NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD 2023 ANNUAL REPORT

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

Update on the Northern Regional Behavioral Health Policy Board activities and overview of the region's identified behavioral health gaps, barriers and priorities for 2023.

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EXECUTIVE SUMMARY

Overview

The current members serving on the Northern Regional Behavioral Health Policy Board (NRBHPB) are not just constituents of the Northern Region but dedicated individuals who are 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 and commendable. Each member of this Board brings a unique perspective, and their diverse perspectives are essential and enriching. They are not just passionate but also eager and willing to collaborate on improving the health and behavioral health systems in the Northern Region. The collaboration, which is a testament to the inclusive nature of the Northern Regional Behavioral Health Policy Board and associated county behavioral health taskforces, coalitions, consortiums, providers, constituents, and other county committees, as well as other facilitated meetings, has not just enabled stakeholders to develop a shared understanding of the health and behavioral health issues facing the region but also fostered a sense of unity and shared responsibility on county-wide issues. These opportunities have allowed the Northern Board to achieve substantial progress on its goals and demonstrated its commitment to working with local, regional, and state partners to identify and align priorities and solutions whenever possible. Through ongoing open board meetings and discussions, the Northern Regional Behavioral Health Policy Board members, shown below, have not just identified the Northern Region's gaps, needs, priorities, and recommendations for this annual report but also demonstrated their dedication to the cause. Current Board members and their term date for reappointment. (NRS 4333.429)

- Dr. Robin Titus, Senator, Nevada Legislator (Term 2/8/26)
- *Dr. Amy Hyne-Sutherland, Board Vice-Chair, Public Health Coordinator, Nevada Association of Counties (Term 11/11/24)*
- Nicki Aaker, RN, Director, Carson City Health and Human Services (Term 10/7/25)
- Erik Schoen, Executive Director, Community Chest (Term 4/19/24)
- Laura Yanez, Executive Director, NAMI Western Nevada (Term 10/7/25)
- Sandy Wartgow, Deputy Chief, Carson City EMS (Term 11/4/25)
- Ken Furlong, Sheriff, Carson City (Term 6/30/25)
- Lana Robards, Director, New Frontier Treatment Center, Fallon, Nevada (Term 10/7/25)
- Dr. Ali Banister, Juvenile Probation Chief – First Judicial District (Term 9/30/25)
- *Shayla Holmes, Board Chair, Executive Director, Lyon County Human Services (Term 9/1/25)*
- Alana Rogne, Medical Director, Rural Nevada Counseling (Term 5/4/25)
- Daria Singer, Executive Director, Partnership Douglas County (Term (6/1/25)
  ** Board openings (1): Private or public insurer representative; if not available, "another person who has experience in the field of insurance or working with insurers."

Working as the coordinator for the Northern Policy Board has been fulfilling, educational, and an honor. As one of five Regional Coordinators, I have had a chance to focus on understanding the

nuances of each county I serve. Understanding that each county has some similar but very different barriers, gaps, and many successful initiatives have been essential with the flux of climates that have been hard to navigate. During this second year as coordinator, the time has enabled me to assess the counties' successes, barriers, and ongoing projects, as well as implemented programs and projects by the NRBHPB, the past coordinator, and the counties and communities making up the Northern Region. One of the board's priorities is to highlight ongoing gaps and barriers, the work being done to eliminate the gaps and barriers, and the many successes of the Northern Region. This annual report will demonstrate all of this and more.

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 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 more significant 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 all Nevada middle schools percent.

Please note the most recent YRBS survey was administered in 2023, and those results will be released in late 2024.

The Northern Regions' adult rates of "experiencing ten 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% compared to the 2020 percentage of 19.2%. In 2022, the question was changed on the BRFSS to "14 plus days when mental health was not good," which in 2022 was at 14.7%. Nevadans percentage for "1-13 days when mental health was not good" sits at 27.8%. Those rates differed from the year before due to the execution of the way the questions were asked.
This change had no bearing on zero days when mental health was not good, which rose back up in 2022 and now sits at 55.8%. In 2021, Nevada dropped from 55.7% to 47.4%. This is a significant 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 and statewide.

Trends Identified by local stakeholders –

The trends identified by the local stakeholders in the Northern Region are both health and behavioral-health-related. As Nevada moves to a Public Behavioral Health and Wellness model, I

will share physical and behavioral health trends affecting the stakeholders across the Northern Region. While the Northern Region does not have the data to quantify all 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 health and behavioral health services (this is statewide)
- Physical distance to both emergency and non-emergency health and behavioral health care
- Lack of reliable transportation, impacting people's health and behavioral health
- An increase in youth experiencing high acuity mental health issues as well as planned and completed suicides
- Problem for all ages in accessing appropriate in/outpatients services
- Increased crisis in our youth and elders (dementia leading cause for calls for our seniors), leading to an increased need for crisis response and hospitalizations
- Economic, political, financial, and cultural pressures or social determinants of health (SDoH) cause a rise in behavioral health and healthcare needs.
- The lack of information with the rollout of 988
- Lack of supportive housing for those with a diagnosis of SMI/SED
- Lack of affordable housing for residents of all income levels and low-incoming housing, which is limited across the region.
- The region is at crisis level for the development of more regional crisis response systems, deflection, and diversion programs, all while obtaining sustainable funding for current crisis stabilization
- Lack of affordable childcare (school truancy, waitlist over a year)

Legislative efforts –

In the 2023 legislative session, 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 developing and providing 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 ongoing problems with our youth facilities and the recent DOJ report, more stringent oversight of services is becoming a severely elevated matter.

Modernizing existing law in NRS 433C, the statute 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 the national Roadmap to the Ideal Crisis System framework—establishes an accountable entity for a community/catchment area with responsibility for designing, financing, and operating a 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 to provide greater system efficiency to individuals and families needing 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, passed in the 2021 Nevada Legislature, will allow for a managed public insurance option for rural areas in 2026. Enabling Regional Behavioral Health Authorities allows community-based participation in approving competitive bid processes with managed care organizations in regional behavioral health service areas.
- It 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 slip 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. Then, it worked diligently to write the language, enabling the Northern Region to operate as an authority. The Board researched fruitful examples, but, in the end, developing the enabling language for the authority became cumbersome and eventually dormant. The 82nd (2023) Legislative Session began, and the board felt that the region's pressure, language, and capacity to move forward with developing a Behavioral Health Authority was a much farther reach than anticipated. As well as, a few bills had been brought to the interim committees, which were looking at taking the Authority piece in a state direction, not just the region. The board's priorities were supporting legislation and advocating for other bills that focused on the Northern Region's goals and priorities. Such as Nevada's mental health workforce, Medicaid, suicide prevention, rise in opioid and substance

misuse, supportive housing, Opening Meeting Law (OML) changes, Community Health Workers (CHWs), and Peer Support Specialists (PRSS/PSS), as well other bills that were on the Board's radar.

Introduction:

The Northern Region consists of Carson City, Churchill, Douglas, Lyon, and Storey Counties, stretching 8,039 square miles in northwestern Nevada. The total population of the Northern Region was estimated to be 207,839 in 2023. The Northern Region comprises roughly 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 persons under the age of 65 years of age are 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 veteran population in the Northern Region reached an estimated 19,400 in 2020[2].

Population breakdown by county 2023 [3]:

Carson: 58,923
Churchill: 26,940
Douglas: 54,343
Lyon: 63,179
Storey: 4,454

Health and Behavioral 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 some of these hospitals now have some 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)

[1] Nevada Statewide Demographer's Office – 07/01/2023
[2] U.S. Census Bureau, 2020
[3] State Office of Rural Health: Nevada Rural and Frontier Health Data Book- 2013 edition

- VA Clinics: (Gardnerville)

Over the past several years, the Northern Behavioral Health Region has continued to make significant gains in enhancing its behavioral health crisis response system through programs such as the Mobile Outreach Safety Teams (MOST), Forensic Assessment Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, developing collaborative relationships with rural/frontier Law Enforcement leaders and staff, community partners and providers. Nevadans in need are receiving well-established treatment from programs such as Assertive Community Treatment (ACT), First Episode Psychosis (FEP), 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 health and 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, their youth, and seniors. For adults, there continues to be limited availability for most health and behavioral health care levels. These challenges are only amplified by staffing shortages across a comprehensive continuum of professionals, burnout in both health care and behavioral health workforce, recent closures of significant providers, and a lack of supportive housing.

The Northern Regional Behavioral Health Policy Board is open to innovative ideas, including telehealth, community health workers, peer recovery/peer support specialists, and supporting regional coalitions and the behavioral health taskforce. 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 and crossing over county lines for close to a decade developing innovative, unique diversion and deflection programs that have left their mark in many communities as thriving up and coming ways to serve our rural/frontier communities where they are with empathy and dignity.

This report provides a framework to improve behavioral health services and enhance the quality of life within the Northern Region's communities. It focuses on identified behavioral health gaps, needs, barriers, and the lack of community services focused on reducing Nevadans' Social Determinants of Health (SDoH). The report will also continue to deep-dive into strategies and recommendations to address the most pressing issues in the region.

NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD 2023 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 2023.

METHODOLOGY FOR IDENTIFYING NEEDS AND GAPS:

The Northern Regional Behavioral Health Policy Board used a variety of methods to identify needs, gaps, barriers, and SDoH in the Northern 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), hospital leadership, 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. Currently all five counties have behavioral health taskforce independently and across the county lines which meet monthly and bi-monthly. Counties have begun combining the public health side into these behavioral health taskforces working in the whole health model.

- ***County Coalitions:*** Similar to the taskforces the coalitions serve one to four counties in their efforts to focus on preventing substance misuse, harm reduction, and 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, bullying, abuse, and all substance use-related products.

- ***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 specific health and behavioral health issues that might create more unique needs for treatment. These meetings bring specific professionals who know said client and collaborate on what has not worked and the next steps, knowing A and B did not work. Focusing on treatment processes for person-centered care. This avenue is to discover the gaps and barriers for our higher-level acuity treatment. The struggle to find inpatient higher acuity treatment placement is still a huge gap that has only gotten worse as the state of Nevadan's mental health reaches critical levels.

- ***Community surveys:*** The Northern Board supported a quad-county community and providers behavioral health survey distributed by the region's coalitions and other community providers. Most of the region's counties have completed their opioid needs assessment. This annual document aims to create a common focus, including all population segments when possible, outline a service development and delivery system, and point out gaps and barriers in the Northern Region. These documents and more can be found at 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 2024 Status Report, Nevada's Behavioral Health Community Integration (BHCI) Strategic Plan 2023 update, Community County Assessments, Fund for Resilient Nevada Annual Report, county-specific Opioids Needs Assessments, 2022 Quad-County

Community Needs Assessment, among others being used to guide 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 Overdose Data to Action (OD2A) reporting, Office of Analytics (OOA), Nevada Rural Hospital Partners (NRHP) website, hospital billing data, the University of Nevada Reno, Rural and Frontier Health Data Book – 11th Edition (1/23), and other reliable sources available. A portion of this data will be the same as the 2022 Governor's Annual Report due to the Regional Behavioral Health Epi reports shifting to every other year.

