find treatment and other resources. Long waitlists, limited insurance providers and difficulty finding places with capacity compound these issues and lead some to give up searching for help.
INSURANCE COVERAGE
Insufficient Medicaid reimbursement and treatment approvals by insurance providers hinder access to treatment options. In some cases, copays and deductibles act as cost barriers, while reimbursement concerns further limit which providers accept insurance.
LACK OF QUALITY PROVIDERS
An acute shortage of mental health providers causes difficulties meeting the growing demand from expanding population and effects of COVID-19. Issues with reciprocity, licensing and finding quality internship spots make retaining professionals in-state difficult.
LACK OF SERVICES
A shortage of resources and bed space leads to some patients being turned away for services as more acute cases are prioritized. With limited options, patients may need to turn to out-of-state care. Additionally, little focus is given to providing preventative service options to the community.
CORRECTIONAL CLIENT
IN-CUSTODY ASSESSMENT
Assessments are challenged by limited or no access to client medical histories. With little opportunities for diversion, some clients that would be better served by treatment are booked into jail.
TREATMENT LENGTH
Due to unknowns of incarceration length, treatment options are typically limited to short-term management, which is not enough for some clients, such as those continually cycling through the system.
DISCHARGE PLANNING
Correctional clients released too quickly are unable to complete discharge planning for post-release guidance. Inmates are responsible for plan implementation after release, a challenge without outside support.
COMMUNITY TRANSITION
Once released from CCDC, correctional clients have few community resources to assist their transition from custody to community.
CONTINUING CARE
The lack of personal support systems, community resources and obstacles to receiving care lead many to re-offend and restart the process.
BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021
APPLIED ANALYSIS


Behavioral Health Services in Southern Nevada
OVERVIEW & OBJECTIVES
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Page 6
CURRENT LANDSCAPE
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PROVIDER FEEDBACK
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CURRENT CHALLENGES
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KEY SUGGESTIONS
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BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021
APPLIED ANALYSIS

Key Areas Identified for Long-Term Success
Structural Improvements

The feedback from service providers and stakeholders resulted in a number of possible "fixes" to the system, including several that were commonly identified. These most notable areas for improvements fall generally into two categories: (1) structural investments to improve the foundation of the system and (2) modifications to improve the effectiveness of the existing system. The structural changes involve increased resources, such as building more facilities with inpatient capacity, recruiting and training additional medical professionals to fill the existing need, and increasing funding for treatment programs.

Key Areas Identified for Long-Term Success
Structural Improvements

There were several areas of concern identified by providers as lacking in Southern Nevada's behavioral health system related to mental health infrastructure:

1) There is not enough system capacity to meet the growing demands of the community. With months long wait lists, a lack of available beds, limited diverse and culturally component providers and difficulties finding providers that accept certain insurance types, getting access to appropriate services is becoming more and more challenging. As identified by officials at CCDC, once inmates are released, especially youthful offenders, there are limited resources and programs available to assist in following a discharge plan. A decrease of the total supply of beds for psychiatric care in recent years is likely exacerbating this problem. Overall, it appears that there are significant demands for services and programs, both inpatient and outpatient, that remain unmet.

2) Another system-wide issue identified by providers and stakeholders was the focus on short-term stability rather than long-term care. CCDC indicated that long-term planning is often impossible given the uncertainty surrounding the length of stay for many inmates and emergency management is the best that can be offered in many circumstances. Hospitals treating patients in the midst of a crisis cannot detain patients once the crisis period subsides, particularly if they don't have the resources for extended care without payment from the patient. Short-term treatment helps to avoid crises and tragedy, but the lack of long-term observation and treatment made possible by additional inpatient capacity increases the likelihood that patients experience repeated crisis situations that place acute stress on the existing system. Further, there is not a robust system in place aimed at prevention, early identification and referral care for clients not experiencing immediate mental health issues. Implementation of long-term prevention strategies could help reduce the escalation of mental health conditions overall, but system improvements in reimbursement for these types of services and care coordination between providers would be important in successful implementation.

Key Areas Identified for Long-Term Success
Structural Improvements

GROWING THE POOL OF MEDICAL PROFESSIONALS

Clark County and the state of Nevada have long had shortages of doctors across many specialties. One of the areas with the most severe shortage is the field of psychiatry, but the need for mental health professionals is not solely limited to doctors. Counselors, therapists, psychologists and social workers are also important component of the system. In order to provide wraparound care, there needs to be an adequate supply of all types of mental health and substance abuse professionals that can coordinate care with one another. Efforts are being made to help alleviate this shortage, such as the creation of the UNLV School of Medicine, the development of the Las Vegas Medical District, and expanding graduate medical education programs, which appear to be helping retention rates of professionals within the state. CCDC has also recently started an internship program for social workers and is in the process of creating other partnerships aimed at developing mental health professionals. However, there is still very clearly a severe shortage of mental health and substance abuse professionals within the state, as a lack of providers within the community was one of the most commonly cited issues to the current system. Although many simply state a need to increase the number of providers, several solutions were identified by providers:

1) Creating more facilities and programs offering quality internship education and training to mental health professionals for licensure. It was speculated throughout interviews with different providers that similar to how the presence of medical schools increases retention rates of doctors in-state, creating more mental health and substance abuse educational training facilities and internship sites would offer similar benefits for retention and workforce development to Clark County.
2) Financial or other incentives offered during higher education or post-graduation encouraging mental health professionals to remain in state and work in high-need areas such as Clark County.
3) Improvement of reciprocity between states for providers coming into Nevada, which is currently a difficult process that causes challenges in recruiting out-of-state professionals.

Key Areas Identified for Long-Term Success
Structural Improvements

TARGETED FUNDING INCREASES

Also among the most commonly cited issue for improvement to the behavioral health system were targeted funding increases. While money is not always the answer, there are a number of ways that greater funding may improve the mental and behavioral health system in Clark County:

1) Additional Medicaid funding to increase reimbursements for treatment was identified by providers as a potential benefit. Survey respondents indicated that a significant number of patients rely on Medicaid for care, and additional funding could potentially alleviate issues in the treatment approval process or raise low reimbursement rates for service providers. Poor reimbursement rates create sustainability challenges for organizations and providers and has led to some refusing to accept certain insurance types at all, limiting access to care for certain groups of vulnerable populations. Further, since many insurance companies base their reimbursement on Medicaid rates, improvements in Medicaid reimbursement could create positive ripple effects across the whole system.
2) Recruitment strategies associated with increasing the mental health and substance abuse professional workforce also require funding. Creating new training programs, whether by building new facilities, expanding existing facilities, or other methods, will require investment either at the public or private level. Developing incentives for trained professionals within the mental health field will also require funding to be successful. Further, shifting the focus from short- to long-term treatment, including prevention efforts, would require that providers have the resources to effectively provide such care in a sustainable fashion. In some cases, additional investment in targeted areas can ultimately save money in others. Note, for example, that investing in preventative care can generate a positive return on investment by reducing costs throughout the system that might otherwise had been incurred. Similarly, Harris County, Texas operates a mental health diversion center that has prevented 3,000 people from going to jail and cycling through the system. Allocating additional resources to a problem by itself is rarely a solution, but targeted expenses can have important impacts and should be considered.

