Washoe County Region:

Washoe County Regional Behavioral Health Policy Board (WRBHPB) addresses the previous year's activities, support, and data collection related to Behavioral Health in Washoe County. While the focus of WRBHPB is on behavioral health issues in Washoe County, coordination and collaboration with other regional boards is important to mitigate duplication and affect positive change for all of Nevada. One method to affect change is the opportunity that the regional behavioral health policy boards are afforded to develop and present a Bill Draft Request (BDR) during each legislative session.
During the 2023 Legislative Session, the consortia introduced Assembly Bill 69 (AB69). The assembly bill includes recommendation to support workforce development, expands the loan repayment program for certain providers of behavioral health care, additional resources to increase the number of providers, provider types, and care settings. AB69 also includes a provision that targets a portion of the funds specifically to behavioral health providers to meet a critical and immediate need.

Washoe Regional Behavioral Health Policy Board (WRBHPB) Overview: The Board's efforts were prioritized in the following areas for 2022:

- Planning and implementation of a Regional Crisis Stabilization Center for Adults
- Children's Mental Health
- Behavioral Health Workforce
- Behavioral Health Equity

The geographic distinctiveness of Nevada provided 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 remained the same across the regions. Several focus areas have emerged and have been identified for WRBHPB board support, influence, and collaboration. The policy board supports the following identified priorities and strategies.

1. **Crisis Response System**: The WRBHPB recognized an issue that continued to emerge in discussions and study was the challenge to provide adequate and appropriate services to these individuals who were experiencing a mental health and/or substance abuse crisis. These individuals are either taken, voluntarily or involuntarily to emergency rooms, and/or jails when they could be better served in an environment that is designed to treat their conditions. 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 the same way they respond to other emergencies. The residents of Washoe County experiencing suicidality or behavioral health emergencies deserve the same prompt, high quality care delivered to individuals with physical medical emergencies. There have been several developments at the national level and within Nevada recently that are focused around addressing crises and preventing suicide. One is the FCC approving 988 as the three-digit call line for anyone experiencing a behavioral health crisis or suicidality. The 988 number went live across the country on July 16, 2022, which will lead to the development of a crisis response system for Washoe region. There are also state resources and federal dollars that helped fund the crisis response system. The core elements of the crisis response system include a statewide crisis call center to manage the 988 crisis line, deployment and utilization of mobile crisis teams, and physical crisis stabilization centers. These efforts are all leading to the development and implementation of a crisis response system for the Washoe Region, which has been the number one priority for WRBHPB for the past several biennia.

The Washoe County Health District (WCHD) contracted with Social Entrepreneurs, Inc (SEI) and together with the different stakeholders convened a planning project in 2021 to support the implementation of a behavioral health crisis response system with Washoe County region including the City of Reno, the City of Sparks, and Washoe County. With active involvement from regional leadership, community members, and service providers, Washoe County endeavored to design the State of Nevada's first comprehensive crisis response system to address critical behavioral health crisis needs of the residents of the Washoe County Region. The goal of the crisis response system is divert behavioral health and suicidality crisis from 911 to 988 with the goals of saving lives, saves costs and ensure every person in crisis receives the right response at the right time.

2. **Children's Mental Health:** As the WRBHPB worked on the adult crisis care, it became obvious that efforts could not be confined to adults. Children, youth, and young adults across the nation are experiencing a rising wave of emotional and behavioral health needs. All too often, these young people are subjected to unnecessary hospitalizations, long stays in inpatient facilities, justice system involvement, disproportionate school discipline, and out of home placements. There are also pronounced disparities impacting young people of color, families from low-income communities, and sexual minority youth. For too many youths, these crises end tragically. All youth and families should have access to a robust crisis response system that has developmentally appropriate policies, staffing, and resources in place to respond to their needs equitably and effectively- the right supports, at the right time, delivered right away (SAMHSA guidelines). It was clear to the WRBHPB that support should also be given to address children's mental health problems. WRBHPB board members are participating in a Youth Crisis System collaboration group seeking to address the challenges faced by youth with behavioral health issues. While the WRBHPB works to see the adult crisis response center become a reality, it looks forward to supporting all efforts for

the development of a crisis response center designed specifically for the unique needs and challenges facing youth.

