2022 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 2022.

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EXECUTIVE SUMMARY

Overview

The current members serving on the Northern Regional Behavioral Health Policy Board are constituents of the Northern Region consisting of community leaders, law enforcement, healthcare and treatment providers, family and peer advocates, and much more. Their knowledge, engagement, and empathy for their counties are invaluable. The members of this Board each bring a uniqueness to the table and the diverse perspectives they bring cannot be minimized. The members are passionate and eager to collaborate on improving the behavioral health system in the Northern Region. Collaboration facilitated by the Northern Regional Behavioral Health Policy Board and associated county behavioral health taskforces, coalitions, consortiums, and other county committees as well as other facilitated meetings have enabled stakeholders to develop a shared understanding of the behavioral health issues facing the region as well as to cross collaborate on county-wide issues. These opportunities have 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. Current Board members and their term date for reappointment. (NRS 4333.429)

- Dr. Robin Titus, Senator, Nevada Legislator (Term 2/28/24)
- Dr. Amy Hyne-Sutherland, Director of Mission Integration, Carson Tahoe Health (Term 11/11/24)
- Nicki Aaker, RN, Director, Carson City Health and Human Services (Term 10/7/23)
- *Taylor Allison, Executive Director, Douglas County Partnership** (Resigned 2/23)*
- Erik Schoen, Executive Director, Community Chest (Term 4/19/24)
- Laura Yanez, Executive Director, NAMI Western Nevada (Term 10/7/23)
- Sandy Wartgow, Deputy Chief, Carson City EMS (Term 11/4/23)
- Ken Furlong, Sheriff, Carson City (Term 6/30/23)
- Lana Robards, Director, New Frontier Treatment Center, Fallon, Nevada (Term 10/7/23)
- Dr. Ali Banister, Juvenile Probation Chief – First Judicial District (Term 9/30/23)
- Shayla Holmes, Executive Director of Lyon County Health and Human Services (Term 9/1/23)

  ** Board openings (3): Representative or interested party of a community-based organization providing behavioral health services; Licensed Nevada clinical psychiatrist or psychologist (with Ph.D.) if none are available, health care provider who has experience working with persons with Serious Mental Illness or who abuses alcohol or drugs; Private or public insurer representative; if not available, "another person who has experience in the field of insurance or working with insurers."

As one of the newest Regional Coordinators, I have had a chance to focus on the development of old and new relationships in the counties as well as work to understand the nuances of each county I serve. Understanding that each county has some similar but very different barriers, and

gaps, as well as many successful initiatives, is important. Taking time to build and rebuild these crucial relationships has enabled me to assess the counties' successes, issues, ongoing projects, and past work completed by the board, the coordinator, and the communities making up the Northern Region. One of the board's priorities is to highlight ongoing issues, the work being done to eliminate the gaps and barriers as well as the successes of the Northern Region.

Data highlights

The Northern Region continues to see an increase in the number of youths reporting they "felt sad or hopeless." From 2017 to 2019 there was a slight decrease in high school-aged youth who considered or attempted suicide. However, in 2021 there was a substantial increase in from 3.7% to 5.5% in high school-aged youth who seriously considered killing themselves. All the while there has been a steady increase in youth who made a plan to suicide which was highest in 2021. This is causing a bigger concern across the region as planning a suicide is one step away from completing a suicide.

From 2017 to 2021, there has been an increase in the percentage of Northern Region middle school students reporting that they "felt sad or hopeless." The percentage who considered suicide or attempted suicide increased from 2017 to 2019 before decreasing in 2021, while the percentage who planned a suicide decreased from 2017 to 2019 before decreasing slightly in 2021. The Northern Region middle school percentages are within 1.0% of Nevada middle school percent.

The Northern Regions' adult rates of them "experiencing 10 or more days of poor mental or physical health that prevented them from doing usual activities" was at an all-time high in 2021 at 28.8% up compared to 19.2% in 2020. As those rates rose the rates of having no days where our adults had good health dropped from 55.7% to 47.4%. This is a big indicator of where Nevadan adults are with their mental health. Anxiety has been the leading mental health-related diagnosis for inpatient admission with depression falling closely behind. These two diagnoses have been the leading reasons for inpatient admissions in the Northern Region as well as statewide.

Trends Identified by local stakeholders –

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

- Provider staffing shortages and strain leading to reduced availability of behavioral health services (this is statewide)
- An increase in youth experiencing high acuity mental health issues and planned suicides
- Problem for all ages in accessing appropriate in/outpatients services
- Increased crisis in our youth and elders leading to an increased need for crisis response and hospitalizations
- A rise in behavioral health and healthcare needs caused by economic, political, and cultural pressures.

- The lack of information with the rollout of 988
- Lack of supportive housing for those with a diagnosis of SMI/SED
- Development of regional crisis response system while obtaining sustainable funding for current crisis stabilization

Legislative efforts –
The Northern Board focused on rewriting the NRS 433C Regional Behavioral Health Policy Board language to include developing a Regional Behavioral Health Authority (RBHA). In response to efforts at deinstitutionalization and development of community-based mental health services, all states in the U.S., including Nevada, developed a legal mechanism to develop local mental health authorities in 1975. For multiple reasons, Nevada remains one of the only states who has been unable to bring a community-based mental health system to fruition.

Lack of local or regional behavioral health infrastructure inhibits local participation and oversight in the development and provision of community-based behavioral health services. The current language in NRS 433C regarding local mental health authorities limits the ability of counties and regions to move forward in developing this infrastructure. This lack of local oversight causes issues with accountability regarding quality treatment and coordination of behavioral health services. With the current ongoing issues with our youth facilities and the recent DOJ report. More stringent oversight of services is becoming an elevated serious matter.

Modernizing existing law in NRS 433C, focused on local mental health authorities, to develop a feasible mechanism that enables counties and local community stakeholders to participate in Regional Behavioral Health Authorities.

- Aligns with national *Roadmap to the Ideal Crisis System* framework – establishes an accountable entity for a community/catchment area with responsibility for designing, financing, and operating best practice crisis system, with the goal of ensuring people-centered services.
- Braided funding model – Allows for accountability and oversight of all funding streams braided under one umbrella with the goal of providing greater system efficiency to individuals and families in need of behavioral health care across the continuum. Further, a Regional Behavioral Health Authority will increase community oversight and use of federal block grants to deliver community-based services to individuals with serious mental illness and substance use disorders.
- Allows for increased community oversight and participation in Medicaid-managed care – Senate Bill 420, which passed in the 2021 Nevada Legislature, will allow for a managed public option insurance option for rural areas in 2026. Enabling Regional Behavioral Health Authorities provides for community-based participation in the approval of competitive bid processes with managed care organizations in regional behavioral health service areas.
- Allows for opportunities to develop additional services through an intentional transparent democratic process with diverse leadership and community representatives.

- Potential for quality assurance system and cost savings through system oversight – establishes a safety net so consumers' needs don't fall through the cracks.
- Offers communities access to necessary data - to provide evidence-informed decision-making and to address and mitigate spikes in behavioral health needs in the communities
- Increases access to care
- Supports state behavioral health authority - with additional value-based infrastructure to address program capacity, contract management, funding coordination, data collection, quality improvement, etc.
- Allows for cross-jurisdictional sharing efforts to obtain grant funding for regional projects

The Northern Regional Behavioral Health Policy Board spent a couple of years researching and bringing other states' examples to the table and then worked diligently to write language that would enable the Northern Region to run as an authority. The Board researched fruitful examples but, in the end, the development of the enabling language for the authority became cumbersome and eventually dormant. The 82nd (2023) Legislative Session began, and the board felt that the pressure, language, and capacity of the region to further a Behavioral Health Authority was a much farther reach than anticipated. As well as a few bills have been brought to the committees which are looking at taking the Authority piece in a state direction, not just the region. The recent priorities of the board geared to legislation have been to support and advocate for other bills that focus on helping with priorities in the Northern Region. Such as Nevada's mental health workforce, Medicaid, suicide prevention, rise in opioid and substance misuse, supportive housing, Opening Meeting Law (OML) issues, Community Health Worker's (CHWs), and other bills that have been on the Board's radar.

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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 was estimated to be 196,082 in 2021, slightly up from 194,464 in 2020. The Northern Region comprises 6.2% of Nevada's population. The Median household income for the Northern Region was $66,069.00 in 2021, up from $60,704 in 2019[2]. Persons in poverty by percent in the region is 9.3% and person under the age of 65 years of age is 10.8%. In terms of ethnicity, 76.5% of residents in the Northern Region are White not of Hispanic origin, 16.9% of residents are Hispanic, 3.2% of the population are Native American, 2.4% are Asian, and 1.9% of the population are Black[1]. The veterans' population in the Northern Region reached an estimated 19,400 in 2020[2].

Population breakdown by county 2023 [3]:

Carson:57,787
Churchill:27,271
Douglas:50,490
Lyon:59,832
Storey:4,593

Health Care Availability – Northern Region

- 4 Rural Community Hospitals: Carson Valley Medical (Gardnerville), Carson-Tahoe (Carson City), South Lyon Medical (Yerington), Banner Churchill Community Hospital (Fallon) Note all these hospitals now have some type of behavioral health professional(s) on staff and have focused on increasing access to these services.
- 3 Tribal Health Clinics: Fallon Paiute-Shoshone (Churchill), Yerington/Campbell (Lyon), Washoe Ranches/Dresslerville/Stewart (Douglas)
- 13 Rural Clinics/4 Rural Nevada Counseling: Rural Clinics Carson/Carson Tahoe Behavioral Health Services/Counseling Center & Supportive Services-3(Carson), Rural Clinics Fernley-5 (Churchill), Rural Clinics Dayton/Rural Clinics Silver Springs-9(Lyon)
- 4 CCBHCs: Rural Nevada Counseling (Lyon), Vitality Unlimited/Community Counseling Center (Carson/Dayton), New Frontier (Churchill)
- 2 Community Health Centers: Virginia City Community Health Center (Storey), Sierra Nevada Health Center (Carson)
- VA Clinics: (Gardnerville)

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. Nevadans in need are receiving well-

[1] Nevada Statewide Demographer's Office
[2] U.S. Census Bureau, 2020
[3] Nevada Rural and Frontier Health Data Book-eleventh edition

established treatment from programs such as Assertive Community Treatment (ACT) and Certified Community Behavioral Health Centers (CCBHCs) and the positive impact these services are having on our communities is evident by the response.

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 a lack of supportive housing.

In response, the Northern Regional Behavioral Health Policy Board is open to innovative ideas including the 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 the 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.

Northern Regional Behavioral Health Policy Board 2022 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 2022.

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 by hearing regular updates from the region's county behavioral health taskforces. These taskforces, composed of diverse community stakeholders including law enforcement, Emergency Medical Services (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.

- *County Coalitions:* Similar to the taskforces the coalitions serve one to four counties in their efforts to focus on preventing substance misuse or abuse among youth. The programs, information, and resources provided by the coalitions are geared to partner

with local schools providing multiple layers of prevention, intervention, and postvention focused on suicide prevention, mental health issues, and all substance use.

- *MDT (Multidisciplinary Team) meetings:* These meetings are called on an as-needed basis, they are a way to bring the clients' care team together and collaborate to understand certain issues that a client might have special needs for treatment. These meetings bring those professionals together who know said client and collaborate on a treatment process for person-centered care. This can also be an avenue to discover where the gaps and barriers are for our higher-level acuity treatment.

- *Community surveys:* The Northern Board supported a quad-county community and provider behavioral health survey that was distributed by the region's coalitions and other community providers. Recently a couple of the region's counties completed their opioid needs assessment. And each Northern Region County has completed its community prevention (CCP) assessment, this is a triannual assessment. The purpose of this document is to create a common focus, including all segments of the population when possible, and outline a system of service development and delivery. These documents and more can be found on https://nvbh.org/northern-behavioral-health-region/

- *Status and Strategic plans from across the state and region:* These reports and more give the board the needed information to look at the gaps, and barriers in the Northern Rural Region and become informed of what the region is facing: Rural Children's Mental Health Consortium 2023 Status Report, Nevada's Behavioral Health Community Integration Strategic Plan, County CCP Assessments, county-specific Opioids Needs Assessment among others are being used to guide the county's strategic plans.