Key Areas Identified for Long-Term Success
Existing System Improvements

While many of the structural changes would require cooperation between local, state, and possibly federal efforts along with contribution from private industry, there are improvements that may be more within local control. Awareness was a key focus area of respondents and stakeholders, along with requiring improvement in the transitional services processes.

INCREASED AWARENESS & MASS EDUCATION

TRANSITIONAL SERVICE IMPROVEMENT & CARE COORDINATION

Key Areas Identified for Long-Term Success
Existing System Improvements

INCREASED AWARENESS & MASS EDUCATION

Awareness is not limited to awareness of the significance of mental health issues in the community. Awareness also applies to helping people recognize the signs of mental illness in order to better understand when to seek out help for themselves and others as well as increasing awareness of the available resources so that individuals seeking help can find it more easily. Among the existing system improvements that would be benefit Clark County are the following:

1) Normalize the concept of mental health and mental health treatment in the community. As providers indicated through the process, stigma surrounding mental health is still very widespread. While the younger generation appears to be becoming more accepting of mental health overall, there is still a large portion of individuals that carry negative perceptions and therefore refuse to get treatment for themselves or their children for fear of how others might react or perceive them. This stigma is even reflected within insurance providers. One interviewee pointed out that some insurance plans in Clark County still do not recognize mental health parity and will not cover treatment for their members.

2) Mass education about the importance of mental health. Providers emphasized on multiple occasions that it is important to convey to the public that mental health is just as important, and just as common, as physical health and can have systemic effects on all aspects of a person's wellbeing. It will be important to come up with creative solutions that educate the public but also circulate through the school system, businesses and employers and multiple industries.

Key Areas Identified for Long-Term Success

Existing System Improvements

1) In many ways, expanding transitional services relates to the awareness issue. Transitional services are most important for individuals with mental health issues that end up in jails or are held involuntarily at hospitals under the Legal 2000 process, which allow s law enforcement and medical professionals to hold individuals for up to 72 hours if deemed a danger to themselves or others. Often times these individuals do not have good personal support systems to assist them upon their release from either the hospital or jail. This makes it significantly more likely that they re-offend or fall back into a crisis and flow through the system once more without making any progress. In addition to continuing the Crisis Intervention Training program of its officers, CCDC recognizes and is working on implementing improved discharge planning processes to assist inmates upon their release. The detention center now offers certain programs to inmates that allow s them to connect with a variety of community resources before transitioning to release. Among the services offered including help applying for IDs, assistance for low-income housing, job searching and connecting with mental health providers, among others. Additional advancements such as those to either divert the mentally ill from the correctional system or provide greater case management following release from jail could reduce recidivism among the mental health population and allow correctional officers to focus on more serious criminals.

2) Improved care coordination among providers is still a pressing issue. However, certain services have already been developed or are in the process of being developed that are designed to improve networking among professionals. For example, the Department of Children and Family Services operates Know Crisis, a mobile crisis response team that is available 24/7 and can connect children and families to mental health resources, although the system is limited in terms of associated providers. While this is a step in the right direction, providers recognized the need for expansion of these types of services to create a centralized mental health line that would connect all Nevada residents with all service providers in the state. The implementation of the 988 national mental health crisis line, expected to be rolled out in July 2022, may provide an avenue for this in the future.

Study Limitations and Key Considerations

While the analysis contained in this briefing report provides an assessment of the mental and behavioral health system in Clark County, there are limitations to the data collected. While a significant number of providers participated in the survey process, many were unable to be reached or declined to participate. While the results of the analysis are representative of the industry, sampling variations and individual responses can impact aggregated results.

As a result, various stakeholders beyond the survey sample were contacted directly to provide insight into aspects of the system to supplement the provider survey. These stakeholders included non-profit advocacy groups such as the Nevada chapter of the National Alliance on Mental Illness and law enforcement organizations (e.g., Las Vegas Metropolitan Police Department and Clark County Detention Center). Combining the insights provided by these stakeholders with data obtained through the provider survey were important to not only provide perspective for the survey, but also to corroborate the data and potentially identify any significant discrepancies in the survey data.

As social, economic, and governmental circumstances change throughout not only Clark County but also the state of Nevada and the United States, the mental and behavioral health needs of the community and the resources available change as well. For this reason, the findings of this report and recommendations made as a result of the analytical process reflect a specific period of time and set of circumstances and are therefore intended only to apply as such.

APPENDIX: SERVICE PROVIDER SURVEY

Research Methodology

General Approach: Survey service providers within the behavioral health services field in Clark County, Nevada to obtain insight on a number of topics, including services provided, patient needs and other relevant topics.

Survey Parameters:

Timeframe: September 2021

Method: Telephone survey

Requirements: Providers must treat patients with mental or behavioral health issues

Sample Frame: 6,300+ potential providers obtained from a wide range of public databases

