Nevada

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/18/2017 8.37.19 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2018
End Year	2019

State SAPT DUNS Number

Number	625364849
Expiration Date	8/13/2017

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Nevada Division of Public and Behavioral Health
Organizational Unit	Nevada Department of Health and Human Services
Mailing Address	4150 Technology Way, Suite 300
City	Carson City
Zip Code	89706

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Amy
Last Name	Roukie
Agency Name	Division of Public and Behavioral Health
Mailing Address	4150 Technology Way Suite 300
City	Carson City
Zip Code	89706
Telephone	(775)684-4200
Fax	
Email Address	amyroukie@health.nv.gov

State CMHS DUNS Number

Number	625364849
Expiration Date	8/13/2017

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Nevada Division of Public and Behavioral Health
Organizational Unit	Nevada Department of Health and Human Services
Mailing Address	4150 Technology Way, Suite 300
City	Carson City
Zip Code	89706

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Amy
Last Name	Roukie
Agency Name	Division of Public and Behavioral Health
Mailing Address	4150 Technology Way Suite 300

City	Carson City
Zip Code	89706
Telephone	775-684-4200
Fax	775-684-4211
Email Address	amyroukie@health.nv.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Marco
Last Name	Erickson
Telephone	775-684-4069
Fax	
Email Address	maerickson@health.nv.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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as authorized by
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and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Nevada's Public and Behavioral Health Governance and Funding Structure

The State of Nevada Department of Health and Human Services (DHHS) operates six divisions to include Aging and Disability Services (ADSD); Child and Family Services (DCFS); Health Care Financing and Policy (DHCFP–Nevada Medicaid); Public and Behavioral Health; Welfare and Supportive Services; and the Public Defender. Nevada is one of three states in the United States that operates the public behavioral health system for its vulnerable residents. In 2013, the Mental Health and Developmental Services division merged with the State Health Division to become the Division of Public and Behavioral Health (DPBH), under the DHHS. This merger brought both the Substance Abuse Single State Authority (SSA) and the State Mental Health Administrator (SMHA) under the same Division allowing for greater collaboration and integration of behavioral health policies, budgeting, and service-delivery. Since 2013, behavioral health services throughout the State of Nevada are undergoing significant change and moving toward a coordinated system-of-care. The public health approach to behavioral health recognizes the interrelatedness of behavioral health and physical health; focuses on prevention and promotes behavioral health across the lifespan; identifies risks that may contribute to illness or disability, as well as protective factors that protect against the development of illness or disability and/or limit its severity; provides individuals with the knowledge and skills to maintain optimal health and well-being; and brings together individuals; families; communities and a variety of health and human service systems to work collaborative toward better behavioral health for the State of Nevada.

DPBH is responsible for the operation of State-funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services, and substance abuse prevention and treatment. By State statute, the Division is responsible for planning, administration, policy setting, monitoring, and budget development of all State-operated adult mental health and developmental services programs. DPBH Administration is also directly involved in decisions regarding agency structure, staffing, program administration, and budget development. The DPBH Administrator is appointed by the Director of the Department of Health and Human Services (DHHS) and serves as both the SSA and the SMHA.

The DPBH Administrator relies on the oversight and direction of stakeholders in several advisory groups:

- Commission on Behavioral Health: The Commission on Behavioral Health is a ten member, legislatively created body, appointed by the Governor and designed to provide policy guidance and oversight of Nevada's public system of integrated care and treatment of adults and children with mental health, substance abuse and developmental disabilities-related conditions. The Commission also promotes and assures the protection of the rights of all clients in this system and has oversight and accountability function for both Behavioral Health and DCFS.

- Local Governing Boards: The Commission on Behavioral Health has created local governing boards in Washoe and Clark Counties and makes appointments to these boards from stakeholders in the community. The boards serve to provide information to the Commission regarding service needs, public input, and other issues pertaining to mental health and the state mental health hospitals.\

- In the 2017 legislative session A.B. 366 created four behavioral health regions in the State of Nevada and a behavioral health policy board for each region. The Northern Behavioral health Region consists of Carson City, and the counties of Churchill, Douglas, Lyon, Mineral, and Storey. The Washoe Behavioral Health Region consists of Washoe County. The rural Behavioral Health Region consists of Elko, Eureka, Humboldt, Lander, Pershing and White Pine. The Southern Behavioral Health Region consists of Clark County, Esmeralda, Lincoln, and Nye Counties. These boards advise the State on behavioral health needs of adults and children for each region. This includes identifying potential problems with proposed policy changes, and service delivery as well as identify gaps in services, and make recommendations for service enhancements, and allocation of funds.

- Substance Abuse Prevention and Treatment Agency (SAPTA) Advisory Board (SAB): The SAB serves in an advisory capacity to the Bureau Chief of SAPTA and the SSA. Its purpose is to ensure the availability and accessibility of treatment and prevention services within the State. It consists of fifteen members who serve for two year terms and are chosen from SAPTA funded prevention and treatment programs. The chairperson is elected by the membership and serves as the chief executive of the Board and provides general supervision, direction and control of affairs of the Board. The Board meets at least quarterly, and the chairperson presides at all meetings.

- Multidisciplinary Prevention Advisory Committee (MPAC): MPAC was originally authorized under the State Incentive Grant (SIG) and the Strategic Prevention Framework (SPF) in 2002. The Committee was re-authorized under the Strategic Prevention Framework Partnerships for Success Grant in 2013. MPAC is established as a freestanding committee advising Division of Public and Behavioral Health/ SAPTA on prevention issues and strategies. The Committee, meeting quarterly, works closely with the State Epidemiological Workgroup for its data needs.

The Mental Health Planning Advisory Council (MHPAC) was established by a governor's executive order in 1989. The MHPAC changed its name to the Behavioral Health Planning Advisory Council (BHPAC) in 2013 by an Executive Order of the Governor with the goal of serving as an advocate for individuals experiencing chronic mental illnesses, children and youth experiencing serious emotional disturbances, and other individuals experiencing mental illnesses or emotional problems, alcohol and substance problems, and co-occurring disorders. The members of the Council work in a variety of ways to improve the way services are provided to consumers, to help bring more money into the State system, to promote awareness of mental health issues, and to provide education and training opportunities. The BHPAC has three federally mandated duties:

1. To review the Combined Health Block Grant Plan and to make recommendations;

2. To serve as an advocate for adults with Serious Mental Illness (SMI), children with Severe Emotional Disturbance (SED), and other individuals with mental illnesses or emotional problems; and person with alcohol / substance abuse and co-occurring disorders, and

3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of behavioral health services within the state.

The Division of Child and Family Services (DCFS) is the state mental health authority responsible for the operation of State-funded children's outpatient community mental health programs, residential programs, juvenile justice programs, and foster care programs. By State statute, the Division is responsible for planning, administration, policy setting, monitoring, and budget development of all State-operated child mental health programs in Washoe and Clark Counties. DCFS Administration is also directly involved in decisions regarding agency structure, staffing, program administration, and budget development. The DCFS Administrator coordinates the administration of children's behavioral health services with the SSA and the SMHA. DCFS receives oversight and direction through stakeholder and advisory groups: the Commission on Behavioral Health, Regional Consortia; and the Children's Behavioral Health

Commission on Behavioral Health: As previously described, the Commission has oversight of the public system that provides care and treatment of mental health, mental retardation, and co-occurring disorders. Commission duties are to establish and set policies, review programs and finances, and to report bi-annually on the quality of care and treatment to the Legislature. The Commission sets aside four days per year to meet with DCFS and to focus on children's mental health issues. The Commission is responsible for appointing a subcommittee on the mental health of children that reviews the findings and recommendations of each regional mental health consortium. The subcommittee is tasked with creating a statewide plan for the provision of mental health services to children.

Consortium.

- Regional Mental Health Consortia: Established in 2001 by the Legislature, the regional mental health consortia are tasked with the development of a long-term strategic plan for the provision of mental health services to children in their jurisdiction. The strategic plan is submitted to the Director of the Department of Health and Human Services. Each even-numbered year, consortia submit a list of priorities of services necessary to implement the long-term strategic plan with an itemized cost to provide the services and any revisions to the strategic plan. On odd-numbered years consortia submit a status report on the long-term strategic plan and any revisions.

- Nevada Children's Behavioral Health Consortium: The Nevada Children's Behavioral Health Consortium was developed in response to the need for a statewide governance body. The mission of the Consortium is to provide Nevada's children and their families with timely access to an array of behavioral health treatment services and support that meet their needs in the least restrictive environment; and to deliver such services through a system of care. To develop financing strategies to support quality service delivery. To provide a mechanism by which system stakeholders can act in concert to ensure that children's needs are met. The Consortium works as a statewide voice for the common themes articulated by the three regional consortia.

Through the DPBH Mental Health and Substance Abuse and Prevention Agencies (SAPTA), Nevada has been working to establish an integrated system of care with our SUD and MH treatment systems to be able to address the needs of individuals with co-occurring disorders. DPBH serves the adult population with serious mental illness (SMI) as well as children and adolescents in the fifteen rural counties outside of Clark and Washoe Counties, who have Severe Emotional Disturbance (SED). The Nevada Division of Child and Family Services (DCFS) serve the needs of young SED clients residing in the urban counties of Clark and Washoe. With the cross-over of systems and supports, Nevada is better able to utilize the sources of funding and resources more effectively. Nevada's system is comprised of federal, state and local provider resources with funding from federal, philanthropic and non-profit grants, gifts and

cooperative agreements; state and county general fund through state tax revenues; Medicaid (State Plan, waiver, Title XIX, Title XXI, expansion); recipient sliding scale payments; Medicare; and private insurance. The prioritization of projects and funding is based on the Governor's performance based budgeting, state strategic and need based plans, as approved by the Nevada State Legislature.

Services throughout the state differ based on target population, geographic region, and funding services. Within the Division of Public and Behavioral Health, there are five service delivery systems operating to protect, promote and improve the physical and behavioral health of the people in Nevada. These systems include four adult mental health agencies: Northern Nevada Adult Mental Health Services; Southern Nevada Adult Mental Health Services; Rural Counseling and Supportive Services, which includes Community Health Nursing; Lake's Crossing Forensic Facility, and SAPTA Treatment and Prevention providers. These programs provide services for adults from inpatient and outpatient services; mobile crisis; outpatient counseling; service coordination; intensive service coordination; medication clinic; residential support programs; mental health court; programs for assert community treatment (PACT) Teams; jail diversion programs, and in Rural Nevada, our community behavioral health clinics also serve as the local children's mental health authority. Lake's Crossing is a forensic facility that provides serves aimed at determining the legal competency of an individual to stand trial and restoration of legal competency for trial purposes.

While Nevada's mental health system is largely State-run, SAPTA provides no direct services but grants funds to community based providers and organizations to provide needed services in the community.

SAPTA certifies and funds nineteen substance abuse treatment providers at fifty-five sites throughout the state. SAPTA also certifies sixty other organizations that provide treatment services in the state. These certified and/or funded programs provide a continuum of care and recovery support services ranging from withdrawal management, crisis triage centers, comprehensive evaluations, residential treatment, outpatient counseling, transitional housing, specialty court services, Medication Assisted Treatment (MAT), targeted case management, and programs for special populations including adolescents, pregnant and parenting women, and the homeless.

In addition, SAPTA funds twelve community prevention coalitions serving all seventeen Nevada counties. The coalitions are responsible to collect local data and develop a needs assessment and strategic plan for the communities they serve. The final document produced is called the Comprehensive Community Prevention Plan or CCPP.

The coalitions also perform community organization work in relation to various issues such as underage drinking, methamphetamine prevention, opioid awareness, mental health promotion, and more. This work is accomplished through issue-oriented coalition development, media efforts, and a number of environmental strategies. SAPTA flows Block Grant funds to the coalitions and those funds are granted through the coalitions to evidence-based prevention efforts in the community based on the coalition's CCPP. This system ensures that funds are allocated according to the demonstrated need in the specific community.

Financing behavioral health services in Nevada depends on state general fund revenue with contributions from grants and Medicaid. Each service system has its own budget established within the state system. The Division of Health Care Financing and Policy (DHCFP), also known as Nevada Medicaid, operates Medicaid Fee-For-Service (rural Nevada); the Managed Care Organizations (MCO) (urban Nevada); and the Care Management Organization (CMO) for patient centered care in rural Nevada.

Since the implementation of the Affordable Care Act January 1, 2014 Nevada has seen a dramatic shift in the numbers of individuals with eligibility for health and behavioral health insurance coverage through Silver State Health Insurance Exchange (SSHIX) and Nevada Medicaid (Table 1). According to the Center for Disease Control and Prevention the number of people who were uninsured decreased in recent years, largely due to the Affordable Care Act. In 2016, a total of 631,843 people had Medicaid as

their insurance. This represents nearly double the population insured in 2013, prior to statewide Medicaid expansion (Division of Public and Behavioral Health, 2016).

Table 1: Medicaid in Nevada

Nevada Medicaid Population Demographics (June 2016)		
	#	%
North	83,324	13.2%
South	485,251	76.8%
Rural	63,268	10.0%
Total	631,843	

Source: (Division of Public and Behavioral Health, 2016)

State efforts are being shifted from direct service delivery for the indigent to assessment, referral, training, education and community capacity building.

Percentage change of uninsured by population in Nevada FY 2013-FY 2015

Population	Pre-ACA-Uninsured	Post-ACA-Uninsured
State Average	20.7%	11.0%
Children under age 18	14.8%	5.4%
Adults age 18 to 64	27.0%	15.2%
Elderly 65 years and older	2.1%	1.9%
Overall for the non-elderly 64 and under	23.6%	12.5%

Collaboration with our state Medicaid agency resulted in the addition of Medicaid coverage of substance use disorder services effective January 2014. This has offset the need for general fund and block grant funding for treatment services provided in the Medicaid-approved model. Medicaid generously worked with SAPTA to develop a Provider Type 17 agency model that resulted in all nineteen providers being able to bill and be reimbursed by Medicaid.

In response to the changing needs of the treatment delivery system, SAPTA is shifting funding previously needed for treatment that Medicaid normally pays for such as outpatient and intensive outpatient to enhancing “gap” service. Some of these gap services include residential, transitional care, targeted case management, recovery-oriented systems of care, and expanding access to recovery support services for adolescents and adults.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH-MENTAL HEALTH SYSTEM

The Nevada Division of Public and Behavioral Health (DPBH) provides mental health, substance abuse, and co-occurring disorders treatment services to adults in the two most populated counties of the State, Clark (the greater Las Vegas area) and Washoe (the Reno/Sparks area). DCFS provides mental health services to children in Clark and Washoe counties. The Division’s Mental Health Rural Services Agency provides mental health services to adults and children in all other counties.

In addition to serving these consumers directly, DPBH works with many stakeholders including family members, advocates, service providers, legislators, law enforcement, and the general public. As a result of these diverse interests, the issues facing DPBH are complex and require input from many different perspectives. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public mental health and developmental services system that meets the needs of Nevada’s citizens.

DPBH Mental Health Services continually works to improve services and access to services for racially and culturally diverse populations. This effort is evidenced by the inclusion of representatives from

diverse populations on various advisory councils. Mental Health Services includes data reflecting the state's racial and ethnic minorities in all needs assessments and gaps analysis in order to monitor access to services by these populations. In addition, surveys to assess consumer/client satisfaction include questions measuring satisfaction in areas of cultural respect shown by staff and treatment team members. All surveys are provided in English and Spanish. Surveys in other languages can be provided by request. Consumer advocates are made available to assist clients, many as peers with similar diversity and background as the consumers that are assisted.

Mental Health Services provides technical assistance and accepts referrals from tribal health clinics located in many of the twenty-seven tribal communities in Nevada. Issues of significance that impact tribal communities include suicide, trauma, depression and substance abuse.
DPBH provides support for various tribal community planning groups and assistance with training.

The administration and services provided by Mental Health are organized into three regions: North, South, and Rural. Four Mental Health agencies deliver mental health care in these regions of the state:

Northern Region
Northern Nevada Adult Mental Health Services (NNAMHS): Founded in 1882, NNAMHS occupies part of 92 acres deeded to the State in the 1800's for the benefit of the mentally ill and developmentally disabled. Located adjacent to the Truckee River in Sparks Nevada, it shares sculpted grounds with Lake's Crossing Center (the State Forensic Hospital), and Sierra Regional Center (the treatment center for the developmentally disabled). In recent years, NNAMHS, formerly known as the Nevada Mental Health Institute, has developed from the only state hospital in Nevada to a comprehensive, community-based, mental health system supported by an acute care psychiatric inpatient hospital. The agency is fully accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). In addition to the Dini-Townsend Hospital, numerous outpatient services are available, including the Medication Clinic, Outpatient Pharmacy, the Program of Assertive Community Treatment (PACT), Peer Counseling and Service Coordination Services.

Southern Region
Southern Nevada Adult Mental Health Services (SNAMHS): The beginnings of the mental health delivery systems differed substantially in southern and northern parts of the Silver State. In northern Nevada, mental health services evolved from a hospital based institutional setting while in southern Nevada the mental health service system relied primarily on community-based programs. Both systems have evolved into a comprehensive service delivery system.
SNAMHS has clinics and locations in various communities within Clark County and a centralized inpatient hospital. The variety of community based clinics offer easy access throughout Clark County. SNAMHS is fully accredited by The Joint Commission and certified by CMS.

SNAMHS provides both inpatient and outpatient services for individuals living in Clark County and in surrounding counties that may be closer geographically to this agency as opposed to a rural mental health center. This includes SNAMHS' regional clinics in the same Nevada rural towns of Pahrump, Mesquite and Laughlin. Services are comparable to NNAMHS, including Inpatient, Medication Clinic, Outpatient Therapy, PACT, Peer Support and Service Coordination Services.

Statewide Forensic
Lake's Crossing Center (LCC): This facility provides forensic mental health services in a maximum security facility. Mentally disordered offenders are referred by the court system for evaluation of their competency to stand trial and/or treated to restore competency. Located on the DPBH Campus in Sparks, LCC is Nevada's only facility for this purpose and, therefore, serves people from throughout the state. LCC also provides treatment for individuals adjudicated Not Guilty by Reason of Insanity (NGRI) and those determined to be incompetent to stand trial but requiring a maximum security setting due to dangerousness. LCC psychologists sit on the Sex Offenders' Certification Panel and the Community Tier Reconsideration Panel.
LCC provides pre-commitment evaluations on an outpatient basis for rural counties and Washoe County.

Rural and Frontier Regions

Rural Community Health Services (RCHS): In 1978, Nevada was granted federal funding to provide comprehensive education and referral services to all ages within the 15 rural counties of the State and to work in close coordination with other health and social services. RCHS is comprised of 16 behavioral health clinics situated in the rural and frontier areas between Clark and Washoe counties. These centers provide a wide array of services to severely emotionally disturbed children and adolescents as well as adults with serious mental illness. Services include psychiatry (medication clinic); group, individual and family therapies; case management services and residential supports. In the more remote areas, the medical staff of Board Certified Psychiatrists and Advanced Practice Nurses provides medication services via telemedicine.

The itinerant offices in Tonopah and Lovelock have therapists available on site less frequently but are able to offer tele-therapy when appropriate so that families do not have to travel to a larger center. Crisis services are available during business hours in most clinics and services are provided for all persons who qualify regardless of their ability to pay. Rural Community Health Services also houses the Community Health Nursing (CHN) program in 14 rural and frontier communities. The CHN program provides public health nursing, preventative health care, early detection of threats to public health, disaster response, and education. Essential services provided include adult and child immunizations, well child examinations, chronic disease education, lead testing, family planning, cancer screenings, and the identification and treatment of communicable diseases including sexually transmitted infections (STI's), Human Immunodeficiency Virus (HIV), and tuberculosis (TB). RCHS is currently working to integrate services for public health and behavioral health through several initiatives aimed at providing a seamless array of health and behavioral health supports in rural and frontier communities.

Demographics

DEMOGRAPHICS - AVATAR USERS: 2015 TO DATE

	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
GENDER								
FEMALE	390	335	276	244		349	1594	38%
MALE	634	168	622	315	233	589	2561	62%
UNKNOWN	1	1	2			1	5	0%
TOTAL	1025	504	900	559	233	939	**4160**	**100%**

	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
AGE								
0 - 6 YRS	5	2	3	11	0	5	26	1%
7 - 12 YRS		42	0	40	0	0	82	2%
13 - 17 YRS	8	53	9	120	0	1	191	5%
18 - 25 YRS	255	72	327	106	37	166	963	23%
26 - 35 YRS	365	138	88	121	78	370	1160	28%
36 - 65 YRS	362	191	461	134	115	379	1642	39%
66 AND ABOVE	30	6	12	27	3	18	96	2%
TOTAL	1025	504	900	559	233	939	**4160**	100%

	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
RACE								
ALASKAN NATIVE	2		3			3	8	0%
AMERICAN INDIAN	34	3	10	19	2	34	102	2%
ASIAN	4		1	4	2	7	18	0%
BLACK	18	13	243	7	20	24	325	8%
MIXED	47	11	46	8	5	8	125	3%
WHITE	694	122	287	339	195	685	2322	56%
OTHER	96	34	65	15	8	88	306	7%
UNKNOWN	130	321	245	167	1	90	954	23%
TOTAL	1025	504	900	559	233	939	4160	100%
	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
ETHNICITY								
HISPANIC	141	36	107	73	12	123	492	12%
NOT HISPANIC	637	81	459	102	215	624	2118	51%
UNKNOWN	247	387	334	384	6	192	1550	37%
TOTAL	1025	504	900	559	233	939	4160	100%
	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
EDUCATION								
1-YR VOCATIONAL	5	1	2	1		1	10	0%
4 - 8 YRS	17	16	14	43	2	10	102	2%
9 - 10 YRS	80	6	62	65	16	67	296	7%
11 - 12 YRS	541	12	328	182	169	466	1698	41%
13 - 14 YRS	172	2	32	43	28	145	422	10%
15 - 16 YRS	29	8	10	15	12	38	112	3%
17 - 19 YRS		3		2	1	14	20	0%
>= 20 YRS	1			2			3	0%
OTHER	2	10	3	22		2	39	1%
UNKNOWN	178	446	449	184	5	196	1458	35%
TOTAL	1025	504	900	559	233	939	4160	100%
	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
VETERAN								
YES	24		9	5	5	11	54	1%
NO	513	40	305	128	200	605	1791	43%
UNKNOWN	488	464	627	432	41	389	2441	59%
TOTAL	1025	504	900	559	233	939	4160	100%
	CCCCC	FCS	HELP	TYFS	STEP1	VITALITY	TOTAL	%
HOMELESS								
HOMELESS	62	1	116	34	3		216	5%
HOMELESS SHELTER	5		80		1	27	113	3%
DEPENDENT LIVING	154	16	232	19	58		479	12%

INDEPENDENT LIVING	134	2	9	46	4		**195**	5%
STREETS			13			121	**134**	3%
NOT HOMELESS	172	7	12	104	35	470	**800**	19%
UNKNOWN	785	502	583	395	219	744	**3228**	78%
TOTAL	1028	504	900	559	234	939	**4164**	**100%**
	CCCCC	**FCS**	**HELP**	**TYFS**	**STEP1**	**VITALITY**	**TOTAL**	**%**
COUNTY								
CARSON CITY	568	1	1	17	12	51	650	16%
CHURCHILL	1	2			1	3	7	0%
CLARK			600	2		24	626	15%
DOUGLAS	101		1	336		12	450	11%
ELKO						61	61	1%
EUREKA						1	1	0%
HUMBOLDT					2	13	15	0%
LANDER						3	3	0%
LINCOLN						1	1	0%
LYON	61	6		17	1	42	127	3%
MINERAL	44				1	8	53	1%
NYE	1	1			1	9	12	0%
PERSHING					2	5	7	0%
STOREY	1					1	2	0%
WASHOE	43	470		6	182	436	1137	27%
WHITE PINE						3	3	0%
UNKNOWN	208	24	298	181	32	266	1009	24%
TOTAL	1028	504	900	559	234	939	**4164**	**100%**

*BASED ON DATA ENTERD INTO AVATAR BY SIX PROVIDERS FROM MID -2015 TO DATE.
REFLECTS INFORMATION RELATING TO CLIENTS SEEKING SUBSTANCE ABUSE TREATMENT.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH-SUBSTANCE ABUSE PREVENTION AND TREATMENT AGENCY (SAPTA)

The mission of SAPTA is to reduce the impact of substance abuse in Nevada. This is accomplished through the identification of the alcohol and drug abuse needs of Nevadans and by supporting a continuum of services including prevention, early intervention, treatment, and recovery support. SAPTA provides regulatory oversight and funding for community-based public and non-profit organizations. SAPTA is also responsible for the development and implementation of a state plan for prevention and treatment, coordination of state and federal funding, and development of standards for the certification of prevention and treatment programs. SAPTA's services are unique when compared to the public adult and children's mental health services - all of SAPTA's prevention and treatment services are provided in the community by private non-profit providers. SAPTA provides no direct services.

The agency has the following objectives:

- Statewide formulation and implementation of a state plan for prevention, intervention, treatment, and recovery of substance abuse.
- Statewide coordination and implementation of state and federal funding for alcohol and drug abuse programs.
- Statewide development and publication of standards for certification and the authority to certify treatment levels of care and prevention programs.

SAPTA funds nineteen different treatment agencies that serve clients from every county in the state. Services provided include:

- Community triage in Reno and Las Vegas.
- Detoxification in Reno, Las Vegas, and Elko (rural/frontier).
- Assessment, evaluation, and targeted case management services.
- Women's services that comply with 45CFR requirements for serving women and their young children. These services are provided in Reno and Las Vegas and include residential, transitional, substance abuse and mental health outpatient, case management, life skills, prenatal care, childcare, employment and training programs, education, and more.
- Adolescent services including residential for boys, outpatient, intensive outpatient, family therapy, and mental health screening and treatment. One detention program for adolescents is funded, as well.
- TB and HIV testing and related services for the funded treatment providers.
- A variety of outpatient services that include help for substance use disorders, co-occurring disorders, mental health problems, family issues, and more. One clinic in Las Vegas specializes in treating urban based Native Americans.
- A variety of residential and transitional living programs. One program serves people re-entering society from prison or jail. This program includes skills training, counseling, mental health counseling, job training, and more.
- Medication Assisted Treatment. SAPTA only funds one MAT program but plans to expand these services throughout all levels of care in the new grant year.
- Crisis call services statewide.
- Peer recovery support services provided in the context of a treatment setting. All residential programs have Recovery Support Workers. SAPTA plans to expand these services to other settings in the new grant year.

SAPTA is working toward helping the providers become more co-occurring enhanced and to integrate their services so that clients with co-occurring disorders can receive treatment in a “one stop shop,” when appropriate.

In addition, SAPTA funds twelve community based prevention coalitions that serve the communities in each county of the state. The coalitions serve the following counties in Nevada:

- Washoe (Join Together Northern Nevada)
- Clark (3 coalitions: CARE, Nevada Community Prevention Coalition, PACT-Prevention, Advocacy, Choices, Teamwork)
- Eureka, White Pine, Elko (Partners Allied for Community Excellence Coalition)
- Humboldt, Pershing, Lander (Frontier Community Coalition)
- Nye, Esmeralda, Lincoln (Nye Communities Coalition)
- Carson City (Partnership Carson City). PCC developed a Latino coalition called the United Latino Community, which includes classes in English as a second language, a GED program, and a citizenship program.
- Douglas (Partnership of Community Resources)
- Lyon, Storey, Mineral (Healthy Communities)
- Churchill (Churchill Community Coalition)
- Statewide Native American Coalition performs coalition work with all twenty-seven tribes in the state. In early 2017 SNAC had staff changes that made it difficult to continue operation therefore they are not being funded as of FY18. When providing services SNAC collaborates with the other coalitions and has developed a promising prevention practice called the Young Men’s and Women’s Gatherings. Working closely with the Nevada Attorney General’s Office, SNAC has create the Nevada Tribal Drug Endangered Children Alliance, which is the first tribal alliance for drug endangered children in the United States.

These important organizations ensure that SAPTA flows Block Grant funds to the coalitions and those funds are granted through the coalitions to evidence based prevention efforts in the community based on the coalition’s CCPP. Funds are granted for implementation of the six SAMHSA prevention strategies of information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental strategies.
This funding system that is based on community data and need ensures that funds are allocated according to the demonstrated need in the specific community.

In the new Affordable Care Act world, the coalitions are branching out from a singular focus on substance abuse into other areas such as utilization of Community Health Workers, building recovery supports in their communities, and engaging in projects that are related to public health and wellness.

STRENGTHS OF THE ADULT BEHAVIORAL HEALTH SYSTEM

- Integration of the State's adult mental health and substance abuse prevention and treatment agency with the Nevada State Health Division occurred July 01, 2013. This allows collaboration and treatment needs of persons with both behavioral health and/or health problems, including mental illness, substance abuse disorders, and chronic diseases, such as hypertension, diabetes and kidney disease. Under this public health model of delivering behavioral health services, The Division of Public and Behavioral Health (DPBH) will be able to focus more on data-driven, population-based needs, and service opportunities.
- Consumer Assistance Program (CAP): The involvement of consumers as stakeholders and service providers in Nevada.
- Multiple access points in Southern Nevada: At SNAMHS psychiatric emergency services are provided at each of the four community mental health centers in the Las Vegas metropolitan area, as opposed to a centralized location in the city.
- Mobile Crisis Team in Las Vegas – At SNAMHS: This specialized unit works with Las Vegas area hospital emergency departments. The Team is comprised of Licensed Clinical Social Workers (LCSW's) who travel to local Emergency Rooms (ER) to evaluate patients on involuntary holds and, when feasible, develop safe discharge plans to allow the ER to discharge the person back to the community. This service averts unnecessary psychiatric hospitalizations, saves ER personnel time and reduces the numbers of psychiatric patients in the ER.
- Mobile Outreach Safety Team – At NNAMHS: This is a specialized program, staffed with two LCSW's, in collaboration with local law enforcement agencies (Reno, Sparks, Washoe County) to offer psychiatric services to homeless mentally ill and those with mental illness who bring themselves to the attention of law enforcement. This helps prevent increasing numbers of persons having mental illness from being incarcerated and assists with enrolling them in appropriate services.
- Teleconferencing therapy and medication management at statewide Rural Clinic sites, to better serve people in frontier and rural Nevada who would otherwise have limited access to services and face transportation barriers.
- Mental Health Court: Mental Health Court is a collaborative effort between DPBH and the Criminal Justice system. This program provides the opportunity for people with misdemeanor and minor felony criminal charges who would benefit from psychiatric treatment to be diverted from the standard criminal justice system if they participate in treatment. It is a service coordination model with a caseload of 25 clients per coordinator, ensuring consumers obtain benefits; comply with court ordered treatment, medication, and substance abuse recovery.
- Program for Assertive Community Treatment (PACT) – Available at NNAMHS and SNAMHS: This program is based on the Evidence-Based Practice (EBP) developed in Wisconsin and implemented globally. Sometimes described as a hospital without walls, this service provides intensive support to people with mental illness who have a history of high use of emergency, hospital, and law enforcement services. The teams work in an interdisciplinary manner to support consumers in living in the community, adherence to their medication regime and employment rehabilitation. DPBH recently convened a Statewide Quality Workgroup/Team to develop a statewide PACT Policy, address addressing areas including, but not limited to, service criteria, documentation requirements, medication storage and administration, and data collection and reporting.
- Twenty-two private, non-profit treatment organizations and government agencies statewide that provide substance abuse related services including detoxification, residential, outpatient, and opioid maintenance therapy.

THE DIVISION OF CHILD ANF FAMILY SERVICES BEHAVIORAL HEALTH SYSTEM

The mission of DCFS is to work together in genuine partnership with families, communities and other governmental agencies, provides support and services to assist Nevada's children and families in reaching their full human potential. DCFS recognizes that Nevada's families are our future and children, youth and families thrive when they:

- Live in safe, permanent settings;
- Experience a sense of sustainable emotional and physical well-being; and
- Receive support to consistently make positive choices for family and the common good.