- *FASTT and MOST programs Region Wide:* Forensic Assessment Services Triage Team (FASTT) and Mobile Outreach Safety Teams (MOST) programs across the Northern Nevada Behavioral Health Region continue providing front-line services to community members and clients. These programs participate in monthly collaboration meetings with one another and other regional behavioral health partners. Each of these programs works to divert or deflect people with mental health and substance misuse concerns away from the justice system and connect them with community resources. Assisting community members in managing their behavioral health needs reduces their likelihood of justice system contact, creating a better life for vulnerable people in our communities and providing more cost-effective and humane justice processes. Currently, in the Northern Region, these programs have been not only a beneficial judicial lift but there is a benefit to the counties and communities where these programs are active.

  MOST works to de-escalate and support community members who are experiencing acute mental health crises. Whenever possible, MOST diverts community members in crisis away from formal justice system processes (i.e., arrest and incarceration) and toward community-based treatment options. In several counties, MOST includes law enforcement and behavioral health professionals, ensuring that they are equipped to respond to the community's safety and the mental health needs of the person in crisis. MOST-like programs work collaboratively with law enforcement in other counties but without formal co-responder teams. MOST and MOST-like programs also collaborate with other community stakeholders – especially those working in behavioral health – to support wraparound services and an effective continuum of care for community members living with behavioral health challenges.

  FASTT programs are voluntary jail reentry programs that use evidence-based practice to help clients plan for their transition from jail back into community life. The program framework is heavily informed by the Risk-Needs-Responsivity (RNR) model, which has been validated throughout the U.S. and shown to be an effective approach to reducing

recidivism. The RNR guides recidivism reduction programs to prioritize high-risk clients for more intensive intervention and match the interventions to the individual needs person's needs and responsivity factors. FASTT works in the jails to evaluate clients using validated risk assessment tools and develop transition plans and goals with clients to prepare them for reentry. Transition plans are client-centered and focus on the individual needs of the client. Some FASTT programs offer group or individual evidence-based curricula to clients while they are in jail or support their enrollment in existing in-jail groups and services. FASTT provides case management to support clients transitioning and connecting to services.

MOST and FASTT programs received additional funding through the Comprehensive Opioid Stimulant Substance Use Programs (COSSUP), which allowed them to expand services and develop their workforce. This funding stream also provided support for developing program handbooks, streamlining data collection procedures, and ongoing evaluation.

In addition to MOST and FASTT, the COSSUP funding also allowed for developing an educational outreach pilot program through Carson Juvenile Services. This program conducts active outreach with justice-involved youth, provides prevention education in local schools, and conducts community outreach with parents of justice-involved youth. COSSUP also supported programs such as drug take-back days through Community Prevention Coalitions in the region. These programs aim to increase public safety, support community members living with behavioral health challenges, reduce financial costs related to recidivism and strengthen behavioral health collaboration in the Northern Region.

In the past year, the Regional Behavioral Health Coordinator (RBHC) for the Northern Region has supported ongoing collaboration between the counties in the Northern Region and has actively included similar programs in other regions. During monthly regional collaboration meetings, FASTT and MOST programs discuss the trends observed in their regions and share strategies to overcome current challenges. The RBHC has also invited numerous other stakeholders to learn about these programs and coordinate efforts to address service gaps and respond to developing trends in the region.

Through these regional collaboration meetings, the programs collaborated on developing a comprehensive FASTT handbook. FASTT program coordinators contributed individual program policy documents and worked together monthly to create and revise the handbook to reflect the similarities and differences across the county's programs. This handbook now outlines the FASTT program with recommendations for implementation in urban, rural, and frontier counties.

Over the past year, FASTT programs have also adapted to the modified data collection platform Bitfocus developed for the CMIS platform. FASTT and other behavioral health, housing, and social service programs across the region use this data management system to promote continuity of care and allow for comprehensive program reporting. Through

the regional collaboration meetings, the FASTT Coordinators and case managers provided considerable feedback that was used to revise the system to improve program data collection and management. Together, the handbook and new data collection design will allow program streamlining and more robust evaluation going forward.

The Data Analyst and evaluation team have submitted to present the FASTT Handbook, collaborative process, and evaluation at the American Society of Criminology annual meeting. The RBHC, the Data Analysts, and several FASTT Coordinators are preparing a submission for the Police Treatment and Community Collaborative (PTACC) yearly conference. Additionally, the working draft of the FASTT Handbook has been distributed to the Rural Regional Behavioral Health Coordinator to support those county's development of FASTT programs.

Coordination between the FASTT and MOST teams has helped coordinators to identify additional program and service needs. In Carson City, the Sheriff's Office is piloting a Family Services Unit to address the needs of families impacted by parental incarceration, which will coordinate with FASTT and MOST—with considerable support from FASTT and MOST collaborators, including the RBHC and law enforcement partners, the University of Nevada, Reno (UNR) submitted a grant proposal to research police responses to opioid overdose throughout the state, which, if awarded, will include producing additional training for law enforcement, peers, and medical and public health professionals who respond to these cases.

This comprehensive data management system, which was recently completed, allows us to see a snapshot of the data across all 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 Campus, PATH, Street Outreach, Rapid Re-Housing, Catholic Charities food pantry, Salvation Army, Elko, Friends in Service Helping (F.I.S.H.), and Veterans Offices of Affairs (VOA). More than half (54%) of clients enrolled in FASTT in March previously received these types of services.

Lyon County case managers tracked 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 range from 15 minutes to 8 hours. Services include assisting clients in developing transition plans, communicating on behalf of clients on resources and service providers, and administering group curricula aimed at changing antisocial peer associations, attitudes, thinking, and behavior patterns associated with increased recidivism risk.

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) had no history of other program involvement.

NORTHERN REGION PRIORITIES, STRATEGIES, AND RECOMMENDATIONS

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

1. ***To have flourishing behavioral health support and services across the spectrum; possible services (direct and community) available to the entire continuum of age and gender – across the life span (regional/statewide)***

   Need/Gap:

   For years, stakeholders in the Northern Region have identified issues with continuity of care across the continuum of age and gender. Barriers to linkages to care include a lack of formalized referral systems, a lack of coordination and communication, insurance concerns, and limited provider capacity.

   Like most rural/frontier regions in Nevada, the Northern Region faces significant barriers caused by a lack of behavioral health workforce, geography, and difficulties that behavioral health professionals encounter to become in-network insurance reimbursement providers. Several areas have been identified where additional workforce infrastructure could lead to greater efficiency as the Northern region works to develop a more robust, sophisticated health and behavioral health system.

   The Northern Board believes that the Peer Recovery Support Specialist/Peer Support Specialist, Community Health Workers, and Prevention Specialist (certified professionals/paraprofessionals) have not been fully developed and utilized in the region. The region looks to bring on more certified professionals and paraprofessionals to fill the gaps and barriers to person-centered, robust systems of care. As a region, we focus on thinking outside the current health and behavioral health systems to upstream measures working to fill the ongoing gaps and barriers.

   We must bring our community partners and state entities to the table, as well as those with lived experiences, to collaborate on helping to develop and drive new programs and initiatives in Nevada to reduce this ongoing issue. This gap impedes timely access to treatment and prevents providers from expanding quality services.

   Stakeholders in the region have also identified a lack of insurance as a barrier to access to health and behavioral health care across the spectrum. Furthermore, there

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

Strategies:

Investigate certified professionals and paraprofessional workforce – The Northern Board meets monthly. It brings subject matter experts (SMEs) to those meetings to help the board become educated on the newer developments of the Peer Recovery Support Specialist/Peer Support Specialist, Community Health Workers, and Prevention Specialist. Looking at pay parity, how to infuse these certified professionals into Nevada's health and behavioral health workforce, reimbursement rates, and what may need to be looked at concerning NAC and NRS to set these professionals up for success. The board realizes the effects of the workforce shortage on its region. It continues to look upstream at these professionals as our future to continue person-centered case management in all health disciplines.

Recommendations:

- Elevate and support the efforts of the Nevada Healthcare Workforce and Pipeline Development Workgroup.
- Continue communicating and collaborating with regional primary care providers, who can serve as critical behavioral health workforce extenders.
- State compact to help recruit, support, and retain a diverse workforce, inclusive of race/ethnicity, culture, language, and other dimensions of identity and experience.
- Modify Medicaid's State Plan to allow community health workers to work under behavioral health providers and vice versa for PRSS/PSS. As stated throughout this report, these up-and-coming certified professionals and paraprofessionals can help fill Nevada's gaps with people-centered full-spectrum services in health and behavioral health.
- Adjust Medicaid rules and procedures to facilitate increased participation from behavioral health providers.
- Explore other options for expanding the workforce to serve individuals living with behavioral health needs and disabilities.
- Improve access to and routinely analyze high-quality workforce data.
- Increase the salaries of all personnel working in clinical and certified professions. This is especially crucial in the rural/frontier regions. One goal is to support these professionals with a livable wage and, second, to keep them in the counties.
- 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 the ratio of active providers to the population in the Northern Region is low to attract more people 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 develop further)-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.

2. *Northern Region communities will collaborate to develop robust and vibrant social connectivity opportunities for its community members across the lifespan, including reliable transportation*

Need/Gap:

Loneliness and social isolation can do more harm to our health than we realize. They can increase the risk of heart disease, depression, and cognitive decline (worsening memory loss). Studies show that one in three adults aged 45 and over feel lonely. In the Northern Region, struggles with social isolation and loneliness have increased partly due to COVID-19, geography, and lack of services and resources in the region. Although we know that not one gender or age group is affected more than the other, social isolation and loneliness can touch anyone, anywhere. The World Health Organization (WHO) recognizes social isolation and loneliness as a global health priority. In the Northern Region, this is no different. The Quad-County Needs Assessment (2023)discovered that over 1 in 3 community members (37.2%) do not have someone who could help them if they were confined to a bed, over 1 in 3 community members (38.7%) do not have someone who hugs them, over 1 in 3 community members (34.3%) do not have someone who could take them to the doctor if they needed it.

Across the Northern Region, community stakeholders and providers voiced concern about access to transportation. Accessing transportation to medical appointments and services around the community adds unnecessary stress to an already struggling population. Unreliability, timely access, and subpopulation criteria for accessible, reliable transportation were also themes heard by many.

Public transportation can impact a person's health and influence equity. Lack of transportation can cause an individual to miss their health and behavioral health appointments or to delay scheduling, which can cause poorer health and behavioral health outcomes while adding health and behavioral health expenditures. Reliable transportation can improve stability in access to health, nutrition, employment opportunities, and social inclusion.

Strategies:

With Nevada's rural/frontier regions moving to MCOs soon, the Northern Region would like to revive the current Medicaid/care transportation service, and perhaps even revamping it may be needed. Oklahoma uses some of the county's DOE buses and bus drivers to fill the gaps and barriers of transportation due to rural/frontier geography. Creating routes that connect just like the Regional Transportation Commission Washoe may be a feasible way to give riders that need to move from one county to another for appointments away to make that happen. With a successful way to transport our constituents around the Northern Region, the ability to create connections may be heightened.

Recommendations:

- Look at alternative modes of transportation, such as the Oklahoma Model
- Create more crisis teams with PRSS/PSS/CHW to be the second line of defense for our people who cannot drive or do not have transportation

3. *Regional/Statewide deflection and diversion programs will be unified in goals, outcomes, and policy structure (post-release, mandated, voluntary, etc.) (goals 3 and 5 are similar)*

Needs/ Gaps:

Individuals experiencing a crisis in the Northern Region often cannot find the care they need when needed. These individuals encounter hospitals, emergency medical services, and law enforcement unprepared 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: MOST, FASTT, Crisis Intervention Team (CIT) Training, Certified Community Behavioral Health Clinics (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 more significant 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 prioritize this until long-term program sustainability is achieved.