No. of Respondents: 122

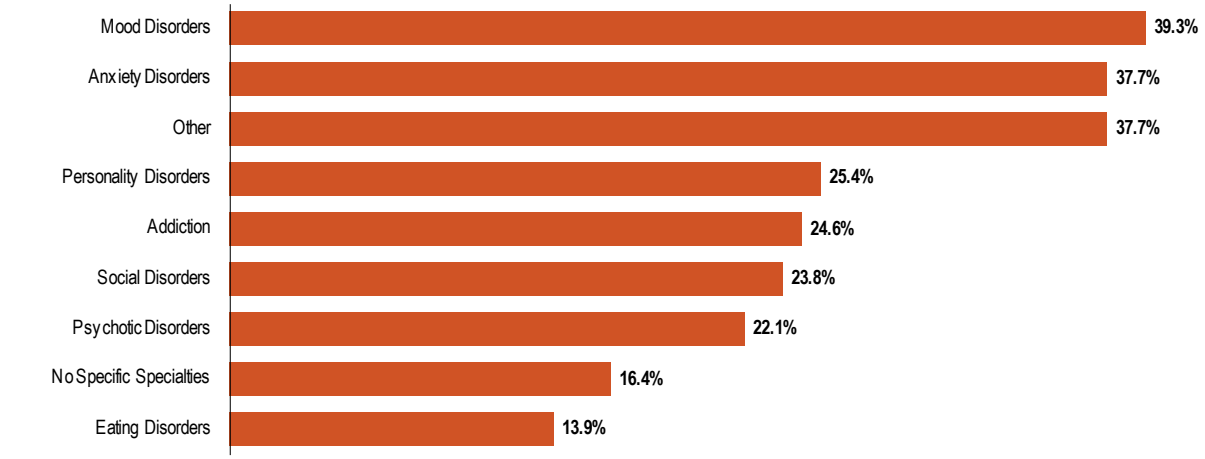
Confidence Interval: 95%

Margin of Error: ±7%

Limitations: Although a number of steps were taken before, during and after the survey process to limit research bias and to ensure the meaningfulness of the results generated, any primary research project of this nature will have some limitations. These limitations should be considered in the evaluation of the findings provided herein.

RESULTS:
TYPES OF PROVIDERS/ SERVICES PROVIDED

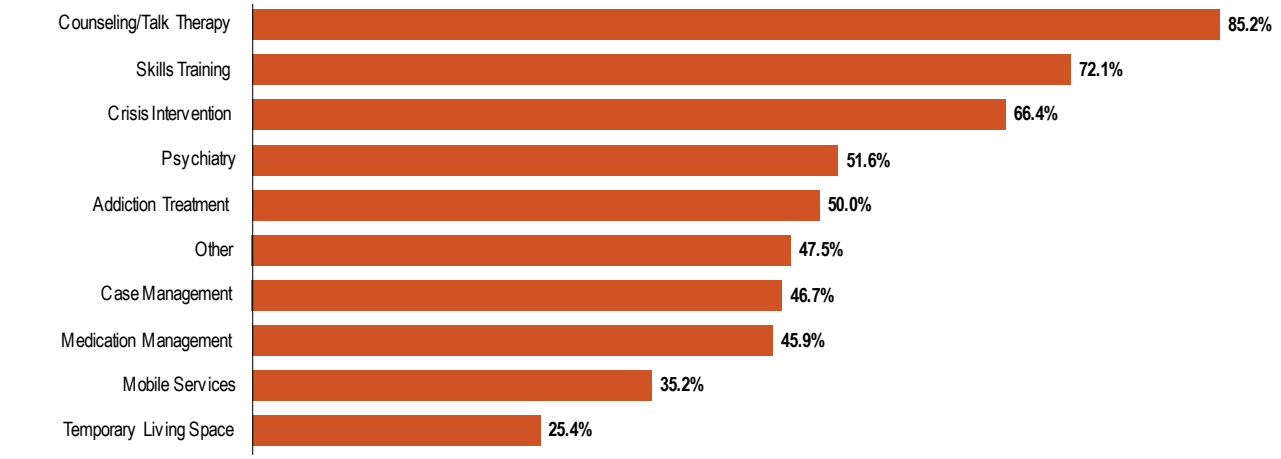
Disorders Treated
Provider Specialties



Source: Applied Analysis. N=122 Note: Multiple responses allowed.

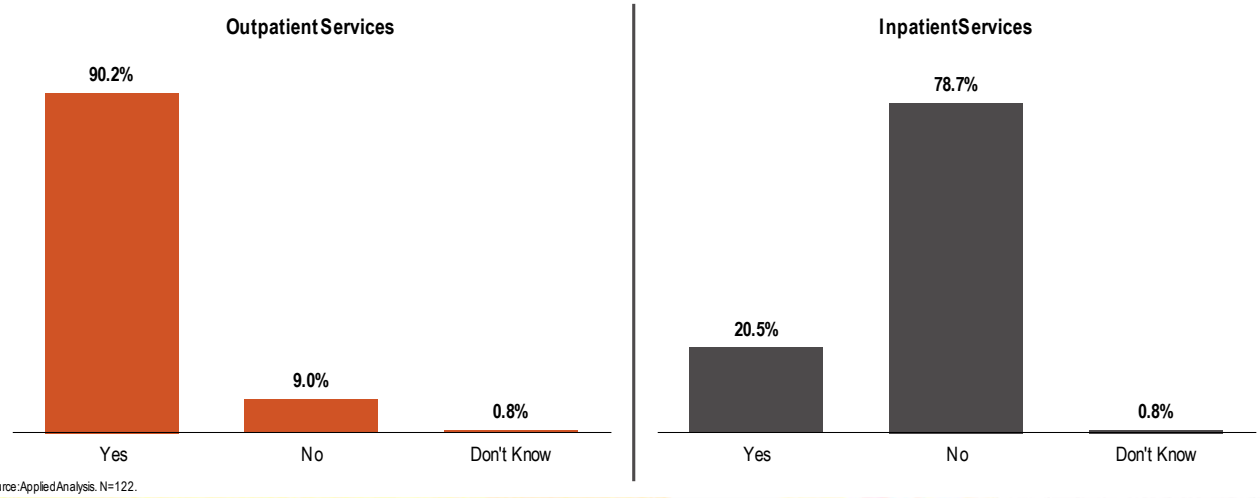
BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021
APPLIED ANALYSIS

Services Provided
Types of Services



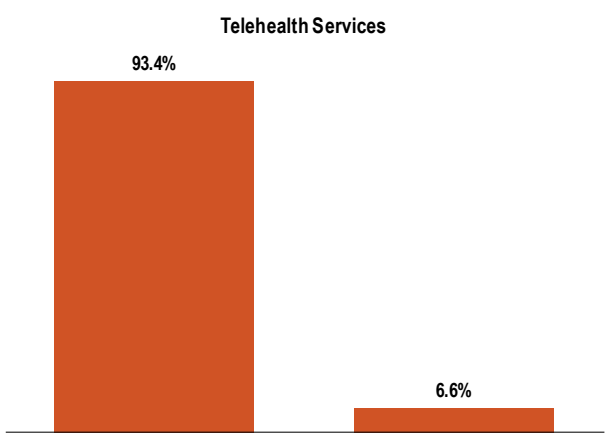
Source: Applied Analysis. N=122. Note: Multiple responses allowed.