DCFS provides a broad range of services and funding for children, youth, and families focused in four primary areas:

1. Child welfare services including direct child protective services, foster care, adoption, independent living services, foster care licensing in fifteen rural Nevada counties and oversight of the statewide Interstate Compact for the Placement of Children (ICPC). Additionally, DCFS has statewide responsibility for the oversight of all child welfare programs including the two urban county child welfare agencies, and the review and reporting of child deaths in Nevada.

2. Funding for domestic violence programs, children's advocacy, and legal services for victims, as well as many community-based nonprofit programs to serve victims of abuse and neglect.

3. Juvenile services including two residential correctional training facilities, statewide supervision of youth paroled from state-operated facilities, provision of statewide interstate compact for the placement of juveniles, specialized transitional aftercare program for delinquents released from state facilities, and pass-through funds to the county-operated youth camps, as well as providing grant funding to local jurisdictions that serve delinquent youth for community-based services and local coalitions addressing underage drinking issues.

4. Community-based outpatient and inpatient mental health services to children and their families in the state. Many of the children and youth entering the child welfare or juvenile justice systems receive treatment and intervention through DCFS programs. DCFS' Wraparound in Nevada (WIN) program serves children in child welfare custody and their families, providing intensive care coordination using the wraparound model. Mental health programming also includes early childhood services, outpatient services, psychiatric services, community-based treatment homes, residential treatment for adolescents, and acute inpatient psychiatric care.

DCFS utilizes a program-based approach to service delivery, organized under Deputy Administrators, in order to carry out responsibilities assigned to them under the Nevada Revised Statutes (NRS). Program-based service delivery intends to achieve the following:

1. Create an opportunity to design service delivery to match strengths and needs;
2. Pair service accountability with fiscal accountability;
3. Involve local communities in the design and governance of services; and
4. Acknowledge the differences in Nevada's people and places.

A program-based approach allows specialized staff to focus on policy, practice and funding issues, while the bulk of staff and resources concentrate on direct service delivery tailored to community need. Statewide, program-based mental health treatment provides a wide range of mental health services to children and adolescents. The staff receive specialized training which includes shadowing seasoned peer staff and direct training in using the state electronic records, understanding Medicaid chapters 400 and 2500, completing a comprehensive assessment, SED determination, CASII, functional assessments, and diagnosis using the DSMV and DC: 0-3. They do training in Wraparound services, targeted case management, and hot co complete an assessment, writing progress notes, conducting a child and family team, treatment planning and care coordination, understanding the system of care values and principles of partnering with the family organization, trauma informed care practices, recognizing signs of suicide, mood disorders in children, ADHD, Anxiety, sensory deficits, introduction to early childhood and infant mental health, and multiple treatment modalities including but not limited to motivational interviewing, art therapy and play therapy, solution focused brief therapy, family checkup, every day parenting, aggression replacement training (ART) positive behavioral supports, trauma focused cognitive behavioral therapy, (TF-CBT) Psychological First aid, Psychoeducational Model (PEM) conflict prevention and response (CPAR). Additionally, the staff at DCFS also attend classes on HIPAA compliance, security awareness, sexual harassment, defensive driving, and other division trainings as required.

Children with mental health needs are identified through a strength-based, family-driven, culturally responsive assessment and service process offered through State-operated, community-based mental health centers, and through community providers. These centers are organized within the following agencies: Northern Nevada Child and Adolescent Services (NNCAS) in urban Washoe County and Southern Nevada Child and Adolescent Services (SNCAS) in urban Clark County.

The summary below provides an expanded analysis of DCFS programs. This report examines served client data statewide and by program area. Children served are those who received a service sometime during the fiscal year.

This descriptive report summarizes demographic and clinical information on the 2835 children served by mental health services across the State of Nevada in DCFS Children's Mental Health Services. DCFS Children's Mental Health Services are divided into Southern Nevada Child and Adolescent Services (SNCAS), with locations in southern Nevada, and Northern Nevada Child and Adolescent Services (NNCAS), with locations in northern Nevada. NNCAS includes the Wraparound in Nevada program serving the rural region. DCFS Children's Mental Health Mobile Crisis Response Team (SNCAS) information is also included in this report.

Table 1. DCFS Child and Adolescent Services Mental Health Programs

Southern Nevada	Northern Nevada
Community Based Programs	
Children's Clinical Services (CCS)	Children's Clinical Services (CCS)
Early Childhood Mental Health Services(ECMHS)	Early Childhood Mental Health Services(ECMHS)
Wraparound In Nevada (WIN)	Wraparound In Nevada (WIN)
Mobile Crisis Response Team (MCRT)	Mobile Crisis Response Team (MCRT)
Treatment Homes	
On-Campus Treatment Homes (Oasis)	Family Learning Homes (FLH)
	Adolescent Treatment Center (ATC)
Residential Facility and Acute Care Psychiatric Hospital	
Desert Willow Treatment Center (DWTC)	
Quality Assurance, Program Planning, and Program Improvement	
Planning and Evaluation Unit (PEU) and System of Care Unit (SOC)	

Age

The average age of children served Statewide was 11.19 years, NNCAS was 10.08 years and SNCAS was 11.55 years.

Age Group	Statewide	NNCAS	SNCAS
0–5 years old	623	178	445
6–12 years old	1003	306	697
13 + years old	1405	258	1147

Gender

Gender	Statewide	NNCAS	SNCAS
Male	1514	383	1136
Female	1519	358	1156
Unknown	2	1	1

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	34	15	19
Asian	60	3	57
Black/African American	630	71	559
Native Hawaiian/Other Pacific	36	8	28
White/Caucasian	2191	642	1549
Unknown	84	3	81
Ethnicity	**Statewide**	**NNCAS**	**SNCAS**
Hispanic Origin	1044	167	877

Custody Status

Custody Status	Statewide	NNCAS	SNCAS
Parent/Family	1938	339	1599
Child Welfare Court Ordered	820	385	435
ICPC	15	6	9
Voluntary Custody	5	2	3
Protective Custody	194	3	191
DCFS Youth Parole	20	4	16
Parental Custody On	32	2	30
Unknown	11	1	10

Severe Emotional Disturbance Status

Statewide	NNCAS	SNCAS
2423	656	1767

Community-Based Services
Outpatient Services of NNCAS and Children's Clinical Services of SNCAS provide community- based outpatient, individual and family oriented mental health services for children from six through eighteen years of age. Psychiatric Caseworker positions in SNCAS and NNCAS provide targeted case management services to children in parental custody. Outpatient clinical services have implemented evidence-based practices to include Trauma-Focused Cognitive Behavior Therapy and Motivational Interviewing.

These services include:

- Individual, family, and group therapies in home, clinic and community settings
- Psychological assessment and evaluation
- Psychiatric evaluation and medication management
- Clinical case management
- Consultation with other stakeholders involved with children in treatment and their families as well as general consultation regarding mental health issues for children and families
- Walk-in crisis assessments
- 24-hour on-call emergency professional coverage
- NNCAS has successfully launched its newest rotation of first and second-year Fellows from the University of Nevada, School of Medicine Psychiatric Fellowship Program. The Fellows provide psychiatric assessment, consultation, and medication management to children and families that are uninsured or underinsured.
- SNCAS provides leadership and participation on Neighborhood Resource Teams and the Clark County Resource Team to assist in breaking down barriers to meet service needs of individual children in the community and supporting successful returns from out of state residential placements.

Community Based Programs:

Goals and Objectives/Services and Programs

The goals and objectives of DCFS Children's Mental Health programs and methods are to ensure that the children and families served receive a thorough intake, diagnostic and biopsychosocial assessment, and that they begin least restrictive, individualized treatment in a timely manner in accordance with SOC values and guiding principles (see Appendix B). This comprehensive assessment builds on strengths and identifies needs resulting in a treatment plan that is developed in partnership with the family or caregiver. The ultimate goal is that the child and family will participate in individualized, coordinated services that improve their functioning and reduce symptoms. DCFS strives to provide services in a culturally and linguistically competent manner. This is often a challenge due to the shortage of a diverse workforce statewide.

Practitioners in DCFS Children's Mental Health treatment programs are trained in numerous evidence based practices in order to improve the functioning of children and adolescents determined to be Severely Emotionally Disturbed (SED).

Community Based Programs – These programs are located in Northern Nevada and in four neighborhood centers in Southern Nevada. Wraparound and Mobile Crisis Response Teams (MCRT) are located in the rural regions as well. Rural MCRT is operated by the Division of Public and Behavioral Health in consultation with DCFS.

Demographics by Program

Community Based Programs:

The following tables include the demographic information for the clients served in Children's Mental Health's community based programs. These programs are available in both Northern and Southern Nevada. Our community based programs consist of Children's Clinical Services, Early Childhood Mental Health Services, and Wraparound in Nevada. Information for our newest program, the Mobile Crisis Response Team, will be discussed in a later section of this summary.

Children's Clinical Services (CCS) – NNCAS and Children's Clinical Services (CCS) – SNCAS

Number of Children Served

Statewide	CCS-NNCAS	CCS-SNCAS
1098	356	742

Age

The average age of children served Statewide was 12.93, CCS-NNCAS was 12.27, and CCS-SNCAS was 13.25.

Age Group	Statewide	CCS- NNCAS	CCS-SNCAS
0–5 years old	17	7	10
6–12 years old	468	176	292
13 + years old	613	173	440

Gender

Gender	Statewide	CCS-NNCAS	CCS-SNCAS
Male	507	179	328
Female	591	177	414

Race and Ethnicity

Race	Statewide	CCS-NNCAS	CCS-SNCAS
American Indian/Alaskan Native	11	4	7
Asian	16	1	15
Black/African American	170	32	138
Native Hawaiian/Other Pacific	9	3	6
White/Caucasian	871	316	555
Unknown	21	0	21
Ethnicity	**Statewide**	**CCS-NNCAS**	**CCS-SNCAS**
Hispanic Origin	463	90	373

Custody Status

Custody Status	Statewide	CCS-NNCAS	CCS-SNCAS
Parent/Family	869	222	647
Child Welfare	179	122	57
ICPC	8	4	4
Protective Custody	27	2	25
DCFS Youth Parole	7	4	3
Parental Custody /	5	1	4
Voluntary Custody	1	1	0

Early Childhood Mental Health Services

Early Childhood Mental Health Services (ECMHS) provide services to children between birth and six years of age with emotional disturbance or those who may have high risk factors for emotional and behavioral disturbance and associated developmental delays. The goal of these services is to strengthen parent-child relationships, support the family's capacity to care for their children and to enhance the child's social and emotional functioning. ECMHS use the Diagnostic Classification 0-3R system, a nationally recognized best practice for young children, allowing for developmentally appropriate diagnoses of children birth to 48 months. Staff provides multiple trainings each year on this diagnostic system to increase community provider capacity. ECMHS is implementing evidence-based practices to include Parent-Child Interaction Therapy, Trauma Focused Cognitive Behavioral Therapy and Motivational Interviewing. During the last two years, EMHS has worked with the Technical Assistance Center for Social and Emotional Intervention (TACSEI) to implement the Pyramid Model. The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children provides a tiered intervention framework of evidence-based interventions for promoting the social, emotional, and behavioral development of young children (Fox et al., 2003; Hemmeter, Ostrosky, & Fox, 2006). The model describes three tiers of intervention practice: universal promotion for all children; secondary preventions to address the intervention needs for children at risk of social emotional delays, and tertiary interventions needed for children with persistent challenges. The Pyramid Model was initially described as an intervention. Early Childhood Mental Health Services are provided by both NNCAS and SNCAS and include:

- Psychological assessment and evaluation
- Family and individual therapies in home, clinical and community settings
- Psychiatric evaluation and medication management
- Day treatment services for severe emotional and behavioral disturbances
- Crisis evaluation, intervention and treatment
- Child care, Head Start, pre-school and kindergarten mental health consultation, outreach, and training
- Clinical case management
- 24 hour on call emergency clinical coverage

Early Childhood Mental Health Services (ECMHS) – NNCAS and SNCAS

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
688	202	486

Age

The average age of children served by ECMHS Statewide was 4.01, ECMHS (NNCAS) was 4.41, and ECMHS (SNCAS) was 3.84.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	595	159	436
6–12 years old	93	43	50

Gender

Gender	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	393	99	294
Female	295	103	192

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	7	4	3
Asian	5	0	5
Black/African American	192	23	169
Native Hawaiian/Other Pacific	6	3	3
White/Caucasian	470	172	298
Unknown	8	0	8
Ethnicity	**Statewide**	**ECMHS (NNCAS)**	**ECMHS (SNCAS)**
Hispanic Origin	159	38	121

Custody Status

Custody Status	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	159	60	99
Child Welfare	411	139	272
ICPC	6	2	4
Protective Custody	111	0	111
Voluntary Custody	1	1	0

Wraparound in Nevada for Children and Families

Wraparound in Nevada (WIN) for Children and Families provides intensive targeted case management services to children and their families. WIN uses a nationally recognized, evidence-based model for providing wraparound. Wraparound is an intensive, individualized care planning and management process. Wraparound's philosophy of care begins from the principle of "voice and choice," which stipulates that the perspectives of the family, including the child or youth, must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent, and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the wraparound process should be "strengths-based," including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities (The National Wraparound Initiative). The WIN program with DCFS recognizes four phases in the wraparound process. They include:

Phase One: Engagement and Team Preparation**.** During Phase One, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. This phase, particularly through the initial conversations about strengths, needs, culture, and vision, sets the tone for teamwork and team interactions that are consistent with the wraparound principles. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.

Phase Two: Initial Plan Development. During this phase, team trust and mutual respect are built while creating an initial plan of care using a high quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks; a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.

Phase Three: Implementation. During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.

Phase Four: Transition. During the fourth phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.

Another important aspect of the Wraparound process includes the addition of a family support partner or "Family Specialist." DCFS Children's Mental Health Services contracts with Nevada Parents Encouraging Parents (PEP) for this service. The Family Specialist is a formal member of the wraparound team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the process. Family Specialists have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Specialists' personal experience is critical to earning the respect of families and establishing a trusting relationship that is valued by the family. The Family Specialist can be a mediator, facilitator, or bridge between families and agencies. Family Specialists ensure each family is heard and their individual needs are being addressed and met. The Family Specialist communicates and educates agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity (National Wraparound Initiative).

Wraparound In Nevada (WIN) Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
735	193	106	436

Age

The average age of children served Statewide was 12.18, North was 11.91, Rural was 10.70, and South was 12.67.

Age Group	Statewide	North	Rural	South
0–5 years old	32	13	14	5
6–12 years old	354	91	58	205
13 + years old	349	89	34	226

Gender

Gender	Statewide	North	Rural	South
Male	416	103	68	245
Female	318	89	38	191
Unknown	1	1	0	0

Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	9	2	6	1
Asian	8	1	1	6
Black/African American	157	19	2	136
Native Hawaiian/Other Pacific	7	2	1	4
White/Caucasian	544	168	94	282
Unknown	10	1	2	7
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	230	55	20	155

Custody Status

Custody Status	Statewide	North	Rural	South
Parent/Family	351	56	42	253
Child Welfare	324	133	63	128
ICPC	1	0	0	1
Protective Custody	43	2	0	41
Parental Custody /	6	1	1	4
Youth Parole	7	0	0	7
Voluntary Custody	1	1	0	0
Unknown	2	0	1	1

Mobile Crisis

Mobile Crisis Response Team (MCRT) - The Mobile Crisis Response Teams (MCRT) provide crisis intervention and support to Nevada families dealing with a behavioral or mental health crisis. MCRT serves youth under the age of 18 showing signs of behavioral or mental health issues that pose a threat to the child's stability within their home, school or community. MCRT responds to youth and families of youth in crisis, over the phone or in person, in order to reduce emergency room visits and ensure everyone receives the proper care. MCRT conducts triage over the telephone in order to evaluate, prevent or resolve a crisis and decide if a referral will be made to a community resource or if care is needed beyond a phone call. A response team will go to the youth and their family and work to resolve the crisis. MCRT offers short-term assistance and case management services inside and outside of the home through a Child and Family Team process. In addition to stabilization services, MCRT also provides referrals to additional community-based services. The youth and family can access MCRT in the future should another crisis should arise. Follow-up and referral care through community partners, including family support through Nevada PEP, is available to the youth and their family. MCRT ensures a smooth transition to any support and services that may be necessary. Since its inception MCRT services have resulted in significant diversion from emergency room and acute care services. Since its inception, the percentage of youth served who have avoided hospitalization has been at 85% or above.

Mobile Crisis

Number of Children Served

Statewide	North	South
810	213	597

Age

The average age of children served Statewide was 14.03, North was 14.01, and South was 14.04.

Age Group	Statewide	North	South
0 – 12 years old	5	0	5
6–12 years old	243	61	182
13 + years old	562	152	410

Gender

Gender	Statewi	North	South
Male	366	92	274
Female	443	120	323
Transgender	1	1	0

Race and Ethnicity

Race	Statewide	North	South
American Indian/Alaskan Native	9	6	3
Asian	32	6	26
Black/African American	174	15	159
Native Hawaiian/Other Pacific	17	5	12
White/Caucasian	531	178	353
Unknown	47	3	44
Ethnicity	**Statewide**	**North**	**South**
Hispanic Origin	320	65	255

Custody Status

Custody Status	Statewide	North	South
Parent/Family	738	186	552
Child Welfare	19	18	1
ICPC	1	1	0
Protective Custody	29	5	24
DCFS Youth Parole	2	1	1
Parental Custody /	12	0	12
Voluntary Custody	2	2	0
Unknown	7	0	7

Other Children's Mental Health Services

Mohave Adult, Child and Family Services of the University of Nevada, School of Medicine provides mental health services to include outpatient counseling for children ages 6 and older and psychiatric services for children ages 5 and older. In addition, Mojave provides clinical assessment and case management and serves individuals with fee-for-service Medicaid coverage.

Specialized Foster Care providers serve children and adolescents who are in the custody of a child welfare agency, youth parole custody, or in parental custody. Specialized foster care can be family-based or group-home treatment. Children and adolescents receive individualized services in a family-home or facility environment. Funding is primarily through fee-for-service Medicaid and through contracts with the state and/or Clark County and/or Washoe County.

Nevada also has a myriad of private non-profit and private for-profit agencies that provide behavioral health services throughout the state. There is currently a movement in Nevada to develop school-based health centers to increase student access to primary care. School-based health centers are especially critical in Nevada's rural counties where health care services are limited.

Family-to-Family Support and Family Advocacy

Nevada PEP is designated by the National Center for Mental Health Services as Nevada's Statewide Family Network. Through National and State support, Nevada PEP provides leadership to encourage fidelity to the fundamental principles of the "System of Care". As a family-driven organization, Nevada PEP understands first-hand the frustrations and barriers that families face in trying to coordinate care for their children. Nevada PEP employs family members of children with behavioral health care needs who, last year, assisted over 580 Nevada families to navigate the maze of programs, services, and resources

to help their children. In line with the System of Care principles, Nevada PEP facilitates family involvement in policy-making decisions at the local and state levels to guide the development of meaningful services for children and families. Nevada PEP provided the family voice on 36 different committees and workgroups; collaborated with DCFS to present Wraparound Trainings and provided over 45 training workshops to help families better understand their child's behavioral health care needs.

Residential Treatment Home Services

Residential Treatment Home Services provide mental health treatment and rehabilitation services based on nationally recognized models built on core values and guiding principles of an individualized, client-centered, strength-based system of care. The following nationally recognized models are utilized in Residential Treatment Home Programs:

- A psychiatric rehabilitation model that incorporates a "bio-psycho-social" treatment approach that extends treatment beyond the normal "therapy hour" to the client's entire day. Through the use of supportive and therapeutic interventions, clients will establish normal roles for re- integration into the community. There is a daily focus on assisting clients in developing social competency, problem identification and resolution, effective communication, moral reasoning, self-sufficiency, and behavior management. (Boys Town Press)
- The Trauma Informed Care Model (TICM) is defined as care that is grounded in, and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence. Experiencing traumatic events has been (linked) to poor treatment outcomes and personal distress. TICM focuses on the impact of traumatic life events, characterized by subjectively perceived threats of harm.
- Aggression Replacement Training® (ART®) is a cognitive behavioral intervention program to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents and is a multi-modal intervention consisting of three components: social skills training, anger control training, and training in moral reasoning. Research has shown that students who develop skills in these areas are far less likely to engage in a wide range of aggressive and high-risk behaviors. Lessons in this program are intended to address the behavioral, affective, and cognitive components of aggressive and violent behavior. (Goldstein and Glick, 2011)
- Positive Behavior Support (PBS) is a process for understanding and resolving the problem behavior of children that is based on values and empirical research. It offers an approach for developing an understanding of why the child engages in problem behavior and strategies for preventing the occurrence of problem behavior while teaching the child new skills. Positive behavior support offers a holistic approach that considers all factors that impact on a child and the child's behavior. It can be used to address problem behaviors that range from aggression, tantrums, and property destruction to social withdrawal.

The Recovery Model is characterized by personal empowerment and a sense of personal control over one's destiny, acceptance of personal responsibility, asking for and accepting help from others, and inclusion into the treatment process. The ultimate goal of services is the maximum reduction of mental illness and restoration to the best possible functional level. It includes a process in which clients develop coping and wellness strategies to approach daily challenges, overcome disabilities, establish skills to live independently, and contribute to society.

Treatment Homes

DCFS Children's Mental Health also serves clients who need more intensive and specialized treatment than that which can be provided within their family home or community placement. The following information describes the children treated at the Adolescent Treatment Center and Family Learning Homes in Northern Nevada, as well as the On-Campus Treatment Homes located in Las Vegas.

Adolescent Treatment Center

The Adolescent Treatment Center (ATC) provides the most intensive level of treatment home services provided by DCFS and in the community to youth ages 12 to 17 years. It is located in Sparks and part of NNCAS. ATC has a service capacity of 16 beds for male and female youth. Service provided within the program include psychiatric evaluation and medication management, individual, family, and group therapies, psychological assessment and evaluation, special education and regular education services on site through Washoe County School District, nursing care and emergency evaluation and stabilization.

Adolescent Treatment Center (ATC) – NNCAS, Family Learning Homes (FLH) – NNCAS, Oasis On-Campus Treatment Homes (OCTH) – SNCAS

Number of Children Served

Statewide	ATC	FLH	OCTH
148	49	48	51

The total count statewide is unduplicated, but the count by program may include clients also admitted
to the other treatment homes.

Age

The average age of children served Statewide was 13.75, ATC was 15.47, FLH was 11.78, and OCTH was 13.94.

Age Group	Statewide	ATC	FLH	OCTH
0–5 years old	1	0	1	0
6–12 years old	44	0	28	16
13 + years old	103	49	19	35

Gender

Gender	Statewide	ATC	FLH	OCTH
Male	76	27	24	25
Female	72	22	24	26

Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	3	2	1	0
Asian	0	0	0	0
Black/African American	29	8	7	14
Native Hawaiian/Other Pacific Islander	2	0	0	2
White/Caucasian	114	39	40	35
Ethnicity	**Statewide**	**ATC**	**FLH**	**OCTH**
Hispanic Origin	38	13	12	12

Custody Status

Custody Status	Statewide	ATC	FLH	OCTH
Parent/Family	64	24	13	27
Child Welfare	62	21	32	9
Protective Custody	13	1	0	11
DCFS Youth Parole	7	2	2	3
Parental Custody /	3	1	1	1

Residential Facility and Psychiatric Hospital:

In Southern Nevada, DCFS Children's Mental Health Services provides both residential and acute care for youth who are in need of this level of care. Below are the demographics for Desert Willow Treatment Center.

Desert Willow Treatment Center Acute Hospital (Acute) and Residential Treatment Center (RTC) – SNCAS

Number of Children Served

Acute	RTC
124	69

Age

The average age of children served by Desert Willow Acute was 15.68, and it was for the Desert Willow Residential Treatment Center 15.00.

Age Group	Acute	RTC
6–12 years old	8	7
13 + years old	116	62

Gender

Gender	Acute	RTC
Male	57	33
Female	67	36

Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	1	1
Asian	5	1
Black/African American	34	10
Native Hawaiian/Other Pacific	1	0
White/Caucasian	76	57
Unknown	7	0
Ethnicity	**Acute**	**RTC**
Hispanic Origin	39	16

Custody Status

Custody Status	Acute	RTC
Parent/Family	114	44
Child Welfare	4	3
ICPC	0	0
Protective Custody	5	4
DCFS Youth Parole	1	7
Parental Custody / Probation	0	11
Voluntary Custody	0	1

Family Learning Homes

Family Learning Homes (FLH) provide intensive, highly structured treatment for children and adolescents six to eighteen years of age with severe emotional disturbances in four individual homes serving five to six youth each. The majority of youth served have no other resource available to them in the community either due to lack of insurance resources or community providers have not accepted them. It is located on the main campus of NNCAS. FLH has four individual homes with a capacity of 20 beds.

Oasis on Campus Treatment Homes

Oasis on Campus Treatment Homes (Oasis) provide intensive, highly structured mental health treatment for children and adolescents, 7-17 years of age with severe emotional disturbances; there are five treatment homes with a total of 27 beds. Two of the homes provide specialized treatment to youth with dual diagnoses of severe emotional disturbance and developmental disability. The homes are located on the main campus of SNCAS. Services within this program include individual, family, and group therapies and behavior management, clinical case management, psychological, psychiatric assessment and evaluation as well as parent training.

Services in all three Residential Treatment Home Programs include:

- As clients are admitted and assessed, specific rehabilitation goals are established and individual recovery skills are identified. Goals specifically address the client's diagnosis and presence of functional impairment in daily living. The assessment is completed and rehabilitation goals are established in partnership with the client, the family, and other formal support services. The recovery skills are designed to focus on those symptoms that interfere most seriously with the client's ability to successfully function in the community. The rehabilitation plan will establish a basis for evaluating the effectiveness of the care offered in meeting the stated goals.

- Residential Treatment Home Services incorporate a positive-based motivation system to augment the supportive interventions. The motivation system will also provide the opportunity for immediate consequences that help the client learn to take responsibility for their behaviors and choices.
- Residential Treatment Home Services recognizes that a biological/medical approach can be a significant component to a successful rehabilitation plan. The program utilizes a Psychiatric Medical Director for clients needing medical supervision.
- Clients receive individual, group, and family counseling. Family counseling incorporates the family's values and strengths in order to provide a smooth transition into the family home.
- Families are invited to attend parent consultation sessions with staff and the client. This is a time the parent can voice concerns about the program, client progress, and have input into the daily treatment interventions. Family sessions will take place at a time and location most convenient for the family. The objective is to help parents continue the client's rehabilitative mental health care in home and community based settings. It targets the restoration of the client's social and behavioral mental health impairment needs.
- Clients will have daily individual "empowerment" conferences with staff in order to review their daily focus areas. The empowerment conference is the time for clients to express any complaints or concerns they have regarding their treatment.
- Clients at ATC and FLH are taught to be a member of the therapeutic community. The therapeutic community or "self-government" is a tool used to involve everyone in the planning of the program structure. This is also an opportunity for the client to address an issue and initiate the Client Complaint Procedure. Clients will attend a daily community meeting.
- Clients and families receive case management services to include discharge planning for follow up services.
- Clients, families, and other support services are invited to participate in regularly scheduled Child and Family Team meetings.

Desert Willow Treatment Center

Desert Willow Treatment Center (DWTC) is an acute and residential mental health inpatient facility located on the SNCAS campus. The facility is comprised of a 58-bed psychiatric hospital with two acute care units, as well as three residential treatment center units. It is licensed as a hospital by the State of Nevada, Division of Health, Bureau of Health Care Quality and Compliance, and accredited by the Joint Commission to provide a secure environment to children and adolescents determined to be severely emotionally disturbed (SED). DWTC's two acute psychiatric hospital units include one acute unit that serves up to 8 children ages 6 to12 years and another acute unit that serves up to 12 adolescents ages 12 to 17 years, unless the youth is still attending school past his/her 18th birthday. These programs provide psychiatric care to youth with the most severe emotional disturbances representing the most restrictive service alternatives in the state. Many of the children served present risks to themselves and/or their community. The services include crisis intervention and stabilization, individual, family, and group therapies and behavior management, clinical case management, psychological evaluation and consultation, psychiatric evaluation and medication management, nursing care, recreational therapy, and special education on site through the Clark County School District.

DWTC also has three residential treatment center units with the capacity to serve up to 38 children, ages 12 to 18 years, unless the youth is still attending school past his/her 18th birthday. Two of the residential units serve up to 12 adolescents each who have been determined to be SED and who require a secure treatment setting. The third residential unit serves up to 14 males who have been adjudicated as sexual offenders.

The inpatient facility contains five patient units, a multi-purpose room, an occupational kitchen, five academic classrooms, a gymnasium, and a patient gardening area. DWTC provides a variety of evidence-based and evidence-informed practices including Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, and Aggression Replacement Training.

Services include:

- Psychiatric evaluation, treatment, and stabilization
- Psychological evaluation and testing
- Psychosocial assessment and treatment planning
- Psychiatric nursing services
- Medication management
- Individual, group, and family therapies
- Psychosocial rehabilitation services
- Therapeutic recreation services
- Special motivational and skill training programs
- Nutrition groups and services
- Coordination of services with other local service providers
- Discharge and aftercare planning
- Structured residential treatment milieu
- Education
- Relapse prevention counseling for youth who have been adjudicated as sexual offenders as they near community re-entry.

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their children have encountered. In FY2016 51 problems had been presented at least once at admission, the 10 identified below (and listed in order of prevalence) accounted for 63.0% of all primary presenting problems reported at admission. The top six presenting problems listed below are the same (in order of prevalence) as the previous year.

- Suicide Attempt-Threat (12.9%) up 2.9% from FY15
- Depression (10.3%) up 0.6% from FY15
- Child Neglect Victim (6.0%) down 0.5% from FY15
- Anxiety (6.0%) up 0.9% from FY15
- Physical Aggression (5.8%) up 0.6% from FY15
- Parent-Child Problems (5.4%) down 0.6% from FY15
- Oppositional (4.5%) down 0.6% from FY15
- School Problems (4.3%) down 0.4% from FY15
- Adjustment Problems (4.0%) down 0.3% from FY15
- Coping Problems (3.8%) down 0.3% from FY15

Diagnosis

The tables below show the most prevalent diagnoses of children by age category and gender.

Age Group 0-5.99

Overall- Both Male and Female (Top 54.1%)		
995.52	15.7%	Neglect
312.9	14.5%	Disruptive Behavior Disorder
225	6.9%	Anxiety Disorder (DC 0-3 Classification)
300.00	6.6%	Anxiety Disorder NOS
300	5.7%	Adjustment Disorder (DC 0-3 Classification)
309.81	4.7%	Post Traumatic Stress Disorder (PTSD)

Age Group 6-12.99

Female (Top 53.5%)		
309.81	13.5%	Post Traumatic Stress Disorder (PTSD)
314.01	8.7%	Attention-Deficit /Hyperactivity Disorder(ADHD)
313.81	6.5%	Oppositional Defiant Disorder
296.90	5.9%	Mood Disorder
300.00	5.1%	Anxiety Disorder
313.89	4.8%	Reactive Attachment Disorder
995.52	4.8%	Neglect
300.02	4.2%	Generalized Anxiety Disorder

Male (Top 56.6%)		
314.01	12.9%	Attention-Deficit /Hyperactivity Disorder (ADHD)
309.81	9.3%	Post Traumatic Stress Disorder (PTSD)
313.81	8.7%	Oppositional Defiant Disorder
312.90	6.4%	Disruptive Behavior Disorder
296.90	5.4%	Mood Disorder
309.40	5.1%	Adjustment Disorder Emotions and Conduct
300.00	4.5%	Anxiety Disorder
995.52	4.3%	Neglect

Age Group 13-17.99

Female (Top 50.6%)		
309.81	12.2%	Post Traumatic Stress Disorder (PTSD)
311.00	8.0%	Depressive Disorder
296.90	6.7%	Mood Disorder
296.23	6.0%	Major Depressive Disorder Single Episode, Severe Without Psychosis
296.33	5.2%	Major Depressive Disorder Recurrent ,Severe Without Psychosis
296.32	3.2%	Major Depressive Disorder Recurrent, Moderate
300.02	3.2%	Generalized Anxiety Disorder
296.22	3.1%	Major Depressive Disorder Single Episode, Moderate
995.53	3.1%	Sexual Abuse of Child

Male (Top 48.4%)		
313.81	10.2%	Oppositional Defiant Disorder
296.90	9.6%	Mood Disorder
314.01	6.8%	Attention-Deficit /Hyperactivity Disorder (ADHD)
309.81	6.0%	Post Traumatic Stress Disorder (PTSD
296.80	3.4%	Bipolar Disorder
300.00	3.2%	Anxiety Disorder
300.02	3.0%	Generalized Anxiety Disorder
311.00	3.0%	Depressive Disorder
314.00	3.0%	Attention-Deficit /Hyperactivity Disorder Inattentive Type

Quality Assurance, Program Planning, and Program Improvement – Located in Reno and Las Vegas

Planning and Evaluation Unit (PEU) - Within DCFS, quality assurance, program planning, and program improvement responsibilities are primary roles of the Planning and Evaluation Unit (PEU). PEU staff also monitor compliance to policies and conducts special investigations when requested.