In addition, the Northern Board is very interested in participating in developing the region's crisis response system. Stakeholder engagement meetings were scheduled in Carson, Douglas, Lyon, and Storey Counties to obtain input and provide it 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, which can be 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

4. *Addressing the social determinants of health (SDoH) in the Northern Region, focusing on housing (affordable and supportive) as well as early childhood care/education*

Needs/ Gaps:

Similar to years before, 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 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:

- Increase the reimbursement rates and add a supplemental rate for nurses and others who provide home healthcare so that home healthcare agencies can offer competitive wages. 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
- Look at programs such as Colorado's Self-Help Home Building Project, especially in the rural/frontier area

5. *Crisis response will be tailored to meet the Northern Region's community's needs and maximize existing programs and service*

Needs/ gaps

With the July 2022 implementation of 988 nationwide, there is an even more significant 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.

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- Support Certified Community Behavioral Health Centers in providing a full range of services in coordination with communities.

6. *The Regional Behavioral Health Policy Board will have a structure that ensures its effectiveness in carrying out its mission, including the coordinator role.*

Needs/Gaps:
Several areas have been identified where additional infrastructure could improve 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 on Behavioral Health Authorities at https://nvbh.org/northern-behavioral-health-region)

Recommendations:

- Develop a sustainable funding mechanism for the Regional Behavioral Health Coordinator and regional data analyst positions. These positions provide the support necessary for the boards to fulfill duties described in NRS 433.4295
- 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

2022 Northern Regional Behavioral Health Board Activities

The Northern Regional Behavioral Health Policy Board met ten times in 2023, hearing various presentations from local, regional, and state organizations on ongoing activities, programs, and priorities. The board carried out ongoing activities on the following topics:

- Legislatively: This past year, the board has focused on examining the gaps and barriers concerning health and behavioral health issues in the northern region. As the second half of 2023 began, the NRBHC reached out to state, county, and community partners for presentations focused on behavioral health and health concerns. Hopefully, these educational and focused presentations will help the board reach a consensus on their 2025 Bill Draft Request (BDR).

- Advocacy: With the recent DOJ report and the ongoing juvenile issues of inpatient treatment locations. Advocating for youth and teen providers is a top priority for this board. The coordinator collaborated with the Attorney General's Office to continue to receive funding from the Comprehensive Opioid, Stimulant, and Substance Use Site-based Program (COSSUP) grant focused on programs that work on deflection and diversion from jails or detention. The region is in year three of this successful funding and hopes that we can work on sustaining these successful programs regionally. 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: This year, the Northern Board spent some time rewriting and finalizing their Priorities and Goals to align with the funding streams the state has recently provided to sustain the coordinator role as well as matching their priorities to the Behavioral Health Community Integration (BHCI) plans 2023 update as well as other documents referenced in this work. The board focused on looking at trends, gaps, and barriers this past year and has worked to develop strong, solid priorities and goals.

- Education: Many of the presentations received this past year were related to Board priorities, resources, programs, community stakeholders, and legislative priorities. Many

invitees to the Board meetings presented new emerging programs, preexisting programs communities forget about, the latest best practices and evidence-based resources, legislation changes, and community survey results. Recently, the focus has been to become educated on the Peer Support Specialist, Prevention Specialist, and Community Health Workers as the region looks to uplift these certified professionals. Another piece of focused education is on Managed Care Organizations (MCO) expansion, which will be introduced and mandated in the rural/frontier regions in 2026.

- **Coordination with local taskforces and coalitions:** The Northern Board received regular updates regarding the county behavioral health task forces (Carson City, Churchill, Douglas, Lyon) 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 assessments, and the new updated BHCI 2023 plan introduced in January to the region. A couple of the counties have also been continuing their focus on the youth Step Up program, looking at the intercepts of each county and where and what resources are viable and available for our youth. Youth and senior suicide have been a current topic as well during these taskforce meetings. Recently, when asking the communities about new emerging trends, acute youth treatment availability and struggles with our seniors and dementia are on top of their list. Most of the Northern region's coalitions have focused on youth prevention concerning smoking, street and prescription drug misuse, suicide, and truancy. The initiatives and programs these bring to each county's communities have been successfully received, but a concern is the sustainability of these programs once funding ends.

- **Subcommittee activities:** No subcommittees were formed in 2023. As the board moves into the new legislation session, board subcommittees will most likely be developed to advance their BDR concept into 2025.

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 https://nvbh.org and 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 2023. * The board's actions and presentations are in bold print.

Date	Topic	Presenters/ Participants
1.05.23	– **Heard a presentation on SB 68 (BDR 25-303), which provides certain assistance for supportive housing** – Approve updates on Bill A B9 language and community approval	Taylor Allison- Board Chair, board members, **Sara Adler**, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator.

2.02.23	– **Heard presentation from RRBHPB Coordinator Bill AB 37 – establishing a Behavioral Health Workforce Development center** – Discussed current bills focused on behavioral health in NELIS as we focus on support letters	Taylor Allison, Board Chair and members; **Valerie Haskins**; and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator.
3.09.23	– **Heard Presentation from WRBHPB coordinator AB 69 – expanding student loans.** – **Heard Presentation on the Mercer NV Opioids Needs Assessment** – Discussed current bills focused on behavioral health in NELIS as we develop and write support letters	Taylor Allison, Board Chair and members; **Dorothy Edwards, Dawm Yohey,** and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator.
4.06.23	– Canceled due to failure to meet quorum	
5.04.23	– Heard nomination bio and interviewed with a vote for Board seat of psychologist or psychiatry – Alana Rogne – Vote in new board chair Shayla Holmes – **Presentation on the Fund for Resilient Nevada yearly report** – **Presentation on the 2021 YRBSS results for Northern Region**	Shayla Holmes, Board Chair and board members; **Alana Rogne, Dawn Yohey, Kristen Clements-Nolle**, and Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator.
6.01.23	– Heard nomination bio and interviewed with a vote for Board seat representing the interest of community-based org that provides behavioral services – Daria Winslow	Shayla Holmes, Board Chair and board members, Cheylyn Rahr-Wood, Regional Behavioral Health Coordinator, **Daria Winslow**
7.06.23	– Vote on new priorities and goals for the 2023-2024 Northern Regional Board strategic plan – **Presentation on the board coordinator scopes of work 2023** – **Presentation on the updates for 988 Suicide Crisis Lifeline** – **Presentation on AB 52/AB 219/OML changes** – **Presentation on the 82nd 2023 Legislative session focused on behavioral health**	Shayla Holmes, Board Chair and board members; Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator; **Rochelle Pellissier, Elyse Monroy-Marsala**
8.03.23	– Vote on new priorities and goals for the 2024 Northern Regional Board strategic plan	Shayla Holmes, Board Chair and board members;

	Discussion and preview of BDR for the 2023 legislative session	Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator; Kim Hopkins
9.14.23	– Canceled due to the coordinator's annual leave	
10.05.23	– Canceled due to failure to meet quorum	
11.02.23	– Presentation on CHW and PRSS workforce and certification – Presentation on the new VA programs for the Northern Region – Prioritize the board's goals and priorities	Shayla Holmes, Board Chair and board members; Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator; Sean O'Donnell, Kim Donohue
12.07.23	– Vote on reappointments for termed-out board seats (Shayla Holmes, Sheriff Ken Furlong, Dr. Ali Banister, Sandy Wartgow, Lana Robards, Nicki Aaker, Laura Yanez) – Presentation on the roles and responsibilities of Prevention Specialist – Presentation on the roles and responsibilities of Peer Support Specialist/Peer Recovery Support Specialist (PSS/PRSS) – Presentation on Community Health Worker I and II (CHW)	Shayla Holmes, Board Chair and Board members; Cherylyn Rahr-Wood, Regional Behavioral Health Coordinator; Natalie Powell, Jordan Baez, Jay Kolbert-Clausen

NORTHERN REGIONAL BEHAVIORAL HEALTH COORDINATORS (NRBHC) ACTIVITIES

The following section outlines some of the major activities and projects engaged by the NRBHC throughout 2023.

Support and facilitate multiple monthly meetings both state and region-wide:

The coordinator supports and facilitates multiple state and county meetings besides facilitating monthly Northern Regional Behavioral Health Policy Board meetings. Above, I briefly mentioned the MOST and FASTT monthly meetings in a comprehensive paragraph.

This coordinator also facilitates monthly Statewide Mental Health Crisis (MHCH) Workgroup. This group brings stakeholders, hospital leaders, and partners from the DOJ to collaborate on concerns and issues still plaguing Nevada regarding MHCH, the completion of the documents, and understanding the statute NRS 433A.160. We spent most of this year looking at scripts for training on the MHCH process and rewriting the youth MHCH packet, as it had not been updated

since the NRS change in 2017/2019209. The AG's office has a draft copy of the new Youth MHCH Packet for approval. We are hopeful that it will be approved and vetted this year.

Another monthly workgroup the NRBHC facilitated is the Nevada Rural Hospital Partners (NRHP) Behavioral Health Workgroup. This workgroup of rural and frontier hospital employees (nurses, BH employees, hospital leadership, etc..) comes together each month to discuss hot topics in the behavioral health world, trends the hospitals are seeing, and resources available in the rural regions. This group is open to all of the rural and frontier regions. The coordinator brought comprehensive trainings quarterly to the group such as de-escalation, rural and frontier resources such as the NAMI WNV Warmlines – (Teen Text Line, Nevada Caring Contacts), Moral Injury, and MHCH training, among others.

Crisis Intervention Team (CIT) Training Development Efforts:

As a continuation of training efforts from 2022, the NRBHC attended the CIT International Curriculum Training for Trainers in Salt Lake City, UT, from February 27th through March 3rd. This intensive 40-hour training prepared participants to utilize a best-practice curriculum developed by CIT International in conjunction with BJA. The Rural RBHC was also in attendance, and both the Rural and Northern RBHCs collaborated to formulate recommendations on how existing CIT programs could be improved using the new curriculum and the recommended implementation strategies.

Post-training efforts brought the Rural RBHC and Northern RBHC together to communicate with their stakeholders regarding possible changes to existing CIT programming. This was met largely with concern and some defensiveness. The Northern and Rural RBHCs continued to collaborate with these stakeholders to put them at ease about proposed changes and to make incremental steps towards utilizing best practices outlined in the training for trainers.

The NRBHC trained multiple counties in different sections of the new CJIT CIT curriculum and put together a full 40-hour CIT for the Fallon Shoshone Paiute Tribe. The coordinator was able to bring in a variety of subject matter experts in each of their fields to provide a comprehensive CIT to the Fallon Shoshone tribe. It was so powerful that Chef Blackeye requested that the coordinator bring CIT to more tribes across Nevada.

Creation of the Northern Region Behavioral Health Resource Guide:

The coordinator spent most of the first two quarters of 2023 developing and researching the community partners, providers, coalitions, hospitals, etc., in the five Northern region counties. Putting together a very comprehensive resource guide. The delivery of the guide was very well received. Working with my counties on the resource guide, one change was suggested: creating a QR code so the changes can be made immediately, allowing for the resource guide to be consistently up to date.

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 the Northern Regional Behavioral Health Policy Board for several years. 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 a future crisis cannot be denied.

Below are a few snapshots of behavioral health trends in the Northern Region. The Regional Behavioral Health Policy Board data dashboard is available 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 proper gaps, barriers, 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 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 433.4295. Here are some current challenges as to why data is hard to obtain.