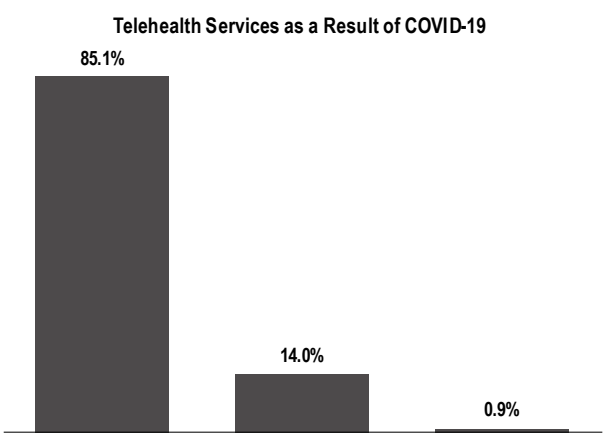
Services Provided
Inpatient & Outpatient Services



Source: Applied Analysis. N=122.

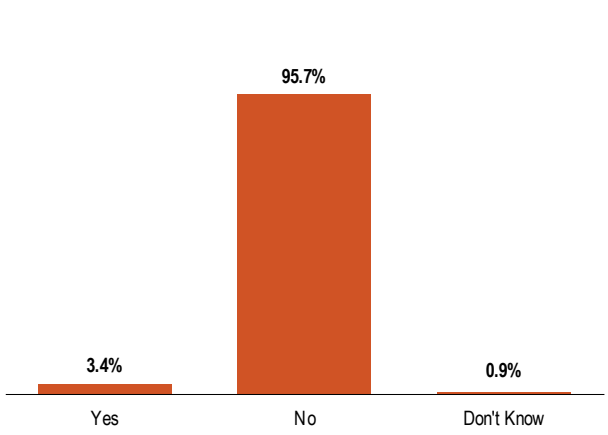
Services Provided
Telehealth

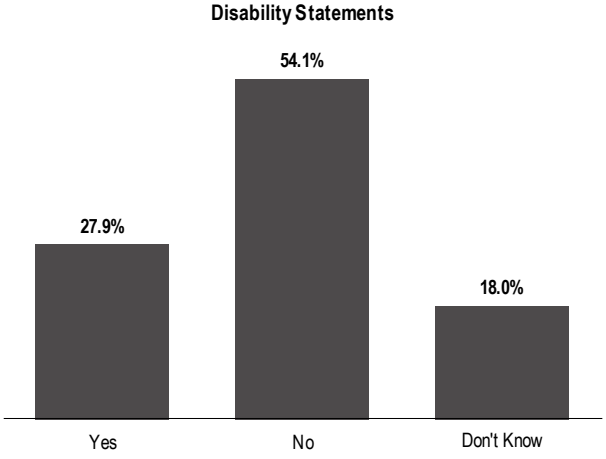




Source: Applied Analysis. N=122 for telehealth services, N=114 for whether telehealth services were the result of COVID-19.

Services Provided
Miscellaneous Services





Source: Applied Analysis. N=116 for free services, N=122 for disability statements Note: Respondents were only asked about free services if they indicated that all patients do not use any of the provided payment for services.

Classification of Providers & Respondents

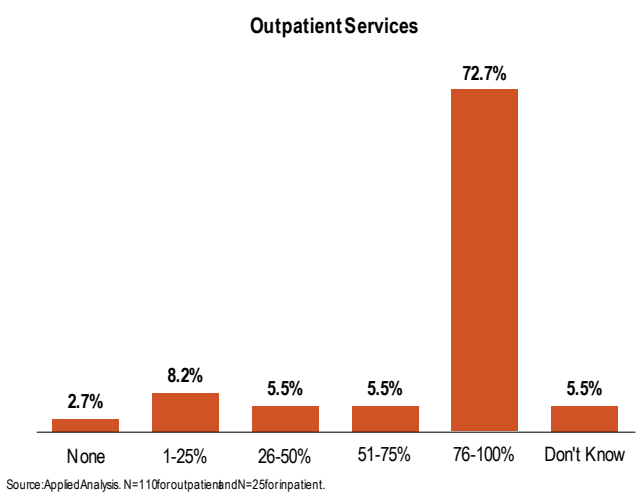
Classification	No. of Respondents	Distribution
Behavioral Technician/Analyst	26	21.3%
Social Worker (Clinical and Other)	18	14.8%
Counselor (Addiction, Clinical and Other)	14	11.5%
Behavioral Health Treatment Group	10	8.2%
Marriage and Family Therapist	10	8.2%
Psychology/PsychologicalAssistant	8	6.6%
Psychiatry/PsychiatricNurse	7	5.7%
Qualified Behavioral Aide (QBA)	7	5.7%
Qualified Mental Health Professional (QMHP)	6	4.9%
Qualified Mental Health Associate (QMHA)	4	3.3%
Not Listed	3	2.5%
Community/Behavioral Health Agency	2	1.6%
Mental Health Services	2	1.6%
Applied Behavioral Analysis (ABA) Group	1	0.8%
Federally Qualified Health Center	1	0.8%
Physician Group (Type 20)	1	0.8%
Psychiatric Hospital, Inpatient	1	0.8%
Rural Health Clinic	1	0.8%
Total	**122**	**100.0%**

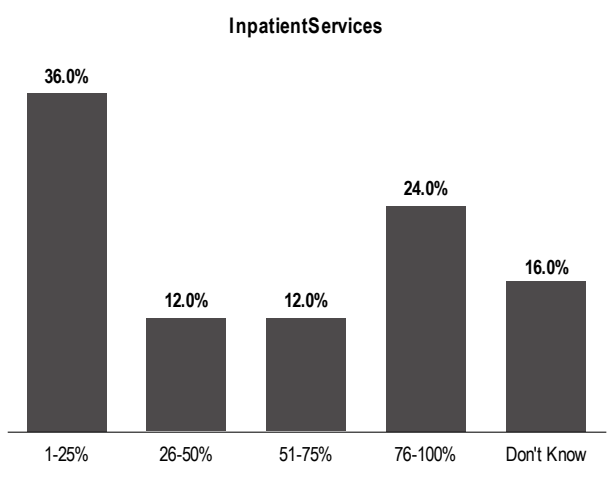
Note: Classifications are sourced to public databases. However, classifications were broadly grouped where applicable.