3. **Behavioral Health Workforce**: Nationally, there is more demand for behavioral health 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, post pandemic numbers of providers reflect increasing retirement which impacted the workforce numbers as well as leaving a historical knowledge gap. Although there is a growth of licensed professionals, it is not enough to keep pace with population growth and need including geographic disparity. Washoe County 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 remains a challenge. Washoe County can stand up in a perfectly planned and funded crisis stabilization center but without the right staff to serve those in crisis, the efforts are in vain. The impact of Nevada's severe behavioral health professional shortage has led to students' mental health needs from K-12 are not always met. Recruitment of experienced faculty to train the next generation of behavioral health providers in Nevada also provides a challenge due to salary disparity between their peers working in private practice as they tend to earn less. The mental health workforce shortage cannot be addressed without reevaluating provider reimbursements. Low reimbursement rates for mental health services drive practitioners to other specialties and increases out of network participation.

   Throughout the previous biennium, the WRBHPB continued to hear from providers as well as those in need of behavioral health services. There were many concepts, policies, and strategies presented to the board to address the workforce crisis including the following: proposal to consider expansion of public higher education health programs and budgets, residency and fellowship program development, state and federal loan repayments, scholarship programs, and licensing reciprocity and health care professions compensation. In discussion and collaboration with subject matter experts, the board crafted and submitted their BDR concept which was subsequently assigned as Assembly Bill 69. As of this writing and submission of this report, AB69 has been heard in the Assembly Committee on Education, passed unanimously, and referred to Assembly Ways and Means. The WRBHPD also participated in the Nevada Health Care Workforce and Pipeline Development Workgroup which is a statewide initiative that aims to improve, grow, and diversify Nevada's public health, behavioral health, and primary care workforces. The board also voted unanimously to support other pieces of legislation which deals with workforce development.

4. **Behavioral Health Equity**: The behavioral health needs of minority communities have been historically and disproportionately underserved. The

WRBHPD believes that providers need to be sensitive to cultural issues and equipped with the necessary language skills that facilitate and promote effective service delivery. Following SAMHSA's commitment to addressing behavioral workforce disparities, WRBHPB seeks to identify and promote the effective recruitment 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 support and promote efforts within the Crisis Stabilization Center and other priorities identified within this report. WRBHPD will continue to welcome presentations and education, studying the cultural attributes that affect our ability to reach and server our diverse community members.

The following are additional areas of support by the WRBHPB including the continued regional education and utilization of the 988 phone line by individuals in need of behavioral health care. This system is a critical requirement and need for the successful implementation of a crisis response center. The WRBHPB also supports the efforts taken for the successful implementation of Community Health Improvement Plan (CHIP). The CHIP is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. The WRBHPB also supports the Nevada Regional behavioral Health Policy Board Data Website. Pursuant to requirements outlines in NRS 433.4295, the Regional Behavioral Health Coordinators began discussion with the state around funding for a data repository website. The website was developed in 2021. While the website is being utilized, challenges remain around staff that can maintain the site and determining the most efficacious way to include current and accurate behavioral health resources, however it is open for the public to view and utilize.

Nevada's Workforce Recommendations

Natasha Mosby, LCSW

The workforce shortages in Nevada affects more than 2 million Nevada residents in Southern and Northern Nevada (Clark, Washoe, Rural and Northern Regions) ranging from primary to mental health care. According to a report by UNLV Brookings Mountain West and the Lincy Institute, all of Nevada's counties are federally designated mental health provider shortage, ranking last in the nation in areas of access to care and the highest prevalence of mental illness. 100% of the Clark County population of 2.4 million residents live in a mental health shortage area, 297,118 (62.9

%) of Washoe County residents live in a mental health professional shortage (HPSA), and 100% of Carson City, Douglas County, Lyon County, and Storey County residents live in a mental HPSA. From a macro system, the following policy strategies were proposed and recommended to address the workforce shortages pertaining to behavioral health:

- Expand public higher education health programs and budgets
- Residency and fellowship program development (GME), including rural residency programs and subspecialty training
- State and federal loan repayment and scholarship programs
- Licensing reciprocity and health care professions compacts

From these recommendations, AB 37 was approved on June 15, 2023, during the Legislative session. AB 37 will aim to increase the behavioral health workforce by creating a pipeline for behavioral health providers, expand existing successful programs and introduce new programs and connections across the educational system and professional licensing boards based on successful models from Nebraska and Illinois.