- Mental Health Crisis Hold Data is difficult to obtain. It 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, maybe 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 that hospitals confirm.
- The disposition data is critical 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 vast and complex lift. However, if we don't know what is happening to all of the folks put on a mental health crisis hold, we are left to use specific case stories that we have been made aware of to monitor quality and participate in problem-solving. Because this data is unavailable, it isn't easy to do more than occasionally put band-aids on the holes.
- The last piece that desperately needs improvement 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 failing as a statewide system.

Conclusion:

The Northern Board was very active in 2023, meeting almost monthly and actively participating in delivering the goals and objectives in the current strategic plan. The board members were 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 within the region. The completion of the Statewide FASTT Handbook, which provides comprehensive guidelines for our rural/frontier counties to develop FASTT programs within their jails and detention centers, has been eager for distribution. The Northern Board aims to continue learning more about priority topics, practicing advocacy, and moving forward with implementing recommendations and identified solutions. Board members request coordination and partnership with the state as the region moves to the next stage of developing access to behavioral health and the ongoing implementation of the 988 and crisis response system. As the Northern region looks forward into 2024, the anticipation of lifting up 988, the development of Nevada's' crisis response system, and the development of the 1115 wavier, among other new and innovative programs and projects being developed or redesigned to work for all Nevadans across our beautiful state.

Appendix A:

Behavioral Health Data for the Northern Region

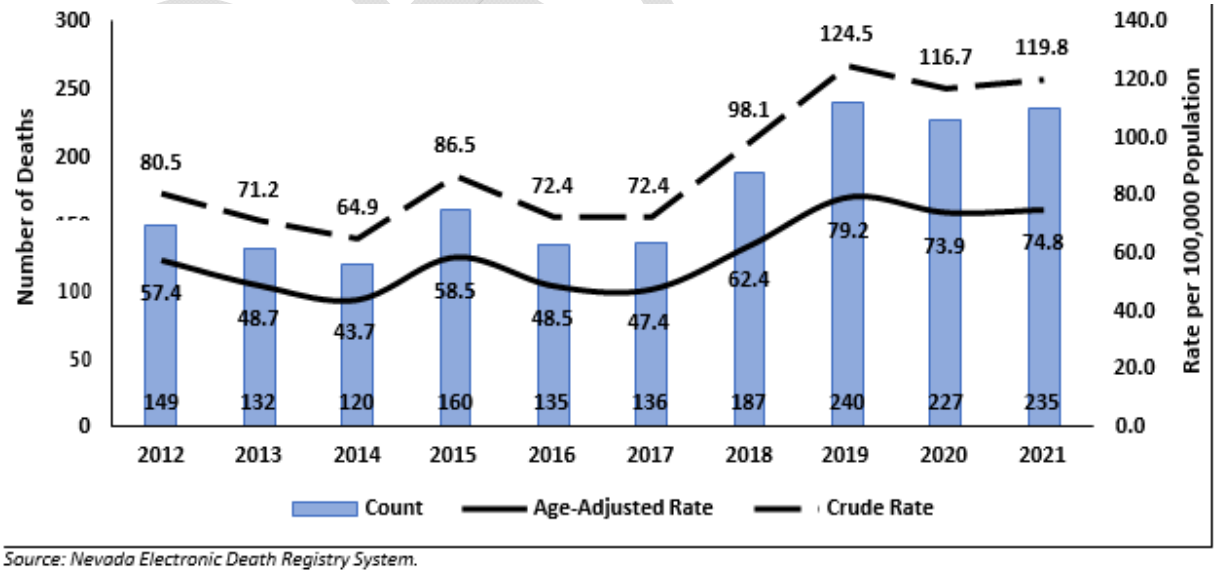
In reading the data below from Nevada's Electronic Death Registry System (DPBH EDRS), DBPH has recognized that rural providers are struggling to use the EDRS system efficiently to process death certificates. Because a body cannot be released for funeral/burial/cremation without the signed death certificate, this creates unnecessary anguish for grieving families.

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

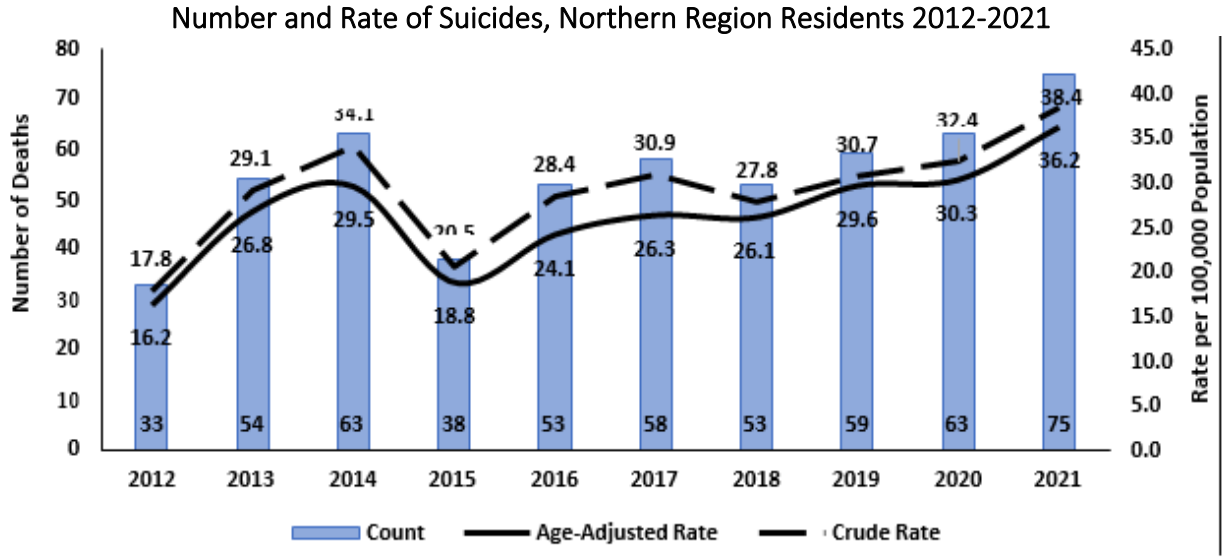
Mental Health-Related Deaths and Rates, 2012-2021



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 2019, 2020, and 2021, each having more than 200 deaths related to mental health.

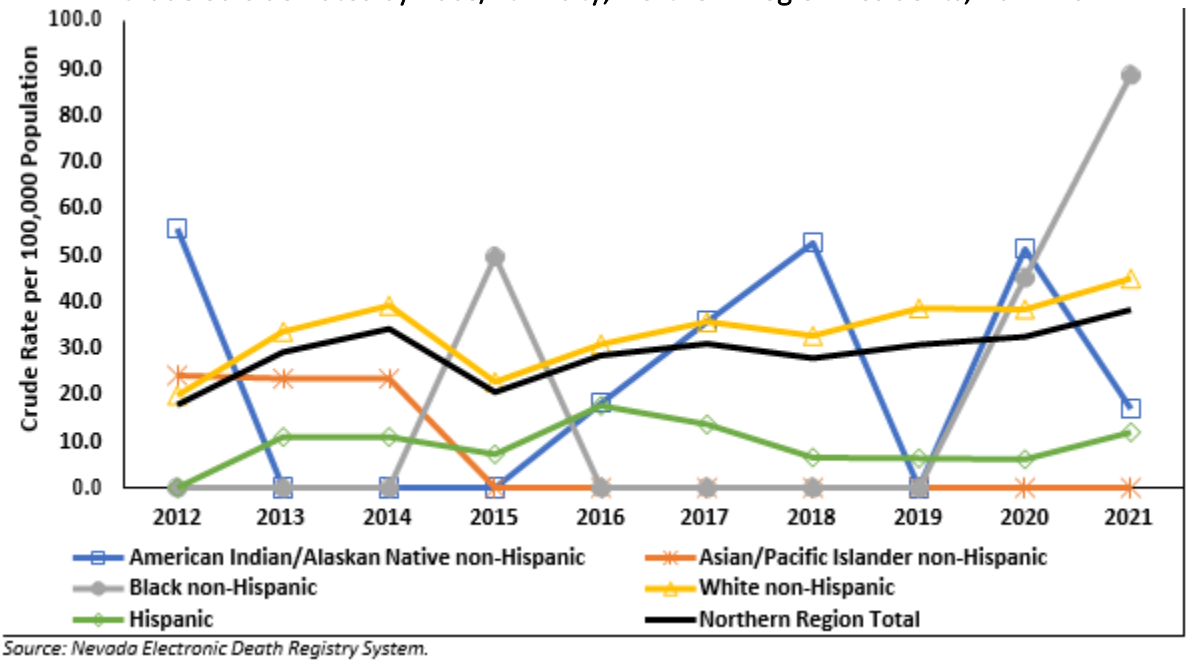
Counts and rates were high in 2019 before decreasing in 2020, followed by a slight increase in 2021.



Source: Nevada Electronic Death Registry System

The number and rates of suicides have 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.

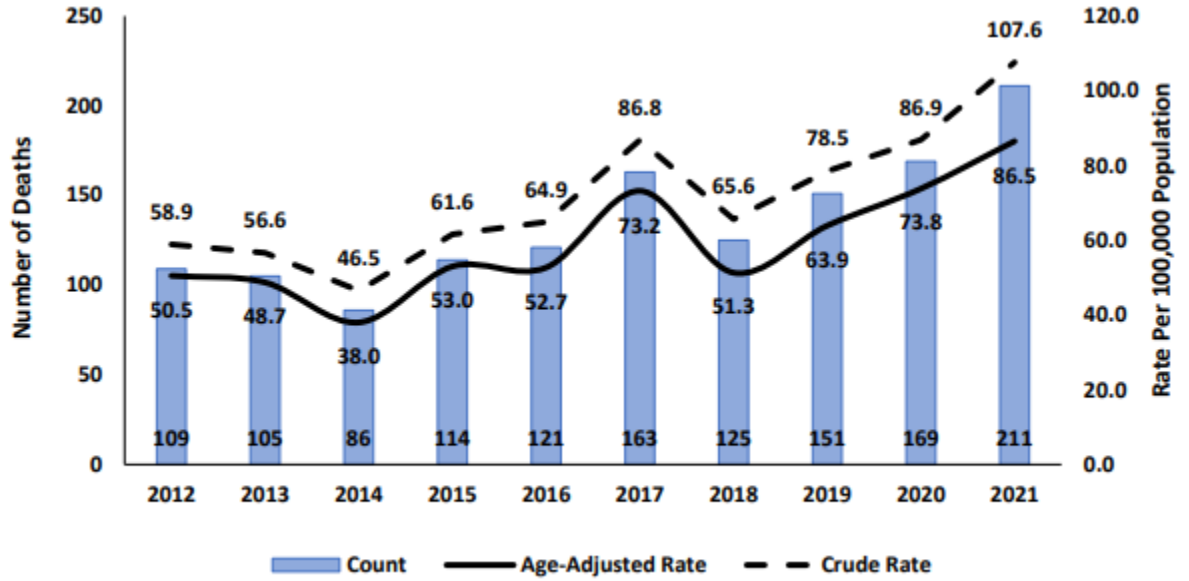
Crude Suicide Rates by Race/Ethnicity, Northern Region Residents, 2012-2021



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.