RESULTS: PATIENT NEEDS

BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021 APPLIED ANALYSIS

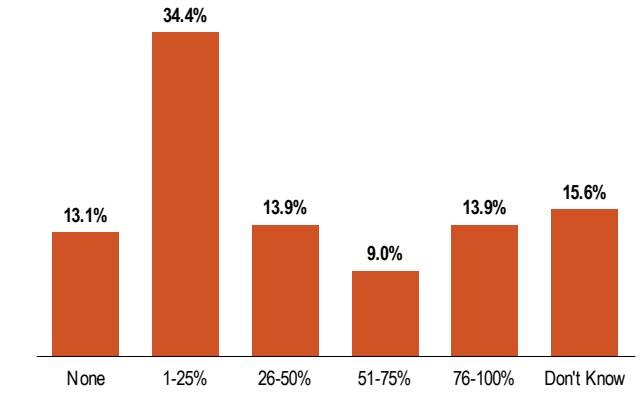
Outpatient vs. Inpatient
Proportion of Patients Needing Services

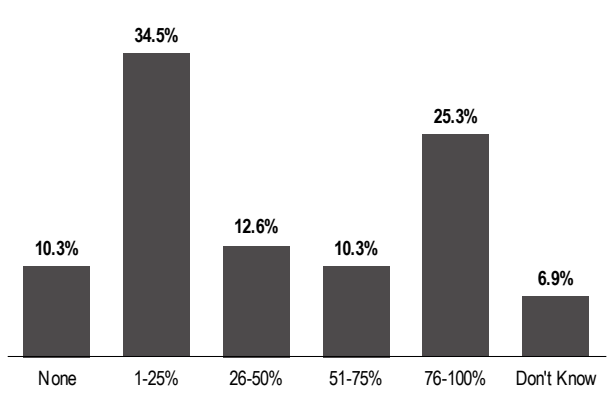




Source: Applied Analysis. N=110 for outpatient and N=25 for inpatient.

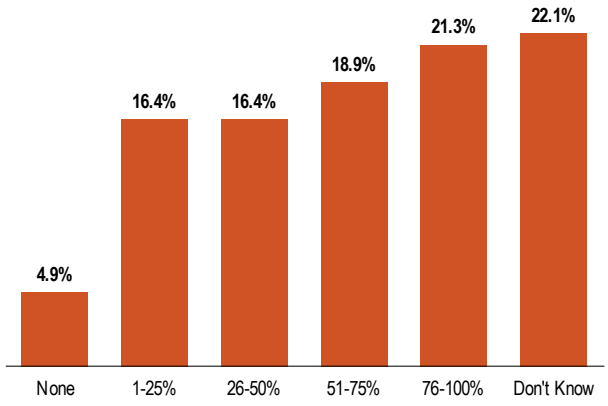
Outpatient vs. Inpatient
Substance Abuse and Mental Disorders

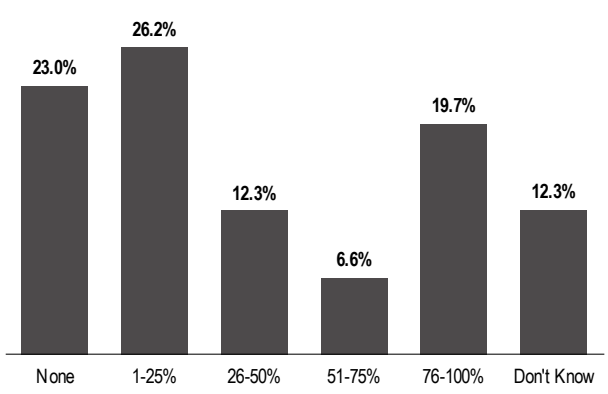




Source: Applied Analysis. N=122 for occurrence and N=87 for treatment.

Outpatient vs. Inpatient
Medication and Case Management



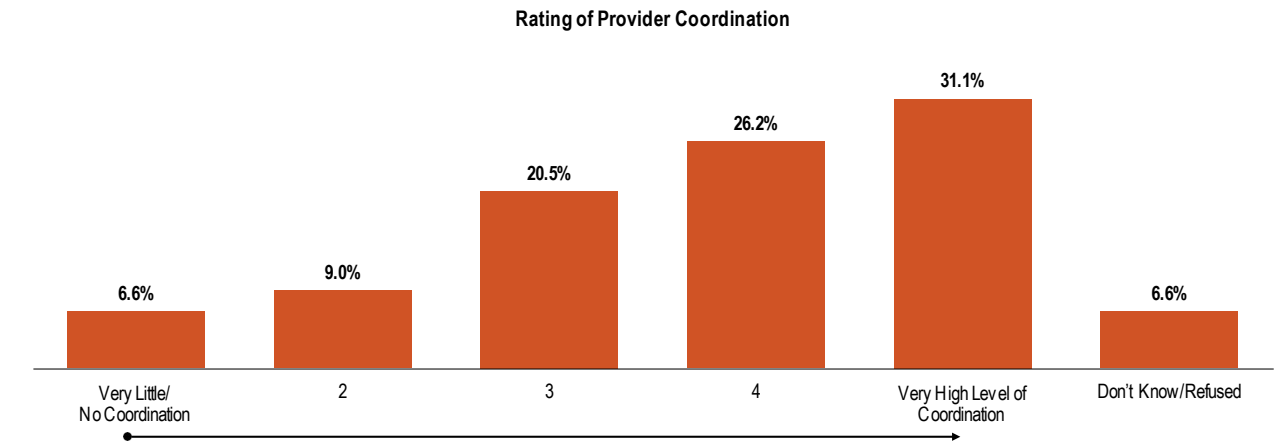


Source: Applied Analysis. N=122.

RESULTS: ACCESS AND EFFECTIVENESS

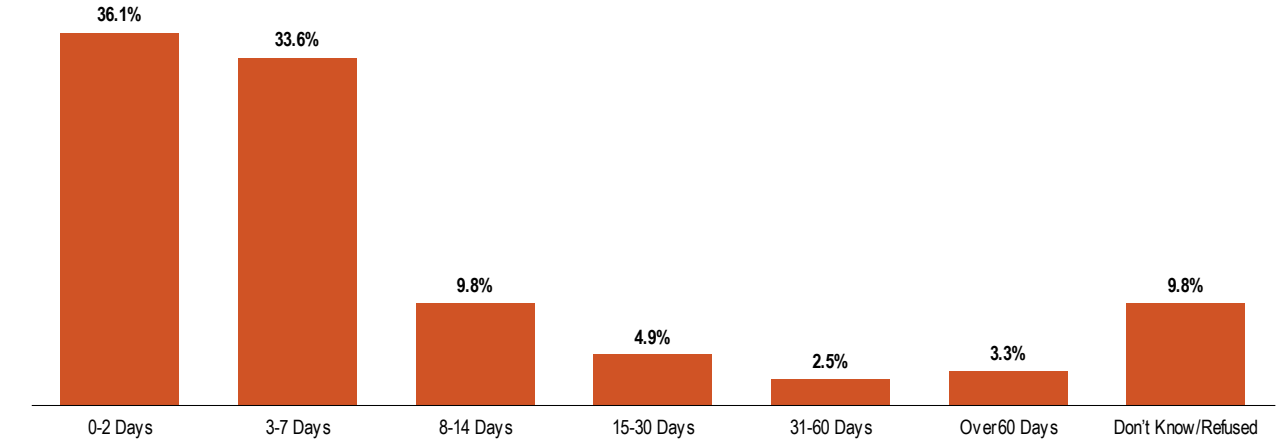
BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021