- *Regional and Statewide Data provided by the Nevada Division of Health and Human Services (DHHS) Office of Analytics, and other resources:*
  The Office of Analytics provides each Behavioral Health Region with data derived from multiple sources including the Behavioral Risk Factor Surveillance System (BRFSS), and Youth Risk Behavior Survey (YRBS), among other data collection platforms. The coordinators also search for data using OD2A reporting, NRHP.org, hospital billing data, the University of Nevada Reno, Rural and Frontier Health Data Book – 11th Edition (1/23), and other sources.

- *FASTT and MOST programs Region Wide:* FASTT and MOST programs across the Northern Nevada Behavioral Health Region work hard to provide front-line services to community members and clients, collaborate with one another, and collaborate with other behavioral health partners in the Northern Region. Each of these programs works to divert or deflect people with mental health and substance use concerns away from the justice system, and toward community resources for managing their needs and reducing the need for justice system contact. Data collection and analysis is an important component for monitoring the program fidelity and effectiveness of these programs, and

data sharing is particularly important for understanding the extent to which these programs are serving the same community members.

Mobile Outreach Safety Teams (MOST) work to de-escalate and support community members who are experiencing acute mental health crises and divert them away from the justice system and toward treatment options. MOST teams include both law enforcement and behavioral health professionals, ensuring that they are equipped to respond to both the safety of the community and the mental health needs of the person in crisis. Data for MOST is collected differently in each county, but typically data that are reported include the number of calls for service received, the number of follow-up calls conducted, and details about the nature of the call and the person or people assisted.

In February, we highlighted Douglas County MOST's data collection efforts. Douglas MOST collects data using a Qualtrics form developed in partnership with the University of Nevada, Reno. In 2022, they reported 548 contacts with over 300 unique community members. Nearly half of these calls involved reported or suspected substance use. Douglas County routinely conducts follow-up calls to community members they have responded to, and in the majority of cases, they find these consumers in stable condition! Douglas MOST also provides families with additional supportive resources, psychoeducation, and case management support.

Forensic Assessment Services Triage Teams (FASTT) conduct risk assessments and develop transition plans with clients who are incarcerated in local jails. The transition plans are based on the client's identified needs so the team can set them up for success in the community when they are released from jail. FASTT uses a robust case management system that also serves as a database, which is also used by numerous other programs such as Catholic Charities, Health and Human Services agencies, Volunteers of America, and more. This integrated case management system allows staff to see what other programs have interacted with their client, allowing them to coordinate care between programs when necessary.

The goal of FASTT is to reduce recidivism by proactively deflecting clients from deeper entrenchment in the justice system. Coordination of data is essential to understand whether this goal is being served effectively because clients might move between programs. Without coordination of data, case managers could spend unnecessary time repeating risk assessments and developing new case plans for clients who have already received these services.

This data management system allows us to see a snapshot of the data across all of the counties. In March 2023, Churchill County FASTT enrolled 10 clients, Lyon County FASTT enrolled 21 clients, Douglas County enrolled 5 clients, and Carson City enrolled 17 clients. Between all of the programs, five clients who were enrolled in March had previously been enrolled in a different county's FASTT program, and one was subsequently enrolled (in April) in another county's FASTT program. In addition to cross-enrollment in multiple

FASTT programs, this data management system also tracks other programs in which the client has previously or concurrently been enrolled. Among FASTT clients, it was common to have received services from food pantries and homeless shelters (e.g., CARES, PATH, Street Outreach, Rapid Re-Housing, Catholic Charities food pantry, Salvation Army, Elko F.I.S.H., and VOA). More than half (54%) clients enrolled in FASTT in March previously received these types of services.

Lyon County case managers track their hours through the software and recorded an average of 2.33 hours per FASTT client in March, providing services to 45 clients. The total time spent with each client for Lyon County FASTT ranged between 15 minutes and 8 hours, and services include assisting clients in developing transition plans, communication on behalf of clients to lawyers and service providers and administering group curricula aimed at changing antisocial peer associations, attitudes, thinking, and behavior patterns that are associated with increased risk of recidivism.

In fiscal year 2022 (10/2021-09/2022), Carson City FASTT enrolled at least 567 new clients. Carson FASTT enrolled 18 new clients in March, most of whom had been involved with other programs in the past (e.g., Catholic Charities, Volunteers of America). Of these, 2 clients had been involved with FASTT prior to 2023. One-third of these enrolled clients (6) did not have a history of other program involvement.

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 robust sophisticated behavioral health system.

Strategies: Explore Regional Behavioral Health Authorities – In May 2022, the Northern Board established a formal multidisciplinary subcommittee to explore concepts for regional behavioral health authorities and models to increase system efficiency/ 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

- Sustain Board Support Positions – advocate for sustainable funding for Regional Behavioral Health Coordinator and regional data analyst positions. These positions provide the support necessary for the Board to fulfill duties described in NRS 433.4295.

- 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 a sustainable funding mechanism for the Regional Behavioral Health Coordinator position
- Support the need for local data aligned with Northern Board priorities
- Stakeholders in the region advocate for increased transparency, coordination, and accountability of behavioral health funding mechanisms recognizing limited capacity at the state level
- Strengthen coordination of funding and programs between state and local stakeholders
- Expand awareness and access to psychological first aid training, suicide prevention, mental health first aid, and other training that can arm our communities with resources and information to help their citizens
- 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 practices for residents with mental health issues in the region.

Strategies:

The Board established a formal subcommittee to address affordable and supportive housing solutions in January 2022. The Northern Region Behavioral Health Housing Subcommittee established the following recommendations that were adopted formally by the Northern Regional Behavioral Health Policy Board on May 5, 2022: Advocate for the State to fund regional housing assessments and systems modeling by organizations such as Corporation for Supportive Housing, recommend the Nevada Division of Housing consider an equitable distribution of the $500 million Home Means Nevada Housing initiative dedicated to supportive housing to create opportunities for all five behavioral health regions, advocate for sustainable

supportive housing, support State and local agencies in the development of 1915i and other applicable home and community-based programs to encourage people-centered services.

Recommendations:

- Recommendations are being developed in the behavioral health housing subcommittee
- Increase the reimbursement rates and/or add a 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 the 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 fully 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 (PRSS). Following this model, the Northern Board has been exploring strategies to increase the clinical workforce and expand the use of CHWs and PRSS to bridge the gaps caused by the lack of clinical providers. The Northern Board plans to obtain more education on CHWs and is 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 the region to avoid misuse. Working closely with NAMI Western Nevada and the University of Nevada Reno, Center for the Application of Substance Abuse Technologies (CASAT) has enabled the board to understand the capabilities of PRSS in the workforce and how their profession has been elevated.

Recommendations:

- Support local agencies facilitating CHW and PRSS workforce development.
- Support legislation that simplifies the clinical insurance paneling process
- Ensure clear differentiation between CHW and PRSS roles and are being utilized within their appropriate scope of practice.

- Address financial barriers to CHW and PRSS training and certification process.
- Expand the ability of CHWs to bill for Medicaid out from under only a "medical provider" and expand to include all behavioral health/substance misuse providers.
- Increase reimbursement rates for all behavioral health professions where there is a low ratio of active providers to the population in the Northern Region to attract more to the workforce.
- Explore additional incentives for practitioners providing services in rural counties. (i.e. Expand the application time window and streamline the process to complete HRSA loan forgiveness applications as a provider agency and provider; housing stipend) (need to further develop)-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 credentialing.
- Support family caregivers through supporting access to reimbursement, increasing access to services, training, and respite care across the life span.

4. *Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion/deflection, and reentry programs and resources (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center, CCBHCs)*

Needs/ Gaps:

Individuals experiencing a 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/deflection programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, CCBHCs, 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 a crisis, however, they do not currently have sustainable funding, and more crisis response interventions are needed.

With the July 2022 implementation of 988 nationwide, there is an even bigger need to coordinate local infrastructure into the state crisis response system. As we lean on fewer suicide prevention crisis lifelines across the nation to be the voice that responds to our constituents with resources and assistance, we add strain to those responders doing the fieldwork. We must begin to work on building more types of deflection and diversion programs that meet our people where they are with trauma-informed care when in a crisis.

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:
- Continued development of sustainable funding mechanisms for current local crisis response and jail diversion programs including MOST, FASTT, CIT programs, and Mallory Crisis Center.
- Develop sustainable Medicaid reimbursement and other funding sources to sustain Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs.
- Prioritize the co-responder model work focused on developing 24/7 local on-call mobile crisis response teams.
- 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 a full range of services in coordination with communities.
- Ensure implementation of feedback or accountability mechanisms for crisis response services. Include transparent data tracking for each county and quality assurance overseen or in collaboration with the local level.
- Focus on building up the CHW and PRSS workforce throughout the Northern Region

5. *Increase access to treatment at all levels of care*

Needs/ gaps
Stakeholders in the region identified a lack of insurance as a barrier to accessing 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. This goes back to the lack of providers to deliver these services.

Strategies:

In exploring access to care issues for individuals who are underinsured 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 the 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 publicity of Medicaid/Medicare open enrollment periods or allow enrollment at any time.
- 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 for respite care, peer drop-in centers, living room models, and community support centers.
- Provide vouchers for drop-in daycare in order to take other children to care.
- Explore the adequacy of reimbursement rates for all youth behavioral health services to ensure access to 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 to linkages to care that include a lack of formalized referral systems, a 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 the 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 look into structural solutions to strengthen warm handoffs.

Recommendations:

- Support formal agreements between CHWs and various existing programs such as Healthlink, OpenBeds, and hospitals.
- Identify the role of peers and family peer support in encouraging clients to follow a self-determined treatment plan and engage in treatment.
- Provide support/funding/mandate/training/ for providers to utilize a bed registry. OpenBeds was the platform being vetted but I believe this has changed so there will be a need for upcoming TA on the registry once one has been identified.

2022 Northern Regional Behavioral Health Board Activities

The Northern Regional Behavioral Health Policy Board met twelve times in 2022, 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 has moved into advocacy this year when it comes to legislation. Having worked diligently on the submission of the 82nd 2023 legislative session came to an end early on. The board has made it a priority to advocate and support many of the behavioral health bills being brought forward in the current session. Looking forward to the next session in 2025, the board has its sights on a few issues that could be viable for legislative change. Once this session is completed the board will begin to look at where their voices can be heard by legislative change.

- Advocacy: The Northern Board wrote multiple letters to DHHS, advocating for the 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. With the recent DOJ report and the ongoing juvenile issues of inpatient treatment locations. Advocating for youth and teen providers is a top priority. The coordinator collaborated with the Attorney General's Office to co-write and then awarded a three-year 5.7 million-dollar COSSUP grant focused on programs that work on deflection and diversion from jails or detention. 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 some time working on the finalization of their strategic plan to align with the funding streams the state has recently provided to sustain the coordinator role. As the new coordinator, I have reached out to the state's new leadership and community stakeholders for input on identifying priorities, and for help in developing the next steps forward to achieve the board and county priorities. Recently we have taken a step back on the plan as all the new leaders and players find

their place in this multi-tiered level coordinator base. As the Board prepares to move forward with their priorities.

- Education: Many of the presentations received were related to Board priorities, resources, programs, community stakeholders, and legislative priorities. Many of the invitees to the Board meetings presented new programs, preexisting programs, resources, and community survey results. During the second half of the year, more presentations were geared to programs and BDR language of statutes that were being introduced in 2023.

- Coordination with local taskforces and coalitions: 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. Currently, a couple of the taskforce are working on updating their strategic plans aligning their objectives and goals with their finished needs assessment and the new BHCI plan which was introduced in January to the region. A couple of the counties have also been focusing on youth Step Up programs looking at the intercepts of each county and where and what resources are viable and available for our youth.