System of Care Unit (SOC) - DCFS was awarded a System of Care (SOC) Expansion Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015. Staff have been hired to develop priorities for grant funded initiatives and implementation in conjunction with DCFS stakeholders with the goal of improving access to care across Nevada. SOC staff have begun to initiate quality assurance activities with community providers who receive funds from the grant.

Service Effectiveness

DCFS Children's Mental Health programs collect and report numerous performance measures to various state and federal entities on an annual basis at a minimum.

One of the performance measures reported that demonstrates effectiveness of clinical services includes the change in scores on the Child and Adolescent Functional Assessment Scale (CAFAS) as well as the Preschool and Early Childhood version (PECFAS). The CAFAS and the PECFAS are standardized instruments commonly used across child-serving agencies to guide treatment planning and as clinical outcome measures for individual clients and program evaluation (Hodges, 2005). Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically

significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. For the PECFAS clinically significant improvement is considered if there is a 17.5 point drop in total score in subsequent ratings. The following table contains information reported in detail in the 2016 Descriptive Summary which is available upon request.

Percent of children served in State Fiscal Year 2016 who show improved functioning on CAFAS/PECFAS ratings at discharge

Performance Measure	Program- Statewide	Number with Clinically Significant Improvement (%)
CAFAS	Children's Clinical Services	267 (51%)
CAFAS	Wraparound In Nevada	168 (53%)
CAFAS	Mobile Crisis Response Team	174 (36%)
PECFAS	Early Childhood Mental Health Services	142 (54%)
CAFAS	Treatment Homes (Oasis, FLH, ATC)	37 (61%)
CAFAS	DWTC Acute	95 (85%)
CAFAS	DWTC Residential	34 (92%)

Additional performance measures collected and reported include data from the DCFS Consumer Satisfaction Surveys that are conducted annually for community based programs and at discharge for residential programs and Desert Willow Treatment Center. Results from these surveys will be discussed elsewhere in this report (see page 13l). The performance measures from the surveys include consumers' perceptions of the youth's ability to cope, interact socially with friends, and function at school since participating in DCFS services. Further performance measures reported from the survey include items related to the quality and appropriateness of the services received. These measures are compared to National Outcome Measures denoted in the Federal Mental Health Statistical Improvement Program (MHSIP) developed by the Center for Mental Health Services to improve quality of mental health service delivery.

DCFS Children's Mental Health programs utilize two checklists to assure staff's procedures and documentation are in compliance with the Medicaid Services Manual Chapter 400 and Chapter 2500. The DCFS Planning and Evaluation Unit (PEU) conducts periodic audits of client files including entries into Avatar, the DCFS electronic health record and billing system. Clinical supervisors are also required to review and approve assessments, treatment plans, and targeted case management plans prior to them being finalized in Avatar. Copies of the checklists are in Appendix E. Plans are also reviewed with the client and family as well as the rest of the Child and Family Team at least every thirty days for clients being served by Wraparound In Nevada and formally updated at a minimum of every 90 days for those clients receiving therapy.

PEU also audits Avatar for cases that are inactive (have no service entries) for 90 days and 180 days so that program managers can prompt staff to close them thus improving accuracy related to client counts, caseloads, and reducing liability. Clients who fail to show for two appointments, don't respond to phone calls, or have otherwise lost contact with their provider are sent letters advising them that their case will be closed if there is no response within 10 calendar days.

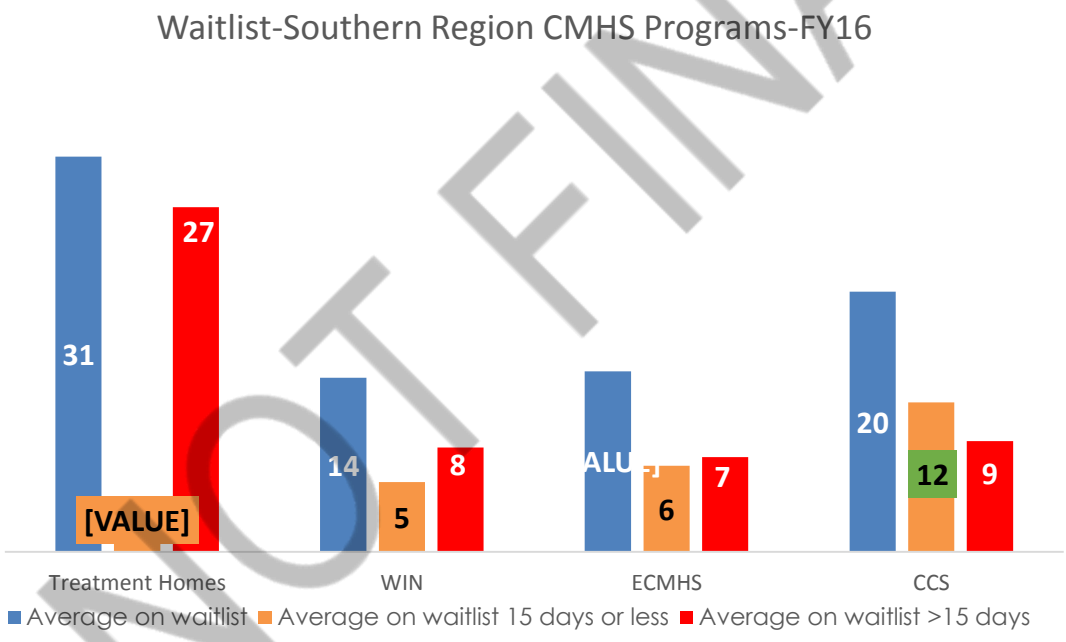
The Planning and Evaluation Unit also conducts audits in DCFS residential programs in order to monitor compliance to the DCFS Medication Administration and Management for Residential Programs Policy as well as other policies related to consent to treat, safety, the physical plant, documentation, etc.

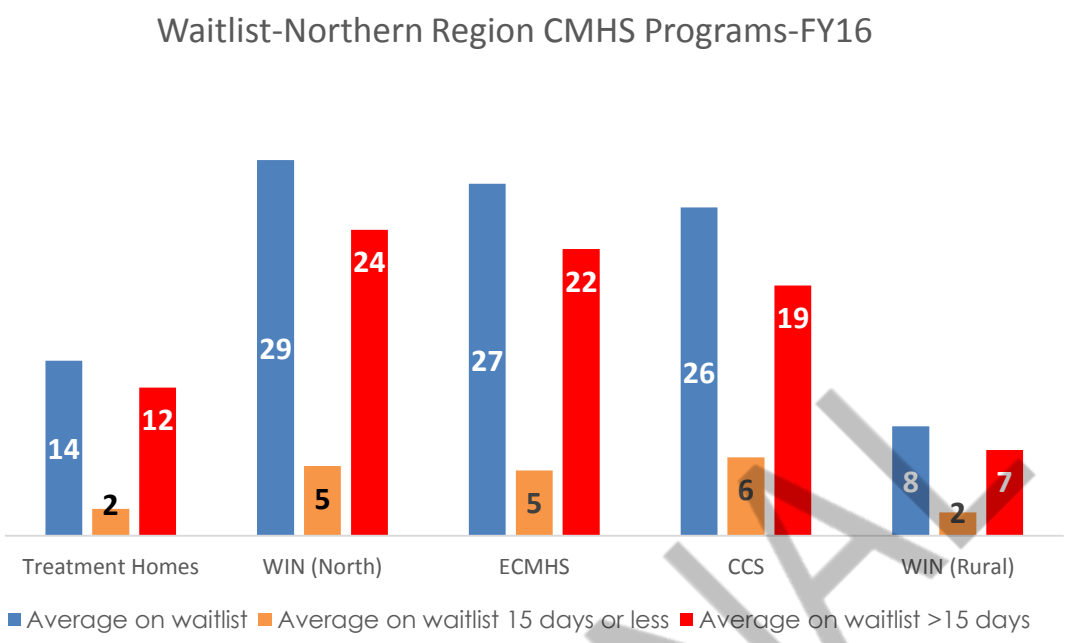
DCFS PEU also conducts special investigations and reviews incidents and consumer complaints upon request of the Administrator and is also responsible for monitoring Children's Mental Health programs' compliance to the Health Insurance Portability and Accountability Act (HIPAA).

Access and Availability of Care

DCFS Children's Mental Health programs are to maintain up-to-date waitlists in Avatar. These waitlists are submitted monthly to the state of Nevada Department of Health and Human Services, are reviewed in DCFS management team meetings, and reported to the Nevada Commission on Behavioral Health.

The following are the average waitlist data for Southern and Northern Children's Mental Health programs. Clients are placed on the waitlist at their/or a referral source's first call to an Intake Coordinator. The client is to be removed from the waitlist when the Intake Coordinator assigns the client to a practitioner in Avatar. Some programs such as the Southern WIN program report having no waitlist for a number of years so it is hypothesized that these averages in the charts below may be the result of clients not being actually removed from the waitlist after assignment, thus inflating the numbers.





DCFS, as a state entity, acts as a safety net providing services regardless of ability to pay or insurance status. Children may be Medicaid Fee for Service recipients, uninsured, underinsured, and in some cases undocumented.

Since January 2014, DCFS has provided Mobile Crisis Response Teams (MCRT) designed to assist youth who are experiencing a mental health crisis. This service has improved access to care and resulted in youth being diverted from unwarranted acute hospitalization. MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department regardless of insurance coverage. The Southern Nevada team has recently begun responding twenty-four hours, 365 days a year. MCRT began in October 2014 in Northern Nevada and in November 2016, DCFS began supporting crisis services in the rural regions through a subgrant with the Department of Public and Behavioral Health.

Child and Adolescent Functional Assessment and the Preschool and Early Childhood Functional Assessment

The Child and Adolescent Functional Assessment Scale (CAFAS)[1] is designed to assess in children ages 6 to 18 years the degree of functional impairment regarding emotional, behavioral, psychiatric, psychological and substance-use problems. There are eight subscales reflecting the client's functioning in that area. Subscale scores can range from Minimal or No Impairment (0) to Severe Impairment (30). Total CAFAS scores can range from 0 to 240, with higher total scores reflecting increased impairment in functioning.

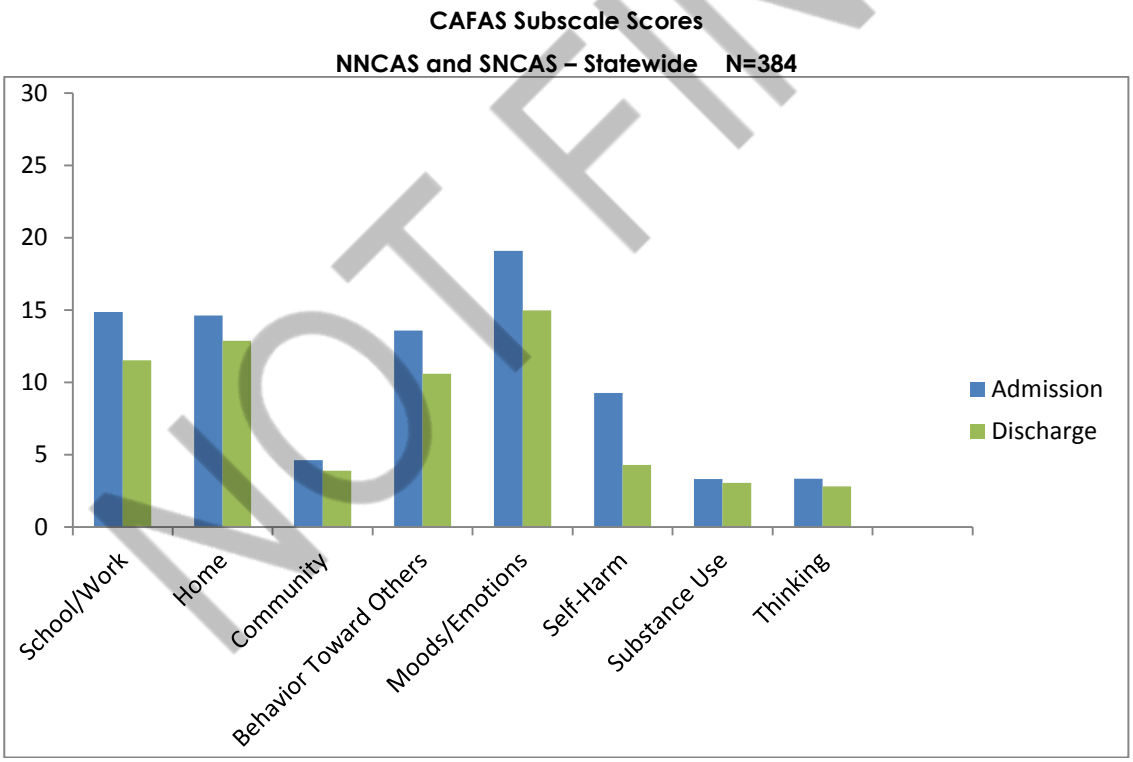
[1] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.

The Preschool and Early Childhood Functional Assessment Scale (PECFAS)[2] was also designed to assess degree of impairment in functioning of children ages 3 to 7 years with behavioral, emotional, psychological or psychiatric problems. Total PECFAS scores range from 0 to 210, with a higher total score indicating greater impairment.

The CAFAS and the PECFAS are standardized instruments commonly used across child-serving agencies to guide treatment planning and as clinical outcome measures for individual clients and program evaluation (Hodges, 2005). The CAFAS and the PECFAS are used as outcome measures for DCFS Children's Mental Health. Only FY 2016 CAFAS and PECFAS scores were used in this Descriptive Summary.

Children's Clinical Services (CCS)

The graph below shows the admission and discharge CAFAS subscale scores for CCS-NNCAS (NNCAS) and Children's Clinical Services (SNCAS) statewide.

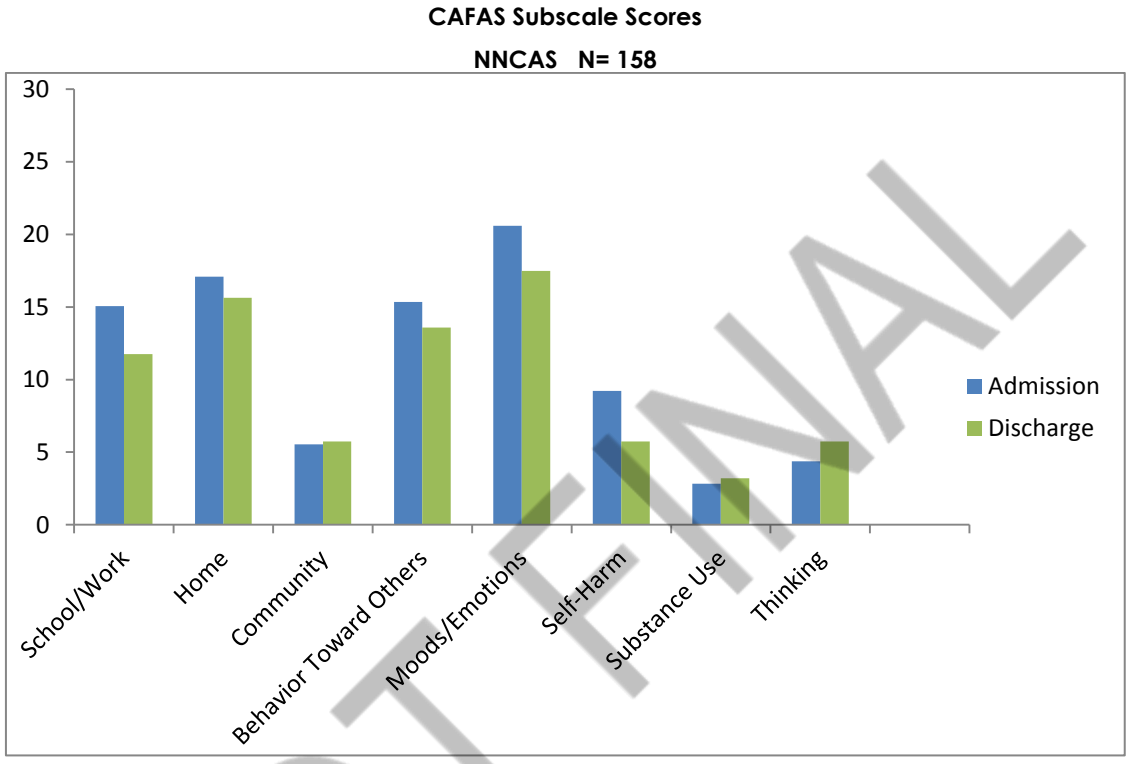


Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 267 (51.0%) of 524 qualified DCFS CCS-NNCAS clients statewide. The mean total score for all clients at admission was 82.21 and the mean total score at discharge was 62.35. Clients were qualified if they had been discharged and if the CAFAS was rated at both admission and discharge.

[2] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.

Children's Clinical Services (NNCAS)

Admission and discharge CAFAS subscale scores for CCS-NNCAS Services are depicted in the following graph.



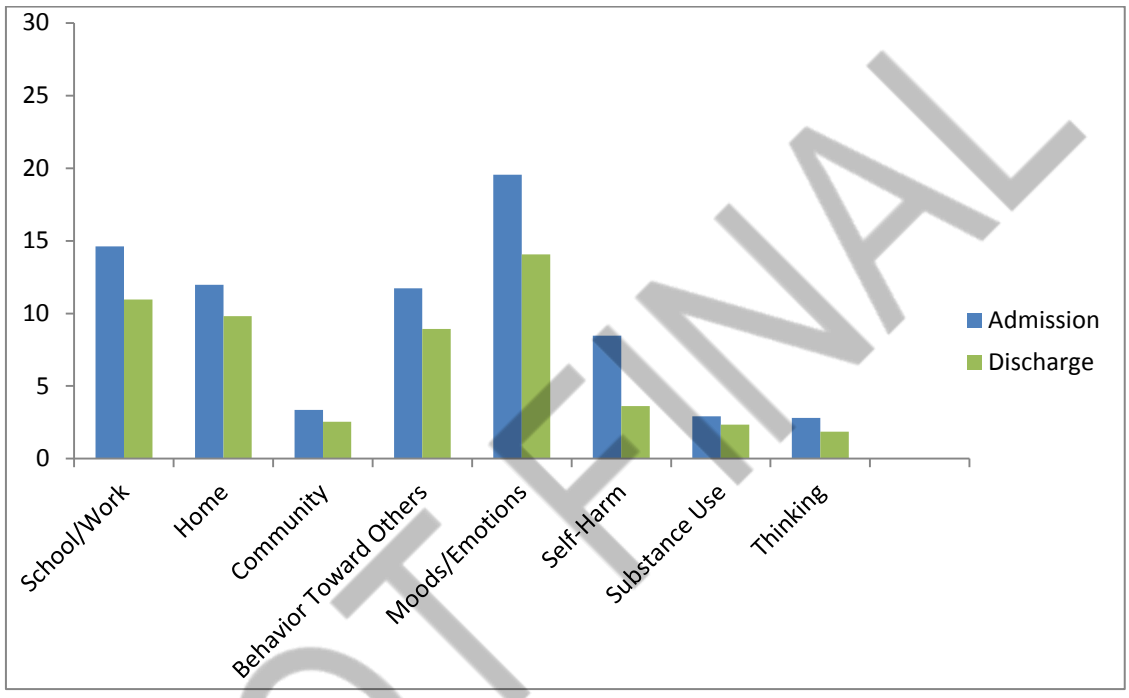
Of those served, 71 (44.9%) of 158 qualified DCFS North Region CCS-NNCAS Services clients showed clinically significant improvement. The mean total score for all clients at admission was 97.91 and the mean total score at discharge was 81.33. Clients were qualified if they had been discharged and if they received CAFAS testing at admission and discharge.

Children's Clinical Services (SNCAS)

The following illustrates the admission and discharge CAFAS subscale scores for Children's Clinical Services (CCS- SNCAS).

CAFAS Subscale Scores

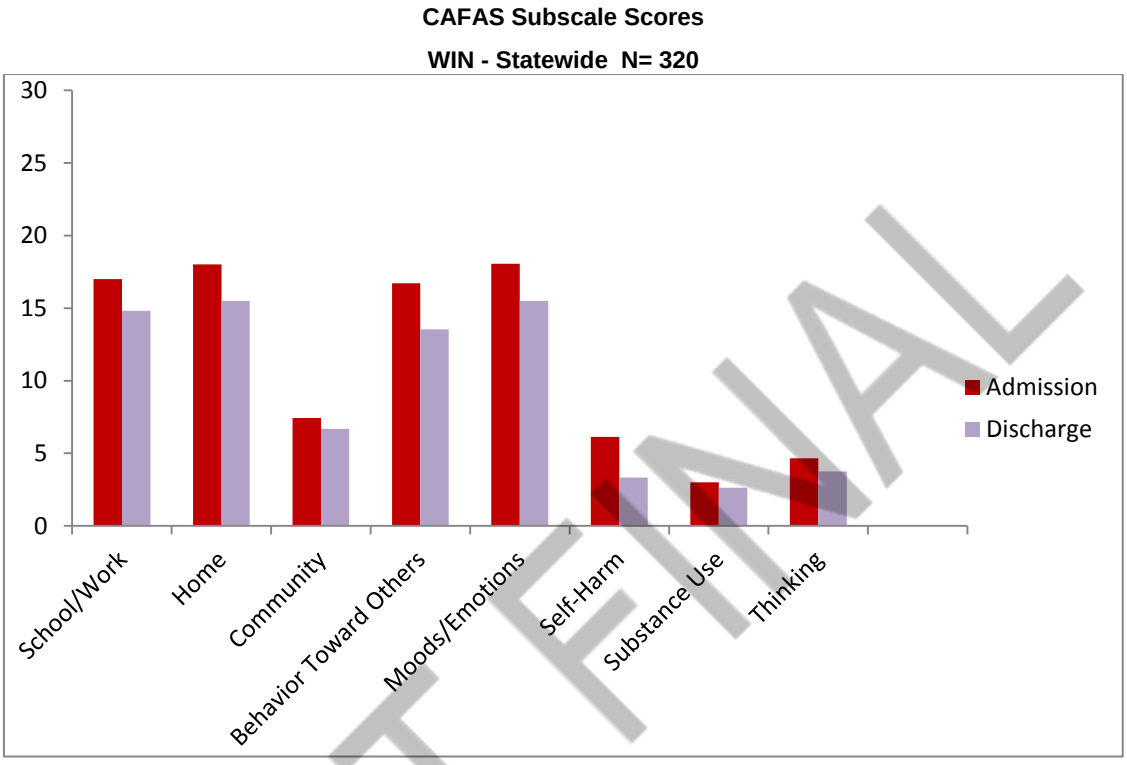
CCS N= 366



Clinically significant improvement was observed for 196 (53.6%) of 366 qualified DCFS South Region Children's Clinical Services clients. The mean total score for all clients at admission was 75.44 and the mean total score at discharge was 54.15. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

Wraparound In Nevada (WIN)

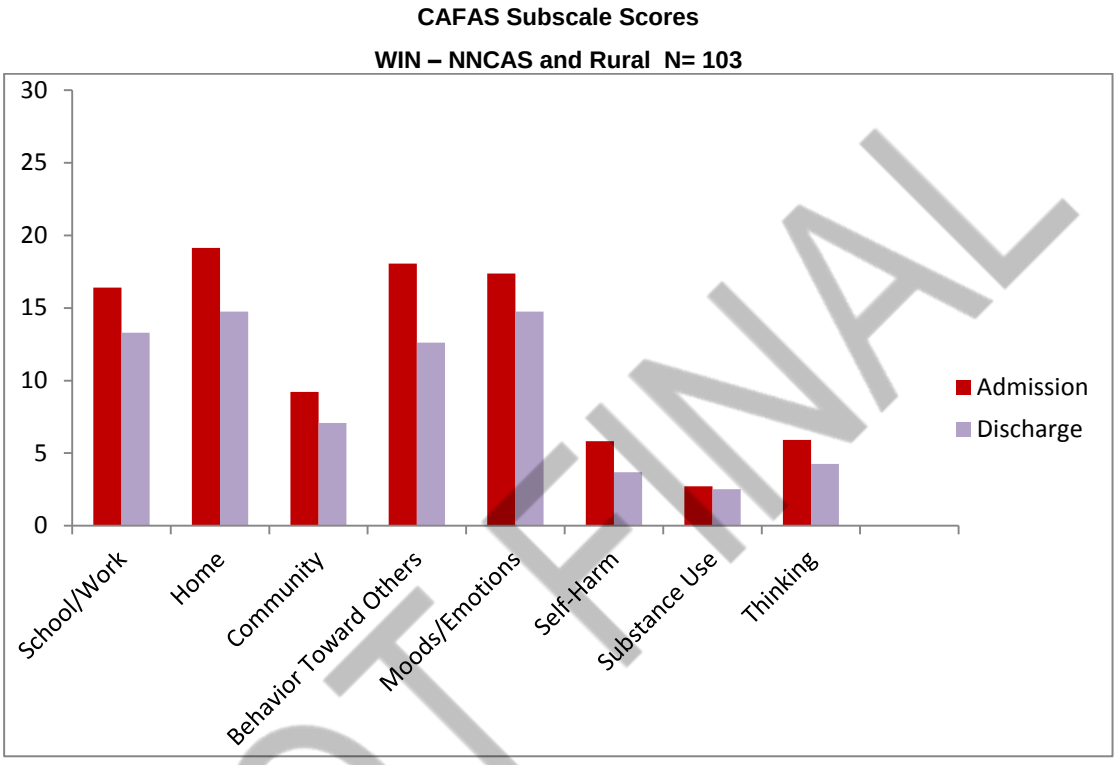
The graph below shows the admission and discharge CAFAS subscale scores for WIN statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 168 (52.5%) of 320 qualified DCFS Wraparound In Nevada (WIN) clients statewide. The mean total score for all clients at admission was 91.00 and the mean total score at discharge was 75.78. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

WIN-NNCAS and Rural

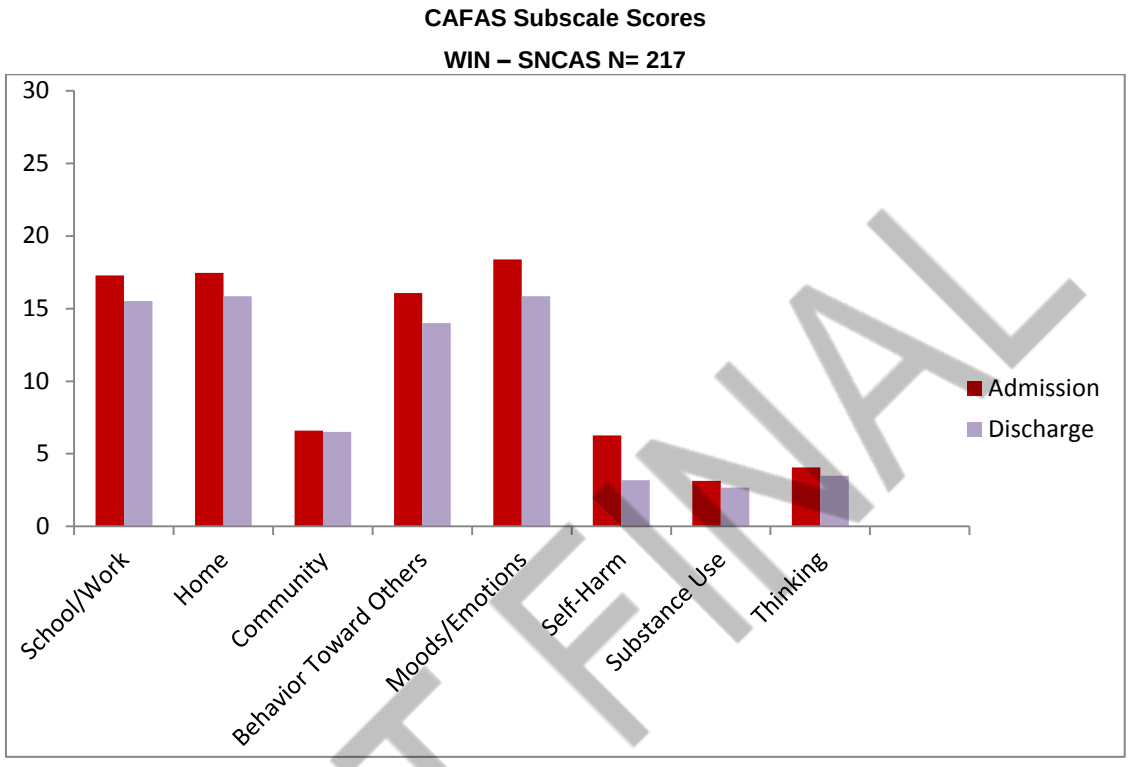
The following graph shows the admission and discharge CAFAS subscale scores for WIN at NNCAS and Rural.



As previously stated, clinically significant improvement on the CAFAS is indicated if the total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 61 (59.2%) of 103 qualified DCFS Northern and Rural Region WIN clients. The mean total score for all clients at admission was 94.66 and the mean total score at discharge was 73.01. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

WIN-SNCAS

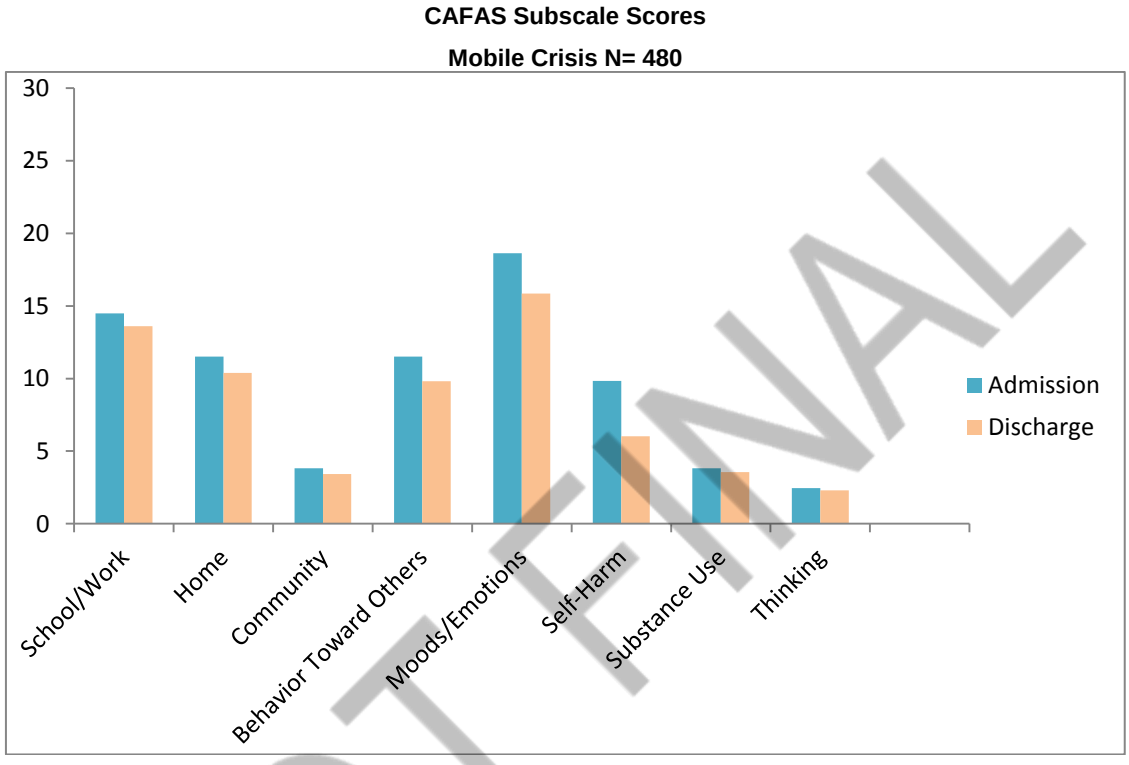
The admission and discharge CAFAS subscale scores for WIN at SNCAS are depicted below.