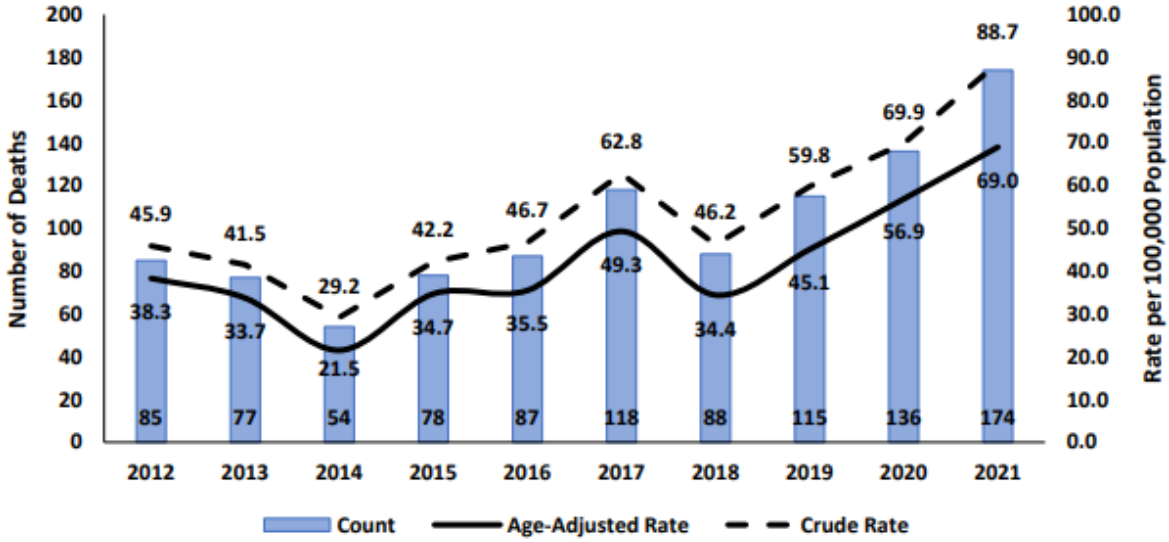
Alcohol-Related and Drug-Related Deaths and Rates in Northern Nevada, Northern Region Residents 2012-2021



Source: Electronic Death Registry System.

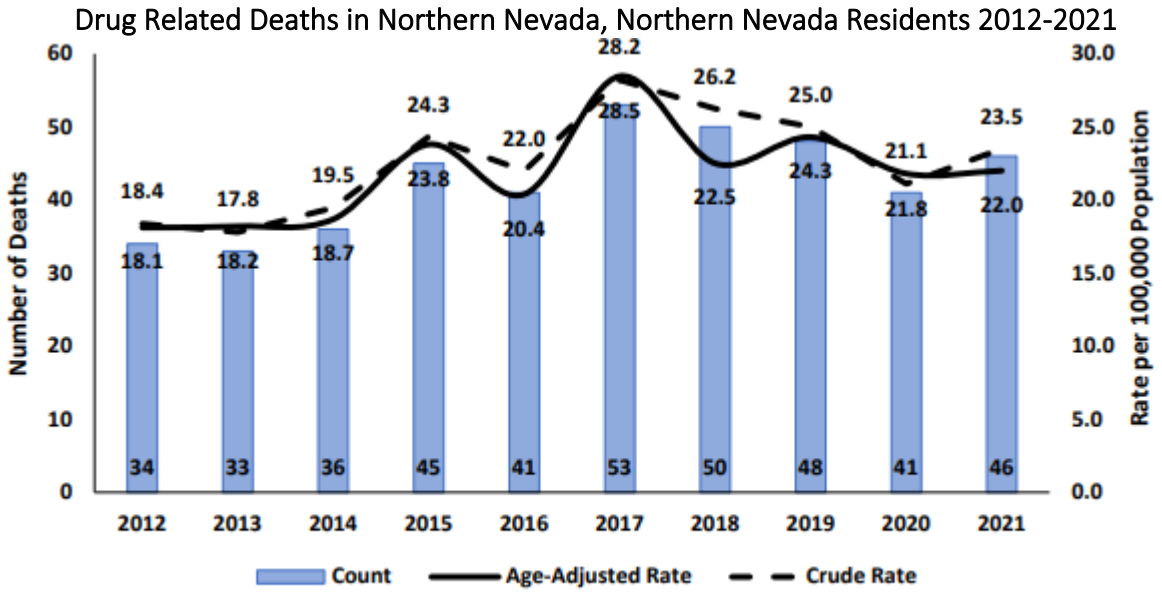
The alcohol-related and drug-related age-adjusted rate increased significantly in 2017 from previous years (95% confidence interval) and decreased in 2018, followed by a gradual annual increase in recent years.

Alcohol-Related Deaths in Northern Nevada, Northern Nevada Residents 2012-2021



Source: Electronic Death Registry System.

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



Source: Electronic Death Registry System.

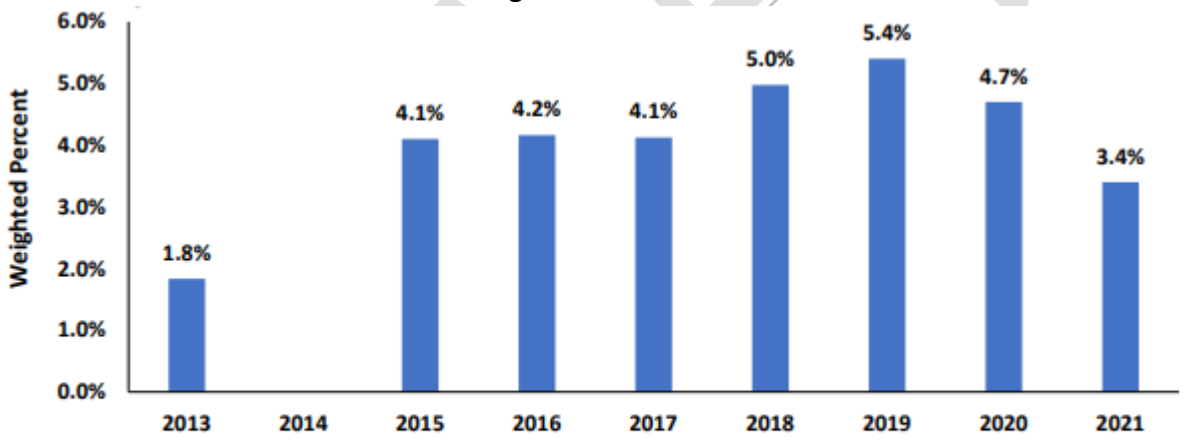
Drug-related deaths among Northern Region residents have risen slightly from 2012-2021. The counts, age-adjusted, and crude rates were the highest in 2017.

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 the fact 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

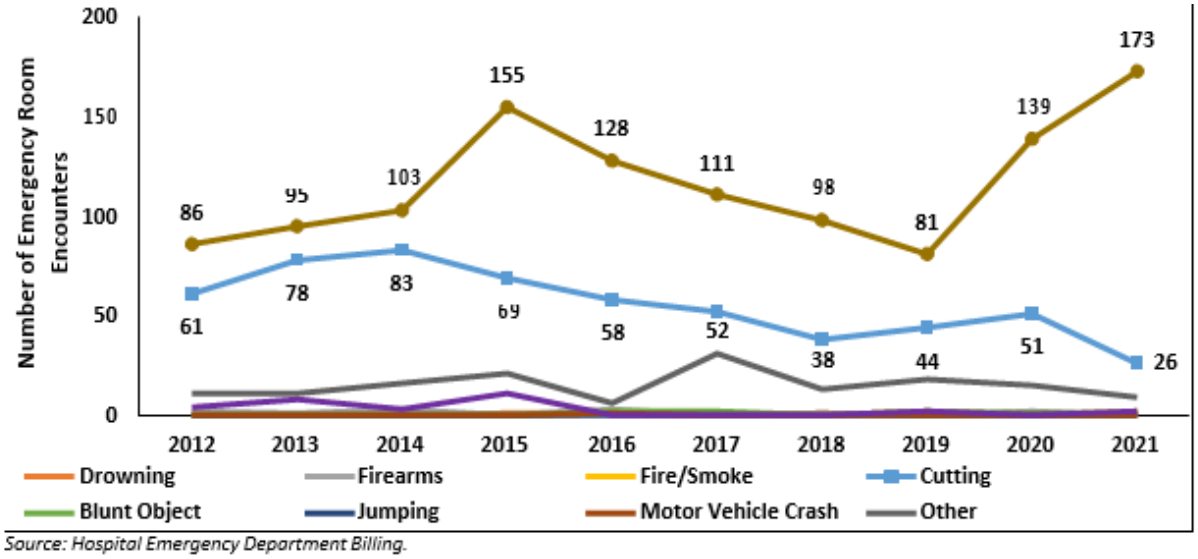
Percentage of Adult BRFSS Respondents Who Have Seriously Considered Attempting Suicide
Northern Region Residents 2013-2021



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 percentage since 2015.

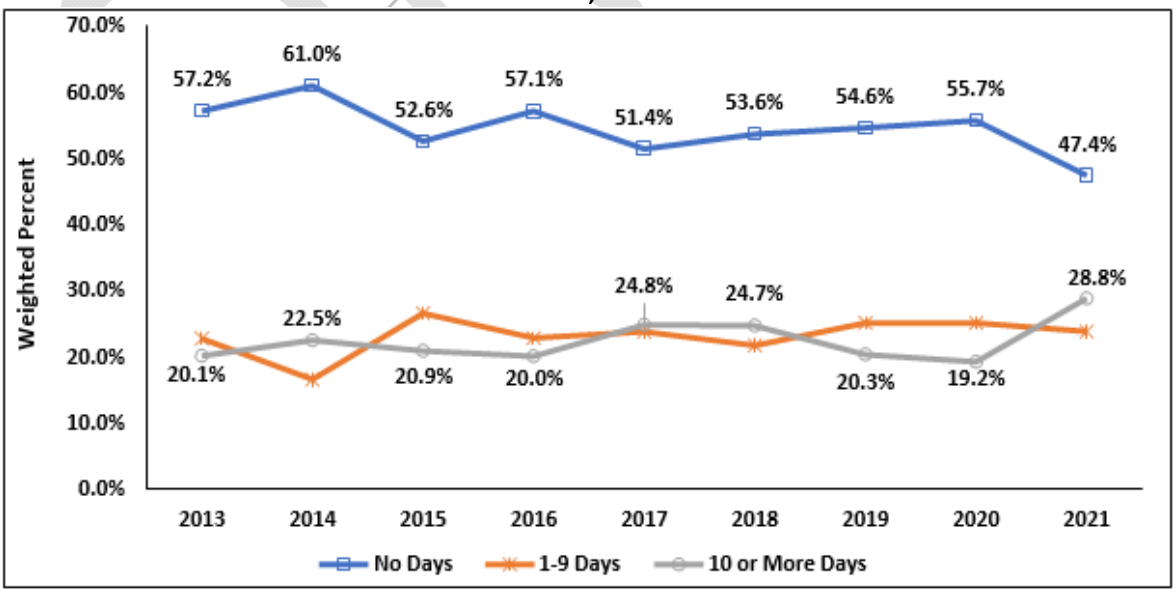
Suicide Attempt Emergency Department Encounters by Method, Northern Region Residents 2012-2021