- Subcommittees activities: In 2022 the Board put two Subcommittees together. One focused on the lack of supportive housing and the issues that come along with the lack of resources for our populations. The subcommittee focused on models and best practices for housing individuals with BH issues as well as they focused on the 1915i waiver. This subcommittee met until legislation on supportive housing was presented then the board took a back seat to the BDRs in order to advocate and collaborate with the supporters. The other subcommittee focused on the development of the Boards BDR concerning the Behavioral Health Authority. This subcommittee met until the board decided that the Regional Behavioral Health Authority concept was a bigger move for the board than anticipated.

- Other board development activities: In 2022, the Northern Board reviewed and adopted bylaws and adopted the Northern Regional Behavioral Health Emergency Operations Plan (BH EOP). The BH EOP has been presented to multiple Northern region counties and those counties have voted to adopt the plan as an addendum to their county EOP. Once their Emergency Operation Managers (EOM) are in place. Movement of the BH EOP should be implemented into a few of the Northern Regions Counties EOP before 2023 has ended. The board also provided input into the statewide Regional Behavioral Health Policy Board website. This new platform is going strong and has been a nice addition to put local resources, documents, and training among other important information on to it. We are working on a robust data collection platform on the website to help with some of the barriers in finding data. Focusing on diversion and deflection co-responder programs has been an ongoing theme with the board. Working closely with the Attorney General's office as a collaborating entity on the 3-year 5.7 million-dollar COSSUP grant for the Northern Regions counties to continue the high-level focus and work on these programs.

The board has been focused on these types of programs for a while now and with the funding we can push these to another level of implication for the region.

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 2022. * The board's actions and presentations are in bold print.

Date	Topic	Presenters/ Participants
1.06.22	– Data Workshop - review current BH data sources identify list of important indicators for the region – **Review and approve the support letter for housing funding and initiatives**	Taylor Allison- Board Chair, **Amy Hyne-Sutherland**, board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
2.03.22	– Updates on the subcommittees and a review of the annual report for 2021	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
3.03.22	– **Approve the annual report, update on the Northern Behavioral health Housing Subcommittee**	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.
4.21.22	– **Presentation on role of mental health peers, strategies to develop workforce and policy recommendations.** – Update on Behavioral Health authority discussion and of next steps – Update from Northern Region Behavioral Health Authority Concept	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator, **Laura Yanez and Cherylyn Rahr-Wood**
5.05.22	– Hear applications for Board seat of psychologist or psychiatry – Board discussion and development for the recommendation for the Northern Regional Behavioral Health Coordinator position and transition	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator.

	– Update from the NRBHPBBH Housing subcommittee. Advocacy letter was recommended and approved	
6.02.22	– Presentation of the Nevada Mental health Workforce and Education Pipeline – Presentation on policy gaps and solutions for Community health Workers – Update on Northern Regional Behavioral Health Policy Board Behavioral Health Housing subcommittee – Update form the Northern Regional Behavioral Health Policy Board - Behavioral Health Authority subcommittee	Taylor Allison, Board Chair and board members, and Jessica Flood Abrass, Regional Behavioral Health Coordinator, **Sara Hunt, Jay Kolbert-Clausell, Shayla Holmes and Nicki Aaker,**
7.07.22	– Presentation on policy solutions to address gaps in supportive housing – Presentation on safer suicided care policy recommendations	Taylor Allison, Board Chair and board members, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator, **Sarah Adler, Cherylyn Rahr-Wood and Misty Vaughan Allen**
8.04.22	– Update and discussion regarding implementation of 988 crisis response line and regional crisis response system – Discussion and preview of BDR for the 2023 legislative session	Taylor Allison, Board Chair and board members, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator, **Kim Hopkins, Cherylyn Rahr-Wood**
9.15.22	– Discussion and decision regarding the Northern Regional Behavioral Health Policy Board By-Laws – Discussion and approval of recommendations from NRBHA subcommittee on NRS433C Language – Review and approve the letter to the Department Division and Commission regarding prioritizing funding for Regional Coordinator positions	Taylor Allison, Board Chair and board members, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator, **Shayla Holmes and Nicki Aaker**
10.06.22	– Presentation on a proposal and possible approval of letter of support for establishing a dementia care specialist program. – Review, discuss and possible approval of the 2023 Nevada Legislative session BDR, action plan	Board members and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator, **Charles Duarte**

	for BDR and overview of the presentation for BDR	
11.03.22	– Presentation and update on OML policies and procedures – Presentation on the Quad-County Public needs assessment focused on the health-related needs in the Northern BH region – Review, discussion, and possible approval of the BDR for the 2023 Legislative session	Taylor Allison, Board Chair and board members, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator, Julie Torres, Amy Hyne-Sutherland
12.01.22	– Review, discussion, and possible approval of the BDR for the 2023 Legislative session	Taylor Allison, Board Chair and Board members, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator

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, coalitions, consortia 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 a behavioral health crisis or is at risk of future crisis cannot be denied.

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

Data Highlights from the Department of Public and Behavioral Health and Substance Abuse Prevention and Treatment Agency 2023 Northern Region and Statewide Epidemiological Profiles

- Unlike Nevada which has the highest percent of the population in the 25-34 age group, followed by the 15-24 age group, Northern Nevada Region's highest percent is among the 65-74 age group, followed by the 55-64 age group.
- Since 2017, Marijuana/hashish has been the most common drug associated with emergency department visits, followed by methamphetamines, and opioids. In 2021, there were 303.4* visits related to marijuana, and 244.3* visits related to methamphetamine. (*visits per 100,000 population).

- Drug-related deaths in Northern Nevada have steadily decreased by 28% from 2017 to 2020. In 2021 there was an increase of 1.2% in drug-related deaths in the Northern region.
- Northern Nevada has seen an increase in drug and alcohol-related deaths. Drug and alcohol-related deaths have sharply increased by 25.5% from 2018 to 2021. With the sharpest increase in 2021 jumping from 169 in 2020 to 211 in 2021.
- From 2012 to 2021 Northern Nevada had 1,012 deaths associated with Alcohol consumption, with each year having an average of 101.2 deaths.
- Drug-related deaths in Northern Nevada have steadily decreased by 28% from 2017 to 2020. In 2021 there was an increase of 1.2% in drug-related deaths in the Northern region.

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. While the Office of Analytics is working hard at updating and gathering data. The release of that information is lagging and getting current up-to-date data can be time-consuming. The Northern Board looks forward to obtaining more recent current data to understand the profound effects of health and mental health issues on our communities.

Here are some of the ongoing issues with obtaining current and up-to-date data. Please note this has been an ongoing issue since the inception of these boards when data was a part of the deliverables in our NRS. Here are some current challenges as to why data is hard to obtain.

- Mental Health Crisis Hold Data is difficult to get. This would definitely take a coordinated effort to get all hospitals, of all eligible types, across the state to code and report this data consistently.
- Another missing piece is gathering data from law enforcement, who in many cases may be the ones to place the initial hold. There's definitely a disparity between the number of holds created by Law Enforcement (LE) and the number of those done by hospitals, or at least those who are confirmed by hospitals.
- The disposition data is so key to truly understanding what's happening to these folks. As there are so many directions the outcome of a hold can take, this will be a huge and complex lift. However, if we don't know what is happening to all of the folks who have been put on a mental health crisis hold, we are kind of left to use specific case stories which we have been made aware of to monitor quality and participate in problem-solving. Because this data is unavailable, it makes it very difficult to do more than occasionally put band-aids on the holes.
- The last piece that desperately needs improvement on truly, is seeing/proving to potential federal funders that we fix the holes in our systems and enable us to get aggregate post-discharge data. Such as: How are folks being discharged from public and private mental health facilities? What appointments, resources, medications, and other resources are they being discharged with? The fact that many folks are being discharged

from various institutions (for both health care and mental health) from Mental Health Crisis Holds (MHCHs) without any resources, medications, or referrals/warm handoffs at all is a place where we're really failing as a statewide system.

Conclusion:

The Northern Board was very active in 2022, meeting monthly, and actively participating in the delivery of the goals and objectives in the current strategic plan. The board members are engaged in writing numerous advocacy letters on topics relevant to the region as well as collaborating on writing and obtaining funding for the sustainability of programs in the Northern Region. Working closely with deflection and diversion programs across the region has been ongoing and a priority that is making a difference across the region. The Northern Board aims to continue learning more about priority topics, practicing advocacy, and moving forward with the 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 ongoing implementation of the 988 system and crisis response.

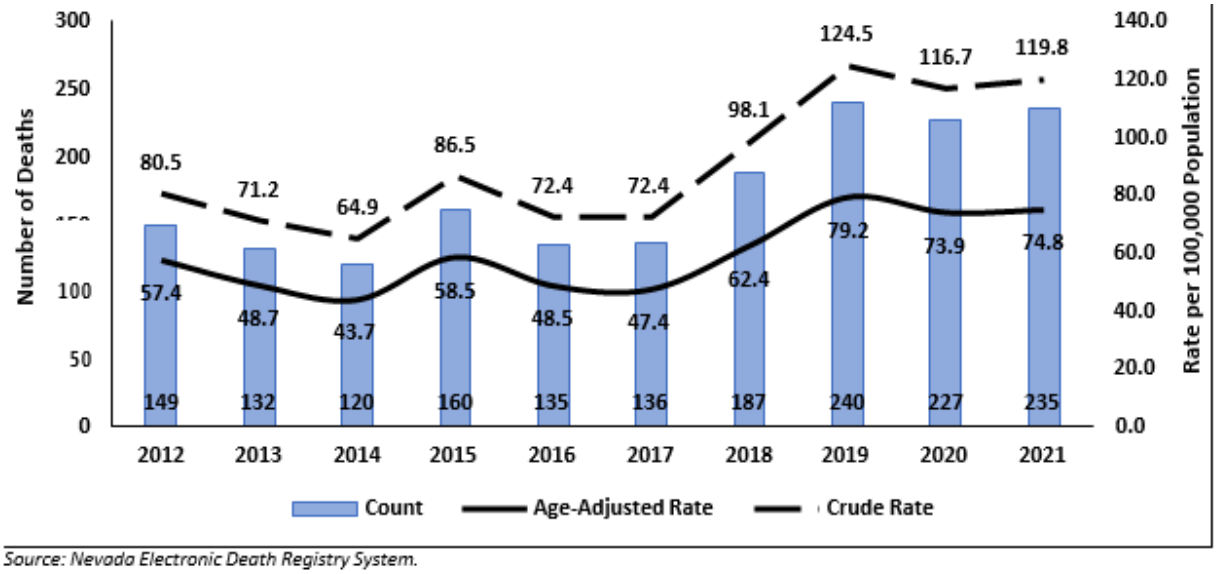
Appendix A: Behavioral Health Data for the Northern Region

Causes of Mental Health Related Deaths in Northern Nevada

Mental health-related deaths include the following ICD-10 codes groups listed as a contributing cause of death (F00-F99 excluding F10-F19):

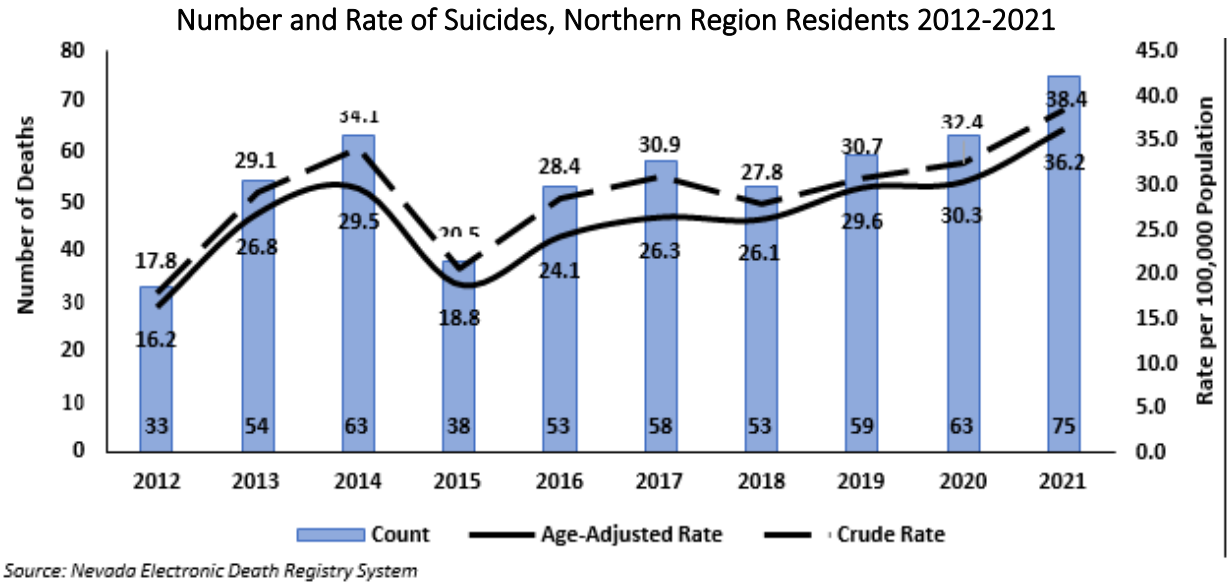
- Organic, including symptomatic, mental disorders
- Schizophrenia, schizotypal, and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Mental retardation
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; Unspecified mental disorder

Mental Health-Related Deaths and Rates, 2012-2021



Source: Nevada Electronic Death Registry System.