A child has improved by a clinically significant difference on the CAFAS if his/her score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 107 (49.3%) of 217 qualified DCFS Southern Region WIN clients. The mean score for all clients at admission was 89.26 and the mean score at discharge was 77.10. Clients were qualified if they had been discharged and if they were rated on the CAFAS at admission and discharge.

Mobile Crisis

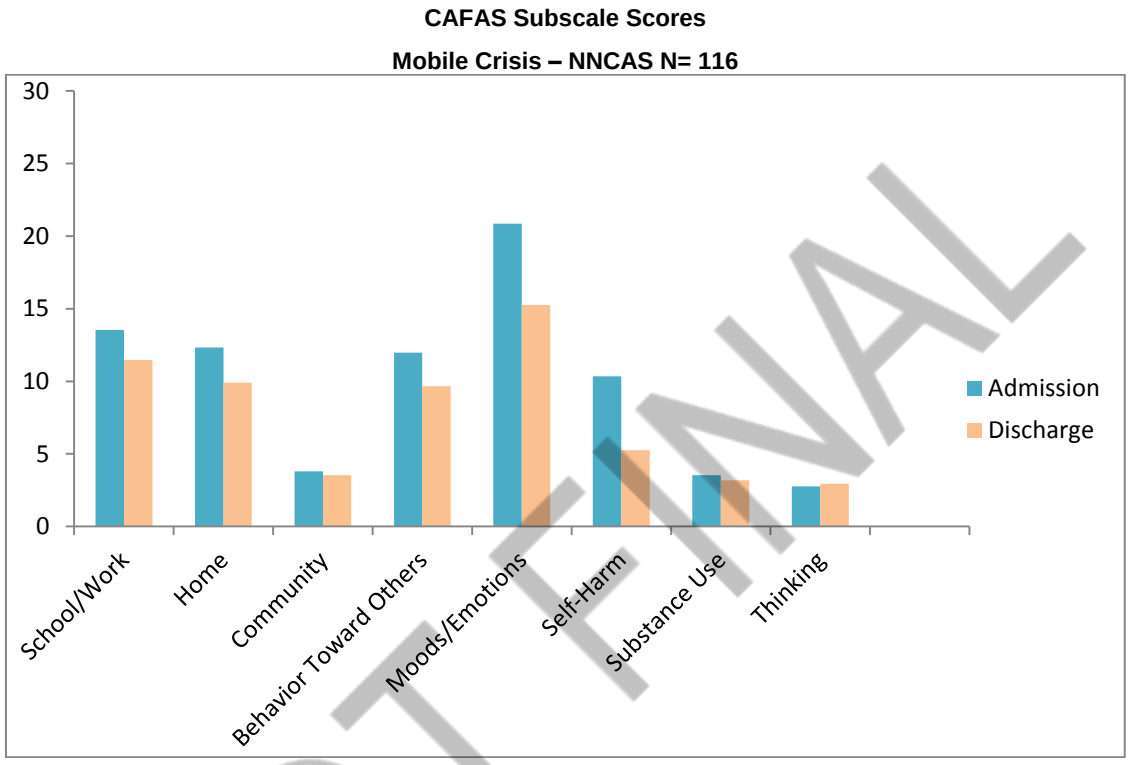
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis Statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 174 (36.3%) of 306 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 76.08 and the mean total score at discharge was 64.96. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

Mobile Crisis - NNCAS

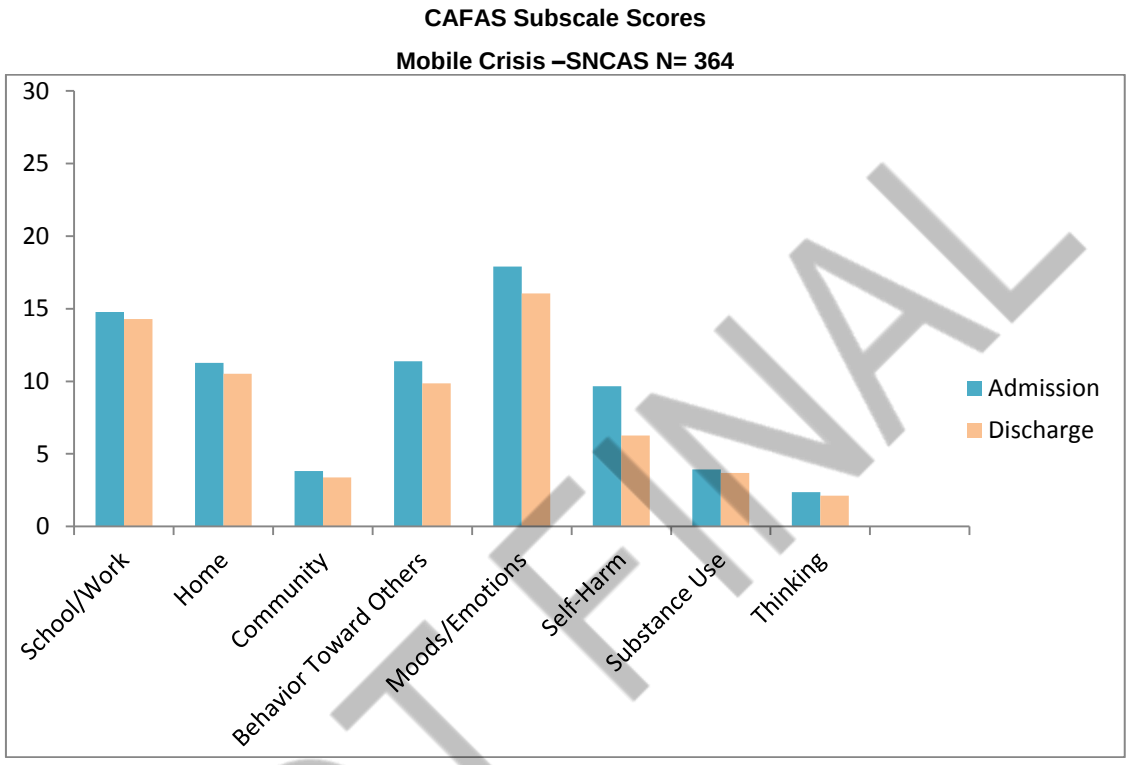
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis - NNCAS.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 60 (51.7%) of 116 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 79.14 and the mean total score at discharge was 61.21. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

Mobile Crisis - SNCAS

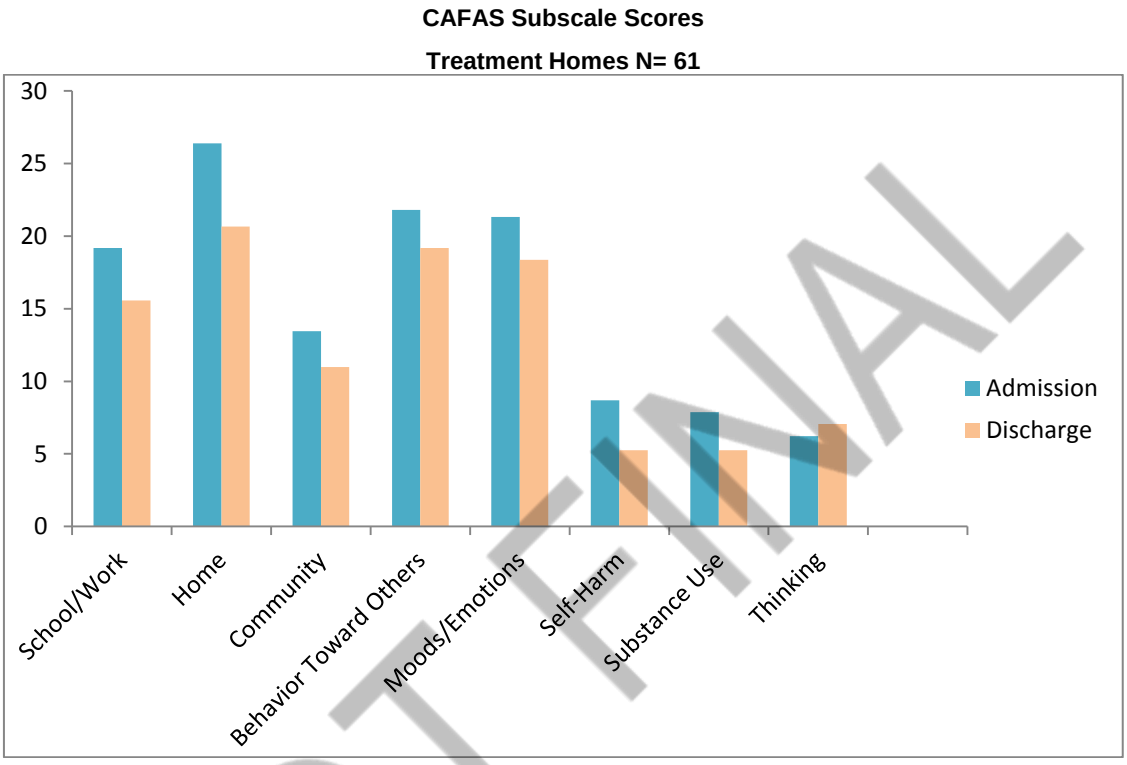
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis SNCAS.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 114 (31.3%) of 250 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 75.11 and the mean total score at discharge was 66.15. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

Treatment Homes

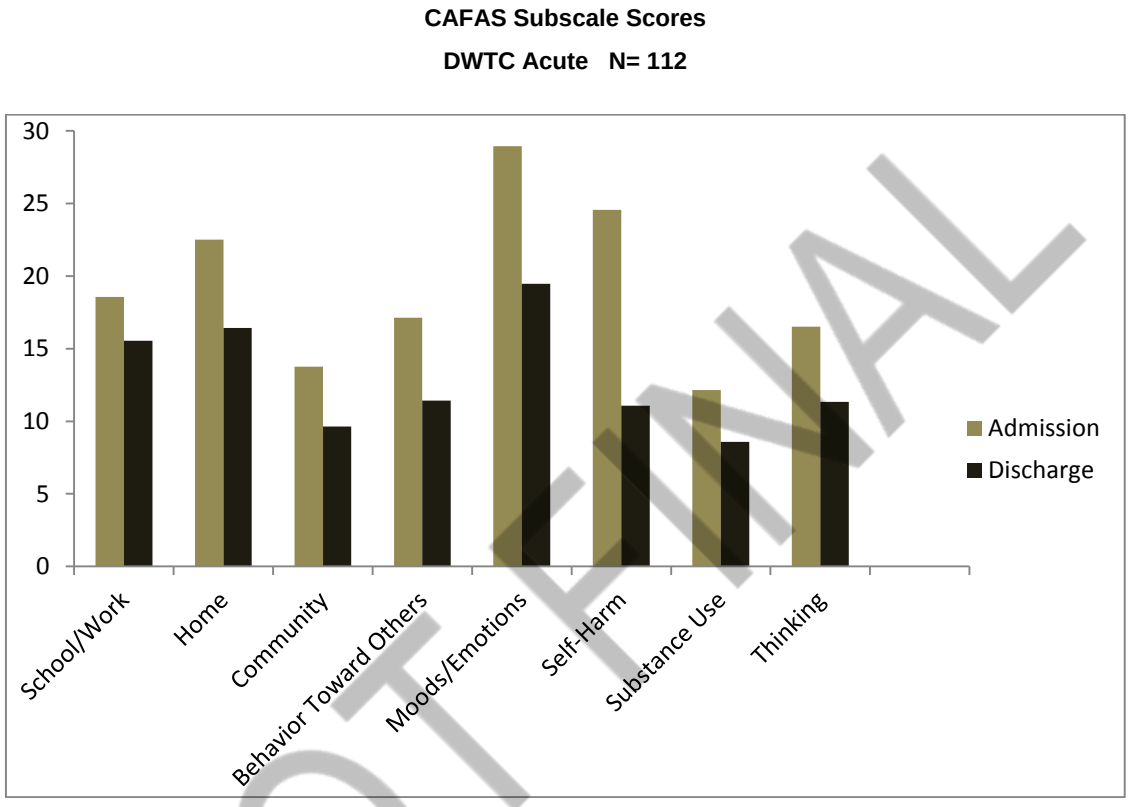
The graph below shows the admission and discharge CAFAS subscale scores for Treatment Homes Statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 37 (60.7%) of 61 qualified DCFS Residential Treatment Center clients. Facilities included in the analysis were Northern Region ATC, Northern Region Family Learning Homes, and Southern Region On-Campus Treatment Homes (OASIS). The mean total score for all clients at admission was 124.92 and the mean total score at discharge was 102.30. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

Desert Willow Treatment Center Acute Hospital

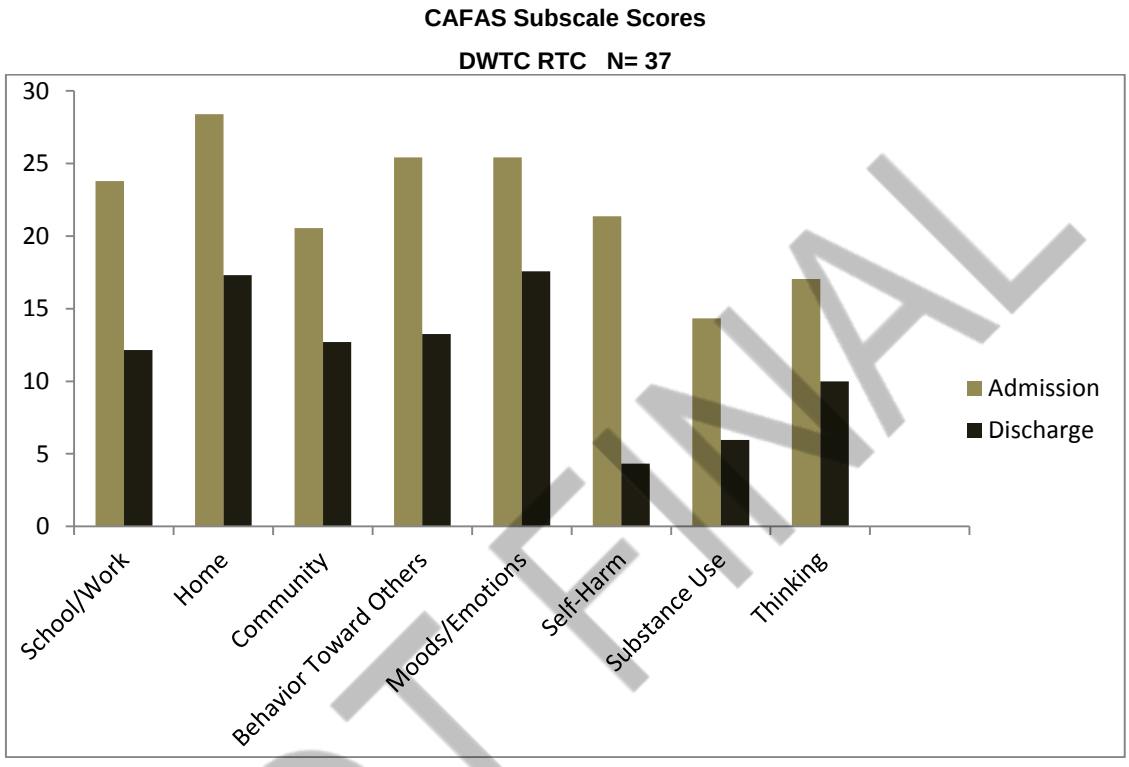
The admissions to discharge CAFAS subscale scores for Desert Willow Treatment Center Acute Hospital are depicted below.



In terms of improvement, 95 (84.8%) of 112 qualified DCFS Desert Willow Treatment Center Acute clients showed clinically significant improvement in their overall functioning as measured by the CAFAS. The mean total score for all clients at admission was 154.11 and the mean total score at discharge was 103.48. Clients were qualified if they had been discharged and if they were rated on the CAFAS at admission and discharge

Desert Willow Treatment Center RTC

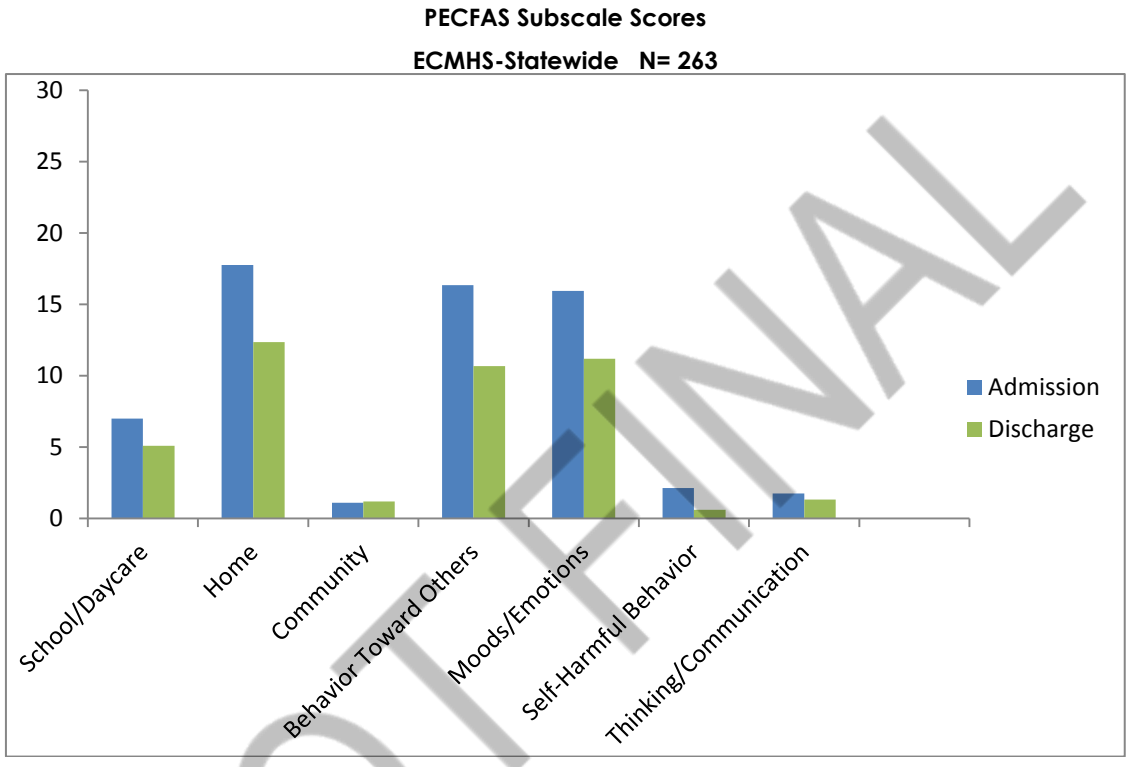
The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Residential Treatment Center.



Clinically significant improvement was observed for 34 (91.9%) of 37 qualified DCFS Desert Willow Residential Treatment Center (RTC) clients. The mean total score for all clients at admission was 176.22 and the mean total score at discharge was 93.24. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

Early Childhood Mental Health Services

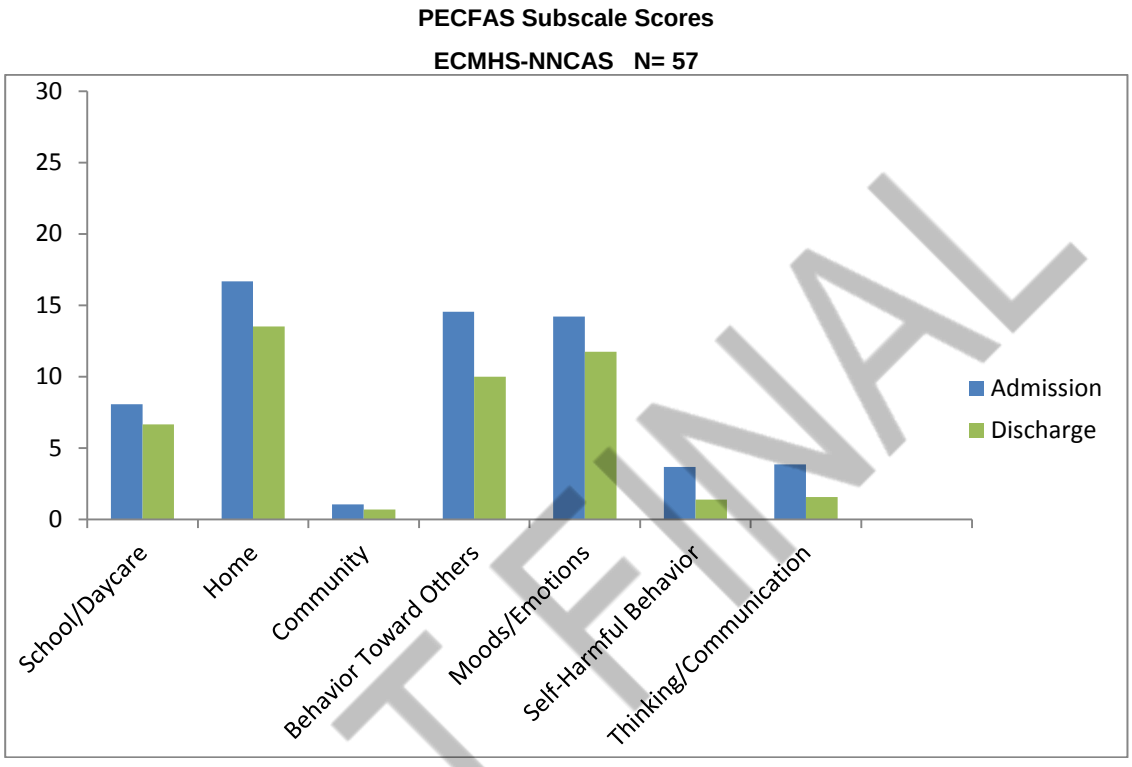
The graph below shows the admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services statewide.



Similar to the CAFAS, although with one less subscale, a child has improved by a clinically significant difference on the PECFAS if his/her score at discharge is at least 17.5 points lower than the initial testing at admission. Clinically significant improvement was observed for 142 (54.0%) of 263 qualified DCFS Early Childhood clients statewide. The mean total score for all clients at admission was 62.02 and the mean total score at discharge was 42.43. Clients were qualified if they had been discharged and if they were rated on the PECFAS at admission and discharge.

Early Childhood Mental Health Services- NNCAS

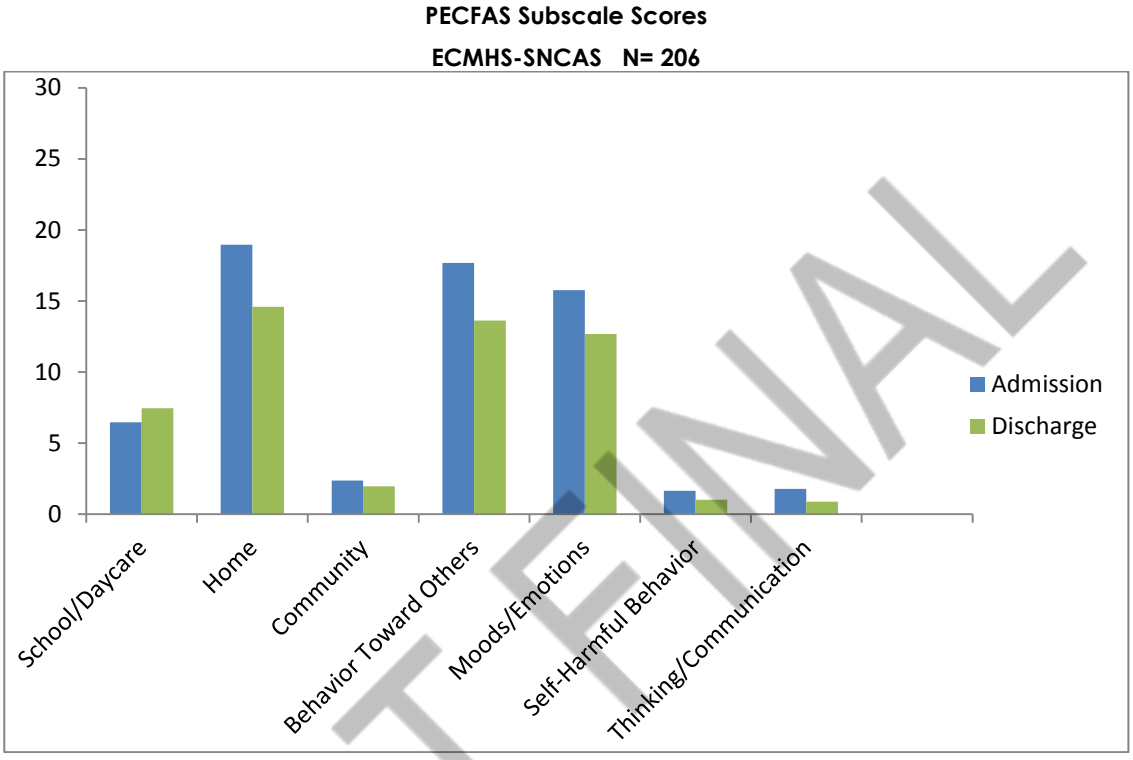
The graph below shows the admission to discharge for PECFAS subscale scores for Early Childhood Mental Health Services at NNCAS.



Regarding improvement, 27 (47.4%) of 57 qualified DCFS Early Childhood clients in NNCAS had clinically significant improvement in total scores. The mean total score for all clients at admission was 62.11 and the mean total score at discharge was 45.61. Clients were qualified if they had been discharged and if they were rated on the PECFAS at both admission and discharge.

Early Childhood Mental Health Services- SNCAS

The Admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services at SNCAS are depicted below.



As previously noted, a child has improved by a clinically significant difference on the PECFAS if his/her score at discharge is at least 17.5 points lower than the initial testing at admission. For SNCAS ECMHS clients, clinically significant improvement was observed for 115 (55.8%) of 206 qualified discharged clients who had ratings at both admission and discharge. The mean total score at admission was 61.99 and the mean total score at discharge was 41.55.

Education and Juvenile Justice Outcomes

An analysis was conducted on client's absences, suspensions/expulsions, and arrests. Each client's absences, suspensions/expulsions, and arrests in the most recent period were compared to his or her average over at least two periods to see if these measures increased, decreased, or stayed the same. If a client was, despite some fluctuation from period to period, reducing or maintaining acceptable levels in these areas, then his or her most recent numbers will be less than his or her average (thereby pulling the average down toward zero) or held steady near zero.

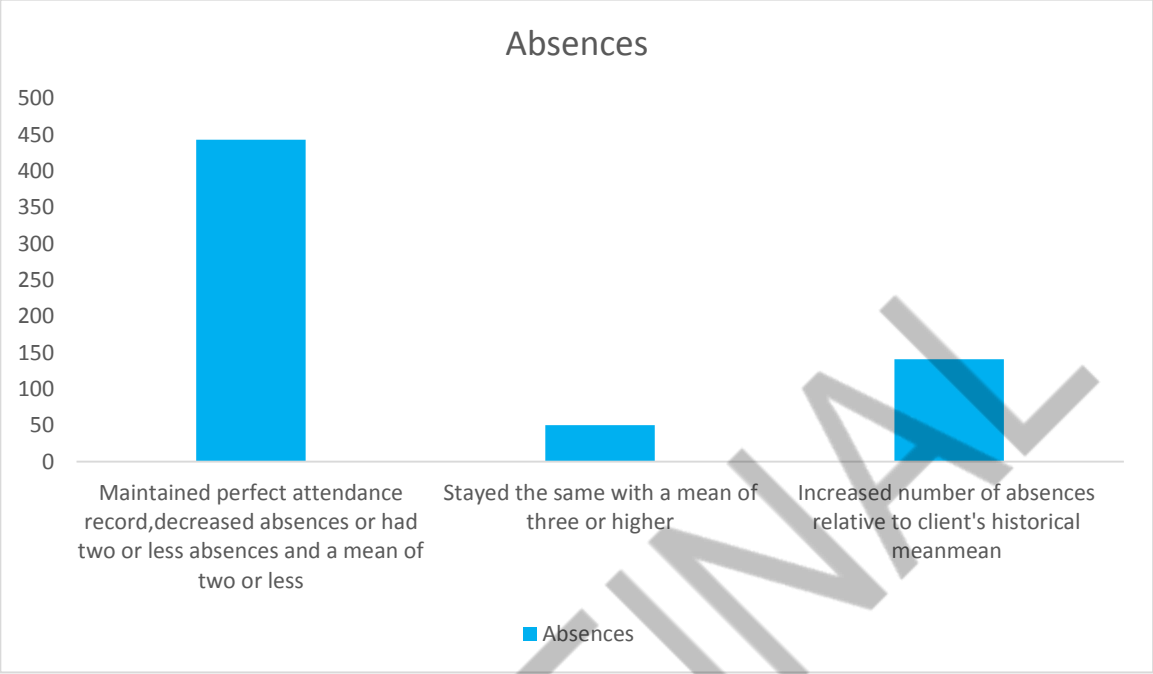
Performance was classified into three categories:

1. A client was considered to be maintaining an excellent performance or showing improvement if he or she met any one of three criteria:
   - The client had a perfect record historically and in the most recent period;
   - The client had a history of averaging no more than two absences per grade period and had two or less in the most recent grade period (absences only); or
   - The client had a historic average of three or more per grade period and showed a reduction from the average in the most recent grade period.

2. A client was considered to have stayed the same at a level that could be improved if he or she had:
   - Three or more absences per period historically and had the same number as his or her average in the most recent period (absences only), or
   - One or more per period and the same number as his or her average in the most recent period (suspensions/expulsions and arrests only).

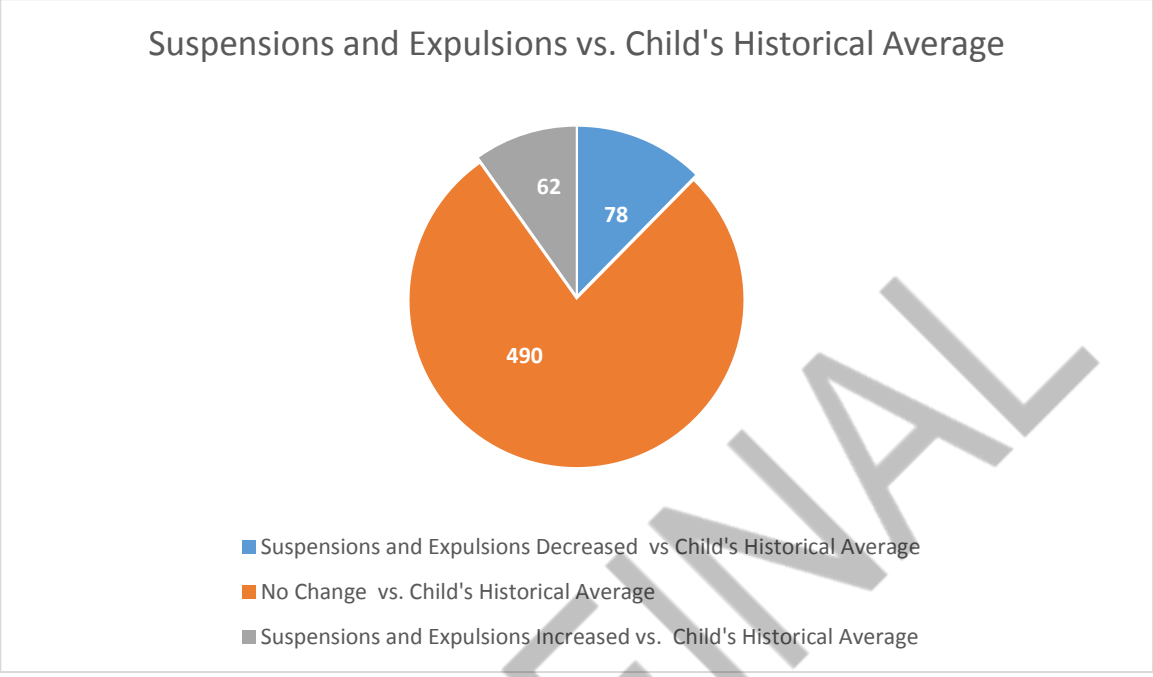
3. A client was considered to have decreased in performance if he or she had:
   - A historical average of three or more per period and more than his or her historical average in the most recent period, or an average from zero to two and absences in the most recent period of three or more (absences only), or
   - A historical average of one or more per period and more than his or her average in the most recent period, or a perfect record historically and one or more in the most recent period (suspensions/expulsions and arrests only).