Coordination Between Providers
Treating Patients for Multiple Disorders



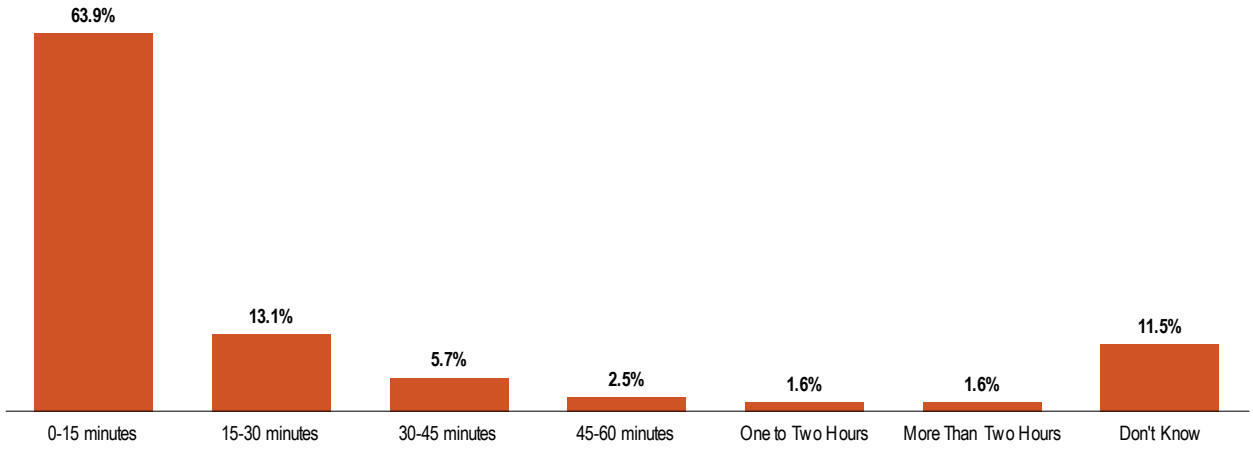
Source: Applied Analysis. N=122.

Waiting Times
Between Call and Appointment Availability



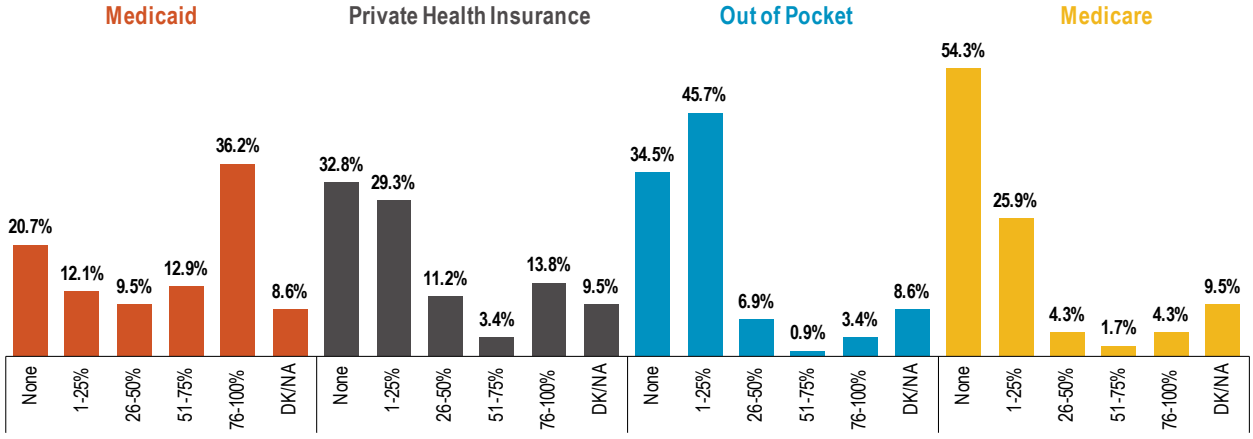
Source: Applied Analysis. N=122.

Waiting Times
Between Arrival at Office and Receiving Care



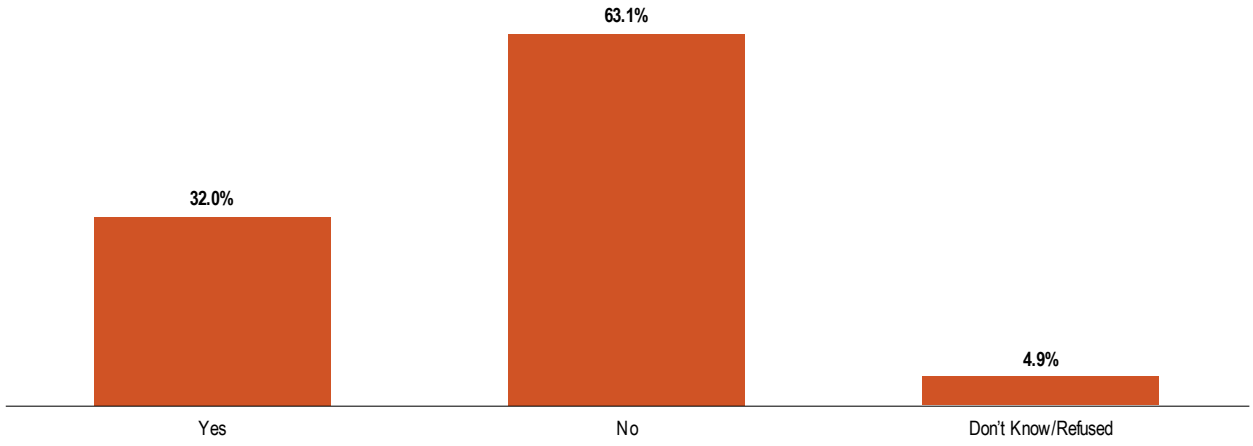
Source: Applied Analysis. N=122.