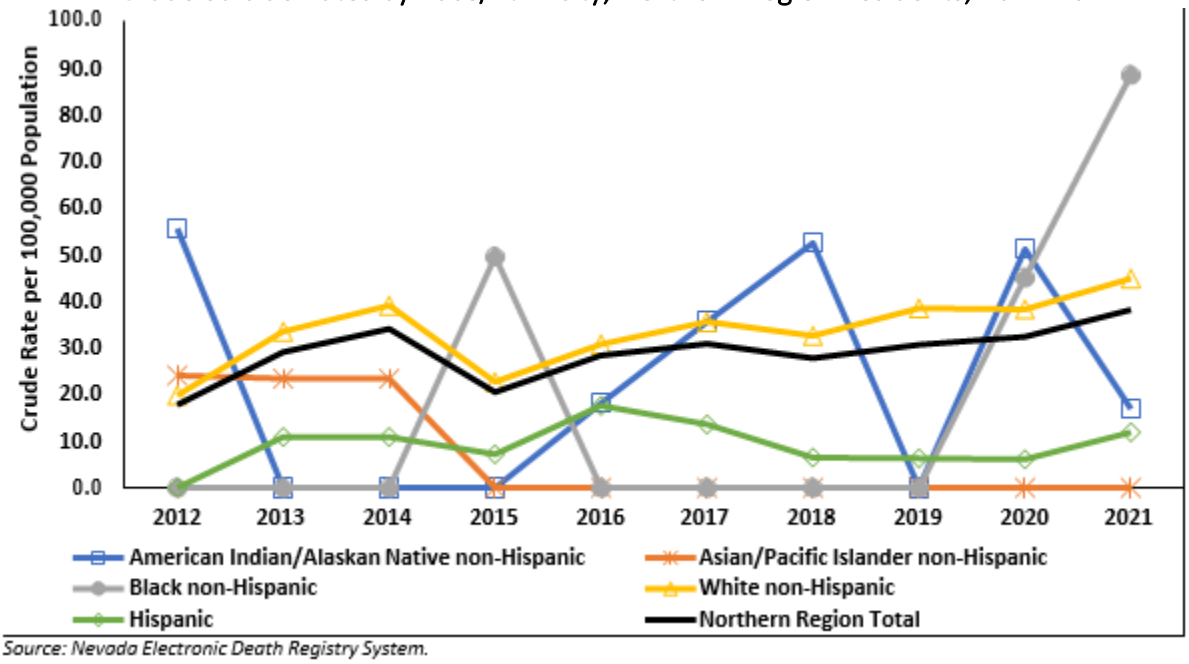
Mental health-related deaths among Northern Region residents were fairly stable between 2012-2017. Yielding an increase of 53 deaths noted between 2017 and 2019. Paying note to the years of 2019, 2020, and 2021, each having more than 200 deaths related to mental health. Counts and rates were at a high in 2019 before decreasing in 2020, followed by a slight increase in 2021.



Source: Nevada Electronic Death Registry System

The number and rates of suicides has steadily risen from 2012-2021 with a notable drop between 2014 and 2015. The Northern Region has experienced a range of 33 to 75 suicides in 10 years along with a rise in both crude and age-adjusted rates. Age-adjusted rates went from a low of 16.2 per 100,000 population in 2012 to a high of 36.2 per 100,000 population in 2021. Likewise, crude rates increased from 17.8 per 100,000 population in 2012 to 38.4 per 100,000 population in 2021.

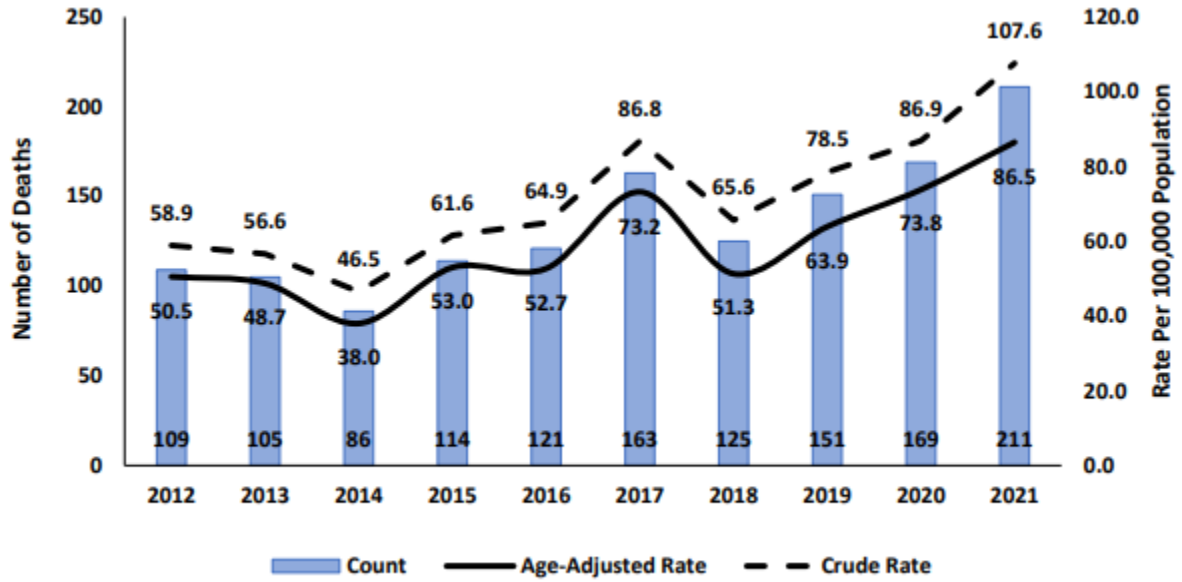
Crude Suicide Rates by Race/Ethnicity, Northern Region Residents, 2012-2021



Source: Nevada Electronic Death Registry System.

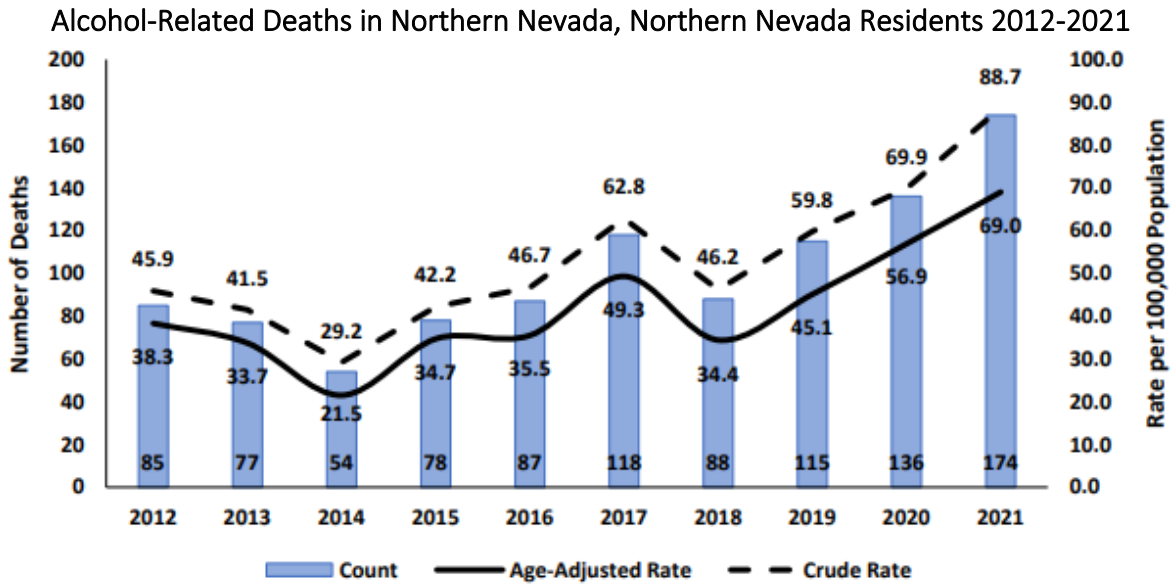
Crude rates of suicide based on race/ethnicity are to be interpreted with caution due to low populations of minority groups such as Black non-Hispanic, American Indian/Alaskan Native non-Hispanic and Asian/Pacific Islander non-Hispanic. Of note however, rates among the Hispanics and White non-Hispanic rates trend closely to the total of the Northern Region Rates.

Alcohol Related and/or Drug-Related Deaths and Rates in Northern Nevada, Northern Region Residents 2012-2021



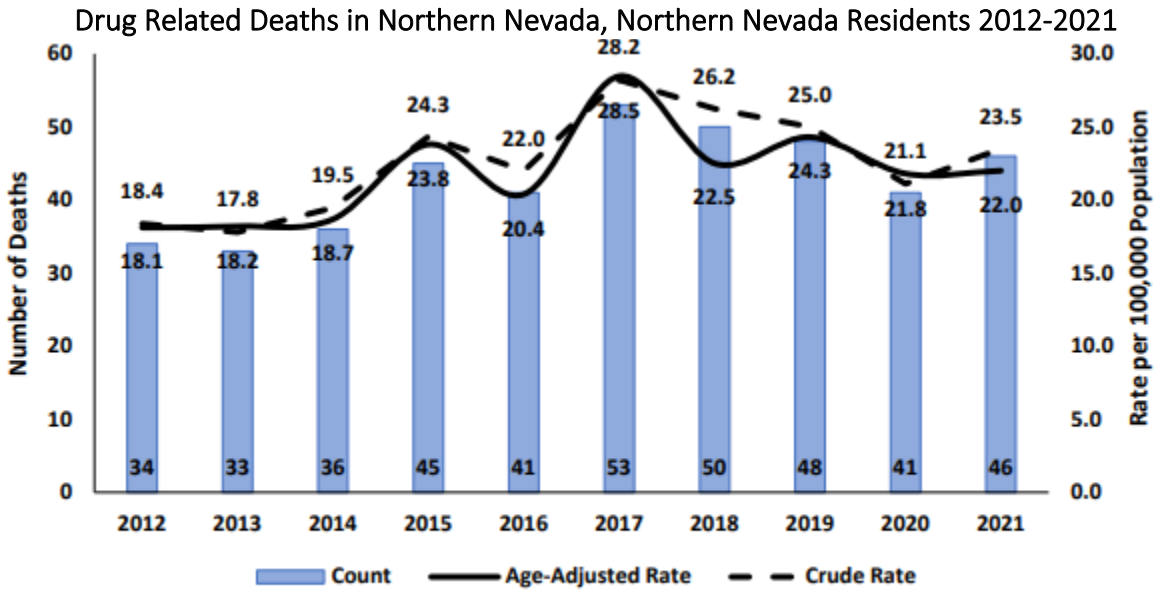
Source: Electronic Death Registry System.