From the mezzo and micro systems, behavioral health agencies are facing challenges post the pandemic with recruiting and sustaining mental health providers. More agencies are collaborating with UNLV mental health and counseling programs and becoming practicum learning sites for undergraduate and graduate students. Practicum placements provides opportunities for students to gain employment post their undergraduate and graduate studies which subsequently addresses the workforce shortages.

Northern Nevada

After July's Board meeting it was identified that most of the recommendations for the 2022 priorities the Northern Reginal Board wrote about in their 2022 Annual Report had forward movement due to new leadership, legislation, policy reform as well the regions focus and hard work. The updated priorities are presented to include underlying needs, gaps, and strategies re-established recently by the Northern Regional Policy Board. With new and revised recommendations from the Northern Regional Policy Board for those priorities listed.

The Northern Regional Behavioral Health Policy Board met eleven times during the calendar year 2022. The board met through web-based videoconferencing, with additional accessibility through teleconferencing, in compliance with NRS to accomplish its mission this year. The board has also made the determination to continue with quarterly in-person (hybrid option), video, and teleconferencing until further notice.

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 each county has some similar but also very different barriers, and gaps, as well as the many successful initiatives, is important. Taking time to build and rebuild these essential relationships has enabled me to assess the counties' successes, issues, gaps and barriers, ongoing projects, as well 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.

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. Collaborating closely with community partners developing innovative programs and strengthening old ones that are communities have grown to love. Nevadans in need are receiving well-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. Add the always and ever-present transportation issues in the rural and frontier areas. This will always be there as we cannot change the geography of Nevada.

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

This letter solidifies the recommendations needed to be made to improve behavioral health services and enhance the quality of life within the Northern Region's communities. The Northern Board's focus is on identifying behavioral health gaps and needs, as well as strategies and recommendations to address the most pressing issues in the region.

The Northern Regional Board continues to embrace a data driven approach to identify the behavioral health needs and system gaps of the region. In review of the data, workforce related issues, with aspects of recruitment and retention, present as a central influence on so many of the priorities the board is focused on. This unfortunately has gone unchanged from their previous report and is consistent with public comments of stakeholders statewide made during regular committee, consortia, behavioral taskforce, coalition meetings within the northern region.

1. **Regional Board Infrastructure Development -** 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.
    - Create a statewide task force to develop crosswalk/spiderweb of all entities that meet: councils, boards, committees, consortia's, subcommittees, etc. Understanding collaboration and cohesiveness of our federal, state and county meetings, who is communicating with who, who is working on what with who.
    - Continue to strengthen coordination of funding and programs between state and local stakeholders, rebuild trust among state and counties.
    - Develop a collaborative symbiotic relationship with the Office of Analytics. With access and ease to retrieve data in real time. Supporting the region's hospitals as the new data regulations are implemented.
    - Expand awareness and access to community trainings such as psychological first aid training, suicide prevention, mental health first aid, and other trainings that can arm our communities with resources and information to help their citizens during prevention, intervention and postvention of a disaster in any Northern Regional County
    - Each county in the Northern Behavioral Health Region formally adopts the Northern Regional Behavioral Health Emergency Operations Plan.

2. **Affordable and supportive housing and other social determinants of health -** 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 lengthy 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.

    Recommendations:

- Advocate for the State to fund regional affordable and supportive housing programs and initiatives within the Northern Behavioral Health Region.
- Advocate for a regional assessment of how many affordable and supportive units would be needed.
- Support the development of a regulatory body focused on supportive housing – staffing needs, insurance coverage, cost of rooms – insurance of the agency, business working for the state – policies created to support the system.
- Advocate for the Northern region counties to have available/affordable childcare for those accessing services.
- Support the DOE with implementing a campaign for obesity in youth, focused on K-7

3. **Behavioral health workforce with capability to treat adults and youth -** 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. This gap impedes timely access to treatment and prevents providers from expanding quality services. In addition, the Northern Board recognizes that the community health worker (CHW) and peer recovery support specialists (PRSS) are underutilized in the behavioral health and health workforce pipeline.

   Recommendations:
   - Evaluate network adequacy related to insurance company credentialing.
   - Support Medicaid and the Northern Behavioral Health Region in educating on the QRR survey for Medicaid reimbursement.
   - Support family caregivers through supporting access to reimbursement, increasing access to services, training, and respite care across the life span.
   - Develop professional guidelines for Nevadan stakeholders focused on the utilization of CHW's and PRSS's workforce.
   - Add incentives for providers who serve substantial risk populations and utilize peer support specialists.
   - Mainstream the application process for behavioral health professionals to become licensed.