Paying for Services
Percentage of Patients Paying Through…



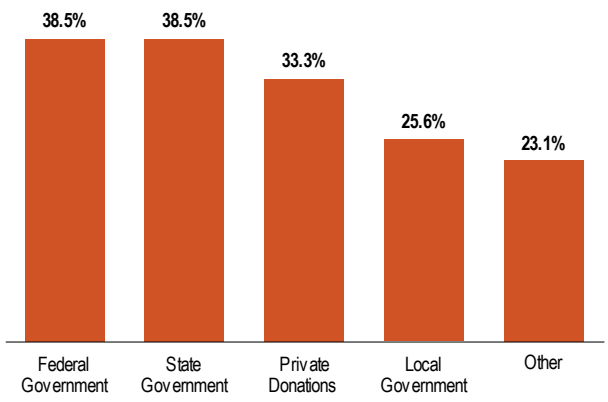
Source: Applied Analysis. N=116.

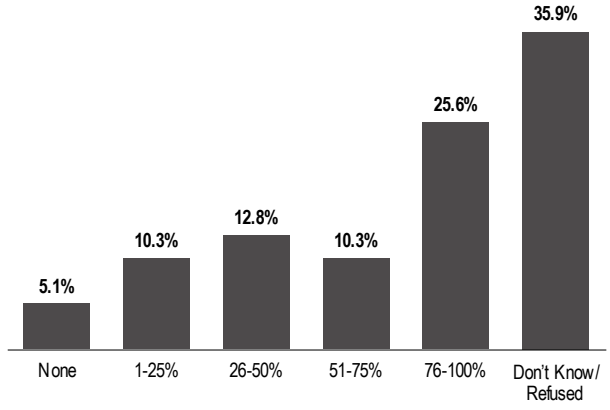
Paying for Services
Funding Sources Beyond Patient Fees



Source: Applied Analysis. N=122.

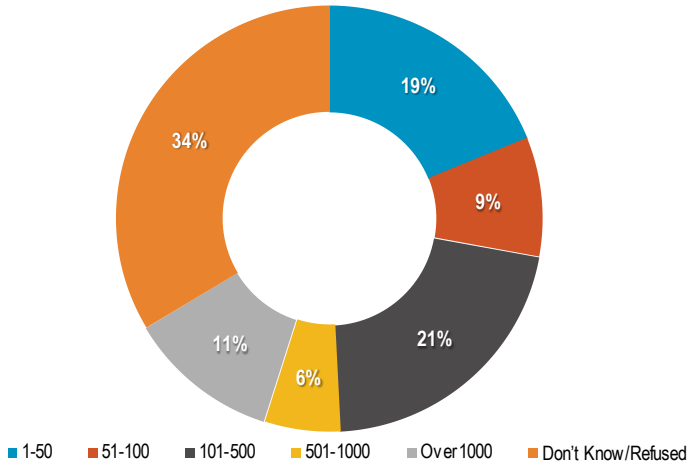
Paying for Services
Funding Sources Beyond Patient Fees





Source: Applied Analysis. N=39. Note: Multiple responses allowed for other funding sources.

Patient Volume
Unique Patients Served in Typical Year



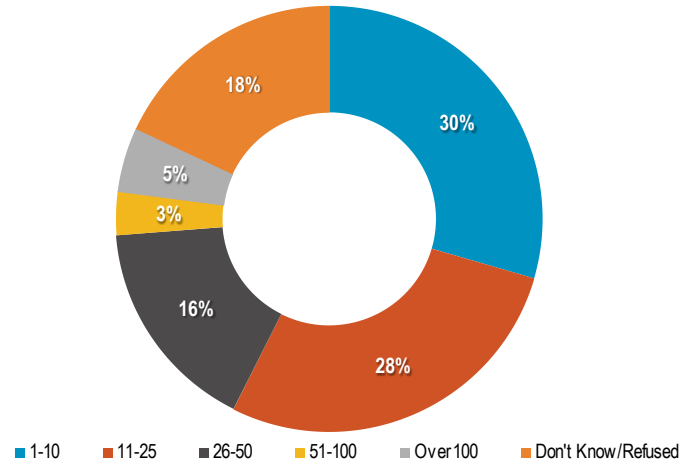
3,155
Average

4
Minimum

100,000
Maximum

Source: Applied Analysis. N=122 Note: An outlier value of 800,000 was removed from summary statistics (average, minimum, maximum).

Patient Volume
Patients Served Daily



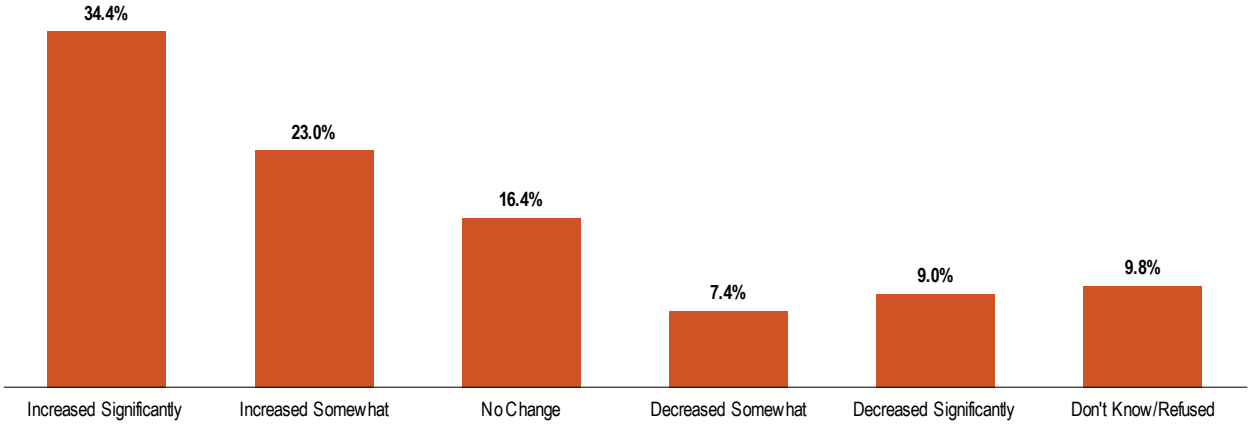
43
Average

2
Minimum

1,000
Maximum

Source: Applied Analysis. N=122 Note: An outlier value of 80,220 was removed from the summary statistics (average, minimum, maximum).

Change in Patient Demand
Resulting from COVID-19 Health Crisis



Source: Applied Analysis. N=122.