The alcohol-related and/or drug-related age-adjusted rate increased significantly in 2017 from previous years (95% confidence interval), decreased in 2018, followed by a gradual annual increase in recent years.



Source: Electronic Death Registry System.

Alcohol-related death rates among Northern Region residents increased significantly in 2017 from previous years (95% confidence interval), decreased in 2018, followed by a significant increase through 2021.



Source: Electronic Death Registry System.

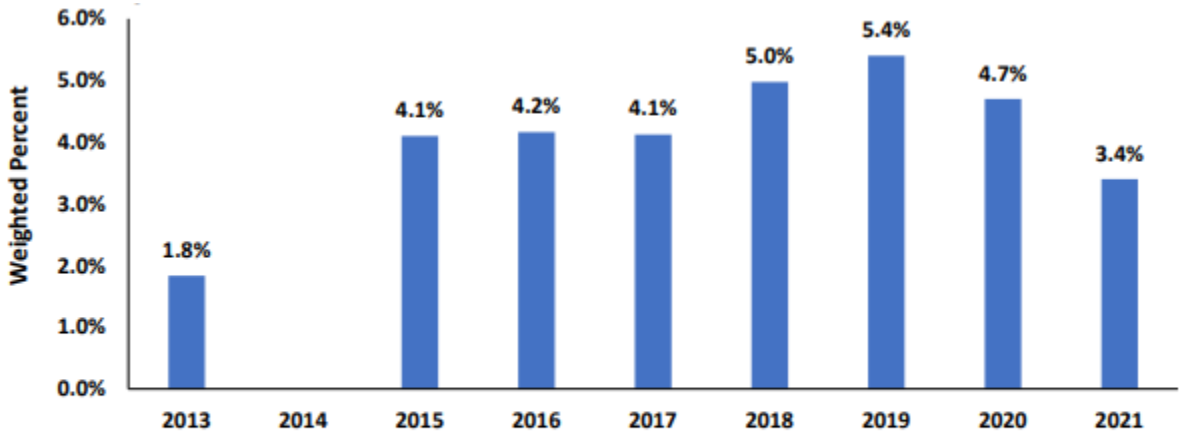
Drug-related deaths among Northern Region residents have risen slightly from 2012-2021. The counts, age-adjusted, and crude rates were the highest in 2017.

Behavioral Risk Factor Surveillance Data

The Behavioral Risk Factor Surveillance (BRFSS) is a statewide survey focused on health risk behaviors, preventative health practices, chronic health conditions, and the community's use of preventative services. According to the Centers for Disease Control and Prevention (CDC), BRFSS is a powerful tool for targeting and building health promotion activities.
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 the possibility of a small sample size that does not reflect the entire population and that the specific questions cannot be compared nationally. Survey questions vary from year to year and the information collected only reflects the willingness of the responders.

Mental and Physical Health Charts

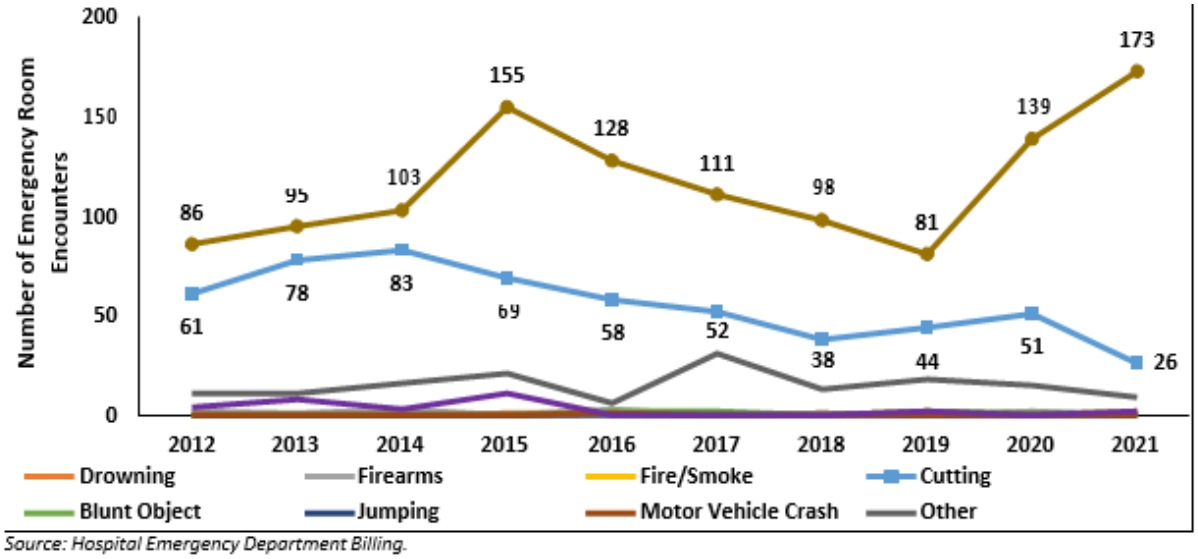
Percentage of Adult BRFSS Respondents Who Have Seriously Considered Attempting Suicide
Northern Region Residents 2013-2021



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Chart scaled to 6.0% to display differences among groups.
Indicator was not measured in 2014.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

When asked "have you seriously considered attempting suicide during the past 12 months," 3.4% of Northern Region residents responded "yes" in 2021, which is the lowest percent since 2015.

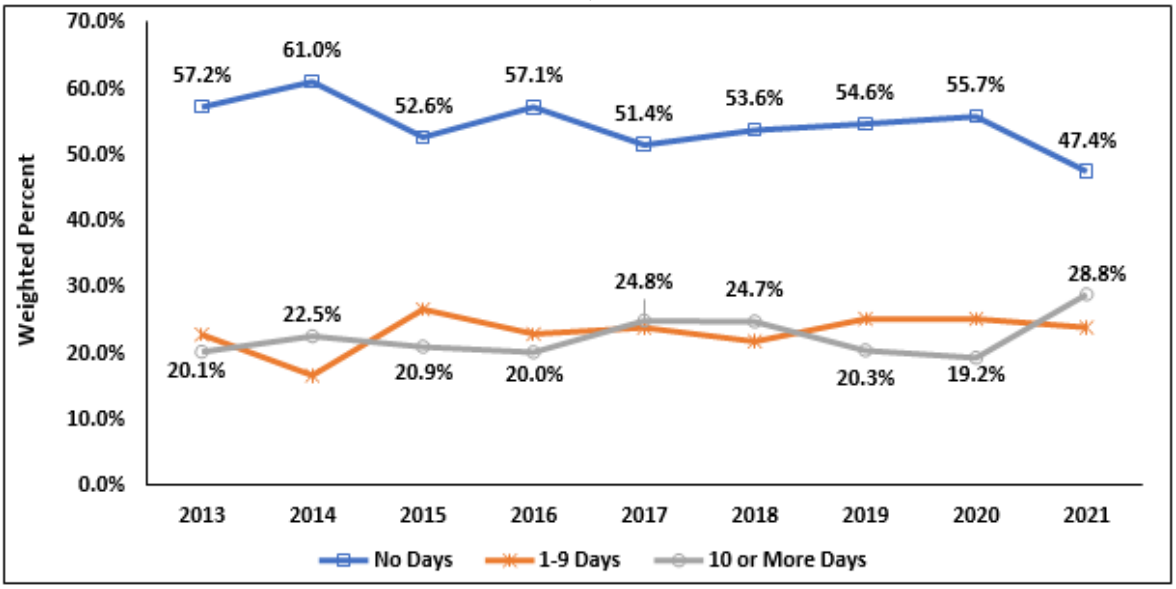
Suicide Attempt Emergency Department Encounters by Method, Northern Region Residents 2012-2021



Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Emergency department encounters related to a suicide attempt, where the patient did not die at the hospital, have remained steady for all methods except substances/drugs from 2012 to 2021 which experienced an increase up till 2015 followed by a period of decline from 2016 to 2019 with post-COVID-19 taking a sharp rise in 2020 and 2021. The most common method for attempted suicide reporting to the Emergency Room is a substance or drug overdose attempt, with 463 emergency department encounters in 2021, down from a high of 510 in 2020.

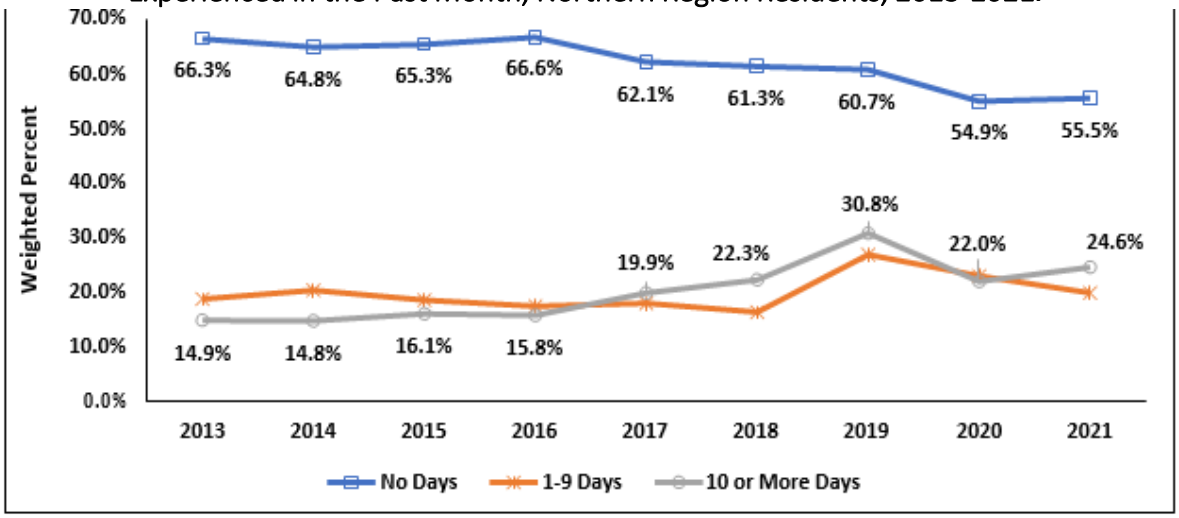
Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Northern Region Residents, 2013-2021



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

The percentage of adult Northern Region BRFSS respondents who reported experiencing no days of poor mental health or physical health that prevented them from doing usual activities was at a low of 47.4% in 2021. This percent has increased and decreased since 2013, with a high of 61.0% in 2014.
In contrast, the percent of adult Northern Region BRFSS respondents who reported experiencing 10 or more days of poor mental health or physical health that prevented them from doing usual activities was at a high of 28.8% in 2021, up from a low of 19.2% in 2020.