Absences: Statewide/All Programs



In FY2016, 634 clients had attendance data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean personal absences of two or fewer for 443 (69.9%) of the clients. Absences remained the same at three or more compared with a mean of three or more for 50 (7.9%) clients. Absences increased to three or more and the client self-average was greater than two days for 141 (22.2%) of the clients.

Suspensions and Expulsions: Statewide/All Programs

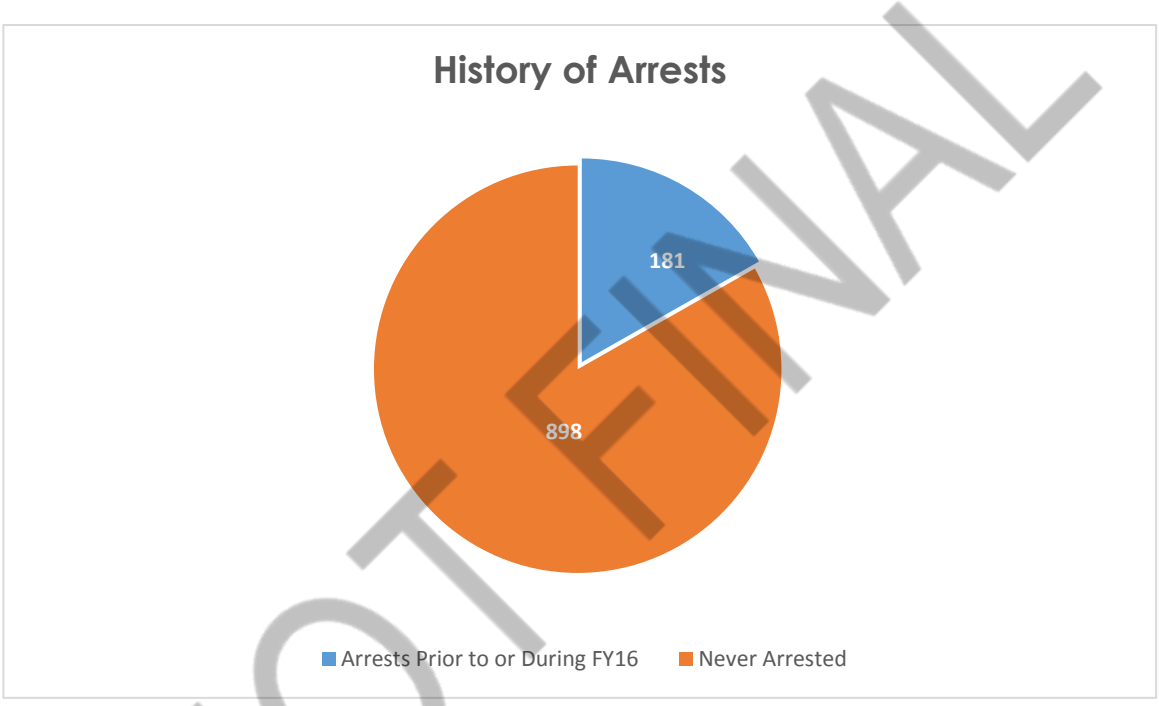


In FY2016, 630 clients had suspensions and expulsions data for at least two grade periods from which an average could be constructed. Suspensions and expulsions decreased versus the client's own average for 78 (12.4%) of the clients. For 490 (77.8%) of the clients, there was no change in suspensions and expulsions versus his or her own average. Suspensions and expulsions increased versus the client's own average for 62 (9.8%) of the clients.

Arrests: Statewide/All Programs

In FY2016, 1079 clients had arrest data to compare to current period arrests. Of the 1079 clients with arrest data, 898 clients (83.2%) had no arrests prior or current and 181 clients (16.8%) had at least one arrest in a prior and/or the current (most recent) period.

Arrests Prior to or During FY2016



Of the 181 youth with prior and/or current arrests, arrests decreased for 121 (66.9%),33 (18.2%) had the same number of arrests as in prior periods, and arrests increased versus prior periods for 27 youth (14.9%).

Consumer Survey Results

It is both system of care best practice and a policy of DCFS that all children and their families/caregivers receiving mental health services are provided an opportunity to give feedback and information regarding the services they receive. In the spring of every year, DCFS conducts a statewide survey for NNCAS and SNCAS children's community-based mental health programs. Parent/caregivers with children in treatment and the children themselves (age 11 or older) are voluntarily participate in completing surveys. Children's residential programs collect surveys at discharge.

Survey participants are asked to disagree or agree with a series of statements relating to seven areas or "domains" that the Federal Mental Health Statistical Improvement Program prescribes whenever evaluating mental health programming effectiveness.
The following tables present respective annual survey positive response percentages for both parent/caregivers and for age-appropriate children as compared to national benchmarks.

Community Based Services Survey – Spring 2015	Youth % positive	Parent % positive	National Benchmark for Parent Response[3]
Services are seen as accessible and convenient regarding location and scheduling	88	91	82.8%
Services are seen as satisfactory and helpful	87	92	87.2%
Clients get along better with family and friends and are functioning better in their daily life	82	76	67.3%
Clients feel they have a role in directing the course of their treatment	71	93	87%
Staff are respectful of client religion, culture and ethnicity	92	95	93%
Clients feel supported in their program and in their community	91	94	83.9%
Clients are better able to cope and are doing better in work or school	81	77	69.5%

[3] 2014 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/dataoutcomes/urs/2014/nevada.pdf

Residential Discharge Services Survey	Youth % positive	Parent % positive
Services are seen as accessible and convenient regarding location and scheduling	84	92
Services are seen as satisfactory and helpful	87	90
Clients get along better with family and friends and are functioning better in their daily life	89	75
Clients feel they have a role in directing the course of their treatment	83	83
Staff are respectful of client religion, culture and ethnicity	95	93
Clients are better able to cope /doing better in work or school	90	70

STRENGTHS Child and Adolescent Behavioral Health System

- Nevada PEP, a family advocacy organization provides support, training, and advocacy for families involved in the public service system e.g. mental health, child welfare, and education.
- Regional and statewide consortia develop plans which guide the children's mental health service system.
- Regional consortia have implemented mental health promotion and prevention programs.
- Placement prevention funds are available for families to assist with rent, utilities, food, medicine, and other types of assistance to help keep children in their homes.
- System of Care principles and values are embraced by child serving system partners.
- Suicide prevention plan developed through the Office of Suicide Prevention.
- Desert Willow Treatment Center is the only public child and adolescent psychiatric hospital in Nevada.
- NNCAS in partnership with the University of Nevada, School of Medicine, funds a residency program for Psychiatric Fellows.
- The WIN program implements the national wraparound model serving children and families statewide.
- The Washoe Wraparound Expansion program added three Wraparound Facilitators through collaboration with Washoe County Department of Social Services, Sierra Regional Services, and Washoe County School District. The additional facilitators serve children and adolescents in parental custody.
- The Provider Support Team consisting of specialized foster care providers and state and county quality assurance staff meet to develop quality of care standards for specialized foster care.
- DCFS Children's Mental Health utilizes evidence-based practices and promising practices such as Aggression Replacement Training, Parent-Child Interaction Therapy, and the Wraparound Model.

Summary of Needs and Gaps

The table that follows, highlights the major needs and gaps that have been repeatedly identified in previous gaps analyses and strategic planning efforts in Nevada (since 2010). A brief summary of the specific levels and types of care that are most needed in Nevada is provided. In addition to the needs/gaps identified in the following table, there are other gaps that are specific to subpopulations. These include a gap in rural Nevada for behavioral health and health services, a lack of providers (both general and specialty), lack of transportation to access services in consumers' communities, and the lack of **s**ervices available in native language, such as the lack of Spanish-speaking behavioral health professionals throughout the state.

Limitations

There are several limitations that must be noted related to the meta-analysis summary. They include:

Consumer-engagement—Consumers participated in a variety of ways to inform the reports analyzed in this summary. Engagement occurred via interviews, focus groups and surveys. These processes, in order to be efficient, are necessarily brief and may not have captured the richness or depth of the consumer's perspective or articulated their thoughts in a manner that promotes a particular framework or evidence-base.

Terminology—Initiatives and needs assessments used varied terminology in the 20 reports that were reviewed. Recommendations and strategies are provided in summary and in some cases the wording was changed when necessary to ensure consistency while retaining the original intent of the sentence.

Additional input—Because planning and initiative work is dynamic in nature, additional data, input and recommendations may have been developed but not identified for inclusion in the meta-analysis summary.

Table 4: Needs and Gaps by Strategic Initiative

STRATEGIC INITIATIVE	NEEDS AND GAPS
PREVENTION OF SUBSTANCE ABUSE AND MENTAL ILLNESS	• Limited crisis intervention services • Limited early intervention services • Lack of early identification and intervention for at-risk populations • Lack of positive community-based activities for the prevention of substance abuse
HEALTH CARE AND HEALTH SYSTEMS INTEGRATION	• Overutilization of emergency rooms due to emotional or psychiatric crisis that could be better served at lower cost in other settings • Fragmentation across systems and lack of resource coordination • Too many youth placed out of state • Insufficient alternatives to hospitalization • Lack of treatment facilities that will serve pregnant women • Long waiting lists/lack of available services and providers
STRATEGIC INITIATIVE	**NEEDS AND GAPS**
	• Distance and time to access nearest available services • Affordability of services • Lack of insurance coverage

TRAUMA AND JUSTICE	• Minimal access to and options for jail diversion, particularly for Black and Hispanic males • Limited access to and options for community re-entry programs • Lack of understanding about how specialty courts function • Limited legal avenues to address misuse/abuse of prescription drugs • Resistance of some judges to use alternative treatment options like telemedicine, and medication assisted treatments • Lack of knowledge about behavioral health and substance abuse issues, especially among first responders and law enforcement
RECOVERY SUPPORTS	• Lack of affordable housing options • Need for habilitative services and support • Cultural and/or community stigma associated with needing or seeking services • Lack of adequate transportation options • Need for peer support services
HEALTH INFORMATION TECHNOLOGY	• No current centralized repository for information sharing • No single set of standards for data collection • No single set of measures for all agencies to collect • No training on HIT and the importance • Lack of broad adoption of HIE • Lack of awareness about resources
WORKFORCE DEVELOPMENT	• Behavioral health workforce shortage • Poor workforce retention/high staff turnover rates • Behavioral health training programs have not worked together • Low wages • Front line staff burnout • Capacity building issues: (a) costs, (b) degree program capacity, (c) recruitment and retention, (d) clinical supervision, and (e) clinical site availability • Scope of practice issues • Licensing and credentialing policies

The largest gaps in behavioral health services in Nevada, as noted in the NDPBH Behavioral Health Services System Report, 2014 Update, are consistently reported to be:

- Inpatient and outpatient treatment statewide
- Services for substance abusing mentally ill consumers
- Substance abuse services for all populations
- Lack of youth services
- Lack of affordable housing
- Care management and wraparound services to help those getting better to maintain stability
- Workforce concerns related to morale, compensation, recruitment and retention.

The largest gaps in behavioral health services in Nevada, as noted in the DHHS June 2015 Needs Assessment, are consistently reported to be:

- Children's residential behavioral health services
- Crisis stabilization
- Acute intensive services: mobile crisis
- Intensive home-based services
- Adult residential behavioral health treatment

These service gaps are exacerbated in rural areas, where there is limited availability of case management services.

The largest gaps in substance use disorder treatment services in Nevada, as noted in the DHHS June 2015 Needs Assessment, are consistently reported to be:

- Youth residential substance abuse treatment
- Adult residential substance abuse treatment
- Recovery Supports: Peer support
- Community Support: Assistance with education
- Community Support: Recovery housing

Key informant interviews, focus groups and provider and consumer surveys used to develop the ADSD Integration Plan identified gaps for children and adults with developmental disabilities (DD) or intellectual disabilities (ID) or both (I/DD) including those with behavioral health concerns noting:

- A growing population of Nevadans will need services at a time when sufficient resources are not available to meet those needs.
- Access to care is oftentimes interrupted by the lack of available primary care providers, specialty providers, transportation, and community-based housing, respite and socialization options, training and employment opportunities. There was a clear indication that overall funding to meet basic and special needs is not sufficient.
- There is a need for a service delivery system that supports people throughout the lifespan with specific supports during times of transition.
- There is a lack of awareness regarding services available and a lack of clarity about how to navigate the service delivery system.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

UNMET SERVICE NEEDS and CRITICAL GAPS within NEVADA'S CURRENT BEHAVIORAL HEALTH SYSTEM

FFY 2018 – 2019 MENTAL HEALTH APPLICATION

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

NEVADA

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

BUREAU of BHAVIORAL HEALTH WELLNESS AND PREVENTION

WORKING DRAFT 081717 PM

STEP 2:

Unmet Service Needs and Critical Gaps within Nevada's Current Behavioral Health System

A wide range of information sources was examined for the purpose of identifying unmet service needs and critical gaps in Nevada's current behavioral health system, which is responsible for serving each of the populations that were targeted by the Substance Abuse and Mental Health Services Administration (SAMHSA) for FFY 2018-2019:

- Children with serious emotional disturbance (SED) and their families
- Adults with serious mental illness (SMI)
- Older Adults with serious mental illness (SMI)
- Individuals with SMI or SED in the rural and homeless populations
- Individuals who have an Early Serious Mental Illness (ESMI) (10 percent MHBG set aside)

C*ommunity psychiatric epidemiology* and *behavioral health* data were reviewed to distinguish the prevalence of mental disorders in Nevada and nationwide. When available, county-level prevalence rates were considered to reveal subsets of the State's population with particular needs. The rates of persons served by the State's current behavioral health system were then evaluated within the context of the prevalence rates reported for the United States as a whole, and for Nevada and its individual counties. Billing data for hospital emergency room visits related to mental health were additionally considered as indicators of SED and SMI that were either untreated or ineffectively managed. Finally, results are reported from recent focus groups that were conducted statewide to identify unmet service needs and critical gaps from the perspectives of stakeholders and consumers.

The combined findings from these multiple sources of information indicate the presence of significant unmet service needs and critical gaps within Nevada's current behavioral health system, and this information shaped the strategic priorities for the work that is planned for each target population during FFY 2018–2019. An overview of these unmet needs and critical gaps is listed below, and the evidence identifying their significance is then summarized.

Overview of Unmet Service Needs and Critical Gaps: Nevada's Current Behavioral Health System

1. ***Nevada's children and adolescents are vulnerable to developing severe mental disorders, which in the absence of effective interventions may progress to chronic and debilitating illnesses.*** *One-third of Nevada's adolescents reported experiencing depressed mood and reduced functioning* during the year before they participated in the most recent 2015 Nevada Youth Risk Behavior Survey, which is conducted by the Centers for Disease Control (CDC) and Prevention, and local and state education and health agencies. *The State's youth were more likely to report one or more suicide attempts during the prior year, compared to their age peers nationwide*. More than *20% acknowledged deliberate acts of self harm, such as cutting or burning themselves, without the intent to die*. Importantly, the clinical outcomes and current mental health status, in 2017, for each adolescent who reported psychological distress and life-threatening behaviors, in 2015, are unknown.
2. ***Expansion of early intervention services for individuals with early serious mental illness (ESMI) and first episode of psychosis (FEP) throughout Nevada is a critical need.*** Between 8% and 13% of Nevada's children and adolescents are at risk for developing severe

mental disorders. An additional 20% are vulnerable to psychological distress, suicide-related behaviors, and acts of deliberate self harm without intent to die. Early intervention services have been initiated for first episode of psychosis (FEP) in the urban counties of northern and southern Nevada. Expanding these services to early serious mental illness (ESMI), and to the rural and frontier regions of the State is vital.

3. ***Access to the State's mental health services for children with serious emotional disturbance (SED) and adults with serious mental illness (SMI) is severely limited.*** The numbers of individuals covered by Medicaid benefits more than doubled between 2013 and 2015 due to the Medicaid expansion by Governor Brian Sandoval in 2014 under the Affordable Care Act (ACA). However, the percentage of Nevada residents with SED and SMI who were served by the State's mental health system was less than 10% of each population in FY 2016; eight percent (8%) of the estimated number of children with SED, and nine percent (9%) of the estimated number of adults with SMI. Service penetration rates for each population were lower than the rates nationwide.

   Access to services is a complex issue. An important factor for Nevada is that almost all of the state qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas (Griswold et al., 2017, *Map 5.3*, p. 148). Equally important is the lack of adequate health information technology and measurement methodology to track productivity metrics associated with community providers whose services are supported through Medicaid fee-for-service and managed care resources. (See Unmet Needs/Critical Gaps # 4 and # 6 below.)

4. ***Nevada's mental health workforce is underdeveloped in volume and in clinical expertise.*** Almost all of the State of Nevada qualifies as a mental health professional shortage area. The State's geography and its low population density in rural and frontier regions amplify the challenges associated with this critical shortage. Stable financial resources and active investment from state leadership are required to incentivize professional training and development for Nevada's current and future mental health workforce.

5. ***Suicide prevention efforts are not integrated with clinical services or post-mortem reviews within the state's current mental health system***. Nevada continues to rank in the top 10 states with the highest rates of suicide deaths nationwide. Countywide rates reflect the highest numbers of suicide deaths per population in the rural and frontier regions. Suicide-related conditions accounted for 39% of all behavioral-health related visits among children and adolescents to Nevada's emergency rooms from 2009 to 2014. Ideally, suicide prevention efforts are integrated with clinical intervention services that involve evidence-based and promising practices, and post-mortem reviews that support quality assurance and performance improvement initiatives. This type of integrated model is incomplete and fragmented in the urban counties of northern and southern Nevada, and nonexistent in the state's rural and frontier counties.

6. ***Health information technology and measurement methodology that support Nevada's current mental health care system, including its community providers, are characterized by critical gaps.*** Data are not organized for prevention, planning, and treatment. This includes a lack of effective support for monitoring and evaluating the efficacy of programs based on access to services and clinical outcomes. Health records databases are not integrated. The reference in Gap #1 (above) to findings from the *2015 Nevada Youth Risk Behavior Survey* serves to illustrate these technical and analytical deficiencies. Specifically,

the clinical outcomes and current mental health status, in 2017, for each Nevada adolescent who reported psychological distress and life-threatening behaviors, in 2015, are unknown.

7. ***Results were examined from ten (10) statewide focus groups that were conducted from April 2016 to June 2016 as part of the planning and development phases for Certified Community Behavioral Health Clinics (CCBHC) in Nevada (Woodard, 2016b).*** Participants included consumers, family members, advocates and providers. Strong agreement across participants was observed regarding broad themes, as well as specific issues. Prominent themes and issues identified by focus group participants included:

    - *Staffing* – Insufficient numbers of behavioral health providers and medical personnel were identified, especially in psychiatry, child psychology and school social work. Professional training for providers was consistently recommended in the areas of crisis management, care coordination and peer support.
    - *Access* – Both providers and consumers identified the need for more services, as well as the need for more varieties of services.
    - *Care Coordination* – The need to improve collaboration, coordination and communication was identified, with sharing of data and electronic records considered to be crucial. The importance of establishing a formal, defined standard of care that is implemented statewide was emphasized. Use of multidisciplinary teams for the care of complex cases was suggested.
    - *Services* – More treatment options for different stages of illness were recommended, as well as more resources devoted to prevention, early intervention, treatment, and crisis management.

- ***CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED) AND THEIR FAMILIES ****

Table 1 (below) shows the population estimates and projections for Nevada's children aged 17 and younger by urban, rural and frontier counties for 2010 to 2022 (Griswold, T., et al., 2015; Griswold, T., et al., 2017; Nevada State Demographer's Office, 2014; Nevada State Demographer's Office, 2016).

Region/County	Table 1: Population Estimates and Projections for Nevada's Residents Aged 0 - 17 by County, 2010 to 2022				
	2010	**2014**	**2017**	**2019**	**2022**
Rural and Frontier					
Churchill County	6,128	6,197	5,787	6,819	6,285
Douglas County	9,128	8,730	8,474	8,170	8,575
Elko County	14,306	11,831	12,593	11,212	12,090
Esmeralda County	144	114	105	104	89
Eureka County	475	415	387	417	355
Humboldt County	4,522	4,349	4,379	4,403	4,212
Lander County	1,573	1,433	1,427	1,500	1,380
Lincoln County	1,336	1,015	860	967	803
Lyon County	12,524	12,107	12,037	12,597	10,581
Mineral County	842	920	988	853	899
Nye County	8,622	8,418	8,090	8,129	7,636
Pershing County	1,247	1,200	1,108	1,000	1,149
Storey County	631	544	541	490	668
White Pine County	2,170	2,095	1,889	1,968	1,721
Rural & Frontier Region Subtotal	63,648	59,368	58,663	58,629	56,443
Urban					
Carson City	11,741	12,639	11,832	12,021	10,867
Clark County	489,207	500,906	517,059	512,497	539,215
Washoe County	99,179	103,464	105,467	109,354	105,197
Urban Region Subtotal	600,127	617,009	634,358	633,872	655,279
Nevada – Total	663,775	676,377	693,021	692,501	711,722

Source: *Adapted from Griswold, T. et al. (2015; 2017) and Nevada State Demographer's Office (2014; 2016)*

***Rates of Serious Emotional Disturbance (SED) in Nevada's Children*:** An estimated 37,266 children in Nevada suffered from serious emotional disturbance (SED) during 2015-2016, which represents 11% of the state's youth population (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada). This estimate is similar to the 12-month prevalence rate of 8% for SED observed among adolescents aged 13 to 17 who participated in the United States community survey involving parallel household and school samples (Kessler et al., 2012, National Comorbidity Survey Replication Adolescent Supplement). It is also comparable to the range of estimates for major depressive episode (MDE) among adolescents in Nevada and the United States obtained by the National Surveys on Drug Use and Health (NSDUH) that are shown in **Table 2 (**below).

Table 2: Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12-17 in Nevada and the United States: 2010-2011 to 2013-2014

Years	2010-2011	2011-2012	2012-2013	2013-2014
Nevada	8.6%	8.5%	9.6%	11.6%
United States	8.1%	8.7%	9.9%	11.0%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, 2015.* HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

The most recent available NSDUH data indicate that approximately 26,000 adolescents in Nevada (11.6% of all adolescents) per year in 2013-2014 experienced at least one major depressive episode during the year before being surveyed. The rate for adolescents in Nevada was similar to the national percentage observed for that same survey period. Importantly, the percentage experiencing at least one major depressive episode during each survey period increased from 2010-2011 to 2013-2014.

Rates of Health Risk Behaviors in Nevada's Children: The *Youth Risk Behavior Surveillance System (YRBSS)* monitors health behaviors among youth and young adults to evaluate the success of public health efforts directed to protect and enhance the wellbeing of these individuals nationwide. *YRBSS* includes school-based survey, the *Youth Risk Behavior Survey (YRBS),* which is conducted by the Centers for Disease Control and Prevention (CDC) and state and local education and health agencies to collect population-based data on health behaviors of interest. This section summarizes findings concerning the emotional health of Nevada's youth who were surveyed for the *2015 YRBS* from February, 2015 through May, 2015.

***Emotional Health Profile of Nevada's High School Students (Grades 9-12), 2015*:**
Tables 2 - 4 (below) summarize responses among Nevada's High School students (Grades 9 –12) to questions about their emotional health and suicide-related thoughts and behaviors that occurred during the 12 months before they participated in the *2015 Nevada High School Youth Risk Behavior Survey*. Overall rates for United States High School students are provided as a comparison. Results indicate that Nevada's youth experienced disturbances to their emotional health during the 12 months before their participation in the survey, and these disturbances included symptoms of depression and suicide attempts.

Psychological Distress and Suicide Attempts among Nevada's Adolescents, 2015:
Two patterns emerged from the results of the *2015 Nevada High School Youth Risk Behavior Survey* (**Table 3 and Table 4 below**) that are informative about the emotional health of Nevada's High School Students, and that indicate the presence of unmet needs and critical gaps within the state's current behavioral health system. The ***first pattern*** concerns the proportion of Nevada's high school students (33%) who reported experiencing the hallmark symptoms of a major depressive episode during the 12 months before the survey—*"feeling sad or hopeless almost every day for two or more weeks so that they stopped doing some usual activities."* The proportion of Nevada's youth who experienced this mood disturbance was elevated compared to the proportion of high school students in the United States as a whole (30%), although this group difference did not reach statistical significance (p=0.09). Moreover, 22% of Nevada's adolescents reported having intentionally cut or burned themselves without wanting to die during the 12 months before the survey.

Thus, converging evidence suggests the presence of emotional disturbance and disability for adolescents in Nevada, as well as nationwide, with 12-month prevalence estimates ranging from 8% (national samples) and 9-13% (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada) for serious emotional disturbance (SED), and 8-11% for major depressive episode (MDE) (SAMHSA, NSDUH samples). Moreover, the hallmark symptoms of a major depressive episode were reported by ***one third of Nevada's adolescents***, which was similar to the national rate. This latter finding is suggestive of levels of psychological distress that are more pervasive in this age cohort than would be expected based on the established 12-month prevalence estimates for serious emotional disturbance (SED) and major depressive episode (MDE).

The ***second pattern*** evident from the *2015 Nevada High School Youth Risk Behavior Survey* involves a heightened risk of injury and death through suicide attempts made during the year before they participated in the survey. As reflected in **Table 3** (below) approximately 11% of Nevada's high school students reported having engaged in one or more suicide attempts during the 12 months before the survey, compared to 9% of US high school students. Importantly, that difference between the proportions for Nevada and US adolescents was statistically significant (p=0.03). **Table 4a** and **Table 4b** (below) provide a detailed profile of this subgroup of Nevada's adolescents by sex, age, grade and race/ethnicity (Table 3a), and by region (Table 3b). Results show the greatest numbers of suicide attempts during the prior 12 months occurred for females, students in the 9th and 10th grades, American Indians/Alaskan Natives, and for students living in rural and frontier counties.

Table 3: Summary of Emotional Health during the past 12 months, Nevada High School Students, 2015 (*Adapted from*: Youth Risk Behavior Surveillance System, 2015 High School Youth Risk Behavior Survey §)						
Question	**Nevada 2015**	**United States 2015**	***p-value***	**Nevada 2015** more likely than United States 2015	**United States 2015** more likely than Nevada 2015	***No difference*** (NV = US)
Felt sad or hopeless? *(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 mos before the survey)* **§**	32.7 (30.0–35.6) ‡	29.9 (28.0–31.8)	0.09			o
Intentionally cut or burned themselves without wanting to die? *(one or more times during the 12 mos before the survey)* †	21.5 (19.9–23.0)	—	~			
Seriously considered attempting suicide? *(during the 12 mos before the survey)* **§**	17.2 (14.8–20.0)	17.7 (16.7–18.8)	0.71			o
Made a plan about how they would attempt suicide? *(during the 12 mos before the survey)* **§**	15.8 (13.8–18.1)	14.6 (13.4–15.8)	0.31			o
Attempted suicide? *(one or more times during the 12 mos before the survey)* **§**	**10.7 (9.1–12.6)**	**8.6 (7.6–9.6)**	**0.03**	o		
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse *(during the 12 mos before the survey)* **§**	2.8 (2.0–3.7)	2.8 (2.2–3.5)	0.98			o

Footnotes: ‡ Percentage, 95% confidence interval; — Data not available; ~ = P-value not available

§ Accessed from ***Application URL*** on June 5, 2017: https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=NV&YID=2015&LID2=XX&YID2=2015&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FIL=I1&FPL=P1&PV=&TST=True&C1=NV2015&C2=XX2015&QP=G&DP=1&VA=CI&CS=N&SYID=&EYID=&SC=DEFAULT&SO=ASC

† Source: Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada High School Youth Risk Behavior Survey (YRBS),* Table 32, p. 36.

Table 4a: Percentage of high school students who attempted suicide [a] by sex, age, grade and race/ethnicity Nevada, Youth Risk Behavior Survey, 2015 §							
		Yes			No		
		N [b]	% [c]	CI (95%) [d]	N	%	CI (95%)
Overall Total	**Total**	488	9.8%	(8.7-10.9)	3928	90.2%	(89.1-91.3)
Sex	**Female**	308	11.7%	(10.0-13.4)			
	Male	176	7.8%	(6.4-9.3)			
Age	**14 years old or younger**	61	9.6%	(6.7-12.6)			
	15 years old	148	11.6%	(9.4-13.8)			
	16 years old	134	10.0%	(7.7-12.4)			
	17 years old	110	9.9%	(7.8-12.0)			
	18 years old or older	34	5.7	(3.2-8.3)			
Grade	**9th grade**	159	11.4%	(9.1-13.7)			
	10th grade	136	11.3%	(8.9-13.7)			
	11th grade	115	8.8%	(6.7-11.0)			
	12th grade	70	7.5%	(5.6-9.3)			
Race/Ethnicity	**American Indian/Alaska Native**	10	16.5%	(5.2-27.9)			
	Asian	19	8.0%	(3.8-12.2)			
	Black	21	8.0%	(4.1-11.9)			
	Native Hawaiian/Pacific Islander	9	9.5%	(2.4-16.6)			
	White	173	8.4%	(6.6-10.1)			
	Hispanic/Latino	210	11.4%	(9.6-13.2)			

Footnotes:

[a] Attempted suicide one or more times during the 12 months before the survey.

[b] Sample size in the total and subgroups may differ due to missing data.

[c] Weighted row percent

[d] Percentage, 95% confidence interval

§ *Adapted from*: Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada High School Youth Risk Behavior Survey (YRBS)*, Table 30, p. 34.

Table 4b: Percentage of high school students who attempted suicide [a] by region Nevada, Youth Risk Behavior Survey, 2015 §							
		Yes			No		
		N [b]	% [c]	CI (95%) [d]	N	%	C.I. (95%)
Overall Total	**Total**	488	9.8%	(8.7-10.9)	3928	90.2%	(89.1-91.3)
Region	**Carson City and Douglas**	35	11.7%	(3.1-20.4)			
	Elko, White Pine and Eureka	37	11.4%	(7.0-15.9)			
	Churchill, Humboldt, Pershing and Lander	26	8.3%	(3.0-13.5)			
	Lyon, Mineral and Storey	25	12.8%	(7.9-17.6)			
	Nye and Lincoln	52	14.9%	(11.4-18.4)			
	Washoe	119	11.7%	(9.0-14.4)			
	Clark	194	9.2%	(7.8-10.5)			

Footnotes:

[a] Attempted suicide one or more times during the 12 months before the survey.

[b] Sample size in the total and subgroups may differ due to missing data.

[c] Weighted row percent

[d] Percentage, 95% confidence interval

§ *Adapted from*: Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada High School Youth Risk Behavior Survey (YRBS),* Table 30, p. 34.