RESULTS:
BIGGEST CHALLENGES FACING THE SYSTEM

BEHAVIORAL HEALTH SERVICES IN SOUTHERN NEVADA 2021 APPLIED ANALYSIS

Biggest Challenges Facing the System

1

LACK OF PROVIDERS AND RESOURCES TO MEET DEMAND

In general, Nevada and Clark County have experienced a doctor shortage for many years, but the impacts seem to be particularly pronounced in the mental health field. While doctors are not the only type of provider, they are an important piece of the system, and given the relatively small size of Nevada's healthcare economy, it is not a surprise that lack of providers and resources within the community was the most common concern cited by service providers in 2016 and is still one of the most pressing issues today.

Biggest Challenges Facing the System

2

ISSUES WITH INSURANCE

Insurance issues were commonly cited as a critical problem in the mental health system. Among the many insurance issues cited by providers included low reimbursement rates (including Medicaid), difficulty getting on "panels" to be able to accept certain insurance types, problems with treatment approval processes, and length of treatment that insurance companies will approve for clients.

Biggest Challenges Facing the System

3

LACK OF FUNDING AND RESOURCES

This sentiment is related to both issues mentioned previously, but many providers indicated that more funding (including local and public funding) was needed to set up additional clinics, hire more workers, and provide more people with care. While lack of coverage for some treatments under Medicaid and other insurance programs forces patients to go without care or providers to write-off treatment costs, it is not the only way to help fund the necessary care.

Biggest Challenges Facing the System

4

ACCESS TO CARE & AFFORDABILITY

Access to care was also a very common theme cited as a problem in the system among providers, although descriptions were more widespread and included a variety of issues. Examples included patients' inability to pay deductibles/copays/out-of-pocket, the need for more wraparound services and expanded service options, long wait times preventing treatment even in the cases of diagnoses, transportation issues, stigma and limited culturally competent or diverse providers available to provide treatment.

Biggest Challenges Facing the System

5

AFFORDABLE HOUSING AND COMMUNITY EDUCATION

Although the top four themes were more common among providers, several other issues were also identified as an issue in the current system. Chief among them were affordable housing options in general and for the homeless population as well as educating the community.

RESOURCES

American Psychological Association. (2020). Stress in America 2020: A national mental health crisis. Retrieved December 1, 2020.

https://addiction.surgeongeneral.gov/vision-future/time-for-a-change

Childhood obesity prevention through a health disparity ... (n.d.). Retrieved March 15, 2022, from https://www.caanv.org/wp-content/uploads/2021/02/Childhood-Obesity-in-Nevada-2-5-2021-FINAL.pdf

https://www.census.gov/quickfacts/fact/table/clarkcountynevada/RHI225220#RHI225220

https://www.countyhealthrankings.org/app/nevada/2021/rankings/clark/county/outcomes/overall/snapshot

https://www.healthysouthernnevada.org/resourcelibrary/index/view?id=240149639255240251

https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2019_2020.pdf

https://www.fox5vegas.com/2022/03/17/nevadans-turn-therapy-resources-2-years-after-covid-19-shutdown-las-vegas/

https://wonder.cdc.gov/

DRAFT

CLARK REGIONAL BEHAVIORAL HEALTH POLICY BOARD
ANNUAL REPORT BRIEF, 2021

Michelle Bennett

Clark Regional Behavioral Health Coordinator

Demographics

CLARK COUNTY

2020 Population = 2,315,963

2020 Percent of State =73.8%

RACIAL/ETHNIC GROUPS

Non-Hispanic Black (12.1%)
American Indian & Alaska Native (1.2%)
Asian (10.4%)
Native Hawaiian/Other Pacific Islander (0.9%)
Hispanic (31.6%)
Non-Hispanic White (41.7%)

AGE

5% under 5 years old

23% individuals under 18 yearsold

15% 65 and over

VETERANS

205,659 Veterans

UNHOUSED

5,083

Clark Regional Behavioral Health Policy Board

2022 Membership NRS 433.4295

Char Frost

Board Chair/Clark County Children's Mental Health Consortium

Senator Fabian Donate

Legislator, Nevada Senate District 10

Dr. Lesley Dickson

Center for Behavioral Health/Nevada Psychiatric Association

Jacqueline Harris

Licensed Marriage and Family Therapist

Michelle Guerra

Director Of Health Equity and Cultural Competency - Molina Healthcare of Nevada, Inc

Jamie Ross

Vice Chair/PACT Coalition

Dan Musgrove

Nevada Strategies 360

Justine Perez

Compassion Community Care Clinic

Ariana Saunders

Corporation for Supportive Housing Southwest

Captain Nita Schmidt

Las Vegas Metropolitan Police Department

Cory Whitlock

Las Vegas Fire and Rescue

Board Meetings

January 28, 2021

March 11, 2021

May 12, 2021

July 28, 2021

November 1, 2021

Board Priorities

Oversight Agency and Workforce Development Issues

Dedicated Funding for Crisis Services

Residential treatment services for youth

Increasing Collaboration on the Spectrum of Substance Misuse and its Relation to Mental Health

* Identify wrap-around services for individuals experiencing homelessness and mental health crisis.

Recovery and Recovery Support

Health
Home
Purpose
Community

Recommendations

Identifying behavioral health needs and system gaps

WORKFORCE

Utilization of peer support services

Address issues with background checks

WORKFORCE

Address the region's counselor to patient ratio

Review the Medicaid reimbursement rate and processing time

CRISIS SERVICES

Develop a plan community partners to model Crisis Now services

Recommendations cont'd

Identifying behavioral health needs and system gaps

YOUTH RESIDENTIAL TREATMENT

Creating more intensive community-based services to enhance system of care.
Support efforts for children with a higher need for care

SUBSTANCE MISUSE & MENTAL HEALTH

Break down biases through education
Address demands of the growing community and the lack of available beds

HOMELESS SERVICES

Develop a task force
Identify overlap and gaps in services

Data Sources

- Center for Disease Control and Prevention
- U.S Department of Labor Statistics
- Healthy Southern Nevada
- Department of Human and Health Services Chart Pack UNLV Center of Business and Economic Research
- Applied Analysis
- Behavioral Health Services in Southern

Data Highlights

34% young adults deteriorated health

20% of population experience 10 or more poor mental health day and categorize themselves as having unfavorable mental health.

21 child and adolescent psychiatrist per 100,00; national average is 89.

18% high school students seriously considered suicide 8.9% tried

Alcohol and substance misuse continue to rise

219 fentanyl overdose deaths

70,000 inmates yearly, with 30% of that population experiencing a mental health need

13,076 individuals will experience homelessness this year

Thank you

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