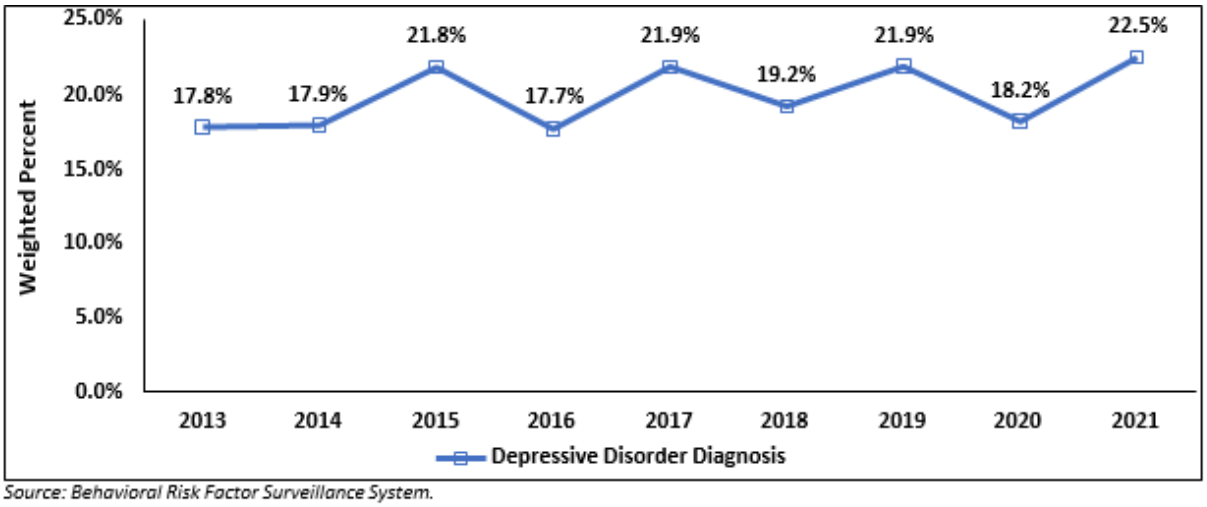
Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Northern Region Residents, 2013-2021.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

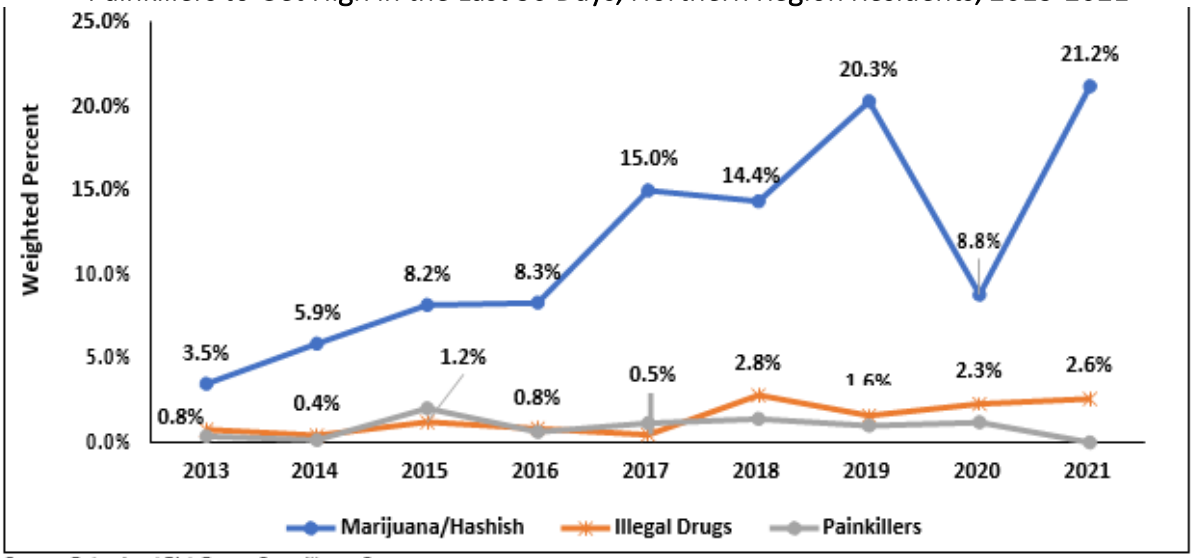
The percent of adult Northern Region BRFSS respondents who reported who experienced no days in the past month in which their mental health was considered by them as "not good" steadily decreased from a high of 66.6% in 2016 to a low of 54.9% in 2020, followed by a slight increase to 55.5% in 2021.
In contrast, the percentage of adult Northern Region BRFSS respondents who reported experiencing 10 or more days in the past month in which their mental health was considered by them as "not good" steadily increased from 14.8% in 2015 to 30.8% in 2019, followed by a decrease to 22.0% in 2020 and an increase of 24.6% in 2021.

Percent of Adult BRFSS Respondents Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Northern Region Residents, 2013-2021.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

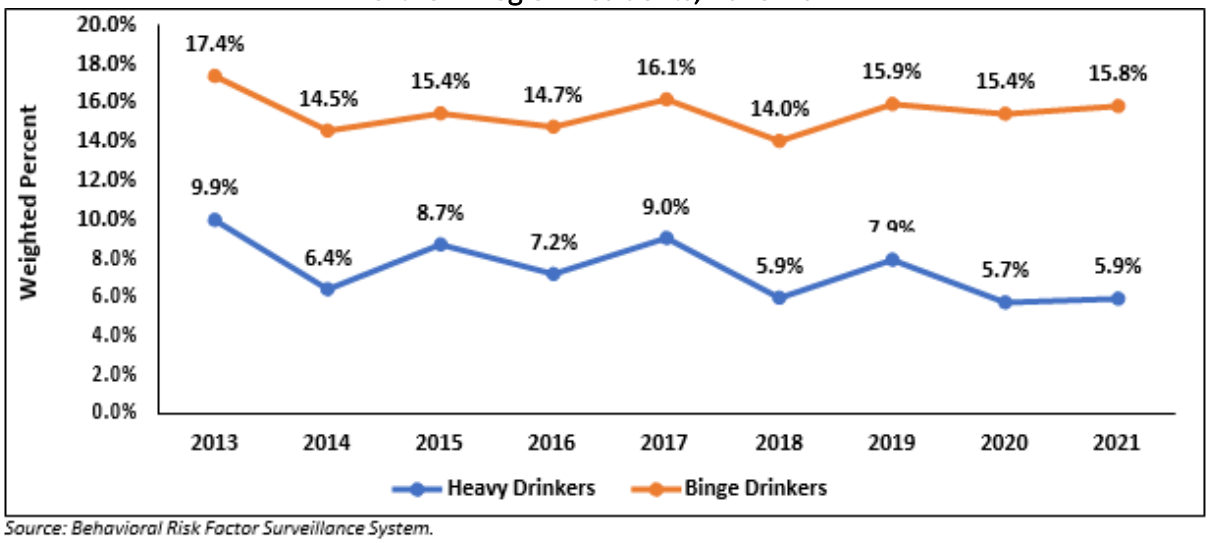
Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Northern Region Residents, 2013-2021.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/prescription drugs without a doctor's order, just to "feel good," or to "get high"?"

Marijuana use has increased over sixfold since 2013. In 2021, 21.2% of Northern Region resident BRFSS respondents have used marijuana in the past 30 days, up from 3.5% in 2013. Marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Of the adult Northern Region residents surveyed, 0% (on average) used painkillers to get high in the last 30 days and 2.6% used other illegal drugs to get high in the last 30 days.

Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Northern Region Residents, 2013-2021.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20.0% to display differences among groups.
Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).
Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).

Binge drinking is defined in men as having five or more alcoholic beverages and woman having four or more alcoholic beverages on the same occasion. Heavy drinking is defined in men as consuming 15 or more alcoholic beverages per week, and women as consuming eight or more alcoholic beverages per week (CDC Binge and Heavy Drinking).

Binge drinking percents among adult Northern Region BRFSS respondents fluctuated from a high of 17.4% in 2013 to a low of 14.0% in 2018. Heavy drinking percentages among adult Northern Region BRFSS respondents fluctuated from a high of 9.9% in 2013 to a low of 5.7% in 2020.

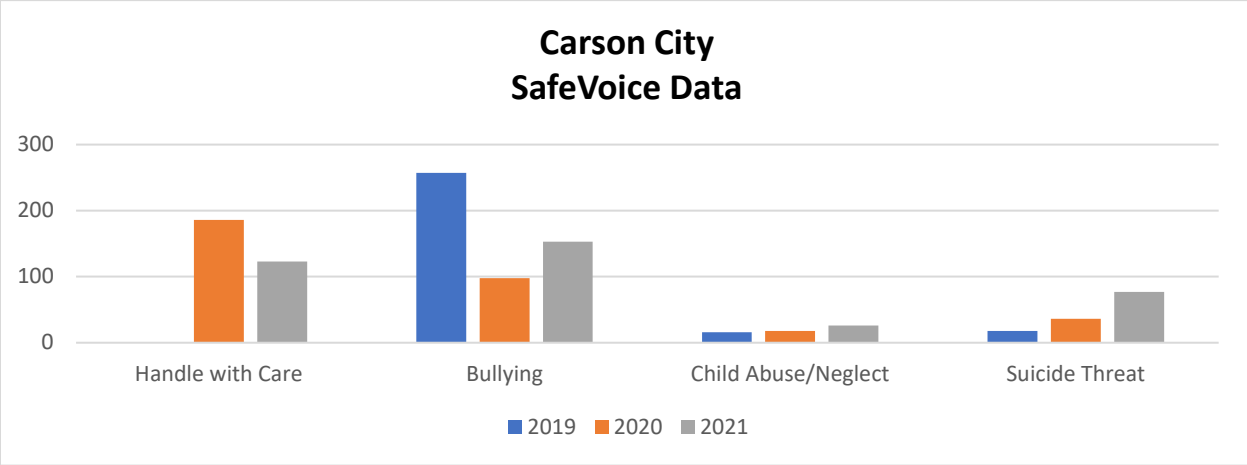
SafeVoice Data Charts

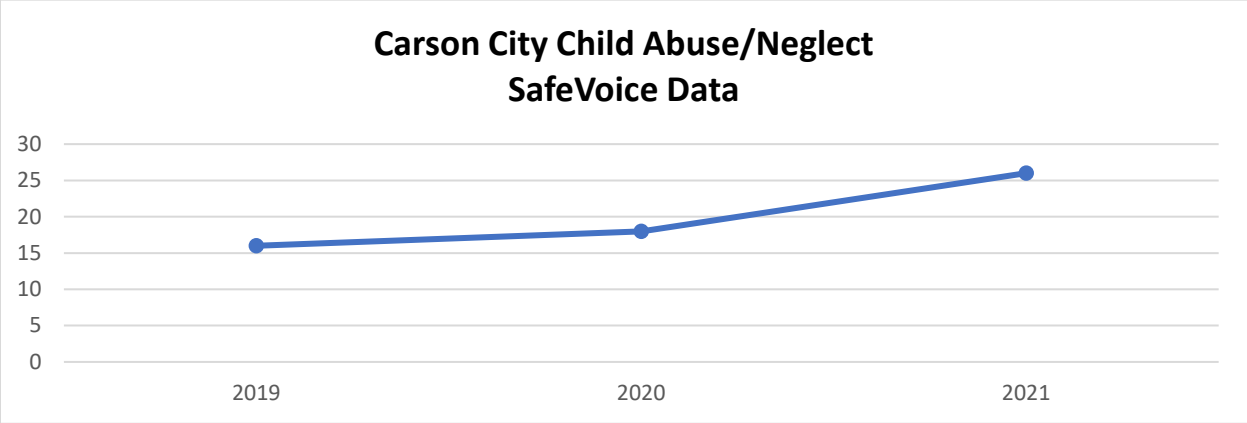
SafeVoice gives students, parents, and faculty access to an anonymous reporting system that prevents violence and saves lives. In partnership with the Nevada Department of Public Safety, SafeVoice allows students a safe place to voice their concerns. SafeVoice was established by the Nevada Department of Education under SB 212 in 2017 and provides a team of first responders 24/7/365. SafeVoice protects students' 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 of charts based on data collected between the calendar years 2019 – 2021 for Carson City, Douglas, Lyon, and counties.

