EXECUTIVE DEPARTMENT BILL DRAFT REQUEST FOR THE 2019 LEGISLATIVE SESSION

Authority: NRS 218D.175

Deadline: Executive Department BDRs must be submitted by no later than **September 1, 2018.**

Person Submitting Request:

Dorothy Edwards on behalf of the Washoe Regional Behavioral Health Policy Board

Person to Contact for Clarification or Additional Information:

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1. **Intent of Proposed Bill or Resolution** (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution – may be attached as separate document):
See attached document

2. **If known, list any existing state law that is sought to be changed or which is affected by the measure (NRS Title(s), Chapter(s) and Section(s) affected, Statutes of Nevada Chapter(s) and Section(s) affected and/or Nevada Constitutional provision):**

3. **Any additional information that may be helpful in drafting the bill or resolution** (May include any relevant legislative measures, cases or federal laws or other supporting materials – may be attached):

According to a study performed by the Substance Abuse and Mental Health Services Administration (SAMHSA, Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf), the most frequently reported funding sources for crisis services are state and county general funds and Medicaid. Although states finance crisis services using different

payment mechanisms, and the concept of crisis stabilization centers may look differently from county to county, many states and jurisdictions are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status. Each of the states studied in this report, indicated that using funding from multiple sources has been an effective way to support a continuum of crisis care. States also emphasized the value of collecting data on crisis services quality indicators to inform policy decisions around crisis care. With this in mind, the Washoe Regional Behavioral Health Policy Board plans to submit further analysis of available data. The report will be available to improve assessment of fiscal impacts prior to the commencement of the 2019 legislative session.

4. Effective Date:

☐ Default (October 1, 2019)
☐ July 1, 2019
X January 1, 2020
☐ Upon Passage and Approval
☐ Other

5. Description of any known cost to the State or a local government that would result from carrying out the changes in the measure if enacted:

State General Funds for services not reimbursable by Medicaid and/or other insurance providers; Medicaid, including Medicaid Waiver funds. These costs may be offset by the reduced cost of crisis stabilization services as compared to costs of treatment in emergency departments and hospitalizations

REQUIRED PREFILING:

A bill draft requested by the Executive Department of State Government is required to be prefiled on or before November 21, 2018. By statute, a measure that is not prefiled on or before that date is deemed to be withdrawn. There is no authority to waive this requirement.

Please submit completed Bill Draft Request form by mail to: Brenda Erdoes, Legislative Counsel, Legislative Building, 401 South Carson Street, Carson City, Nevada 89701, by e-mail at erdoes@lcb.state.nv.us or by fax at (775) 684-6761.

EXECUTIVE DEPARTMENT BILL DRAFT REQUEST FOR THE 2019 LEGISLATIVE SESSION, CONT.

Intent of Proposed Bill or Resolution (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution)

Definition (s)

Crisis Stabilization**:**

Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder". Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis.

Behavioral Health:

Behavioral health includes mental health *and* substance use, encompassing prevention, early intervention, education, treatment, recovery, and resiliency.

Co-occurring Disorders:

Co-occurring disorders describe the presence of both a mental health and a substance-use disorder.

Problem to be Solved:

Nevada currently has a critical need to fill a gap in crisis stabilization services. This gap in services leaves those in a behavioral health crisis to receive treatment in the hospital emergency departments resulting in a significant increase in overall healthcare expenditures. Populations include some of Nevada's most vulnerable such as seniors, veterans, homeless and those experiencing Post Traumatic Stress Disorder. The ability to address diversity and cultural differences must also be included as a critical role in the direction of resources and services.

Providing behavioral health crisis assessment and treatment in busy emergency departments that produce long waits for care can be a challenging environment for those in need of immediate treatment for psychological needs. "Cold" referrals to mental health care run the risk of minimal follow up and emergency departments have become the default mental health crisis center. Crisis service settings often have more in common with jails; police transport to sometimes distant hospitals, taking law enforcement off the "beat" and the result can be stigmatizing for people in crisis. Despair and isolation is worsened by attempting to navigate a complex mental health system maze.