4. **Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion and reentry resources (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center) -** The Northern Region has made significant progress in addressing gaps in crisis response services through the following community-based crisis stabilization, jail diversion, as well deflection and reentry programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory

Crisis Center. As with all programs sustainability is this focus of the counties when wanting to move a program forward. (Please see https://nvbh.org/education/ for more information on these programs.) In addition, there is a need to coordinate local infrastructure into the state crisis response system with the implementation of the 988 system.

Recommendations:

- Continued development of sustainable funding mechanisms for current local crisis response and jail diversion and street deflection programs including MOST, FASTT, CIT programs, and Mallory Crisis Center.
- Develop more sustainable Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs in the Northern Region.
- Prioritize the co-responder model focused on developing multiple per county 24/7/365 local on-call mobile crisis response teams for the Northern Region.
- Develop a follow-up co-responder program utilizing a CHW and PRSS as follow-up for the county's frontline established MOST 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/
- Ensure the implementation of feedback or accountability mechanisms for crisis response services.
- Continue to build the statewide handbook for both the MOST, and FASTT deflection/ diversion programs being implemented in the northern region. This will be beneficial for other counties wanting to implement a program such as these in their county.

5. **Increase access to treatment in all levels of care -** 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.

   Recommendations:

   - Develop funding for respite care, peer drop-in centers, living room models, and community support centers.
   - Explore the adequacy of reimbursement rates for all youth behavioral health services to ensure access to treatment.
   - Work to develop community-based policies and legislation around self-care safeguards for behavioral health providers.

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

Recommendations:

- Support formal agreements between Community Health Workers (CHWs) and various existing programs such as Healthlink, OpenBeds, behavioral health care and health care hospitals.
- Identify the role of Peer Recovery Support Specialist/Peer Support Specialist (PRSS/PSS) and family peer support in encouraging clients to follow a self-determined treatment plan and engage in treatment.
- Develop more robust follow-up programs for all ages (such as NAMI WNV Nevada Caring Contacts - Adults and Youth line). Using peers (all) as the nucleus of the program. An upscaled version of the buddy system.
- Provide support/funding/mandate/training/ for providers to utilize a bed registry. OpenBeds is the platform being used so again upcoming - distribution, usage, and implementation and then TA needs to be done.
- Prioritize social and community connectivity efforts to protect and promote well-being including researching policy solutions and evidence-based programs.
- Establish a facilitated entry access to state mental hospitals for high acuity behavioral health patients and inmates.
- Increasing collaboration on the spectrum of substance misuse and its relation to mental health.

Rural Region:

When assessing the behavioral health needs in the rural regions of Nevada the number one area of focus surrounds access. Though the populations in these regions are small – the availability of behavioral health specialists per capita remains out of sync with urban centers of Nevada. The governor can support increased access to behavioral health services in the following ways:

I. Increase investments in Nevada Medicaid reimbursement for behavioral health services.

Behavioral health organizations and individual providers that are interested in providing services in the rural regions of Nevada face increased costs of providing care. Recently, organizations have attempted to establish new access points to behavioral health services in rural Nevada but have been discouraged due to the above average cost of operating and below average Medicaid reimbursement as compared to neighboring

states like Utah. Incentivizing behavioral health organizations and practitioners to increase access in these areas through an enhanced Medicaid reimbursement rate may aid in filling this access gap.

II. Continued support for programs and funding that would increase the number of behavioral health providers across the state of Nevada.

The passage of AB37 in the last legislative session should be celebrated as a huge victory for the state's ability to develop a robust behavioral health workforce. Continued support from the governor as the behavioral health workforce development centers are established, staffed, and begin to deliver outcomes will be crucial. We cannot let this be another example of a good idea that fails due to insufficient state support and poor execution.