Carson City

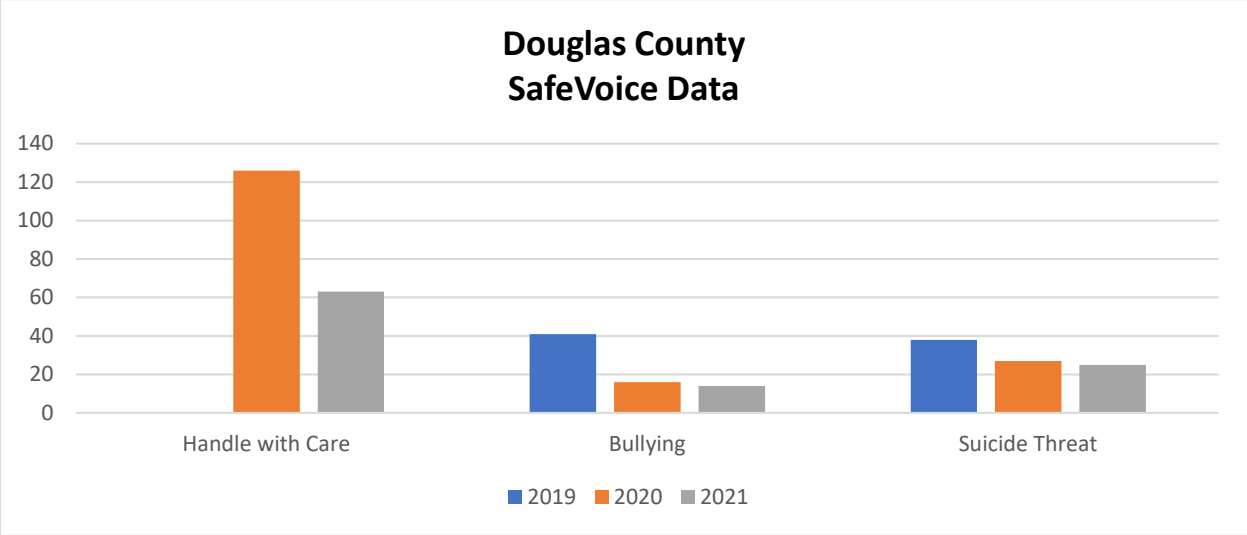




From 2019 to 2021, Carson City saw an increase in suicide threat and child abuse/neglect. The amount of youth at risk for suicide saw a 327.8% increase over the two-year span. The number of children reported to being abused and neglected increased 62.5% from 2019 to 2021.

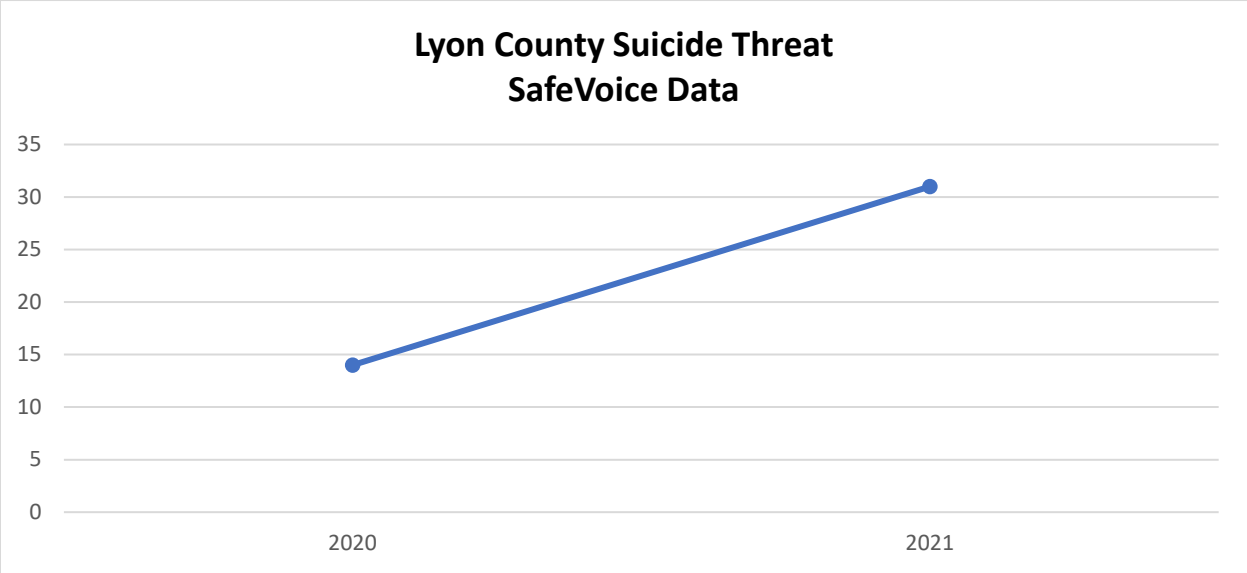
After a sharp decline in the number of reported cases of bullying in 2020, SafeVoice reports an upward trend in bullying 2021. Reports of bullying decreased 61.9% from 2019 to 2020, only to increase 56.1% in 2021. Handle with Care notifications at schools decreased 33.9% between 2020 and 2021.

Douglas County

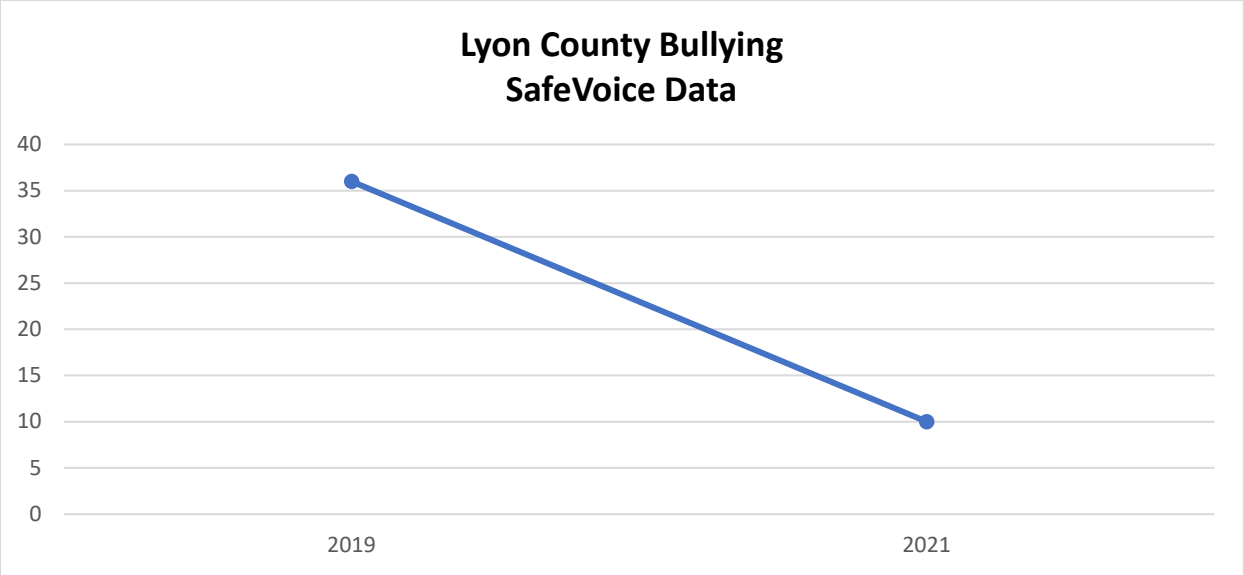


Between 2019 and 2021, SafeVoice reported to Douglas County having a downward trend in handle with care notations, bullying, and suicide threat.

Lyon County

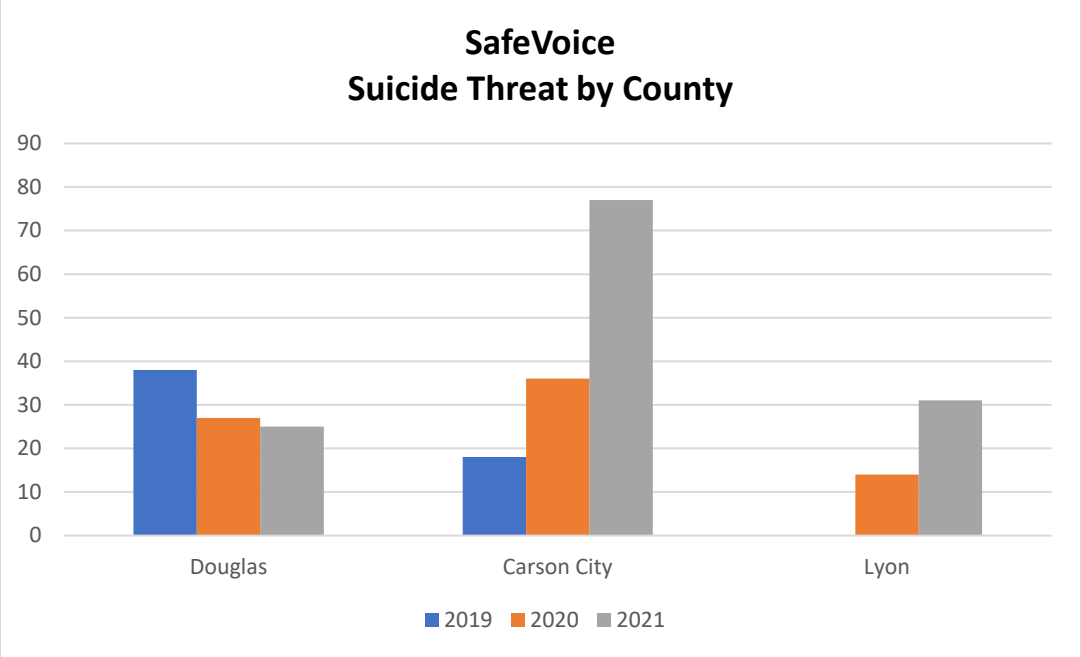


Lyon County saw an exponential increase in youth reported to being at risk for suicide. From 2020 to 2021, the youth suicide threat increased 121.4%.



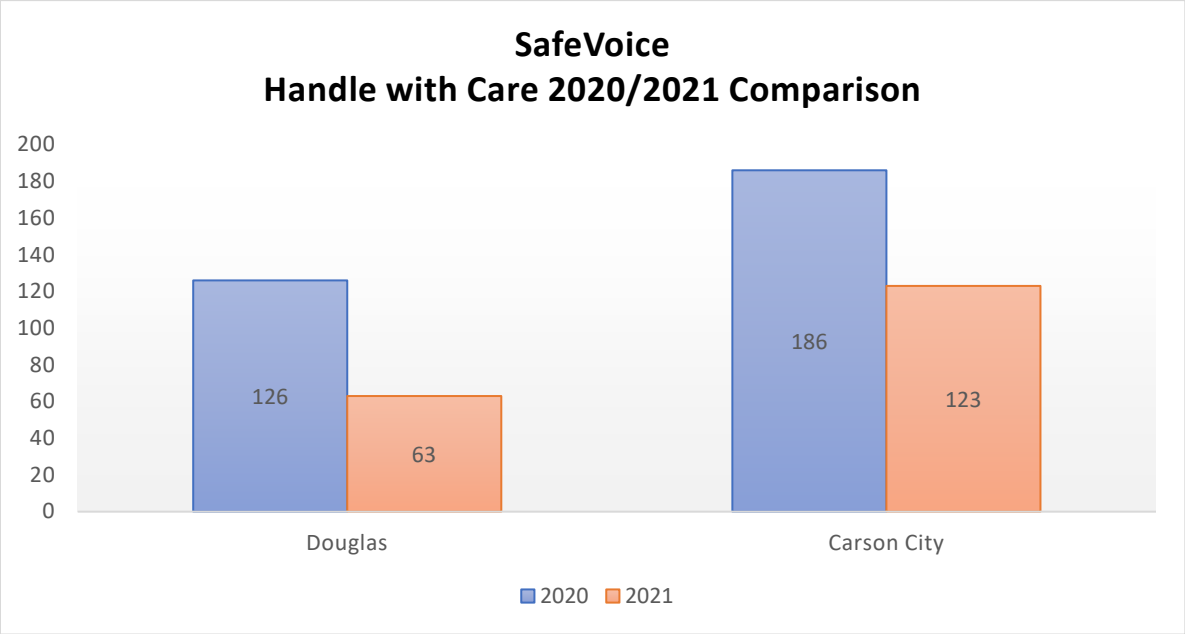
From 2019 to 2021, Lyon County saw a 72.2% decrease of youth bullying reports, in contrast to the rising cases of suicide threats.