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

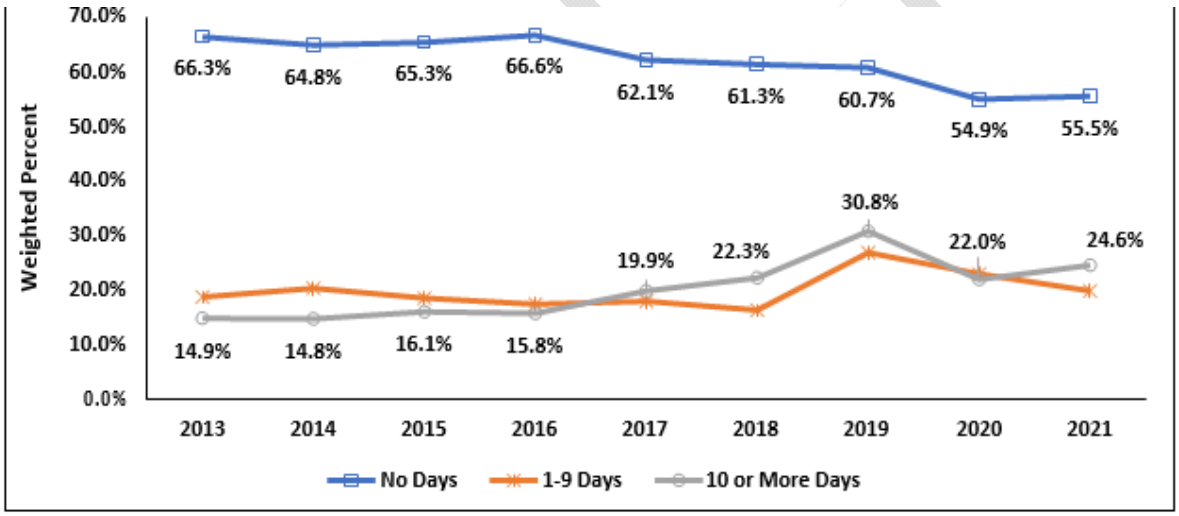


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or 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 percentage has increased and decreased since 2013, with a high of 61.0% in 2014.

In contrast, the percentage 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.

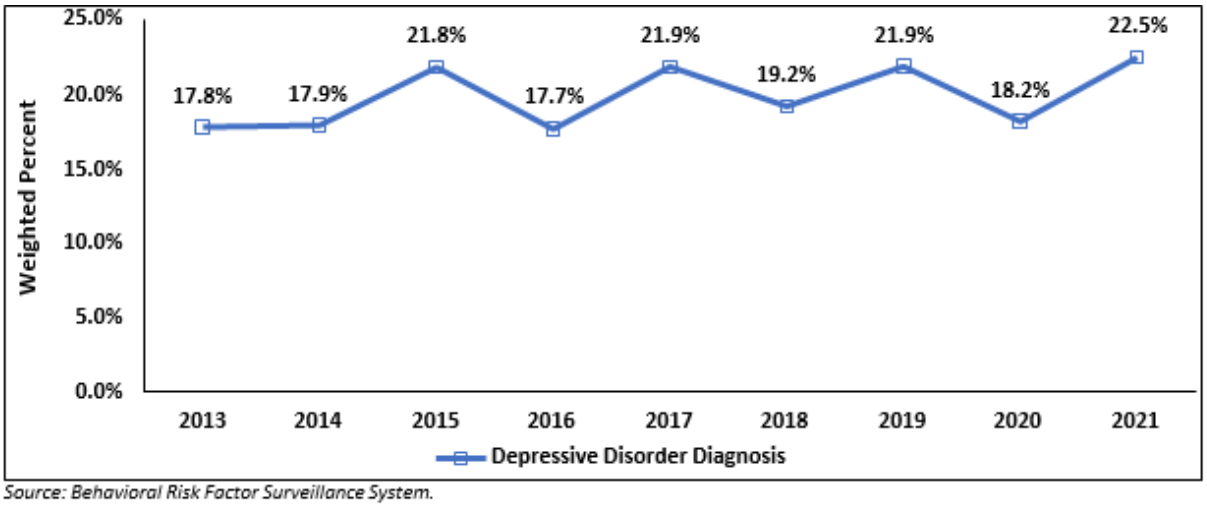


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental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

The percentage of adult Northern Region BRFSS respondents who reported experiencing no days in the past month in which their mental health was considered by them to be "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.

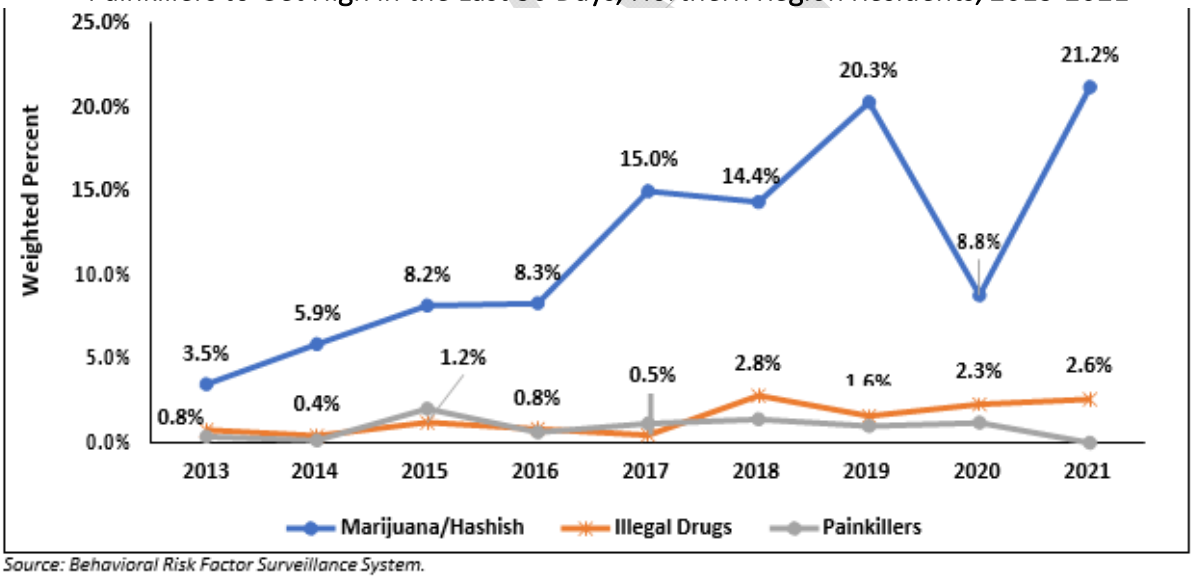
In contrast, the percentage of adult Northern Region BRFSS respondents who reported experiencing 10 or more days in the past month in which they considered their mental health as "not good" steadily increased from 14.8% in 2015 to 30.8% in 2019, followed by a decrease to 22.0% in 2020 and an increase 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)?"

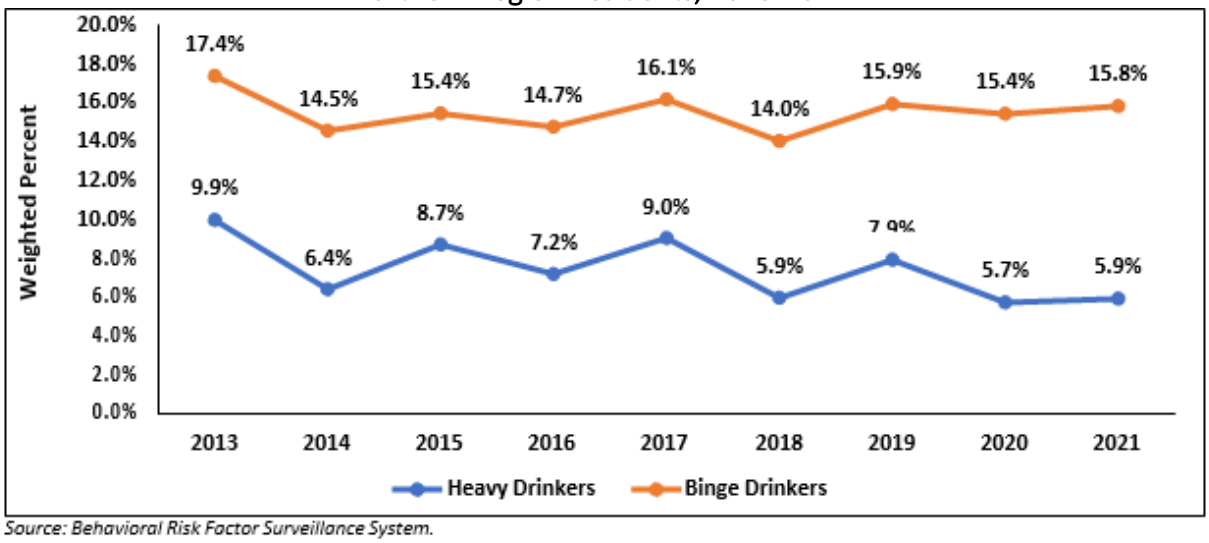
Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Northern Region Residents, 2013-2021.



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 previous 30 days.

The percentage of Adult BRFSS Respondents Who are Considered Binge 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 women have 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 in women as consuming eight or more alcoholic drinks per week (CDC Binge and Heavy Drinking).

Binge drinking percentages 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 and reports:

SafeVoice (anonymous tip line) 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 anonymously.

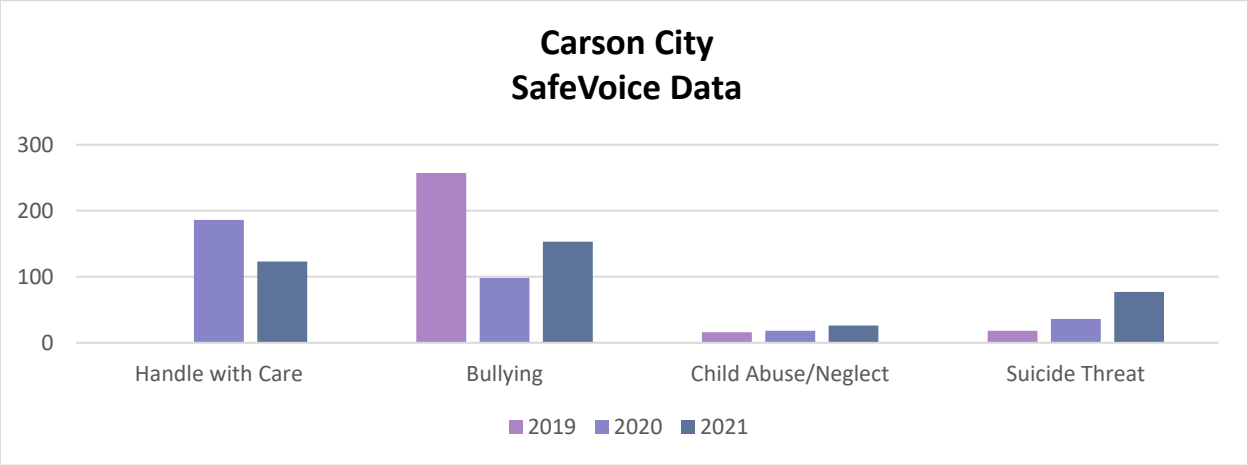
In response to growing concerns about school safety in the State of Nevada, the Nevada State Legislature amended Nevada Revised Statute 388 (NRS 388) in 2015 to establish the SafeVoice program (initially known as Safe2Tell). Although commonly referred to as a "tip line," SafeVoice is a multifaceted initiative that facilitates the collection of information about potentially harmful events in schools and disseminates the information to entities that can intervene to prevent or mitigate the events. The Office for a Safe and Respectful Learning Environment (OSRLE) within the Nevada Department of Education (NDE) manages and oversees the program, and the Department of Public Safety (DPS) operates the SafeVoice communications center 24 hours per day, 365 days per year.