III. Support behavioral health transportation solutions and pilot programs.

As the state endeavors on the long-term effort of increasing access and the number of providers providing behavioral health care in our rural regions, attention and funding need to be directed toward meeting the short-term need of citizens living in these regions today. Simply investing in transportation solutions for rural Nevadans to access existing services in other parts of the state is a critical need. Most urgent is an emergency/crisis transport system to aid rural Nevadans returning from higher levels of care in other areas of the state. Current transportation options to access this lifesaving care are air transports that are costly (and not reimbursable through insurance) or multi-day bus & train routes that seem insurmountable to an individual in a behavioral health crisis. Additionally, when utilizing these routes with multiple trains/buses, people being discharged from inpatient care are often not provided with ample medication, food, water, or any other means to maintain their safety and stability over the several days it takes to return home. The governor's support in cultivating innovation in this space will be key to connect the most vulnerable Nevadans to the care they desperately need.

IV. Increased data collection for behavioral health admissions and outcomes.

Per statute (NRS 433.4295) data surrounding mental health crisis holds, emergency & court ordered admissions, and mandated assisted outpatient treatment are to be collected by the state. However, this data is not being reliably reported by state and private mental health facilities, nor is the outcome data and follow-up measures of citizens receiving these services. Without reliable data in these areas it is difficult to effectively channel resources to the appropriate communities or identify

areas where additional resources are needed. The governor's awareness of this hole in our state's clinical data may assist in the appropriate departments developing systems for collecting and reporting this data back to the regional behavioral health policy boards.

Data Highlights:

· All counties in the Rural Region have inadequate local availability of l icensed Alcohol and Drug Counselors, Clinical Alcohol and Drug Counselors, and Certified Problem Gambling Counselors.
· All counties in the Rural Region have inadequate local availability of Licensed Marriage and Family
Therapists and Licensed Clinical Professional Counselors.
· There are no licensed psychiatrists located in any counties included in the Rural Region.
· There is only one licensed psychologist located within
the Rural Region, in Elko County.
· There are 29 Licensed Clinical Social Workers located within
the Rural Region; 20 of which are in Elko County.

- Substance Abuse and Gambling in Nevada
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- The Washoe Regional Behavioral Health Policy Board highlights a challenge to provide adequate and appropriate services within the region to individuals who are experiencing mental health and/or substance abuse crisis. These individuals would be better assisted if supported by a crisis response system that provides a continuum of services in order to stable but also then continue to manage the issues surround the substance abuse. Utilization of 988 services are a great first step to allowing individuals to reach out for help, however additional assistance in ensuring that those in crisis receive the right response in the right place is needed. This is also a concept that is echoed by many of the other policy boards throughout Nevada.
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- The Southern Region Policy board has stated that a priority recommendation is to enhance networking, coordination, collaboration, and accountability between the boards, regions, local and state individuals and entities. They also identified there is a need for increased harm reduction and resources around opioid misuse in some of the rural counties.
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- The Rural Region Policy board discussed seeing a need for additional treatment providers due to increased substance abuse, along with the emerging threat of Xylazine. They have noted that due to misuse of Medication assisted treatment modalities some members of the community, in particular law enforcement and

elected officials, have began to not trust a truly remarkable treatment approach. This is in part due to not having counseling as part of programs due to not having the appropriate workforce. Workforce concerns are paramount yet again this year, stating that the number of providers available do not meet the need that is seen in the community.

- The Northern Regional Behavioral Health Policy Board highlights increasing workforce. This includes fostering relationships between mental health providers, peer support professionals, and community health workers. The Northern Region struggles to attract and retain skilled workforce to provide quality behavioral health services. the board recommends the state explore mechanisms for recruitment and retention of workforce including licensing, reimbursement, and education. The Northern Policy Board also pointed out that there is a lack of services provided at all levels of care, something the other boards have hinted at as well. Additional services are needed for mid level care, above a traditional outpatient but below a hospital stay.
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- A priority of the Clark County Regional Behavioral Health Policy Board highlights
- increasing collaboration on the spectrum of substance misuse and its relation to mental health: The Policy Board needs to effectively address behavioral health in the community and to 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.” According to the Youth Risk Behavior Survey (YRBS) in Clark County, 2019: From 2010 to 2019, the number of emergency department encounters related to alcohol and drug usage have steadily increased in Clark County, the number of inpatient admissions related to alcohol and drug usage have steadily increased also. 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. Having knowledge that mental health and substance use disorders are co-occurring, the community must work to join resources and direct them to raise the health equity in Clark County.
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- The Department of Health and Human Services Problem Gambling Services developed a strategic plan for FY22 and FY23 in which there were identified strengths and limitations in the treatment of problem gambling in Nevada. Some of those strengths include having committed stakeholders, collaborative relationships, and

having affordable treatment. Some of the limitations included lack of public awareness, lack of service in rural communities, lack of programs available, and lack of workforce. One area of focus is prevention and health promotion programs in order to reduce the impact of problem gambling on the community, including families and individuals. The appointed Advisory Committee on Problem Gambling has not met in 2023 per their website.