Region Comparison Suicide Threat



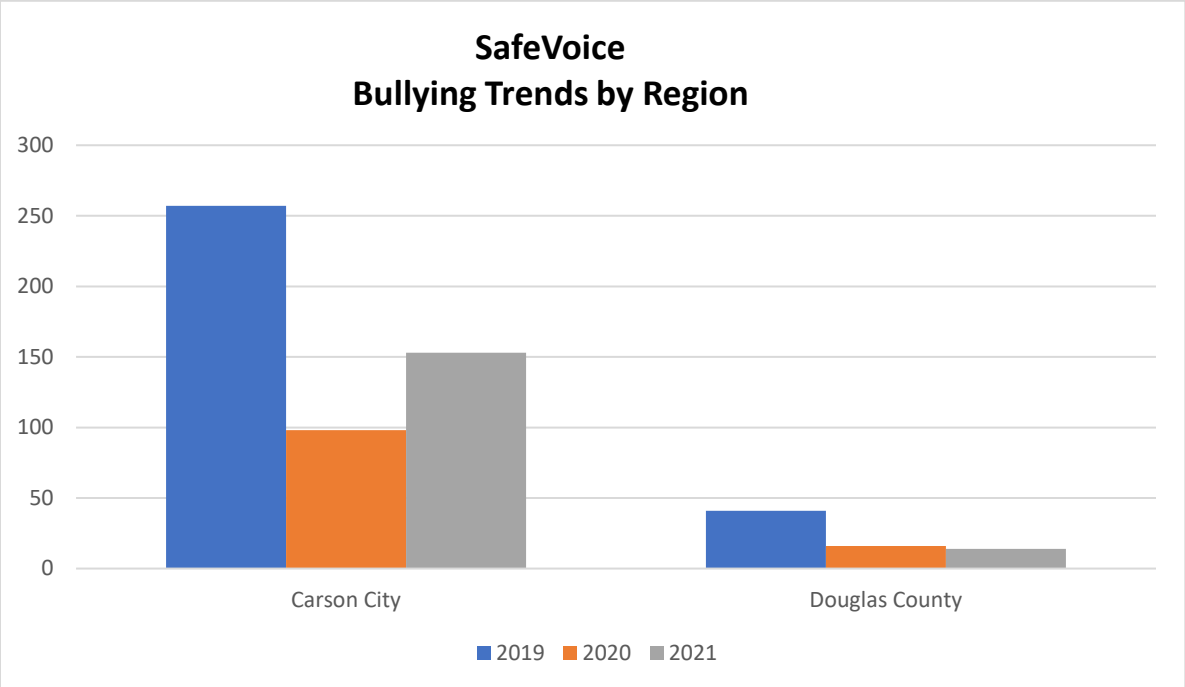
Carson City and Lyon Count experienced an upward trend in youth suicide threat reports, whereas Douglas County saw a decreasing trend.

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 the 2021 Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a national surveillance system that was established by the Centers for Disease Control and Prevention (CDC) to monitor the prevalence of health risk behaviors among youth. Every two years, little over 30 high schools from Nevada were randomly chosen by the CDC to represent Nevada. However, to ensure greater representation from schools in all Nevada districts, the Nevada Division of Public and Behavioral Health contracted with the University of Nevada, Reno School of Public Health to conduct the YRBS in all high schools throughout the state. The Nevada High School YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in regular public, charter, and alternative schools. Students self-report their behaviors in six major areas of health that directly lead to morbidity and mortality; these include:

1. Behaviors that contribute to unintentional injuries and violence
2. Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other sexually transmitted diseases, and unintended pregnancy
3. Tobacco use
4. Alcohol and other drug use
5. Unhealthy dietary behaviors
6. Physical inactivity

Nevada is among the few states that collect data in middle schools. The Nevada Middle School YRBS is biennial, anonymous, and voluntary survey of students in 6th through 8th grade in regular public, charter, and alternative schools. Students self-report their behaviors in five major areas of health that directly lead to morbidity and mortality, these include:

1. Behaviors that contribute to unintentional injuries and violence
2. Tobacco use
3. Alcohol and other drug use
4. Unhealthy dietary behaviors
5. Physical inactivity

For more information on CDC's Youth Risk Behavior Surveillance System (YRBSS): CDC YRBSS For more information on Nevada YRBS: Nevada YRBS

Youth Mental Health:

- From 2017 to 2021, there has been a steady increase in the percent of Northern Region high school students reporting that they felt sad or hopeless. The percent who reported that they considered suicide, planned suicide, or attempted suicide decreased from 2017 to 2019 before increasing in 2021 to percents higher than in 2017. The 2021 Northern Region high school percents are within 1.0% of the 2021 Nevada high school percents.
- From 2017 to 2021, there has been an increase in the percent of Northern Region middle school students reporting that they felt sad or hopeless. The percent who considered suicide or attempted suicide increased from 2017 to 2019 before decreasing in 2021, while the percent who planned suicide decreased from 2017 to 2019 before

increasing slightly in 2021. The Northern Region middle school percents are within 1.0% of Nevada middle school percents.

Youth Electronic Vapor Product Use:

- The percent of Northern Region high school students who reported ever or currently using electronic vapor (E-vapor) products were highest in 2019 followed by a decrease in 2021. The percent of Northern Region high school students who reported currently using electronic vapor (E-vapor) products is significantly higher than the percent of Nevada high school students.
- The percent of Northern Region middle school students who reported ever or currently using electronic vapor (E-vapor) products were highest in 2019 followed by a decrease in 2021. The percent of Northern Region middle school students who reported ever using electronic vapor (E-vapor) products is significantly higher than the percent of Nevada middle school students.

Youth Alcohol Use:

- The percent of high school students in the Northern Region who ever drank alcohol and currently drink alcohol has steadily declined from 2017 to 2021. The percent of Northern Region high school students in 2021 who ever drank alcohol, currently drink alcohol, and drank before a certain age is higher than Nevada high school students, but not significantly.
- The percent of Northern Region middle school students who ever drank alcohol, currently drink alcohol and drank before a certain age was highest in 2019 followed by a decrease in 2021. The percent of Northern Region middle school students in 2021 who ever drank alcohol, currently drink alcohol, and drank before a certain age were all higher than the percent of Nevada middle school students, but not significantly.

Youth Marijuana Use:

- The percent of high school students in the Northern Region who ever used marijuana and currently use marijuana were at the lowest in 2021, while the percent who used marijuana before a certain age (13 years old) was at the highest since 2017. The percent of Northern Region high school students in 2021 who ever used marijuana, currently use marijuana, and used marijuana before a certain age were all higher than the percent of Nevada high school students, but not significantly.
- The percent of middle school students in the Northern Region who ever used marijuana and currently use marijuana were at the lowest in 2021, while the percent who used marijuana before a certain age (11 years old) was lower than in 2019 but higher than in 2017. The percent of Northern Region middle school students who ever used marijuana, currently use marijuana, and used marijuana before a certain age in 2021 were all higher than the percent of Nevada middle school students, but not significantly.

Youth Lifetime Drug Use:

- From 2019 to 2021, all categories of lifetime drug use listed in Figure 33a above decreased among the Northern Region high school students. All have steadily decreased since 2017 except for cocaine use, which increased from 2017 to 2019. Lifetime cocaine, ecstasy, and methamphetamine use among the Northern Region high school students in 2021 are higher than Nevada high school students, but not significantly.
- From 2019 to 2021, all lifetime drug use listed in Figure 33b above decreased among Northern Region middle school students, except for heroin, which remained the same. Lifetime ecstasy, heroin, and synthetic marijuana use among the Northern Region middle school students in 2021 are higher than Nevada middle school students, but not significantly.

Special Populations – Maternal and Child Health:

- The data in this section are reflective of self-reported information provided by the mother on the birth record. On average, there were 1,803 live births per year to Northern Region residents between 2012 and 2021. In 2021, four birth certificates indicated alcohol use, 87 birth certificates indicated marijuana use, seven indicated meth/amphetamine use, one indicated opiate use, and one indicated heroin use during pregnancy.
- Of the self-reported substance use during pregnancy among Northern Region persons who gave birth between 2012 and 2021, the highest rate was marijuana use in 2021, at 48.0 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 2.2 per 1,000 births in 2021. Meth/amphetamine use during pregnancy reached a high of 4.6 per 1,000 live births before decreasing to 3.9 per 1,000 live births in 2021. Polysubstance use (use of more than one substance) has increased from 2.7 per 1,000 live births in 2017 to 5.5 per 1,000 live births in 2021.
- Because alcohol and substance use during pregnancy is self-reported by the mothers, rates are likely lower than actual rates due to underreporting, and expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.
- Neonatal abstinence syndrome (NAS) is a group of conditions that occur in a newborn who was exposed to addictive, illegal, or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth. The NAS rate in the Northern Region decreased from a high of 9.5 in 2016 to 1.7 in 2021.

Northern Region
Carson, Churchill, Douglas, Lyon, Storey

Cherylyn Rahr-Wood, MSW
Northern Regional Behavioral Health Coordinator
Assembly Health and Human Services, August 18, 2022

Rural RBHPB S

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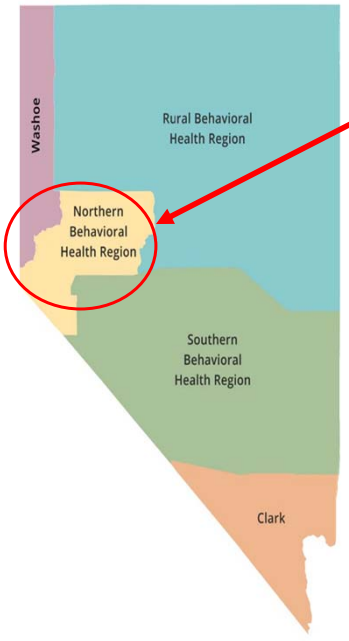

Northern Region

Carson, Churchill, Douglas, Lyon, and Sto

- Approximately **8,049+ square miles** in Northern Nevad
- The total population of the Northern Region is estimat to be reaching 200,000

- In terms of ethnicity, 74.1% residents in the Northern Region are White not of Hispanic origin, 16.6% residen are Hispanic, 3.2% of the population are Native Americ 2.4% Asian, and 1.9% of the population are Black or African American.

United States Census Bureau. (2020, August 8). Nevada: 2020 Census. Retrieved May 18, 2022 from http://www.census.gov/library/stories population-change-between-census-decade-html

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Northern Regional Behavioral Health Board

Taylor Allison, (Board Chair) Public Health Coordinator, Nevada Association of Counties

Dr. Ali Banister, (Board Vice-Chair) PhD, Juvenile Probation Chief – First Judicial District

Dr. Robin Titus, Assemblywoman, Nevada Assembly

Dr. Amy Hynes- Sutherland, Development Officer, Carson Tahoe Health Foundation

Nicki Aaker, RN, Director, Carson City Health and Human Services

Erik Schoen, Executive Director, Community Chest

Ken Furlong, Sheriff, Carson City

Sandy Wartgow, Carson City Fire Department

Lana Robards, Director, New Frontier Treatment Center, Fallon, Nevada

Dr. Amy Kegel, Clinical Psychologist, Nevada Behavioral Health Systems

Shayla Holmes, Executive Director of Lyon County Health and Human Services

Laura Yanez, Executive Director, NAMI Western Nevada

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Northern Regional Policy Board Areas of Discussion and Support

- BEHAVIORAL HEALTH WORKFORCE CAPACITY
- REGIONAL CRISIS RESPONSE
- ACCESS TO CARE FOR ALL LEVELS OF TREATMENT
- AFFORDABLE AND SUPPORTIVE HOUSING
- TRANSPORTATION
- KNOWLEDGE O STATEWIDE AN COMMUNITY PROGRAMS AN RESOURCES

4

RESILENCEY

Regional CIT, FASTT, MOST Teams

MDT (Multi Disciplinary Teams)

Local Behavioral Task Force

Carson City Behavioral Health
Douglas Behavioral Health
Lyon County Public and Behavioral Health
Storey County Behavioral Health
Churchill Behavioral Health

Northern Regions Assets

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2023 Legislative Priorities

- Support Legislation that impacts Behavioral Health
  - Letters of Support/Testimony/Intra Regional Legislative support/education

- **2021 BDR: NRS433A**
  - Language on the Legal 2000/Legal Hold
  - Mental Health Crisis Hold

2023 Proposed BDR Concept:
Other Region BDRs:
- Northern: Behavioral Health Authority
- Rural: Workforce Education
- Clark: Supportive Housing
- Southern:

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