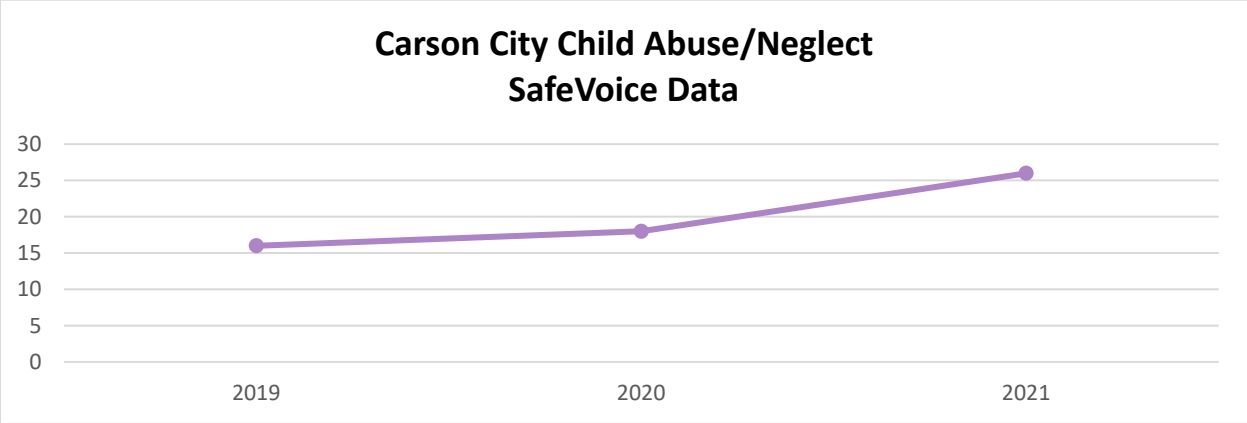
A critical element of NRS 388 is the establishment of a team in every public school to respond to information obtained through SafeVoice (NRS 388.14553). The legislated teams must consist of at least three members, including a school administrator and a school counselor, psychologist, social worker, or similar person if the school employs such a person full-time. These multidisciplinary teams (MDTs) must respond to safety threats and follow up on reports as needed. In short, SafeVoice is a mandated program that provides a statewide mechanism for students, staff, and parents to report harmful or potentially harmful events, for state public safety officers to receive reports and distribute them to local jurisdictions, and for local officials to respond promptly. SafeVoice operates in every school district throughout Nevada. Nevada public schools serve nearly 500,000 students in 763 schools across 17 districts (2021-2022 data from the Nevada Report Card). School district enrollment ranges from 83 students in Esmeralda County School District to 310,556 students in Clark County School District—the fifth largest school district in the country and home of Las Vegas. Unlike several districts that serve urban populations (e.g., Las Vegas, Reno, Carson City, and Henderson), Nevada's school districts are primarily rural and frontier. For example, Nye County is the third largest county by area in the contiguous United States. Still, it has a total population of only 53,450 (US Census Fact Quick Facts, population estimates for July 1, 2021), including 5,353 students in grades k - 12. With such highly varied school districts in Nevada, any statewide program faces consistent and effective implementation challenges.

Please note: Any tips under 10 for each category are not considered in these reports as they are 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.

Below is a series of charts based on data collected between 2019 and 2021 for Carson City, Douglas, Lyon, and the counties.

Carson City

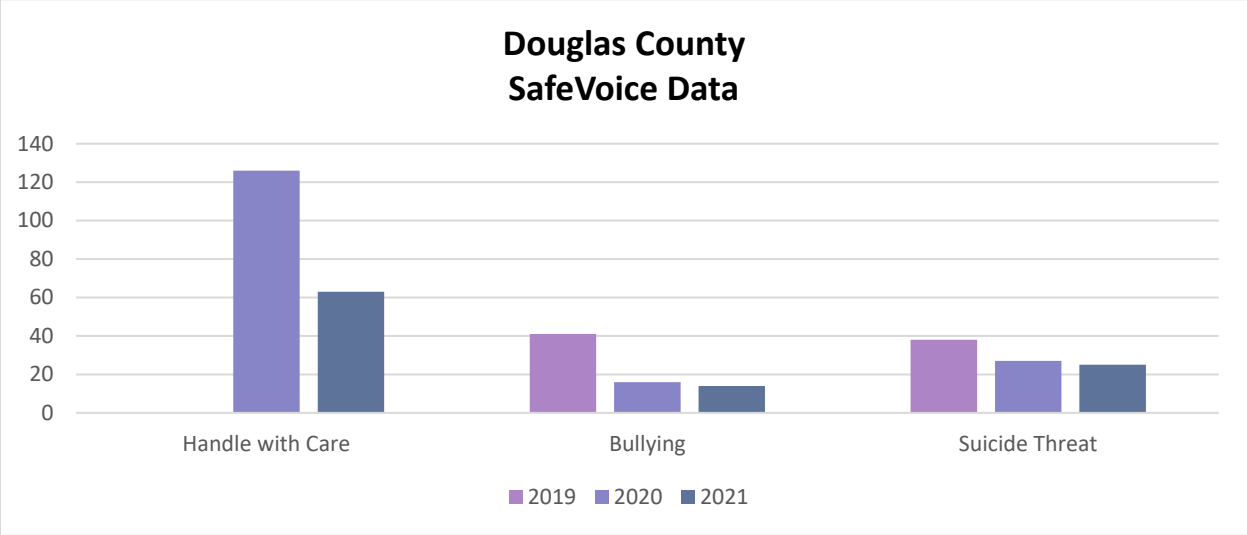




From 2019 to 2021, Carson City saw an increase in suicide threats and child abuse/neglect. The amount of youth at risk for suicide saw a 327.8% increase over the two years. The number of children reported being abused and neglected increased by 62.5% from 2019 to 2021.

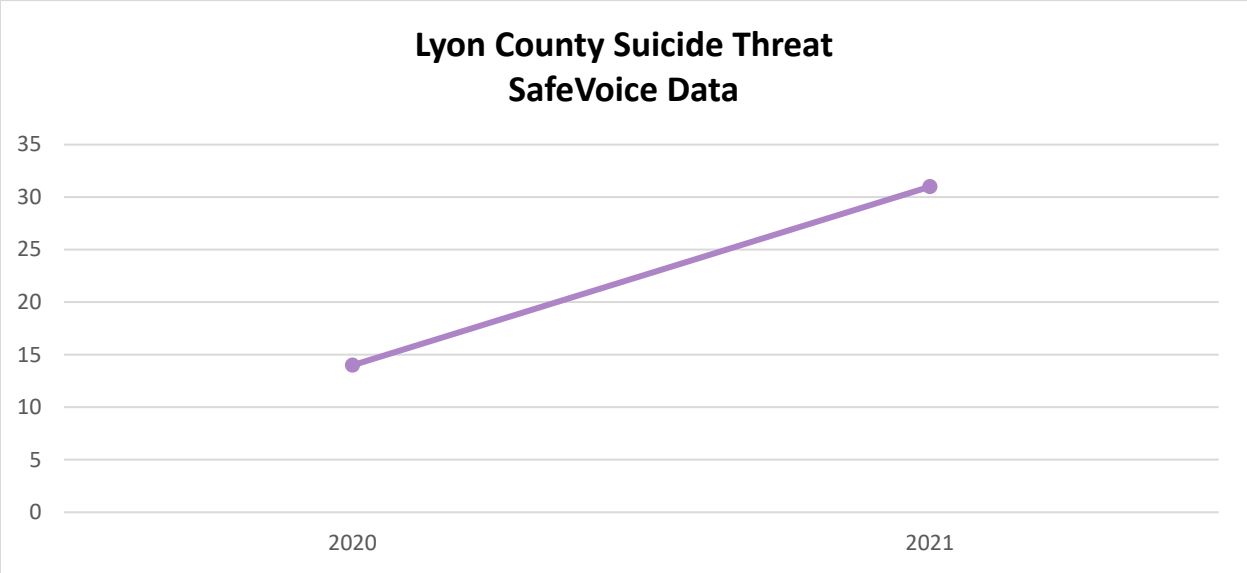
After a sharp decline in reported cases of bullying in 2020, SafeVoice reports an upward trend in bullying in 2021. Reports of bullying decreased 61.9% from 2019 to 2020, only to increase 56.1% in 2021. Handle with Care school notifications decreased by 33.9% between 2020 and 2021.

Douglas County

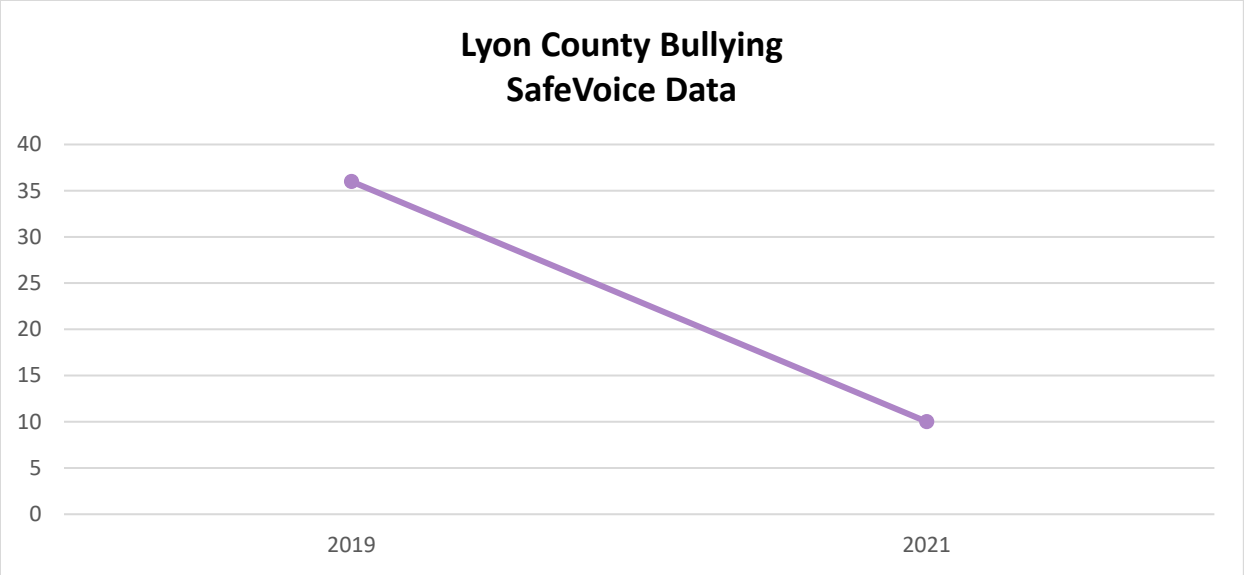


Between 2019 and 2021, SafeVoice reported Douglas County has a downward trend in handling care notations, bullying, and suicide threats.