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– Mental Health America ranks states on a basis on 15 criteria which includes but is not limited to: Adults with Substance Use Disorder in the Past Year and Youth with Substance Use Disorder in the Past Year. While the above measures are not a complete picture of the mental health system, they do provide a strong foundation for understanding the prevalence of mental health concerns, as well as issues of access to insurance and treatment, particularly as that access varies among the states. Related to adults in the reports through Mental Health America, Nevada Ranks 42nd. However, based upon the work our community has been doing, our ranking for the youth in Nevada is 9th vs. 51st in years past. Nevada ranked 51st overall in the last 6 years, however in 2023, Nevada has moved up to 29th overall.

Children's

The state of Nevada is unique in its geography and demography. Since the late 1990s, Nevada has been the fastest growing state in the nation and today ranks at the top in population growth with a 2021 state census population of 3.2 million, 74.1% of which are centered in Clark County. Nevada is geographically the seventh largest state with a landmass of 110,000 square miles. Distances between rural towns average 100 miles, with distances of 180-200 miles between more isolated areas, and 500 miles between major metropolitan areas. Ninety percent of the population lives in three urban counties separated by vast deserts and high mountain ranges. The balance of residents live in fourteen other counties, three of which are designated rural and eleven of which are frontier, defined as sparsely populated rural areas with a population density of six or fewer people per square mile. (1) The population of our state is also relatively young: 32.6% of our population are 24 and under. We are a racial and ethnically diverse state: 10.1% Asian or Pacific Islander, 9.0% Black (non-Hispanic), 30.7% Hispanic, and 49.0% White.Males and females equally comprise the total population, and 5.5% of Nevadans identify as LGBTQ+. This is notable as LGBTQ+ individuals face additional health disparities linked to societal stigma and discrimination which has been associated with higher rates of psychiatric disorders, substance use and suicide. (2)

Nevada has persistent workforce shortages in nursing, medicine, and behavioral health across the state.. Our health professionals are geographically maldistributed across the state, and more than 1.9 million Nevada residents are in a health professional shortage area (HPSA). The maldistribution of healthcare professionals in Nevada is such that even 64.2% of Clark County residents (our most populous county

and home to Las Vegas) reside in a HPSA. Our state's mental health workforce is even more dire. Three million Nevadan's (94.5% of state population) reside in a Mental Health Workforce Shortage area. As of 2021, 100% of Clark County's 2.4 million residents reside in a Mental Health Workforce Shortage Area. (3)

The state health workforce shortages are especially severe for youth patients. State licensure data from 2021 indicates that our state has 11.9 pediatricians per 100,000 population, and it is estimated that our state needs 214 additional pediatricians to meet the US average. (3) Similarly, our state has 30.4 family medicine physicians per 100,000 population. An additional 74 family medicine physicians are needed to meet the national average. Our state's dearth of physicians, nurses, and behavioral health clinicians are the foundation of barriers to care our youth face. Families who are undocumented citizens (roughly ⅓ of our target population) face additional barriers related to lack of insurance benefits. Additionally, state data indicate 24% of youth and families do not have access to reliable high-speed internet. This is a unique barrier to care within our rural/frontier communities, which inhibits the ability to access telehealth resources.

The Centers for Disease Control and Prevention (CDC) has stated that as many as 20% of children may have diagnosable mental, emotional or behavioral health needs. Only 1 in 5 children receive the care they need. (4) In Nevada, the 2018-19 National Survey of Children's Health determined that more than half (60.8%) of youth with mental or behavioral conditions did not receive treatment. (5)

Youth needing specialty mental health care struggle nationally to find child and adolescent psychiatrists. In Nevada, the American Academy of Child and Adolescent Psychiatry (AACAP)'s
data indicates there are 45 child psychiatrists, placing the entire state in a severe shortage. The American Board of Psychiatry and Neurology roster of board certified child psychiatrists in Nevada reflects a more dire picture; accounting for those who left the state and/or passed away in the last year, Nevada only has 39 child psychiatrists. Nevada has 7 child psychiatrists per 100,000 youth; it is estimated that 47 child psychiatrists per 100,000 youth are needed to have a sufficient workforce.(6)