Suicide Attempts with Injuries and Medical Intervention among Nevada's Youth, 2015: The *2015 Nevada High School Youth Risk Behavior Survey* results determined that 3% of Nevada's high school students reported having made suicide attempts that resulted in injury, poisoning or overdose, and that required treatment from a doctor or nurse. The national rate for suicide attempts that resulted in medical intervention did not differ from Nevada's rate. Thus, Nevada's adolescents were more likely to have made a suicide attempt during the 12 months before participating in the survey, compared to US adolescents as a whole, but this group effect did not hold for attempts that required treatment from a medical professional.

Tables 5a – 5g (below) show the frequencies of suicide related injuries among Nevada's residents who were treated during emergency department visits from February 1, 2014 to May 31, 2015. Frequencies represent numbers of injuries that are reported by external cause of injury (methods of self injury), age and region. Age is distinguished among children younger than 14, adolescents aged 14 to 19, and adults aged 20 and older. The most frequently used methods for these attempts statewide were self-inflicted poisoning by solid or liquid substances and self-inflicted injury by cutting and piercing instrument. These most common methods were observed across all urban and rural regions of the state.

Tables 5a – 5e: Rural and Frontier Counties

Table 5a: Carson City & Douglas County
Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	3	33	38
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	1	0
Hanging Strangulation and Suffocation	0	1	4
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	0	1
Cutting and Piercing Instrument	1	18	44
Jumping form High Place	0	0	0
Other and Unspecified Means	0	5	9

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Table 5b: Elko County, White Pine County, Eureka County
Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	1	19	45
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	0	1
Hanging Strangulation and Suffocation	0	1	1
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	1	1
Cutting and Piercing Instrument	0	7	16
Jumping form High Place	0	0	0
Other and Unspecified Means	1	1	4

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Table 5c: Churchill County, Humboldt County, Pershing County, Lander County
Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	5	17	52
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	1	0
Hanging Strangulation and Suffocation	0	3	5
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	0	3
Cutting and Piercing Instrument	1	10	21
Jumping form High Place	0	0	0
Other and Unspecified Means	0	2	6

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017scharge*

**Categories are not mutually exclusive.*

Table 5d: Lyon County, Mineral County, Storey County

Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	5	10	23
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	0	0
Hanging Strangulation and Suffocation	0	0	2
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	0	0
Cutting and Piercing Instrument	0	13	15
Jumping form High Place	0	0	0
Other and Unspecified Means	2	0	6

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Table 5e: Nye County & Lincoln County

Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	2	21	68
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	0	1
Hanging Strangulation and Suffocation	0	0	3
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	0	1
Cutting and Piercing Instrument	5	19	27
Jumping form High Place	0	0	0
Other and Unspecified Means	0	5	14

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Tables 5f – 5g: Urban Counties

Table 5f: Washoe County

Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	10	130	352
Gases in Domestic Use	0	0	0
Other Gases and Vapors	0	0	1
Hanging Strangulation and Suffocation	0	7	8
Submersion [Drowning]	0	0	0
Firearms Air Guns and Explosives	0	0	6
Cutting and Piercing Instrument	5	39	231
Jumping form High Place	0	0	3
Other and Unspecified Means	2	17	44

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Table 5g: Clark County

Suicide Attempts: External Cause of Injury, Emergency Room Visits by Age, 02/01/2014-5/31/2015

	Age during Emergency Room Visit		
	< 14	**14-19**	**20+**
	f	***f***	***f***
Solid or Liquid Substance	49	381	1437
Gases in Domestic Use	0	0	2
Other Gases and Vapors	0	3	15
Hanging Strangulation and Suffocation	6	21	66
Submersion [Drowning]	0	0	1
Firearms Air Guns and Explosives	0	1	30
Cutting and Piercing Instrument	41	229	631
Jumping form High Place	0	2	17
Other and Unspecified Means	11	64	236

Source: *Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017*

**Categories are not mutually exclusive.*

Emotional Health Profile of Nevada's Middle School Students (Grades 6-8):

Table 6 (below) summarizes the results from the *2015 Nevada Middle School Youth Risk Behavior Survey* (Grades 6-8). Because not all states conduct the *Middle School Youth Risk Behavior Survey (YRBS)*, a representative national sample is not available for comparison. Results show that more than 30% of Nevada's Middle School students reported experiencing depressed mood every day for two or more weeks in a row and reduced involvement in their typical activities. This rate is numerically comparable to the proportion of Nevada's High School students who reported this mood disturbance. Suicidal thoughts and behaviors reported by Nevada Middle School students ranged from suicidal ideation and suicide planning to attempted suicide, and the proportions of Middle School students in each of these categories paralleled the proportions observed for the older state and national High School samples. Importantly, 20% of Nevada's Middle School students reported having engaged in intentionally injuring themselves without wanting to die, which is similar to the proportion of Nevada's High School students reporting those behaviors.

Table 6: Summary of Emotional Health, Nevada Middle School Students, 2015
(*Adapted from*: Youth Risk Behavior Surveillance System, 2015 High School Youth Risk Behavior Survey §)

Question	Nevada Middle School Students (Grades 6-8)
Felt sad or hopeless. *(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities)*	31.4 (29.0–33.7) ‡
Ever seriously considered killing themselves.	22.9 (21.2–24.6)
Ever made a plan about how they would kill themselves.	13.4 (12.1–14.8)
Ever tried killing themselves.	8.7 (7.5–9.8)
Ever done something to purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose.	20.2 (18.5–21.9)

Footnote: ‡ Weighted percentage, 95% confidence interval

§ *Adapted from*: Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada Middle School Youth Risk Behavior Survey (YRBS)*, Tables 21-25, pp. 24-28.

SUMMARY: Findings from the recent ***2015 National Surveys on Drug Use and Health*** and the ***2015 Nevada High School Youth Risk Behavior Survey*** indicate the health and well being of Nevada's children and adolescents are compromised, and raise serious questions about the services available to these individuals through the state's current mental health system. An important question concerns whether responsible adults and educators were aware that Nevada's high school and middle school students were experiencing significant psychological distress, and engaging in suicide attempts and deliberate acts of self harm that did not necessarily result in medical intervention. A related question concerns the severity of their distress, and the degree of their suicide risk and self injury. It is possible that the acuity of psychological distress and the lethality of suicidal behaviors were low to moderate, and that each resolved without attracting much attention. It is also possible that in the absence of effective mental health intervention, such ***psychological distress*** and ***'silent' suicide attempts*** may escalate in syndromal distinctiveness and severity, and in risk for injury and death. Providing appropriate and optimal interventions to such individuals will depend on a range of health services capacities, including the accurate identification of subsets within these populations. ***Nevada's current mental health workforce is underdeveloped, and ongoing training and educational efforts have been identified as a program priority for FFY2018-2019.***

Access to Services for Nevada's Children with Serious Emotional Disturbance (SED):

Services Provided by the Nevada State Mental Health Authority (SMHA): An estimated 37,266 children in Nevada suffered from serious emotional disturbance (SED) during 2015-2016, which represents 11% of the state's youth population (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada). Based on the National Outcomes Measures (NOMS) for this period, 3,035 children with serious emotional disturbance (SED) were served by Nevada's State Mental Health Authority (SMHA), which represents eight percent (8%) of the estimated services need for this population. Service penetration rates are presented below for Nevada's children aged 0-17, and the national rates are provided as a comparison.

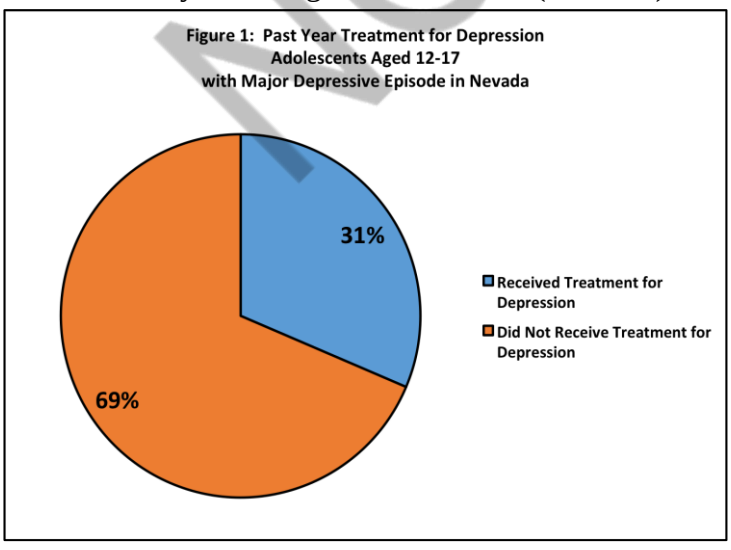
Table 7: Children with SED served by the Nevada State Mental Health Authority by Age, FY 2016

	Total Served				Penetration Rates (per 1,000 population)	
	Nevada		US			
Age (years)	n	%	n	%	State	US
Total Served *(all ages 0-75 yrs)*	13,435	100.0%	4,979,257	100.0%	4.6	15.3
0-12 yrs	1,404	10.5%	769,252	15.4%	2.9	14.6
13-17 yrs	1,631	12.1%	639,492	12.8%	8.7	30.6

Source: 2016 SAMHSA Uniform Reporting System (URS) - Nevada

Division of Child and Family Services (DCFS), in the Nevada Department of Health and Human Services (DHHS), reported serving 2,486 children with SED during FY 2016. Of the 3,035 children with SED who were served by the State Mental Health Authority, an estimated 530 children were provided care in Nevada's rural communities through the Division of Public and Behavioral Health (DPBH) Rural Clinics for Mental Health Services. These services include patient assessments in the rural hospitals, and direct care services at each of 16 Rural Clinic locations.

Treatment for Depression Among Nevada's Adolescents with Major Depressive Episode, Aged 12-17: As summarized in the previous section, the most recent available data reported by the National Surveys on Drug Use and Health (NSDUH) indicate that approximately 26,000 adolescents in Nevada (11. 6% of all adolescents in the state), per year in 2013-2014, experienced at least one Major Depressive Episode (MDE) during the year before being surveyed. Nevada's percentage of adolescents experiencing MDE was similar to the national percentage. Importantly, as shown in **Figure 1** (left), almost one-third of Nevada's adolescents with MDE received treatment for depression (31.4%), which was similar to the annual national average (38.6%) from 2010 to 2014.



Source: SAMHSA, Center for Behavioral Health and Quality, NSDUH, 2010-2014

Hospital Emergency Room Visits for Mental Health Conditions Among Nevada's Youth, Aged 17 and Younger: Limited access to community-based mental health services contributes to over-utilization of hospital emergency departments. Billing data for hospital emergency room visits related to mental health conditions were examined as indicators of serious emotional disturbance (SED) that was either untreated or ineffectively managed. **Table 8** (below) provides the frequencies of emergency room visits by mental health conditions in four domains: mental disorder categories (mood, anxiety, psychosis); suicidal behaviors (tendencies and ideation); suicide attempts by method; and substance use disorders (alcohol and other drug). Condition frequencies are based on emergency room billing codes compiled by University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). Data are based on visits, not patients, with any single individual potentially representing multiple visits.

Depression, drug-related conditions, suicidal ideation and anxiety were the most frequent mental health conditions diagnosed for Nevada youth who presented to emergency rooms in Nevada hospitals from 2009 to 2014. Suicide conditions accounted for 39% of the total visits over that six-year period for this cohort of youth aged 17 and younger. Suicide attempts, combined across methods (n=2,989 visits), represented 13% of suicide conditions. Suicidal tendencies and ideation (n=5,907 visits) accounted for an additional 26% of the suicide category.

Table 8: Select Mental Health Related Emergency Room Visits by Gender, Aged 17 and Younger, Nevada Residents, 2009-2014

Condition	Female		Male		Unknown		Total
	N	Row %	N	Row %	N	Row %	
Anxiety	2,668	65.1%	1,428	34.9%	0	0.0%	4,096
Depression	4,294	66.2%	2,197	33.8%	0	0.0%	6,491
Bipolar	1,243	49.8%	1,252	50.2%	0	0.0%	2,495
PTSD	270	57.6%	199	42.4%	0	0.0%	469
Schizophrenia	202	49.3%	208	50.7%	0	0.0%	410
Suicidal Tendencies	877	66.7%	437	33.3%	0	0.0%	1,314
Suicidal Ideation	2,767	60.2%	1,826	39.8%	0	0.0%	4,593
Alcohol Related	1,501	47.1%	1,687	52.9%	0	0.0%	3,188
Other Drug Related	3,394	52.9%	3,018	47.1%	1	0.0%	6,413
Suicide Attempt- Solid or Liquid	1,334	77.7%	382	22.3%	0	0.0%	1,716
Suicide Attempt- Gases in Domestic Use	0	0.0%	1	100.0%	0	0.0%	1
Suicide Attempt- Other Gases and Vapors	5	35.7%	9	64.3%	0	0.0%	14
Suicide Attempt- Hanging, Strangulation, Suffocation	43	46.7%	49	53.3%	0	0.0%	92
Suicide Attempt- Cutting & Piercing Instrument	642	73.2%	235	26.8%	0	0.0%	877
Suicide Attempt- Firearms, Air Guns, Explosives	2	20.0%	8	80.0%	0	0.0%	10
Suicide Attempt- Jumping from High Place	8	66.7%	4	33.3%	0	0.0%	12
Suicide Attempt- Drowning	2	100.0%	0	0.0%	0	0.0%	2
Suicide Attempt- Other Unspecified Means	104	39.2%	161	60.8%	0	0.0%	265
Total Behavioral Health Visits*	**13,012**	**56.9%**	**9,851**	**43.1%**	**1**	**0.0%**	**22,864**

Source: Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017

** Categories are not mutually exclusive.*

MEDICAID Expansion under the Affordable Care Act (ACA) and Health Services Utilization: Health care financing plays a significant role in the frequency and type of health services that people use. Equally important is the availability and quality of health care services. Both factors are clearly reflected in the patterns of health services utilization observed among Nevada residents. Firstly, the numbers of Nevada residents covered by Medicaid benefits more than doubled when the state expanded Medicaid coverage in 2014 by Governor Brian Sandoval under the Affordable Care Act (ACA), increasing from ***351,315 in 2013*** to ***654,442 in 2015***. Secondly, as reflected in **Table 9 (below)**, this increase in health care coverage appears to have impacted the frequency with which Nevada residents used health care services, most notably inpatient facilities and hospital emergency departments. Thus, the dual influences of increased health care coverage, and limited access to appropriate and optimal services are demonstrated in the utilization of Emergency Department Services for a wide range of mental health-related conditions from 2009 to 2014, shown in **Table 8 (above)**, and the dramatic increase in emergency room visits in 2015, after Medicaid expansion in 2014, shown in **Table 9 (below)**.

Table 9: Medicaid Managed Care Organizations (MCO) and Fee-for-Service (FFS) Utilization, 2015

MCO and FFS Utilization: Percent Change from Calendar Years 2013 – 2015

Provider/Service Type	2013	2015	% Change
MCO			
Inpatient	441	6,626	93%
Outpatient	588,868	1,482,972	60%
Emergency Room Visits	9,014	48,784	82%
FFS			
Inpatient	4,656	8,645	46%
Outpatient	2,197,658	2,474,380	11%
Emergency Room Visits	6,298	12,019	48%

Source: S. Woodard and Nevada Division of Health Care Financing and Policy (2016)

MEDICAID Reimbursements for Behavioral Health Services, 2015: Youth Aged 0-17 years:
Table 10 (below) provides the demographic characteristics for individuals aged 17 and younger with one or more behavioral health procedure codes or diagnosis codes during calendar year (CY) 2015, which were reimbursed through Medicaid Fee-for-Service (FFS) or Managed Care Organization (MCO) (*adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*). Medicaid Fee-for-Service (FFS) subsidized services provided by the state mental health system, as well as services from the private provider community. Medicaid Managed Care (MCO) reimbursement supported services provided by the private provider community.

Table 10: Medicaid Fee-For-Service and Managed Care, 2015
Individuals Aged 17 years and younger with one or more health procedure code or diagnosis code during CY 2015

Fee-For-Service Demographics, 2015		**Age Group**	
		Aged 0-17 years (n=61,457 unique individuals)	
Sex	Male	34,383	56%
	Female	27,164	44%
Region	Clark	36,024	59%
	Washoe	7,743	13%
	All Other Counties	17,780	29%
Race/Ethnicity	White, non-Hispanic	23,838	39%
	Black, non-Hispanic	10,158	17%
	Hispanic	20,409	33%
	American Indian/Native American	1,463	2%
	Asian, non-Hispanic	1,315	2%
	Other/Unknown	4,364	7%
Managed Care Demographics, 2015		**Age Group**	
		Aged 0-17 years (n=229,175 unique individuals)	
Sex	Male	116,030	51%
	Female	113,145	49%
Region	Clark	196,336	86%
	Washoe	32,827	14%
	All Other Counties	12	< 1%
Race/Ethnicity	White, non-Hispanic	51,013	22%
	Black, non-Hispanic	42,868	19%
	Hispanic	106,501	46%
	American Indian/Native American	1,923	1%
	Asian, non-Hispanic	8,378	4%
	Other/Unknown	18,492	8%

Source: *adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*

Access to Licensed Mental Health Care Specialists in Nevada: **Table 11** (below) presents the numbers of specialty mental health professionals who held current licenses in 2016 that were recognized by the State of Nevada Boards of Examiners for their respective disciplines, including psychiatry, psychology, and social work.

Table 11: Distribution of Licensed Mental Health Care Specialists in Nevada by County, 2016

Region/County	Licensed Psychiatrists [1]		Licensed Psychologists [2]		Licensed Clinical Social Workers (LCSW) [3]
	Number	Number per 100,000 population	Number	Number per 100,000 population	Number
Rural and Frontier					
Churchill County	0	0.0	1	3.9	4
Douglas County	1	2.1	5	10.4	8
Elko County	0	0.0	0	0.0	6
Esmeralda County	0	0.0	0	0.0	0
Eureka County	0	0.0	0	0.0	0
Humboldt County	0	0.0	0	0.0	4
Lander County	0	0.0	0	0.0	2
Lincoln County	0	0.0	0	0.0	3
Lyon County	0	0.0	4	7.4	6
Mineral County	0	0.0	0	0.0	0
Nye County	0	0.0	2	4.4	5
Pershing County	0	0.0	0	0.0	0
Storey County	0	0.0	0	0.0	0
White Pine County	0	0.0	0	0.0	3
Rural and Frontier Subtotal	1	0.1	12	4.2	41
Urban					
Carson City	4	7.3	17	30.8	30
Clark County	120	5.6	215	10.3	459
Washoe County	65	11.8	146	32.4	168
Urban Subtotal	189	7.1	378	14.5	657
Nevada – Total	190	6.8	390	13.4	698

Adapted from: *Griswold et al., Nevada Rural and Frontier Health Data Book – Eighth Edition (January 2017)*

[1] Nevada State Board of Medical Examiners, 2016; [2] Nevada State Board of Psychological Examiners, 2016; [3] State of Nevada Board of Examiners for Social Workers, 2016

Summary: Access to Services for Nevada's Children (aged 0-17) with Serious Emotional Disturbance (SED). Access to services is a complex issue. A critical factor for Nevada is that almost all of the state qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2017, *Map 5.3*, p. 148). This circumstance is reflected in Table 11 (above), which indicates an overall rate of 6.8 psychiatrists and 13.4 psychologists per 100,000 population. However, access to services becomes even more challenging for Nevada's children living in the remote and less densely populated regions of the state, with less than 1 psychiatrist and 4.2 psychologists per 100,000 population for all rural and frontier counties combined. Equally important for those children is the apparent reduced availability of managed care providers outside the urban counties of Washoe and Clark. As reflected in the behavioral health services data presented in Table 10 (above), the proportion of rural and frontier residents aged 0-17 that received Medicaid Fee-For-Service (FFS) was intermediate between the rates of children receiving Medicaid FFS and living in the urban counties of Washoe and Clark. Medicaid FFS subsidized services provided by the state mental health system, as well as services from the private provider community. Table 10 also shows that 229,175 unique individuals aged 0–17 were served by Medicaid managed care organizations (MCOs) during calendar year 2015. However, less than one percent receiving MCO services was residing in the rural and frontier counties. Medicaid MCO reimbursement supported services that were delivered by the private provider community.

- ***ADULTS WITH SERIOUS MENTAL ILLNESS (SMI) ****

Table 12 (below) shows the population estimates and projections for Nevada's residents aged 18 to 64 by urban and rural counties and regions for 2010 to 2022 (Griswold, T., et al., 2015; Griswold, T., et al., 2017; Nevada State Demographer's Office, 2014; Nevada State Demographer's Office, 2016).

Region/County	Table 12: Population Estimates and Projections for Nevada Residents Aged 18 - 64 by County, 2010 to 2022				
	2010	**2014**	**2017**	**2019**	**2022**
Rural and Frontier					
Churchill County	14,652	15,289	15,563	15,771	16,062
Douglas County	27,877	27,639	27,362	26,481	26,851
Elko County	30,886	35,855	32,827	37,759	30,815
Esmeralda County	428	529	626	698	566
Eureka County	1,239	1,312	1,239	1,327	1,169
Humboldt County	10,489	11,491	10,119	11,814	8,543
Lander County	3,570	4,355	4,069	4,199	3,289
Lincoln County	2,982	2,679	2,643	2,834	2,981
Lyon County	30,477	31,119	32,529	33,778	30,834
Mineral County	2,708	2,616	2,764	2,386	2,549
Nye County	24,045	24,332	23,997	24,474	23,114
Pershing County	4,528	3,290	3,091	3,331	3,346
Storey County	2,494	2,431	2,454	2,264	2,574
White Pine County	6,398	5,095	4,960	5,024	4,432
Rural & Frontier Region Subtotal	162,773	168,032	164,242	172,140	157,125
Urban					
Carson City	34,261	29,898	30,535	30,944	30,407
Clark County	1,250,003	1,277,188	1,326,583	1,309,201	1,395,647
Washoe County	273,032	272,309	278,197	292,181	281,563
Urban Region Subtotal	1,557,296	1,579,395	1,635,315	1,632,326	1,707,617
Nevada – Total	1,720,069	1,747,427	1,799,557	1,804,466	1,864,742

Source: *Adapted from Griswold, T. et al. (2015; 2017) and Nevada State Demographer's Office (2014; 2016)*

***Rates of Serious Mental Illness (SMI) Among Nevada's Adults Aged 18 and Older*:**
An estimated 119,373 adults in Nevada suffered from serious mental illness (SMI) during 2015-2016, which represents 5.4% of the state's adult population (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada). This estimate is generally consistent with the 12-month prevalence rates for adults aged 18 and older who participated in national and international community epidemiology surveys. Based on the U.S. National Comorbidity Survey Replication (Kessler et al., 2005), the 12-month prevalence estimate for the presence of a serious mental disorder was 5.7%. Based on the World Health Organization-World Mental Health Surveys (Kessler et al., 2012), involving 28 countries, the 12-month prevalence estimates for serious mental illness (SMI) were: 4.0-6.8% for one-half of the surveys; 2.3-3.6% for another quarter; and 0.8-1.9% for the final quarter. Finally, those prevalence estimates are also similar to the range of estimates for serious mental illness (SMI) among adults in Nevada and the United States based on the National Surveys on Drug Use and Health (NSDUH), which are presented in **Table 13** (below).

Table 13: Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in Nevada and the United States: 2010-2011 to 2013-2014

Years	2010-2011	2011-2012	2012-2013	2013-2014
Nevada	4.0%	3.9%	4.1%	4.3%
United States	3.9%	4.0%	4.1%	4.2%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, 2015*. HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

The most recent available NSDUH data indicate that approximately 91,000 adults in Nevada (4.3% of all adults), per year in 2013-2014, experienced serious mental illness during the year before being surveyed. Nevada's rate was similar to the national percentage for that same survey period. The percentage of adults with SMI did not change significantly from 2010-2011 to 2013-2014.

It is worthwhile to note the quality of the assessment methodology used to obtain the estimates of serious mental illness in the 2015 National Survey on Drug Use and Health (NSDUH). Estimates for this diagnostic category were based on follow-up telephone interviews of a sub-sample from the Mental Health Surveillance Study (MHSS). These follow-up contacts included the administration of structured clinical interviews (Structured Clinical Interview for DSM-IV, SCID-IV: First et al., 2002) by trained mental health clinicians. Adults with serious mental illness (SMI) were identified from among individuals who met the criteria for any mental illness (AMI) based on these interviews. An adult with AMI was any person having the presence of any mental, behavioral or emotional disorder during the past year that met DSM-IV criteria, excluding developmental disorders and substance use disorders. Adults with AMI were defined as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities (Center for Behavioral Health Statistics and Quality, 2016).

***Expected Rates of Specific Mental Disorders Among Nevada's Adults, Aged 18 and Older*:**
Lifetime and twelve-month prevalence rates for specific mental disorders are available from a

nationally representative face-to-face household survey (Kessler et al., 2005, *United States National Comorbidity Survey Replication*) and international face-to-face community surveys conducted in seventeen countries in Africa, the Americas, Asia and the Pacific, Europe and the Middle East (Kessler et al., 2007b, *World Health Organization's World Mental Health Survey*). Both surveys were conducted from February 2001 to April 2003. Consideration of these data provides empirically-derived benchmarks for anticipating the expected rates for Nevada residents who are members of the targeted populations, as well as for assessing the levels of access to appropriate and optimal services for those targeted population members.

Table 14a and **Table 14b** (below) present the ranges of lifetime and 12-month prevalence estimates for specific classes of disorders (anxiety disorders, mood disorders, impulse-control disorders, substance use disorders, and any disorder) that were determined by the *United States National Comorbidity Survey Replication* and the *World Health Organization's World Mental Health Survey.*

Table 14a: Lifetime prevalence of DSM-IV Disorders, International [1] and National [2] Surveys

Survey	Any anxiety disorder	Any mood disorder	Any impulse-control disorder	Any substance-use disorder	Any disorder
WHO World Mental Health Surveys [1]					
All 17 Countries combined *(Aged 18 & older; 14 countries)*	*Median % (IQR)* [a] 4.8-31.0 (9.9-16.7)	*Median % (IQR)* 3.3-21.4 (9.8-15.8)	*Median % (IQR)* 0.3-25.0 (3.1-5.7)	*Median % (IQR)* 1.3-15.0 (4.8-9.6)	*Median % (IQR)* 12.0-47.4 (18.1-36.1)
United States *(Aged 18 & older)*	*%/N* [b] *(SE)* [c] 31.0/2692 (1.0)	*%/N (SE)* 21.4/2024 (0.6)	*%/N (SE)* 25.0/1051 (1.1)	*%/N (SE)* 14.6/1144 (0.6)	*%/N (SE)* 47.4/3929 (1.1)
United States National Comorbidity Survey Replication[2] *(Aged 18 & older)*	*% (SE)* 28.8 (0.9)	*% (SE)* 20.8 (0.6)	*% (SE)* 24.8 (1.1)	*% (SE)* 14.6 (0.6)	*% (SE)* 46.4 (1.1)

Adapted from: [1] Kessler et al. (2007b); [2] Kessler et al. (2005a).

[a] IQR; 25th – 75th percentiles across countries. [b] N=number of respondents with the disorders indicated in the column heading; denominators were the numbers of respondents by disorder in each sample by country. [c] SE; standard error.

Table 14b: Twelve-month prevalence of DSM-IV Disorders, International [1,2] and National [3] Surveys					
Survey	**Any anxiety disorder**	**Any mood disorder**	**Any impulse-control disorder**	**Any substance-use disorder**	**Any disorder**
WHO World Mental Health Surveys [1,2]					
All Countries combined *(Aged 18 & older)*	*Mean % (IQR)*† 8.3 (6.5-12.1)	*Mean % (IQR)* 5.1 (3.4-6.8)	*Mean % (IQR)* 0.1-10.5.0 (0.6-2.6)	*Mean % (IQR)* 0.2-6.4 (1.2-2.8)	*Mean % (IQR)* 4.3-26.4 (9.1-16.9)
United States *(Aged 18 & older)*	*Mean % (SE)* § 19.0 (0.7)	*Mean % (SE)* 9.7 (0.4)	*Mean % (SE)* 10.5 (0.7)	*Mean % (SE)* 3.8 (0.4)	*Mean % (SE)* 27.0 (0.9)
United States National Comorbidity Survey Replication [3] *(Aged 18 & older)*	*% (SE)* 18.1 (0.7)	*% (SE)* 9.5 (0.4)	*% (SE)* 8.9 (0.5)	*% (SE)* 3.8 (0.3)	*% (SE)* 26.2 (0.8)

Adapted from: [1] Kessler et al. (2007b); [2] Kessler et al. (2004); [3] Kessler et al. (2005b).

† IQR; 25th – 75th percentiles across countries

§ SE; standard error

Expected Rates of Schizophrenia, Non-affective Psychosis (NAP) and Bipolar Disorder Among Nevada's Adults, Aged 18 and Older*:** The median rate of new cases of ***schizophrenia each year, or incidence, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007). The estimated lifetime prevalence rates for schizophrenia and schizophreniform disorders range from 0.3-1.6% per 1,000 population (Kessler et al., 2005c). The lifetime prevalence rate for the broader category of ***non-affective psychosis (NAP)*** is estimated at approximately twice the rate for schizophrenia and schizophreniform disorder (Kessler et al., 2005c). Non-affective psychosis (NAP) has been examined systematically in at least one large-scale community epidemiology survey (Kendler et al., 1996), in which a probability subsample received an initial screen for psychotic symptoms, and detailed follow up interviews that were conducted by mental health professionals of *one-third of the initial participants* based on their responses to the screen. Clinician defined diagnoses of non-affective psychosis in that study resulted in lifetime prevalence rates of 0.2% for narrowly-defined NAP and 0.7% for broadly-defined NAP. Clinical validity was additionally examined, with the clinician defined diagnoses determined to be predictive of clinical (hospitalization, mediation, illness duration, thought disorder) and social functioning (chronic impairment, low income, unemployment, urban residence, and marital status of single, divorced or separated) characteristics.

The lifetime prevalence rates for ***bipolar disorder (BPD)***, estimated from a nationally representative community survey of United States households, indicate average (standard deviation)

rates of 1.0% (13.2) for *Bipolar I*; 1.1% (10.6) for *Bipolar II*; and 2.4% (23.3) for *Subthreshold Bipolar Disorder* (Merikangas et al., 2007). Twelve-month prevalence rates estimated from the same survey included: 0.6% (9.2) for *Bipolar I*; 0.8% (9.9) for *Bipolar II*; and 1.4% (15.4) for *Subthreshold Bipolar Disorder*.

Age of Onset: Age at onset estimates for those mood diagnoses ranged from averages of 18.2 years and 20.3 years for *Bipolar I* and *Bipolar II*, respectively, and interquartile ranges (25th-75th percentiles) from 12.3-21.2 years and 12.1-24.0 years, respectively. Age-of-onset was somewhat later for *Subthreshold Bipolar Disorder*, with an average of 22.2 years and a range from 13.0-28.3 years. Importantly, prevalence rates for the same categories of *bipolar disorder* observed by the World Mental Health Survey Initiative (Merikangas et al., 2011), based on 11 countries, are generally consistent with the rates obtained from the community survey of U.S. households described above.

To reemphasize, findings from the community epidemiological surveys summarized above provide empirically-derived benchmarks for anticipating the expected rates for Nevada residents who are members of the targeted populations, as well as for assessing the levels of access to appropriate and optimal services for those targeted population members.

***Rates of Specific Mental Disorders Among Nevada's Adults, Aged 18 and Older*:**

Division of Public and Behavioral Health (DPBH or the Division) is the largest provider of mental health services in Nevada. During the period from 2010-2014, the Division provided mental health services to 57,920 Nevada adults. Females comprised 54% of the patient population and males represented 46%. White non-Hispanic individuals represented 62% of patients. The largest age group was 31-50 years old, and this group accounted for 45% of patients. Twenty-five percent (25%) of patients were high school graduates, 20% had "some college," and 20% reported "less than 12th grade, no diploma." **Figure 2** (left) shows the most common mental disorder diagnoses that were assigned to those Nevada residents during the 5-year period from 2010-2014. Schizophrenia and mood disorders were most frequently diagnosed, and adjustment and anxiety disorders, including post-traumatic stress disorder, were the least frequently diagnosed.