Lyon County

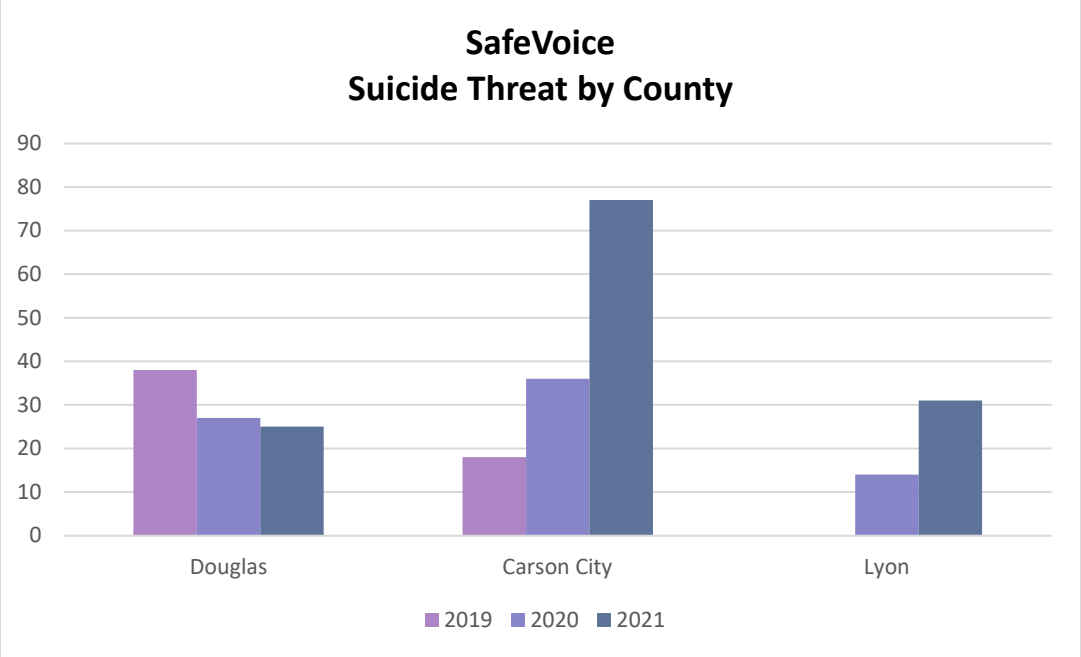


Lyon County saw an exponential increase in youth reported to be at risk for suicide. From 2020 to 2021, the youth suicide threat increased 121.4%.



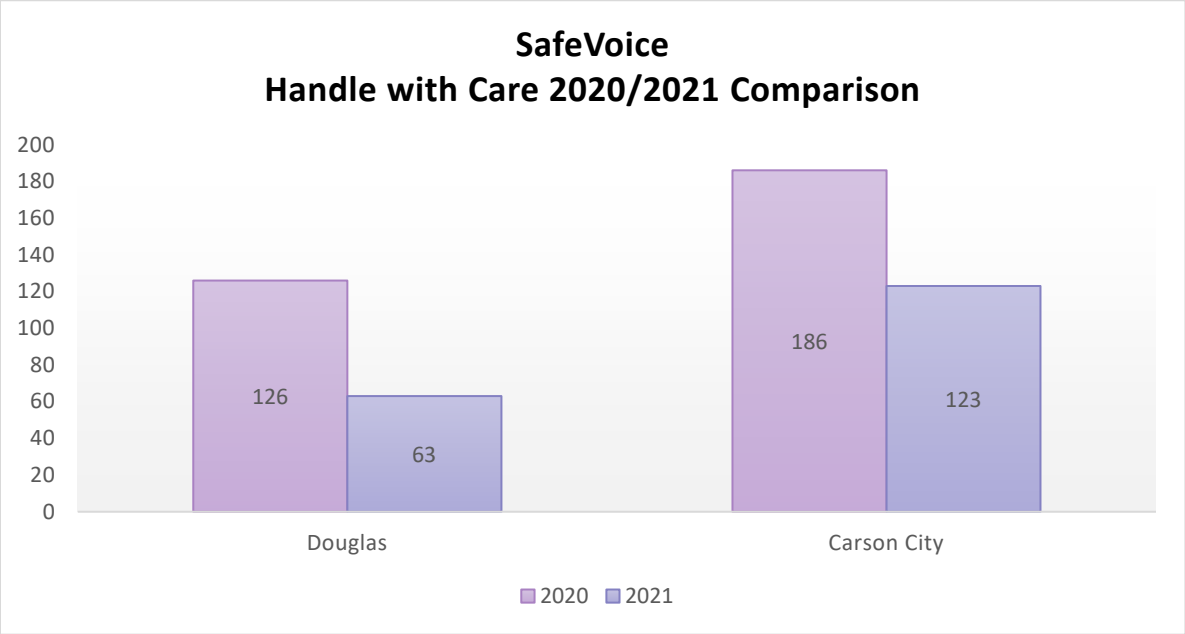
From 2019 to 2021, Lyon County saw a 72.2% decrease in youth bullying reports, in contrast to the rising cases of suicide threats.

Region Comparison Suicide Threat



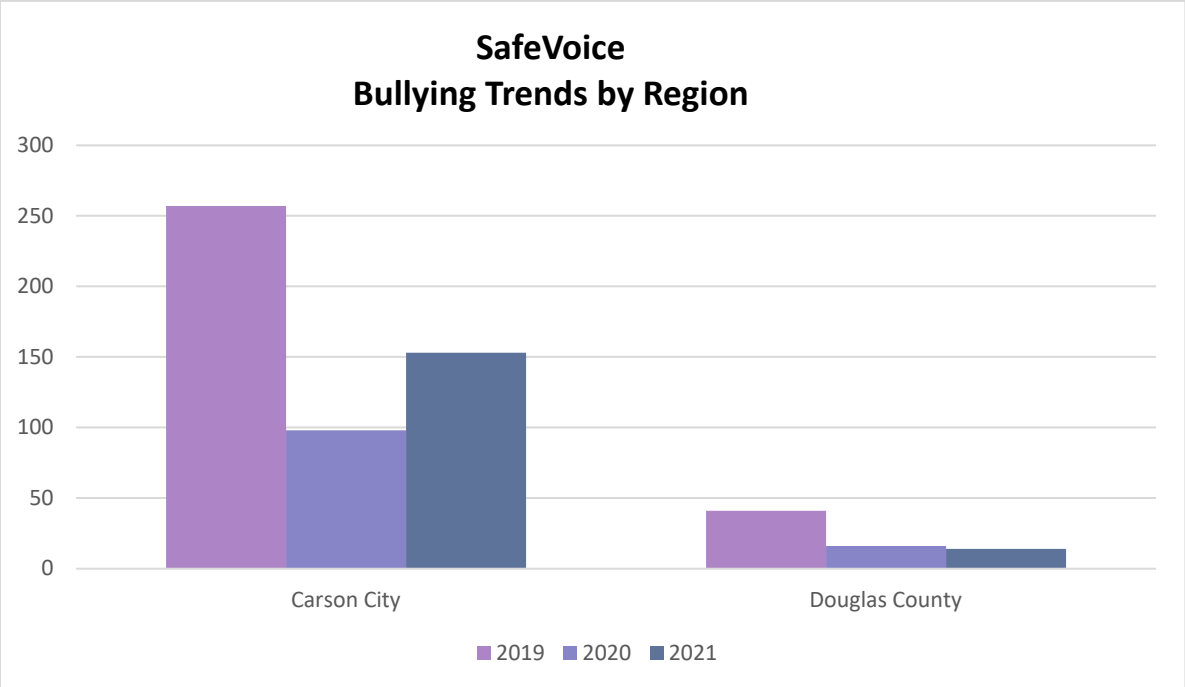
Carson City and Lyon Count experienced an upward trend in youth suicide threat reports, whereas Douglas County saw a decreasing trend.

County Comparison Handle with Care



Between 2020 and 2021, Douglas County and Carson City 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 established by the Centers for Disease Control and Prevention (CDC) to monitor the prevalence of health risk behaviors among youth. Every two years, the CDC randomly chose a little over 30 high schools from Nevada to represent Nevada. However, to ensure more excellent 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 9th through 12th grade students in regular public, charter, and alternative schools. Students self-report their behaviors in six significant 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 a biennial, anonymous, and voluntary survey of 6th through 8th grade students in regular public, charter, and alternative schools. Students self-report their behaviors in five significant 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 the 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 Northern Region high school students reporting that they felt sad or hopeless. The percentage who reported that they considered suicide, planned suicide, or attempted suicide decreased from 2017 to 2019 before increasing in 2021 to percent higher than in 2017. The 2021 Northern Region high school percent is within 1.0% of the 2021 Nevada high school percent.
- 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 suicide decreased from 2017 to 2019 before

rising slightly in 2021. The Northern Region middle school percentage is within 1.0% of Nevada middle school percent.

Youth Electronic Vapor Product Use:

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

Youth Alcohol Use:

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

Youth Marijuana Use:

- The percentage of high school students in the Northern Region who ever used marijuana and currently use marijuana was at the lowest in 2021, while the percentage 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 percentage of middle school students in the Northern Region who ever used marijuana and currently use marijuana was at the lowest in 2021, while the percentage 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 decreased among the Northern Region high school students. All have steadily declined 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 is higher than Nevada high school students, but not significantly.
- From 2019 to 2021, all lifetime drug use listed 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 stated 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.

Additional data points necessary for the region:

Total Numbers of Social Workers by License Level and County Date: 07/13/2022
Data is through 06/30/2022.
License Levels are as follows –

- Licensed Clinical Social Worker (LCSW) – Independent clinical practice in behavioral health and any practice areas of other license categories.
- Licensed Independent Social Worker (LISW) – Independent non-clinical practice.

- Licensed Master Social Worker (LMSW) – General practice, case management, entry-level license
- Licensed Social Worker (LSW) – General practice, case management, entry-level license Licensed Associate of Social Work (LASW) – Grandfathered licensing category that is no longer used. Allows for general practice, case management

	County	LCSW	LISW	LMSW	LSW	LASW	Total
1	Carson City	33	2	20	49	2	106
2	Churchill	9	0	3	17	0	29
3	Douglas	25	1	20	16	0	62
4	Lyon	22	0	16	17	1	56
5	Storey	4	0	0	1	0	5

This graph describes the lack of LCSWs as well as the need for more qualified LCSWs in the Northern Region why there are counties that have LCSWs, but getting the LMSW supervised and certified as a clinician takes many hours of supervision. Within the northern region, there is a struggle to find enough qualified supervisors. Supervision comes at a cost for these newly graduated social workers that, combined with the cost of student loans, becomes unattainable and overwhelming. The passing of AB 45 will have an impact on all graduate students who can benefit from this legislative change. More to come on the successes of this statute.

See below the information provided to the Regional Behavioral Health Coordinators according to AB 457. To provide data on the completes issued to the Social Worker Board and the number of licensure applications.

Board of Examiners for Social Workers

AB457	Complaints					Applications for Licensure				
	Sect. 18(1)	Sect. 18 (1)	Sect. 18 (1)	Sect. 18 (1)	Sect. 18 (1)	Sect. 18 (2)	Sect. 18 (2)	SB 44	Sect. 18 (2)	Sect. 35.5
Year	# of Complaints Filed	# of Investigations Completed	# of Cases Dismissed	# of Cases Settled	# of Cases to Hearing	# of Applications for Initial Licensing	# of Applications Requiring Additional Review	# of Applications Denied and Reasons	# of Applications for Renewal	# of Endorsed Licenses
2023	32	31	21	0	0	1028	54	0	3485	332