The State of Mental Health 2022 report from Mental Health America continues to rank Nevada 51st in overall mental health metrics. (7) A dive into their youth data reflects Nevada did improve from 46th to 39th in the percentage of youth with private insurance that did not cover mental or emotional problems (from 12.6% 2017-18 to 7.1% 2018-19). Their report ranked Nevada 47th for prevalence of youth with at least one major depressive episode (17.93%) and 49th for youth with reported substance use disorder (5.59%). Those data coincide with Nevada ranking 40th in youth with a major depressive episode who did not receive care (65.2%) and 45th for youth with a major depressive episode who received some care (18.7%). These data clearly reflect the need for more robust access to care. Paired with workforce data, Nevada has the opportunity to leverage all opportunities for youth to receive mental health care

Further, In October 2022, US Department of Justice, Civil Rights Division concluded their investigation related to the state's violation of children's right to be treated in the

least restrictive environment. In summary of findings, the Department of Justice concluded that, "Nevada does not provide its children with behavioral health disabilities with adequate community-based services. Instead, Nevada relies on segregated, institutional settings like hospitals and residential facilities to serve children with behavioral health disabilities."

There has been scant progress towards the state's core goals over the past year, which presents vasts opportunities to improve the current state of public children's mental health in NV:

1) Sustainably fund statewide Mobile Crisis Response Teams for youth, with a goal of mitigating unnecessary acute hospitalizations and to meet the needs of youth and families in the least restrictive setting.
2) Expand statewide family peer-to-peer support.
3) Fully implement the Building Bridges model to facilitate successful transition of youth back into the state from out-of-state residential treatment placements.
4) Expand the children's mental health service array by increasing the children's mental health workforce and by sustainably funding public and private efforts to support youth with mental and behavioral health diagnoses in the least restrictive setting.

The narrative and data above tell the story of the state of children's mental health needs in Nevada. The core areas in which our state struggles include access to care and fiscal support/insurance coverage for necessary care. These issues are again addressed by our state's three regional children's mental health consortia annual reports, highlights of which are summarized below.

1. Mental Health Professionals: Nevada faces a shortage of behavioral health professionals, especially in rural areas.

2. Youth Mental Health: A significant portion of Nevada's youth experience depressive episodes, and a concerning number consider or attempt suicide. These figures are worrisome, especially when compared to national averages. Several novel programs have grown out of our academic health centers, UNR and UNLV. Our state has grant-funded First Episode Psychosis programs at both institutions. UNLV has grant-funded coordinated speciality care programs addressing early severe mental illness and early bipolar disorder. DCFS and UNLV have partnered to expand the state's child psychiatry access program. UNR continues to participate in Project AWARE, promoting mental and behavioral health access in Washoe County schools.

3. Substance Use: Youth in Nevada have exposure to various substances. Opioid misuse emerges as a concern in certain communities, while alcohol and marijuana remain prevalent substances of misuse among teenagers. Opportunities remain to expand our array of adolescent substance use and co-occurring disorders services.

4. State Response: There is a growing emphasis on early intervention in Nevada.

Schools now play a vital role in this shift, integrating mental health education and offering resources to students for proactive issue addressing. A coalition of professionals has re-invigorated the state's efforts to serve youth 0-5 years of age.

5. Telehealth: Given the geographical challenges and shortage of professionals, Nevada invests in telehealth resources to reach children and families in need of behavioral health services, especially in the more isolated parts of the state. Opportunities remain for expanded, consistent broadband access in our frontier and rural areas.

6. Funding and Programs: Federal and state grant programs provide funding for children's behavioral health services. Nevada actively utilizes these funds to initiate programs focused on early intervention, crisis response, and ongoing treatment. Nevada has the opportunity to fully avail itself of the Family First Act, to build services to serve youth and families to mitigate entry into the child welfare system.

7. Integration Efforts: Nevada works towards a more seamless integration between behavioral health services and other child and family services, such as education, juvenile justice, and child welfare. In addition, Nevada efforts to expand its integration efforts of mental health into primary care to stretch the impact of its small children's behavioral health workforce.

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