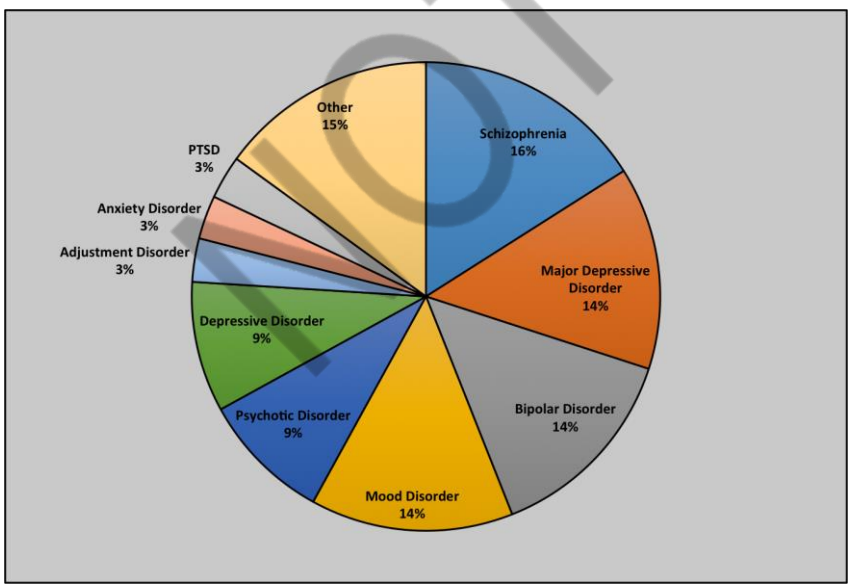


Figure 2: Most Common Mental Health Diagnoses, 2010-2014
Nevada Division of Public and Behavioral Health

Source: AVATAR, Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017

Suicide-related Behaviors Among Nevada's Adults Aged 18 and Older:

Rates of Suicide Ideation Among Nevada's Adults Aged 18 and Older: The most recent available data from the National Surveys on Drug Use and Health (2015 NSDUH) indicate that approximately 92,000 adults in Nevada (4.4% of all adults), per year during 2013-2014, had serious thoughts of suicide during the year before participating in the survey. Nevada's rate was similar to the national percentage observed for that same period. **Table 15** (below) presents the range of estimates for serious thoughts of suicide among adults in Nevada and the United States. The percentages did not change significantly across the five-year period.

Table 15: Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in Nevada and the United States: 2010-2011 to 2013-2014

Years	2010-2011	2011-2012	2012-2013	2013-2014
Nevada	3.6%	3.8%	3.8%	4.4%
United States	3.8%	3.8%	3.9%	3.9%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, 2015.* HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Access to Mental Health Services for Nevada's Adults with Serious Mental Illness (SMI):

Services Provided by the Nevada State Mental Health Authority (SMHA): An estimated 119,373 adults in Nevada suffered from serious mental illness (SMI) during 2015-2016, which represents 5.4% of the state's civilian adult population (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada). Based on the National Outcomes Measures (NOMS) for this period, 10,400 adults with serious mental illness (SMI) were served by Nevada's State Mental Health Authority, which represents 9% of the estimated services need. **Table 16** (below) presents service penetration rates for Nevada's adults with SMI, and national rates provide comparisons.

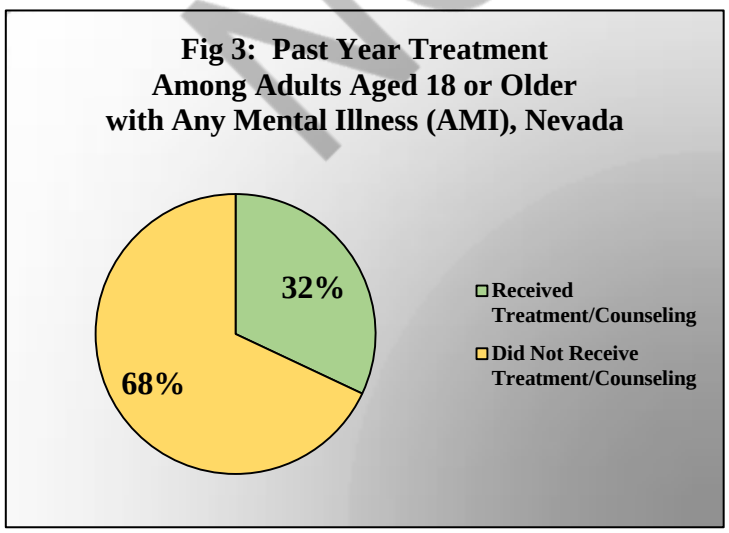
Table 16: Adults with SMI served by the Nevada State Mental Health Authority (SMHA) by Age, FY 2016

	Total Served				Penetration Rates (per 1,000 population)	
	Nevada		US			
Age (years)	n	%	n	%	State	US
Total Served *(all ages 0-75 yrs)*	13,435	100.0%	4,979,257	100.0%	4.6	15.3
18-20	288	2.1%	205,480	4.1%	3.0	16.0
21-64	9,512	70.8%	3,143,936	63.1%	5.6	16.8
65-74	533	4.0%	162,995	3.3%	2.0	5.9
75 and over	67	0.5%	56,810	1.1%	0.4	3.1

Source: 2016 SAMHSA Uniform Reporting System (URS) - Nevada

Thirty-four percent (34%) of the 10,400 adults with SMI who were served by Nevada's mental health system received their care from the Rural Clinics for Mental Health Services, which include patient assessments in rural hospitals, and direct care at each of the 16 rural clinic locations.

Mental Health Treatment/Counseling for Any Mental Illness Among Nevada's Adults, Aged 18 or Older: As summarized in the previous section, the most recent available data reported by the National Surveys on Drug Use and Health (NSDUH) indicate that approximately 91,000 adults in Nevada (4.3% of all adults in the state), per year in 2013-2014, experienced serious mental illness (SMI) during the year before being surveyed. Nevada's percentage of SMI was similar to the national percentage for that same period. Moreover, the percentage of adults with SMI did not change significantly from 2010-2011 to 2013-2014. As shown in **Figure 3 (left)**, approximately 113,000 adults with any mental illness (AMI) in Nevada (32% of all adults with AMI), per year from 2010 to 2014, received mental health treatment or counseling within the year before being surveyed. However, Nevada's annual average (32%) for treatment of AMI was *lower than* the national annual average (42.7%), 2010 - 2014.



Source: SAMHSA, Center for Behavioral Health and Quality, NSDUH, 2010-2014

Hospital Emergency Room Visits for Mental Health Conditions Among Nevada's Adults, Aged 18 or Older: Limited access to effective community-based mental health services, including crisis interventions, contributes to over-utilization of hospital emergency department services. Billing data for hospital emergency room visits related to mental health were considered as indicators of serious mental illness (SMI) that was either untreated or ineffectively managed. **Table 17** (below) provides the frequencies of visits to Nevada hospital emergency rooms among adults aged 18 or older by mental health conditions in four domains: mental disorder categories (mood, anxiety, psychosis); suicidal behaviors (tendencies and ideation); suicide attempts by method; and substance use disorders (alcohol and other drug). Frequencies are based on emergency room billing codes compiled by University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). Data are based on visits, not patients, with any single individual potentially representing multiple visits.

Anxiety, substance use conditions, depression and suicide-related behaviors were mental health conditions most frequently diagnosed for Nevada residents aged 18 or older who presented to emergency rooms in Nevada hospitals from 2009 to 2014. Suicide conditions accounted for 15% of the total mental health related visits over that six-year period. Suicide attempts, combined across methods of self injury (n=17,034 visits), represented 23% of suicide conditions. Suicidal tendencies and ideation (n=57,072 visits) accounted for an additional 77% of the suicide category.

Table 17: Select Behavioral Health Related Emergency Room Visits by Gender, Ages 18 and Older, Nevada Residents, 2009-2014

Condition	Female		Male		Unknown		Total
	N	Row %	N	Row %	N	Row %	
Anxiety	97,406	66.6%	48,761	33.4%	3	0.0%	146,170
Depression	72,565	61.2%	45,987	38.8%	2	0.0%	118,554
Bipolar	30,814	59.6%	20,890	40.4%	1	0.0%	51,705
PTSD	5,385	55.9%	4,244	44.1%	0	0.0%	9,629
Schizophrenia	11,407	37.5%	19,035	62.5%	1	0.0%	30,443
Suicidal Tendencies	4,937	46.1%	5,769	53.9%	0	0.0%	10,706
Suicidal Ideation	19,635	42.3%	26,731	57.7%	0	0.0%	46,366
Alcohol Related	43,725	30.3%	100,378	69.7%	6	0.0%	144,109
Other Drug Related	48,645	44.9%	59,627	55.1%	3	0.0%	108,275
Suicide Attempt- Solid or Liquid	6,528	64.0%	3,670	36.0%	0	0.0%	10,198
Suicide Attempt- Gases in Domestic Use	2	33.3%	4	66.7%	0	0.0%	6
Suicide Attempt- Other Gases and Vapors	33	32.0%	70	68.0%	0	0.0%	103
Suicide Attempt- Hanging, Strangulation, & Suffocation	104	29.9%	244	70.1%	0	0.0%	348
Suicide Attempt- Cutting & Piercing Instrument	2,614	56.3%	2,031	43.7%	1	0.0%	4,646
Suicide Attempt- Firearms, Air Guns, & Explosives	31	18.8%	134	81.2%	0	0.0%	165
Suicide Attempt- Jumping from High Place	21	28.0%	54	72.0%	0	0.0%	75
Suicide Attempt- Drowning	5	50.0%	5	50.0%	0	0.0%	10
Suicide Attempt- Other Unspecified Means	622	41.9%	861	58.1%	0	0.0%	1,483
Total Behavioral Health Visits*	**253,312**	**50.6%**	**247,454**	**49.4%**	**14**	**0.0%**	**500,780**

*Source: Hospital Emergency Room Discharge, Nevada Division of Public and Behavioral Health, Office of Public Informatics and Epidemiology, June 2017; NOTE: * Categories are not mutually exclusive.*

Medicaid Expansion under the Affordable Care Act (ACA) and Health Services Utilization: For ease of reference, the following information, which was presented above in the section concerning serious emotional disturbance (SED), is re-presented below because of its importance to systems function and the target population, serious mental illness (SMI), under consideration.

Health care financing plays a significant role in the frequency and type of health services that people use. Equally important is the availability and quality of health care services. Both factors are clearly reflected in the patterns of health services utilization observed among Nevada residents. Firstly, the numbers of Nevada residents covered by Medicaid benefits more than doubled when the state expanded Medicaid coverage in 2014 under Governor Brian Sandoval and the Affordable Care Act (ACA), increasing from ***351,315 in 2013*** to ***654,442 in 2015***. Secondly, as reflected in **Table 18 (below)**, this increase in health care coverage appears to have impacted the frequency with which Nevada residents used health care services, most notably inpatient facilities and emergency departments. Thus, the dual influences of increased health care coverage, and limited access to appropriate and optimal community-based services are demonstrated in the utilization of emergency department services for a wide range of mental health-related conditions from 2009 to 2014, shown in **Table 17 (above)**.

Table 18: Medicaid Managed Care Organizations (MCO) and Fee-for-Service (FFS) Utilization, 2015

MCO-FFS Utilization: Percent Change from Calendar Years 2013 – 2015

Provider/Service Type	2013	2015	% Change
MCO			
Inpatient	441	6,626	93%
Outpatient	588,868	1,482,972	60%
Emergency Room Visits	9,014	48,784	82%
FFS			
Inpatient	4,656	8,645	46%
Outpatient	2,197,658	2,474,380	11%
Emergency Room Visits	6,298	12,019	48%

Source: S. Woodard and Nevada Division of Health Care Financing and Policy (2016)

MEDICAID Reimbursements for Behavioral Health Services, 2015: Adults Aged 18 - 64.

Table 19 (below) provides the demographic characteristics for individuals aged 18 and older with one or more behavioral health procedure codes or diagnosis codes during calendar year (CY) 2015, which were reimbursed through Medicaid Fee-for-Service (FFS) or Managed Care Organization (MCO) (*adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*). Medicaid Fee-for-Service (FFS) subsidized services provided by the state mental health system, as well as services from the private provider community. Medicaid Managed Care (MCO) reimbursement supported services provided by the private provider community.

Table 19: Medicaid Fee-For-Service and Managed Care, 2015
Individuals Aged 18 - 64 with one or more health procedure code or diagnosis code during CY 2015

Fee-For-Service Demographics, 2015		**Age Group**			
		18 – 25 (n=18,602)		**26 – 64 (n=82,024)**	
Sex	Male	6,651	36%	34,520	42%
	Female	11,951	64%	47,504	58%
Region	Clark	11,188	60%	49,645	61%
	Washoe	2,123	11%	10,012	12%
	All Other Counties	5,291	28%	22,367	27%
Race/Ethnicity	White, non-Hispanic	8,602	46%	47,216	58%
	Black, non-Hispanic	3,897	21%	15,373	19%
	Hispanic	4,081	22%	10,963	13%
	American Indian/Native American	515	3%	2,296	3%
	Asian, non-Hispanic	404	2%	2,396	3%
	Other/Unknown	1,103	6%	3,780	5%
Managed Care Demographics, 2015		**Age Group**			
		18 – 25 (n=56,862)		**26 – 64 (n=182,849)**	
Sex	Male	20,798	37%	77,239	42%
	Female	36,064	63%	105,610	58%
Region	Clark	48,217	85%	155,548	85%
	Washoe	8,632	15%	27,256	15%
	All Other Counties	13	<1%	45	<1%
Race/Ethnicity	White, non-Hispanic	18,415	32%	82,184	45%
	Black, non-Hispanic	14,959	26%	39,074	21%
	Hispanic	16,806	30%	36,574	20%
	American Indian/Native American	595	1%	2,080	1%
	Asian, non-Hispanic	2,055	4%	10,678	6%
	Other/Unknown	4,032	7%	12,259	7%

Source: *adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*

Summary: Access to Services for Nevada's Adults Aged 18 to 64 with Serious Mental Illness (SMI). Access to services for Nevada's residents is influenced by multiple factors. An ongoing challenge is the fact that almost all of the state qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2017, *Map 5.3*, p. 148). This circumstance is clearly evident in Table 11 (above), which provides the distribution of licensed mental health care specialists by county for 2016. The overall rates for psychiatry and psychology statewide highlight the severity of this shortage, with 6.8 psychiatrists and 13.4 psychologists per 100,000 population. However, access to services becomes even more challenging for Nevada's residents who live in the state's remote and less densely populated counties, with less than 1 psychiatrist and 4.2 psychologists per 100,000 population for the combined region of all rural and frontier counties. Equally important for those residents is the apparent reduced availability of managed care providers outside the urban counties of Washoe and Clark. As reflected in the behavioral services data presented in Table 19 (above), the proportions of rural and frontier residents aged 18-25 and 26-64 that received Medicaid Fee-For-Service (FFS) were intermediate between the rates for residents of the same ages who were living in the urban counties of Washoe and Clark. Medicaid FFS supported services provided by the state mental health system, as well as services from the private provider community. Table 19 also shows that 239,711 unique individuals aged 18-64 were served by Medicaid Managed Care Organizations (MCOs) during calendar year 2015. However, less than one percent receiving managed care services was residing in the rural and frontier counties. Medicaid MCO reimbursement supported services provided by the private provider community.

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- ***OLDER ADULTS WITH SMI ****

Table 20 (below) shows the population estimates for Nevada's residents aged 65 and older by urban and rural counties and regions for 2017 (Griswold, T., et al., 2017; Nevada State Demographer's Office, 2016).

Region/County	Population Estimates for Nevada's Residents Aged 65 and Older by County, 2017	
	Population	**Percent of Total Population**
Rural and Frontier		
Churchill County	4,126	16.2
Douglas County	12,967	26.6
Elko County	6,596	12.7
Esmeralda County	274	27.3
Eureka County	357	18.0
Humboldt County	2,117	12.7
Lander County	893	14.0
Lincoln County	1,078	23.5
Lyon County	10,875	19.6
Mineral County	941	20.1
Nye County	12,691	28.3
Pershing County	953	18.5
Storey County	1,213	28.8
White Pine County	1,804	20.8
Rural & Frontier Region Subtotal	56,885	20.3
Urban		
Carson City	10,401	19.7
Clark County	288,882	13.5
Washoe County	67,922	15.5
Urban Region Subtotal	367,204	13.9
Nevada – Total	424,089	14.5

Adapted from: *Griswold, T. et al. (2017) and Nevada State Demographer's Office (2016)*

Access to Mental Health Services for Nevada's Residents Aged 65 and older with SMI:

Services Provided by the Nevada State Mental Health Authority (SMHA): An estimated 23,814 adults aged 65 and older in Nevada suffered from serious mental illness (SMI) during 2015-2016, which represents 5.4% of the state's civilian adult population (2016 SAMHSA Uniform Reporting System (URS) Output Tables-Nevada; Annual Estimate of Civilian Population by Age, US Census Bureau, July 1, 2016). Based on the National Outcomes Measures (NOMS) for this period, 600 adults aged 65 and older with serious mental illness (SMI) were served by Nevada's State Mental Health Authority, which represents 2.5% of the estimated services need. **Table 21** (below) presents the service penetration rates for Nevada's adults with SMI, and the national rates provide comparisons.

Table 21: Adults with SMI served by the Nevada State Mental Health Authority (SMHA) by Age, FY 2016

	Total Served				Penetration Rates (per 1,000 population)	
	Nevada		US			
Age (years)	**n**	**%**	**n**	**%**	**State**	**US**
Total Served ***(all ages 0-75 yrs)***	13,435	100.0%	4,979,257	100.0%	4.6	15.3
65-74 yrs	533	4.0%	162,995	3.3%	2.0	5.9
75 yrs and over	67	0.5%	56,810	1.1%	0.4	3.1

Source: 2016 SAMHSA Uniform Reporting System (URS) - Nevada

MEDICAID Reimbursements for Behavioral Health Services, 2015: Adults Aged 65 and older. **Table 22** (below) provides the demographic characteristics for individuals aged 65 and older with one or more behavioral health procedure codes or diagnosis codes during calendar year (CY) 2015, which were reimbursed through Medicaid Fee-for-Service (FFS) or Managed Care Organization (MCO) (*adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*). Medicaid Fee-for-Service (FFS) subsidized services provided by the state mental health system, as well as services from the private provider community. Medicaid Managed Care (MCO) reimbursement supported services provided by the private provider community.

Table 22: Medicaid Fee-For-Service and Managed Care, 2015
Individuals Aged 65 and older with one or more health procedure code or diagnosis code during CY 2015

Fee-For-Service Demographics, 2015		**Age Group**	
		65+ (n=22,919)	
Sex	Male	7,751	34%
	Female	15,168	66%
Region	Clark	16,894	74%
	Washoe	3,187	14%
	All Other Counties	2,838	12%
Race/Ethnicity	White, non-Hispanic	10,580	46%
	Black, non-Hispanic	2,091	9%
	Hispanic	5,501	24%
	American Indian/Native American	329	1%
	Asian, non-Hispanic	3,552	15%
	Other/Unknown	866	4%
Managed Care Demographics, 2015		**Age Group**	
		65+ (n=464)	
Sex	Male	216	47%
	Female	248	53%
Region	Clark	375	81%
	Washoe	89	19%
	All Other Counties	0	0%
Race/Ethnicity	White, non-Hispanic	213	46%
	Black, non-Hispanic	43	9%
	Hispanic	100	22%
	American Indian/Native American	2	<1%
	Asian, non-Hispanic	57	12%
	Other/Unknown	49	11%

Source: *adapted from S. Woodard and Nevada Division of Health Care Financing and Policy, 2016*

Summary: Access to Services for Nevada's Adults Aged 65 and Older with Serious Mental Illness (SMI) reflects the challenges discussed in earlier sections with respect to mental health professional shortages that exist throughout the state (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2017, *Map 5.3*, p. 148). As shown in Table 11 (above), the distribution of licensed mental health care specialists by county for 2016 highlights the severity of this shortage, with 6.8 psychiatrists and 13.4 psychologists per 100,000 population. Moreover, the pattern observed for Nevada's residents in the age groups of 0-17, 18-25 and 26-64 years is also observed for the state's residents aged 65 and older; namely, limited access to services becomes even more challenging for Nevada's residents who live in the state's remote and less densely populated counties, with less than 1 psychiatrist and 4.2 psychologists per 100,000 population for the combined region of all rural and frontier counties. Equally important for those residents is the apparent reduced availability of managed care providers outside the urban counties of Washoe and Clark. As reflected in the behavioral services data presented in Table 22 (above), the proportion of rural and frontier residents aged 65 and older that received Medicaid Fee-For-Service (FFS) was less than their age counterparts in urban Clark County, but similar to their age peers in urban Washoe County. Medicaid FFS subsidized services provided by the state mental health system, as well as services delivered by the private provider community. Table 22 also shows that 464 unique individuals aged 65 and older were served by Medicaid Managed Care Organizations (MCOs) during calendar year 2015. However, none of this age group received managed care services in the rural and frontier counties. Medicaid MCO reimbursement supported services by the private provider community.

- ***INDIVIDUALS WITH SMI OR SED IN THE RURAL AND HOMELESS POPULATIONS, AS APPLICABLE ****

Almost all of Nevada qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2017, *Map 5.3*, p. 148). The state's geography and its low population density in rural and frontier counties amplify the challenges associated with this critical health care shortage. The current population of Nevada is 2,940,058 (https://www.census.gov/topics/population/data.html), and the State's land mass encompasses 109,286 square miles. Ninety percent (90.3%) of the State's population live in its three urban counties—Clark County in southern Nevada, and Carson City and Washoe County in northwestern Nevada. The remaining 10% of Nevada's residents, an estimated 281,019 individuals, live in the fourteen rural and frontier counties, which span 87% of the State's land area and covers 95,431 square miles (Griswold et al., 2017). The average population density is 26.5 people per square mile, although the variation is considerable with 0.3 persons per square mile in Esmeralda County to 382.6 persons per square mile in the State Capital in Carson City (Griswold et al., 2017). One illustration used to convey the enormity of the State's geography and vast spaces between people is to map seven northeastern states within its borders and still show land area to spare (Griswold et al., 2017): Massachusetts with 10,555 square miles and 6.7 million population, Rhode Island with 1,545 square miles and 1.1 million population, New Hampshire with 9,350 square miles and 1.3 million population, Connecticut with 5,544 square miles and 3.6 million population, Delaware with 2,489 square miles and 0.9 million population, Vermont with 9,615 square miles and 0.6 million population, and New Jersey with 8,722 square miles and 2.9 million population.

Details concerning the scarcity of services that characterizes rural and frontier Nevada have been included throughout this needs assessment for the targeted populations in this application. An important focus is the strategic priority for FFY 2018 and FFY 2019 to expand the scope and capacity of the early interventions service for individuals with first episode of psychosis (FEP) to include individuals with early serious mental illness (ESMI). As suggested by the distribution of the State's population across its geographic regions, extending this service to Nevada's residents in the State's rural and frontier counties represents an urgent need that will be challenging to meet.

Region	Table 23: Population Estimates by Age Category and Region in Nevada, 2017		
	17 and under	**18 to 64**	**65 and over**
Rural and Frontier Region	**58,663**	**164,242**	**56,885**
Urban Region	634,358	1,635,315	367,204
Nevada – Total	693,021	1,799,557	424,089

Source: *Adapted from Griswold, T. et al. (2017) and Nevada State Demographer's Office (2016)*

For the approximately 280,000 individuals who reside in the State's rural and frontier counties, which are highlighted for easy identification in the table above, access to health care services is limited, and this is especially so for mental health services. As discussed in an earlier section, there are *less than 1 psychiatrist and only 4.2 psychologists per 100,000 population for all of the rural and frontier counties combined.* Using the prevalence rates adopted by SAMHSA of 5.4% for Serious Mental Illness (SMI) among adults, and 11% for Serious Emotional Disturbance (SED) among children, the expected rates of SMI and SED are summarized in the table below.

Table 24: Rates of Serious Mental Illness and Serious Emotional Disturbance, Rural Nevada, 2017

Number of Nevada residents with SED, aged 17 and younger	**2017 Rural Nevada Population, aged 17 and younger [1]**	**Estimate of 2017 Rural Nevada Population, aged 17 and younger, with SED (11%) [2]**
	58,663	**6,453**
Number of Nevada residents with SMI, aged 18 and older	**2017 Rural Nevada Population, aged 18 and older [1]**	**Estimate of 2017 Rural Nevada Population, aged 18 and older, with SMI (5.4%) [3]**
	221,127	**11,941**

[1] Population Data Source, 2017: Griswold, T. et al. (2017) and Nevada State Demographer's Office (2016)

[2] 11% is mid-point of 9 - 13% range of prevalence rates for children adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

[3] 5.4% prevalence rate for Serious Mental Illness (SMI) adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

- ***INDIVIDUALS WHO HAVE AN EARLY SERIOUS MENTAL ILLNESS (ESMI) (10 percent MHBG set aside)***

Clinical Staging Interventions for Serious Mental Illness in Nevada's Residents:
Evidence reviewed in earlier sections indicates that 12-month prevalence estimates for serious emotional disturbance (SED) range from 8% in representative national community surveys (Kessler et al, 2012), and 9-13% for the states and nation as a whole (2016 SAMHSA Uniform Reporting System Output Tables-Nevada). Those rates are comparable to the range of prevalence estimates of 8.1-11.6% for major depressive episode (MDE) among adolescents aged 12 to 17 in Nevada and the United States obtained by the National Surveys on Drug Use and Health (NSDUH) from 2010-2011 to 2013-2014. Moreover, the median rate of new cases of schizophrenia each year is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). Moreover, as shown in **Table 25** (below), while a number of serious mental disorders first appear during late childhood, adolescence and early adulthood, the range (25^{th}-75^{th} percentiles) of ages of onset for many disorders extends into middle age.
[Note: For ease of reference, lifetime prevalence rates for specific disorder categories are re-presented from Table 14a above.]

Table 25: Age of onset distributions for specific DSM-IV Mental Disorders [1]

DSM-IV Mental Disorders	Lifetime prevalence *% (SE)* [1]	Age of onset (yrs) (Median) [1]	Age of onset (yrs) (25^{th}–75^{th} percentiles) [1]
Any anxiety disorder	**28.8 (0.9)**	**11**	**6-21**
Panic disorder	4.7 (0.2)	24	16-40
Specific phobia	12.5 (0.4)	7	5-12
Social phobia	12.1 (0.4)	13	8-15
Generalized anxiety disorder	5.7 (0.3)	31	20-47
Post-traumatic stress disorder	6.8 (0.4)	23	15-39
Obsessive-compulsive disorder	1.6 (0.3)	19	14-30
Any mood disorder	**20.8 (0.6)**	**30**	**18-43**
Major depressive disorder	16.6 (0.5)	32	19-44
Dysthymia	2.5 (0.2)	31	17-43
Bipolar I and II disorders	3.9 (0.2)	25	17-42
Any impulse-control disorder	**24.8 (1.1)**	**11**	**7-15**
Any substance use disorder	**14.6 (0.6)**	**20**	**18-27**
Alcohol abuse	13.2 (0.6)	21	18-29
Alcohol dependence	5.4 (0.3)	23	19-31
Drug abuse	7.9 (0.4)	19	17-23
Drug dependence	3.0 (0.2)	21	18-28

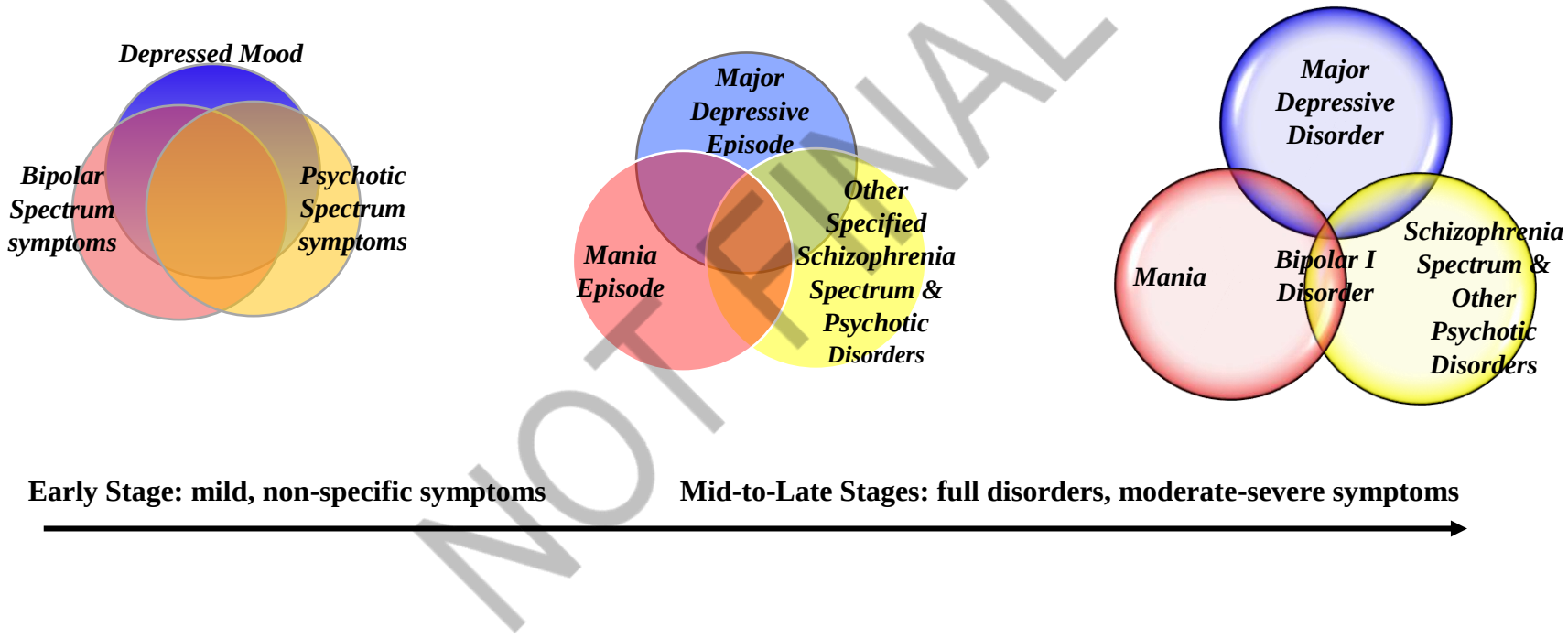
[1] *Adapted from* Kessler et al., 2005a.

In summary, extending early intervention efforts to identified cases of early serious mental illness (ESMI) among adolescents and young adults represents an optimal strategy for reducing the duration of untreated illness, a factor known to be associated with treatment response and clinical course of psychotic disorders (Addington et al., 2015; Kane et al., 2016). As noted above and reflected in Table 25, later ages of onset occur for some disorders, including schizophrenia. Therefore, *Early Serious Mental Illness (ESMI)* is considered as an initial stage or age of onset of an SMI.

Differential diagnoses for sub-populations with emergent Serious Mental Illness (ESMI): The emotional health profile identified for Nevada's youth, grades 6-12, during 2015 indicated the following pattern of psychological distress: one third experienced depressed mood and reduced functioning during the prior year; as a group, they were more likely to report one or more suicide attempts without subsequent medical intervention, compared to their age peers nationwide; and more than 20% acknowledged deliberate self injuries, such as cutting or burning themselves, without the intent to die (*Nevada Youth Risk Behavior Survey, 2015*). It is likely that some of these adolescents experienced challenging life circumstances that produced strong adjustment reactions (mood disturbance, suicidal thoughts and behaviors, deliberate self harm), which peaked and then resolved successfully. It is also probable that other adolescents were experiencing the early stages of a first episode of psychosis (FEP) or an emerging serious mental illness (SMI), which in the absence of optimal interventions may progress to chronic and debilitating illnesses. As such, the year 2015 represented a critical period for a subset of Nevada's youth, and thereby afforded an opportunity for early interventions. **Figure 4** below (adapted from McGorry et al., 2010) illustrates the idea of chronic ***serious mental illness (SMI)*** as a dynamic process that evolves over time, and that begins as a diffuse constellation of features, characteristics and mild symptoms, which gradually cohere within syndromal boundaries.