A recent Washoe County Behavioral Health Profile, supported with data from regional and national sources, revealed devastating numbers related to behavioral health not only in Washoe County but Nevada as a whole. A few of the related statistics include:

- On average from 2012 to 2016, the percentage of adults in Washoe County who experienced any mental illness (19.6%) and serious mental illness (5.1%) was higher than Nevada and the United States, however the percentage of adults who received mental health services in the past year was lower in Washoe County (13.2%) compared to the United States (14.5%).

- In 2016, the age-adjusted rate of death due to intentional self-harm in Washoe County (26.8 per 100,000 people) was nearly double the rate of the United States (13.5 per 100,000 people).

- From 2006 to 2016, the average suicide rate in Washoe County (20.4 per 100,000 population) was higher than Nevada (19.1 per 100,000 population) and the United States (12.4 per 100,000 population).

- Aggregate data from 2012 to 2016 indicate the rate of death due to suicide in Washoe County increased as age increased. The rate of death due to suicide among Washoe County residents aged 85+ (72.3 per 100,000 population) was more than six times the rate among residents aged 15-24 years (11.5 per 100,000 population).

- The rate of death due to suicide among those aged 85+ in Washoe County was nearly four times the rate for the United States, and the rate of death due to suicide among those aged 65 to 84 years in Washoe County was more than double the United States.

- In 2017, the top conditions seen in emergency departments in Washoe County were anxiety (28.1% of encounters), drug-related (18.4%), alcohol-related (16.5%), and depression (15.9%). In 2017, the top conditions that led to an inpatient admission in Washoe County were depression (21.8% of admissions), drug-related (20.7%), anxiety (20.1%), and alcohol-related (16.7%).

Intended Effect:

Crisis Stabilization Centers (CSCs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders and substance abuse events) with prompt action, gentle response and effective support in a respectful environment.

CSCs are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of CSCs is significantly less than psychiatric inpatient units and satisfaction among clients is greater. (Saxon, V. 2018). Crisis stabilization services are designed to stabilize and improve symptoms of distress and feature a continuum of core services including 23-hour crisis stabilization/observation beds, medical detox, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services. Different crisis stabilization models exist but generally a CSC can provide intensive, short-term voluntary interventions for someone experiencing a psychiatric and/or substance abuse crisis, including stabilization services and medical detoxification. If inpatient care is required, a stay of five days or less in the proposed average.

The research based on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes (SAMSHA, 2014). Many communities have only two basic options available

to those in crisis, and they represent the lowest and highest end of the continuum. For those individuals whose crisis represents the middle of the ladder, outpatient services are not intensive enough to meet their needs, and acute care inpatient services are unnecessary. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, and more easily designed for successful and deliberate focus and response.

The expectation is to begin to mitigate the growing crisis around our behavioral health issues by supporting our current successful programs such as the Mobile Outreach Support Team (MOST), and to create new and critical resources.

Goal(s) of Proposed Bill:

1. This bill would authorize the establishment of a certified crisis stabilization center to be operational during the 2019-2020 interim.
    - The expansion of crisis stabilization services in Nevada and establishment of a certified 24 hr. walk-in crisis stabilization center.
    - The purchase of crisis services from a private behavioral health organization through a request for proposal (RFP) process. Services would be managed via performance contracts and formal reviews.
        - Contracted services will include at a minimum:
            - The establishment of treatment protocols, documentation standards, and administrative procedures, consistent with best practices and other evidence-based medicine, for appropriate treatment to individuals who are provided crisis stabilization services.
            - Planning and delivery of services consistent with the philosophy, principles, and best practices for mental health consumers.
            - Assurance of behavioral health equity which is the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, geographical location and social conditions through prevention and treatment of mental health and substance use conditions and disorders.
            - The promotion of concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
            - The promotion of consumer-operated services as a way to support recovery.
            - Planning for each consumer's individual needs.

2. This bill would authorize funding at sufficient levels to ensure that Nevada can provide each individual served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan developed by the successful contractor.
    a. Funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.