The objective of providing early interventions for individuals who are at risk for developing severe mental illness has a long history in the fields of psychiatry and psychopathology. It received renewed focus and vitality from the success achieved recently by the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) initiative (Heinssen, Goldstein and Azrin, 2014). In a comparison of comprehensive and usual community care for first episode psychosis, Kane et al. (2016) demonstrated the feasibility of implementing a comprehensive recovery-oriented, evidence-based intervention for first-episode psychosis that was carried out in community health clinics in the United States. Importantly, greater improvements in clinical and functional outcomes were observed for participants who received this comprehensive, multidisciplinary, team-based treatment. ***Extending early intervention services to individuals with early serious mental illness, as well as to individuals with first episode of psychosis, and to the rural and frontier regions of Nevada, is a strategic priority for FFY 2018-2019.***

Figure 4: The Trajectory of Serious Mental Illness (SMI) as a Dynamic, Emerging Process (*adapted from* McGorry et al., 2010)



Access to Mental Health Services for Nevada's Adults with Early Serious Mental Illness (SMI), including First Episode Psychosis (FEP): In July 2015, Nevada introduced a newly established service of early interventions for residents experiencing a first episode of psychosis (FEP). This service is supported with the 10 percent MHBG set aside, which is sub-contracted through Nevada Division of Child and Family Services to private sector entities, including The Children's Cabinet and its community partners. This service offers interventions for individuals diagnosed with FEP in the urban counties of Washoe and Clark in northern and southern Nevada. Known as *Enliven,* the service involves a team-based, multi-component approach that includes intensive case management, education and supported employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy for patients and family members. An array of social supports services is also provided, including housing assistance, access to food banks, and financial, transportation and clothing assistance. **Table 26** shows the number of individuals served by the *Enliven* service since its inception in July 2015 and through May 2017.

Table 26: Number of Nevada Residents Served by Enliven, 2015-2017	
Northern Nevada, Washoe County	***Nevada Residents Served (n)***
Brief Contact	25
Screening and Evaluation: Pending Referred Out	 0 43
Excluded (Did not meet criteria)	0
Active Cases of FEP	31
Southern Nevada, Clark County	***Nevada Residents Served (n)***
Brief Contact	5
Screening and Evaluation: Pending Referred Out	 6 0
Excluded (Did not meet criteria)	6
Active Cases of FEP	9

Source: *Enliven Service, The Children's Cabinet, Nevada Division of Child and Family Services, May 18, 2017*

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Step 2:

Unmet Service Needs and Critical Gaps within Nevada's Current Behavioral Health System

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Youth Risk Behavior Surveillance System, 2015 Middle School Youth Risk Behavior Survey. Accessed from ***Application URL*** on June 5, 2017: https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=NV&YID=2015&LID2=XX&YID2=2015&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FIL=I1&FPL=P1&PV=&TST=True&C1=NV2015&C2=XX2015&QP=G&DP=1&VA=CI&CS=N&SYID=&EYID=&SC=DEFAULT&SO=ASC

UNMET SERVICE NEEDS AND CRITICAL GAPS

WITHIN NEVADA'S CURRENT SUBSTANCE ABUSE AND PREVNETION SYSTEM

FFY 2018-2019 Joint SABG MHBG Application

Substance Abuse Prevention and Treatment Block Grant

(SABG)

Plan and Report

Nevada

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION

Working Draft: 8/14/17

Introduction

Several documents and additional research were utilized to compile the following analysis of substance use disorder prevalence in the state of Nevada. It summarizes the key findings of the State's strengths, needs and priorities, taking into account specific populations required by the block grant.

Both quantitative and qualitative data were used to develop the analysis. Data from multiple sources, including data systems, reports, town halls, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps, and recommendations. Informants include services providers, educators, consumers, family members of consumers, and other community members.

Nevada's population is growing. An increase of 1.9% occurred from 2015-2016 according to estimates from the Nevada Department of Taxation. Much of the data available indicates that more resources and better outcomes are needed for prevention, treatment, and recovery of substance use disorders to properly serve a continuing population growth. Currently, there appears to be an over reliance on emergency rooms and criminal justice settings to identify and engage individuals with substance use disorder and mental health needs. Individuals may not be informed on what to do if they feel they have a problem or do not have adequate health insurance to utilize more effective portals to treatment. Additionally, wait lists for services are long within the State, according to qualitative date from informants surveyed. Instability around the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Two insurance companies recently left the insurance marketplace, devastating rural areas. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives.

A situational analysis was completed in January 2017 by the Division of Public and Behavioral Health (DPBH) to prepare an updated strategic plan for the Substance Abuse Prevention and Treatment Agency (SAPTA). Nevada's identified issues align well with SAMHSA's strategic initiatives. Several highlights are provided below, followed by a summary of what is working, needs and issues, emerging issues, and opportunities identified through the analysis.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

Focus on high risk populations - Key informants (as noted above) identified subpopulations that have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

Integrate behavioral health with health promotion and health care delivery - Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the analysis suggests that stronger support for people with co-occurring disorders should be a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems - Data from the analysis suggests considerable gains are possible through attention to trauma. The State is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. An example of this is the Forensic Assessment Services Triage Team (FASTT) program in place since 2012. FASTT utilizes an array of services in an attempt to reduce the involvement of individuals with mental health and substance use disorders with the criminal justice system. Some of these include notifying the Crisis Intervention Team (CIT) when there is a crisis discovered by a police officer, offering treatment programs in jails, and wrap around services recommended for clients as they exit jail. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, 'upstream' prevention efforts, for example focusing on reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience - Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services, such as residential treatment, were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT - Nevada has made much advancement in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between State and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

Support active strategies to strengthen and expand the behavioral health workforce - Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure

issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the State to address issues of reimbursement and payment for providers.

Limitations

Information presented in this document was intended to inform planning. For each data source, there are limitations. Caution should be used when interpreting data from a single source, as various factors can contribute to the result. Data from multiple sources is presented when possible to provide a more complete picture of the current situation. Limitations that particularly effect the interpretation and presentation of a data set are noted within the document. These may include (but are not limited to):

- Some data are preliminary, particularly estimates for 2015.
- MyAvatar, a Netsmart product, is a database containing demographic, treatment, billing, and financial information for Nevada State funded mental health facilities throughout the state of Nevada. This data is representative of Nevada State funded mental health facilities only. It does not include data for those mental health facilities that do not receive State funding; and therefore, is not an accurate picture of all mental health within the State.
- Some methods limit comparability of data across geography. For example, differences in consent models for the Youth Risk Behavior Surveillance System (YRBS) should be considered in comparing geographies as well as understanding the overall rates presented.
- Reports from State data systems typically collect and compile information for a particular purpose and may not be comprehensive. For example, substance abuse information provided from state systems reflects State-funded programs and services, and not all seeking or using services across the State.
- Data that require self-reporting may include bias due to inaccurate recall, fear, or stigma related to reporting accurately. A related issue is that while the actual demand for services isn't known, not all who meet the criteria for treatment services may be interested in receiving them. Experts note that strategies to reduce this treatment gap should focus not only on increasing access to effective treatment but on reducing stigma, raising awareness, and providing appropriate screening and referrals (National Institute on Drug Abuse, n.d.).
- Changes to International Classification of Diseases (ICD) codes from year to year can impact comparability through time. For example, in 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice Organization, 2017). Data sources Center for Health Information Analysis (CHIA) as well as other sources may include this limitation.
- Town Hall meetings were largely made up of professionals representing consumers, rather than by consumers and their families.

The following table was created by SAPTA for the 2017 Situational Analysis, using SWOT to identify the State's strengths, weaknesses, opportunities, and threats to steer the SAPTA Strategic Plan 2017-2020.

What's Working Well	*Examples and Support for Finding*
Improvements to Nevada's Behavioral Health System	Nevada has successfully applied for a number of grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard-to-reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities.
Substance Misuse Decreasing for Many Substances and Populations	Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for claims that are denied by Medicaid.
State-level Improvements	Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges	*Examples and Support for Finding*
System Challenges	➡ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps. ➡ Services aren't well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer. ➡ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area. ➡ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state. ➡ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration. ➡ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others. ➡ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.

Issues and Challenges	*Examples and Support for Finding*
Substance Misuse Is Elevated for Many Substances and Populations	➡ Rates of substance misuse including dependency are higher among many populations within Nevada compared to the nation. ➡ Survey data shows that many people needing treatment do not get the care they need. ➡ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➡ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
Workforce Shortages	➡ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➡ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➡ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➡ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➡ More outreach and services are needed in languages other than English and that are culturally competent. ➡ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➡ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.

Issues and Challenges	*Examples and Support for Finding*
Service Gaps	➡ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery. ➡ Insurance requirements can create problems with continuity of care and individualization of care. ➡ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	➡ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation. ➡ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc. ➡ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations. ➡ For funded providers throughout the state, enhanced two-way communication with the state would support data, evaluation, reporting, and funding.

Threats and Emerging Issues	***Examples and Support for Finding***
Policy Changes	➡ The ACA has contributed many improvements to Nevada's system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➡ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	➡ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➡ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➡ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	➡ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➡ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities	***Examples and Support for Finding***
Engage in Effective Planning	➡ Many states are innovating, including Nevada. Nevada can learn from other states' efforts to improve policies, systems, and practices toward improved behavioral health outcomes. ➡ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada's planning efforts. ➡ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.

Opportunities	***Examples and Support for Finding***
Build Sustainability	➢ Outreach indicated a willingness by providers to work with limited resources and collaborate to better serve communities. The state can help to increase this capacity by enhancing transparency related to funding that would allow for a clearer picture of the funding available and the identification of effective collaborations. ➢ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➢ The work of other planning processes, for example Olmstead Planning and *Nevada's No Wrong Door,* can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
Enhance Communication, Relationships, and Collaboration	➢ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➢ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➢ There are many opportunities for the state to work more closely and collaboratively within communities. ➢ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
Regional and Local Control	➢ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.

Opportunities	Examples and Support for Finding
Develop the Workforce	Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.
Expand Knowledge and Practice of Effective Services	Key informants identified many practices that hold promise for improved outcomes, including: ▪ Targeted outreach and messaging for prevention ▪ Assistance with navigation and coordination for services ▪ Interventions that utilize family members and peer support ▪ Medication-assisted treatment (MAT), including walk-in clinics ▪ Trauma–informed approaches to care ▪ Cognitive behavioral therapy and related practices ▪ Best practices for working with people recovering from opioid addiction ▪ Supportive transitions through a continuum of treatment services Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Statewide Needs

A needs assessment of behavioral health identified consumers' barriers to accessing care through both surveys and focus groups. The following qualitative data was collected and summarized, primarily from Nevada's Division of Public and Behavioral Health (DPBH), under the Department of Health and Human Services (DHHS) meta-analysis. Additional documents were reviewed to gain a comprehensive picture of the State. The documents included are listed below:

1. Washoe County Children's Mental Health Consortium Summary of the Annual Plan 2017-18
2. Nevada Rural Children's Mental Health Consortium Strategic Plan 2017 Status Report
3. Nevada Children's Mental Health Needs Assessment 2016
4. Clark County Children's Mental Health Consortium Strategic Plan 2017 Status Report
5. State of Nevada Plan to Reduce Prescription Drug Abuse 2015
6. PACT Coalition Comprehensive Community Substance Abuse Prevention Plan 2014

In the statewide survey of providers, five populations were identified as having high need for substance abuse services:

• Adolescents with substance abuse and/or mental health problems

- Parents with substance use and/or mental disorders who have dependent children
- Individuals with substance abuse disorders in rural areas
- Women who are pregnant and have a substance use and/or mental disorder
- Unaccompanied minor children and youth

Barriers Identified:

- Cost
- Lack of knowledge of resources
- Lack of transportation
- Lack of insurance coverage
- Lack of available providers
- Long wait lists
- Fear
- Stigma
- Perception that treatment wouldn't help
- People that are undocumented are not able or willing to seek help for fear of being deported

One of the many issues identified is that the needs for behavioral health care cannot be met through current resources (State of Nevada, 2016). Lack of access to community-based crisis services contributes to high rates of utilization of emergency room (ER) services for behavioral health needs within both fee-for-service (FFS) and managed care Medicaid. The most common primary diagnoses in individuals treated in the ER for behavioral health needs in 2015 included non-dependent abuse of substances, alcohol abuse and/or intoxication, anxiety disorders, mood disorders, suicidal ideation, and psychotic disorders. ER visits related to alcohol and other drug use from 2009 to 2014. Alcohol-related visits increased from 21,063 visits in 2009 to 30,180 visits in 2014, a 43% increase. Visits related to other drugs followed the same trend, with a low of 13,969 visits in 2009 to a high of 28,065 visits in 2014, a 101% increase.

Substance Use Disorder Prevalence/Treatment

The data in this section is reflective of services received by Nevada residents at treatment facilities funded by the Nevada Division of Public and Behavioral Health. This does not include data from facilities that do not receive State funding and is not a comprehensive accounting of all Nevada residents who receive substance use treatment. The data are based on the number of admissions, not the number of patients; therefore a single person may represent multiple admissions.

Top Primary Substances of Admissions to Nevada Substance Abuse Treatment Facilities, Nevada Residents, 2014.

Rank	Substance	Percent
1	Alcohol	35.0
2	Amphetamines/Methamphetamines	28.4
3	Marijuana/Hashish	13.4
4	Heroin	12.4
5	Other Opiates/Synthetic Opiates	5.8

Source: Division of Public and Behavioral Health, Nevada Health Information Provider Performance System

Of the Nevada residents who received substance abuse treatment services from a SAPTA provider in 2014, alcohol was the most common substance abused (35.0%), followed by amphetamines/methamphetamines (28.4%), marijuana (13.4%), and heroin and other opiates (12.4% and 5.8% respectively).

It is highly important to ensure that appropriate detoxification services are provided to persons who are under the influence of a substance. Many of the substances will cause withdrawal that can range from anxiety, hallucinations, seizures or even death.

Demographics of Unduplicated Persons in Nevada State Funded Substance Abuse Treatment Facilities, State Fiscal Year 2011-2015.

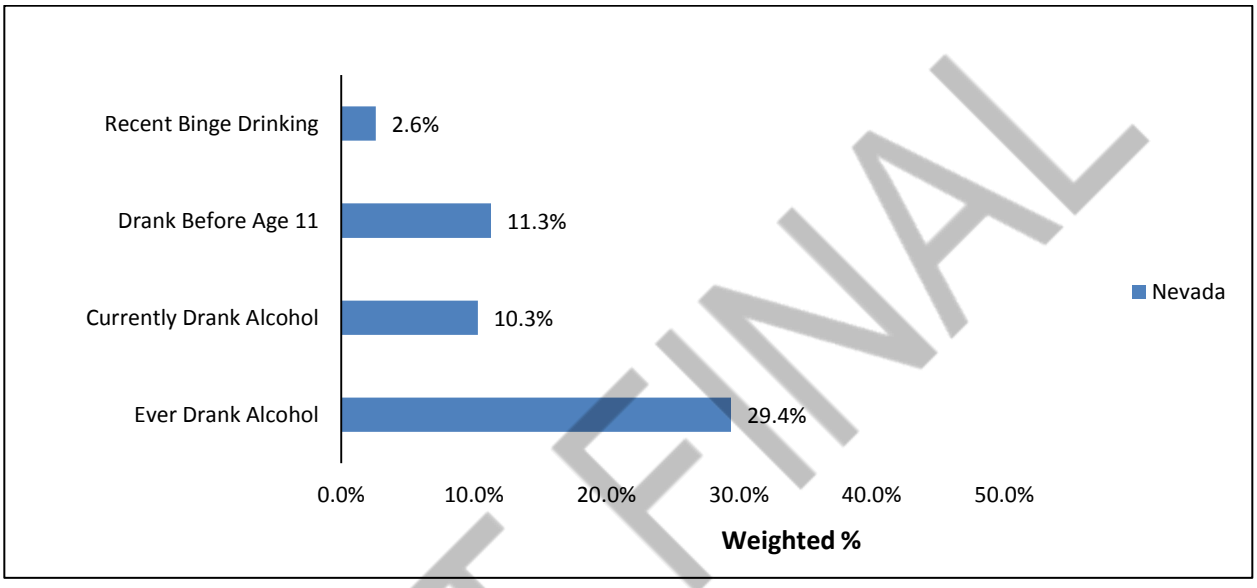
	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Sex					
Male	5,659	6,688	6,662	4,660	5,677
Female	2,912	3,834	3,974	2,853	3,788
Pregnant Woman	133	190	192	139	190
Age					
0-17	928	1,060	1,038	574	605
18-24	1,788	2,189	2,176	1,384	1,632
25-44	3,845	4,832	5,100	3,787	5,048
45-64	1,950	2,366	2,236	1,705	2,119
65+	60	75	86	63	61
Race/Ethnicity					
White	5,790	7,074	7,208	5,064	6,625
Black or African American	1,021	1,191	1,135	845	1,005
Native Hawaiian/Other Pacific Islander	66	75	99	63	91
Asian	64	111	107	56	68
American Indian/Alaska Native	222	280	274	221	272
Multiple	383	481	521	347	391
Unknown	1,025	1,310	1,292	917	1,013
Total	**8,571**	**10,522**	**10,636**	**7,513**	**9,465**

Source: SAMHSA Block Grants, WebBGAS

Adolescent Rates and Access to Treatment

Adolescent drug and alcohol use will be broken down into the top primary substances used and the access to treatment. The top substance used was alcohol. Statistical tests (t-tests) have been conducted for all statements appearing in the text of the report that compare estimates between years or between the State and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

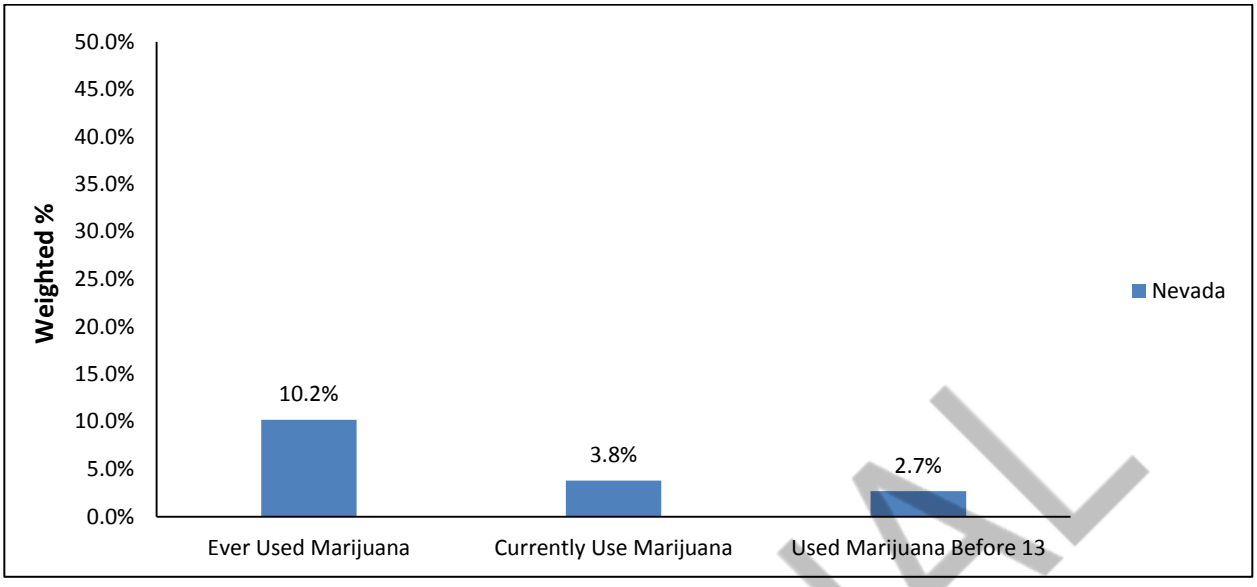
Alcohol Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately one third (29.4%) of middle school students in Nevada have had at least one drink of alcohol (more than a few sips). About 10% of middle school students currently drink. About 11% of Nevada middle school students had alcohol before the age of 11 years, and over 2% of students had a recent binge drinking experience (had at least 5 drinks in a couple of hours in the past 30 days).

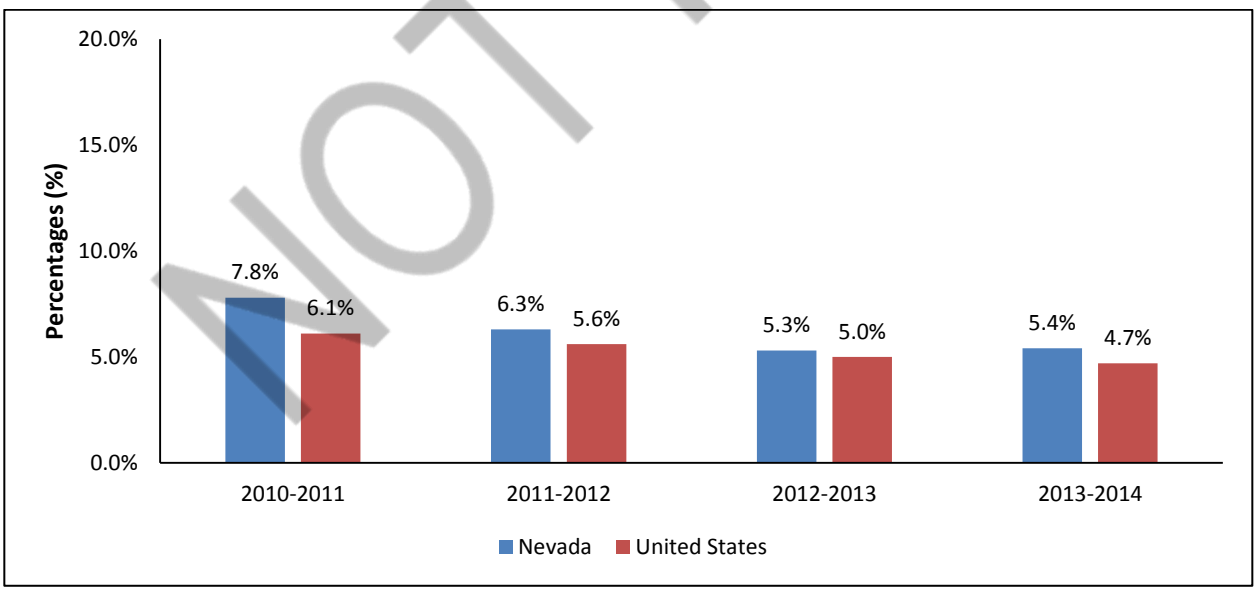
Marijuana Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 10% of middle school students in Nevada reported trying marijuana, and 4% have used marijuana in the past 30 days. Approximately 3% of middle school students have tried marijuana before the age of 11 years.

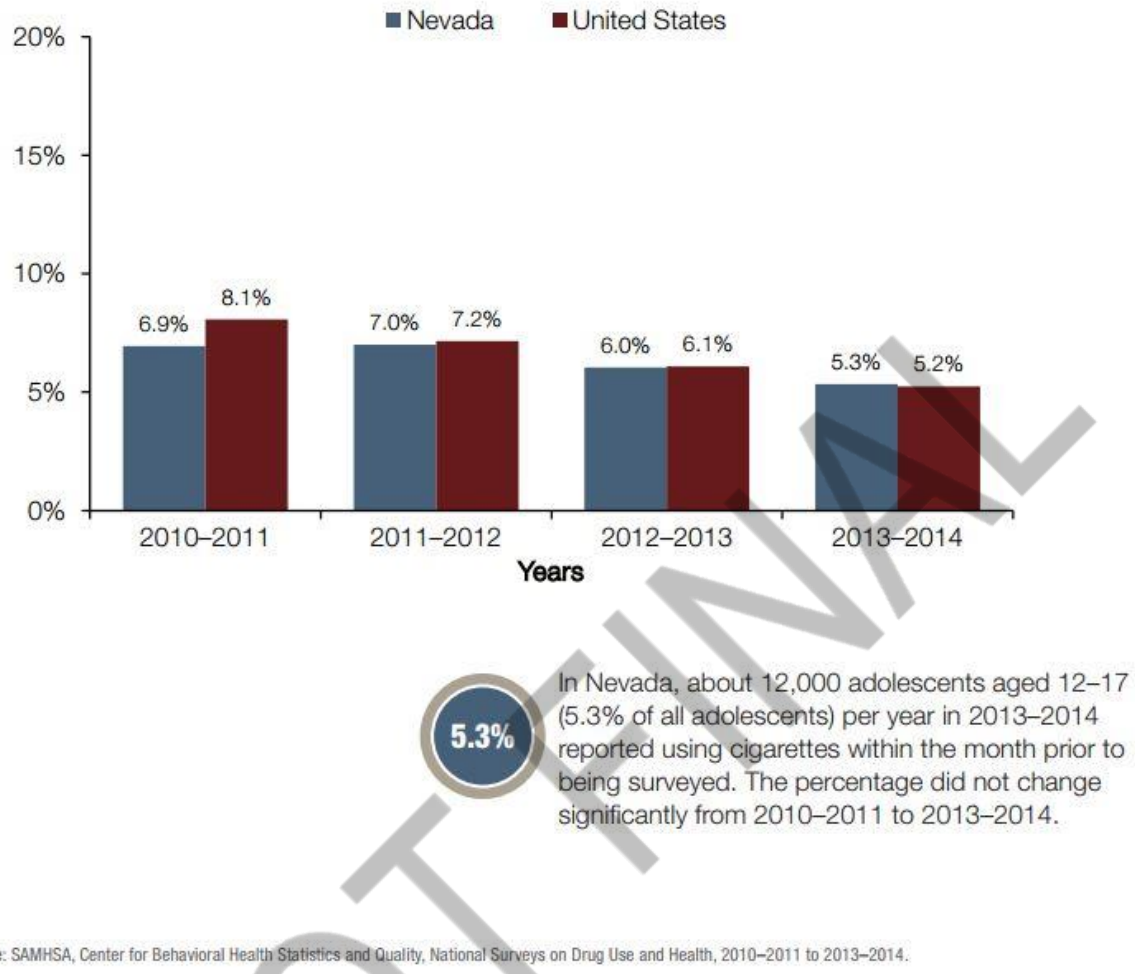
Past Year Nonmedical Use of Pain Relievers Among Adolescents Aged 12-17 in Nevada and the United States 2010-2011 to 2013-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

Approximately 4% of middle school students in Nevada have already tried prescription drugs that were not prescribed to them in their lifetime, while about 2% of students have used them in the past 30 days.

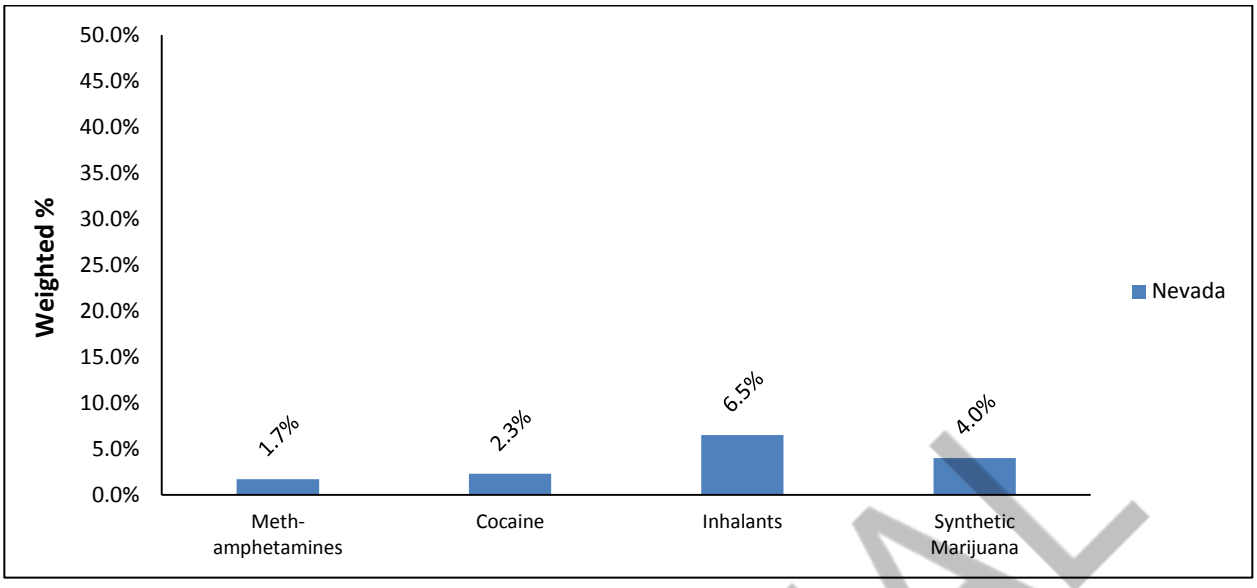
Past Month Cigarette Use among Adolescents Aged 12-17 in Nevada and the United States



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014.

Cigarette use by individuals under 18 in Nevada is comparable to use nationally, following a recent decrease. This could be contributed to the recent trend in vaping and use of nicotine in electronic form. Although the decrease is positive, it should continue to be prevented to keep the use down.

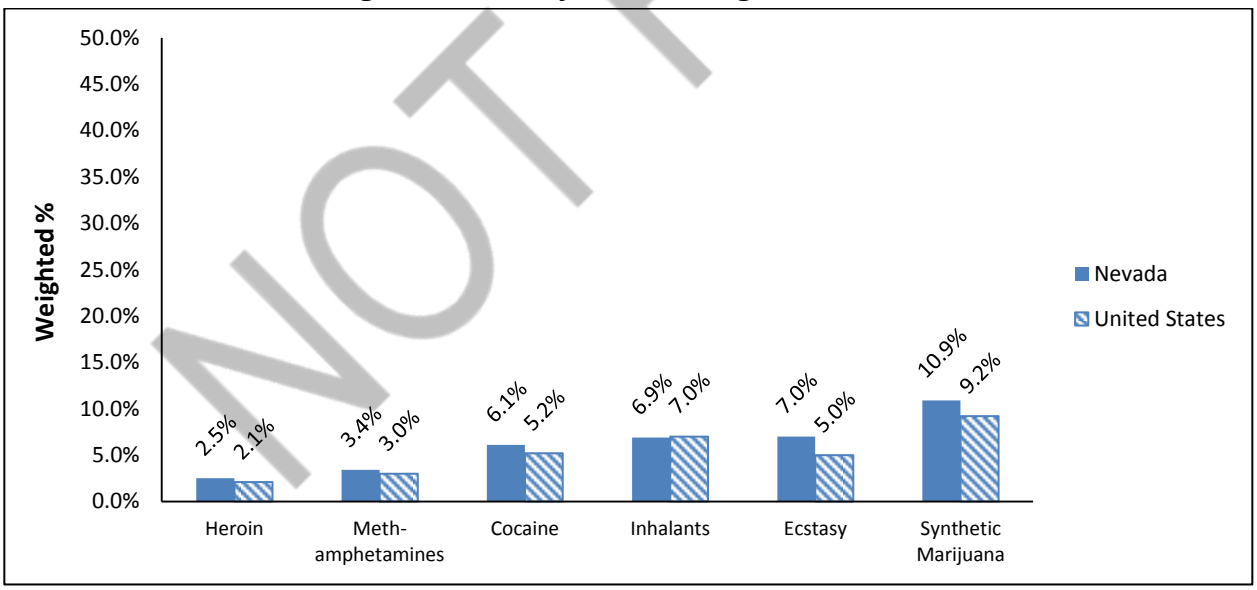
Lifetime Drug Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

In terms of substance abuse among middle school students in Nevada, nearly 7% have used inhalants, the highest percentage of the select substances. About 2% of students have used cocaine, 2% have used methamphetamines, and 4% have used synthetic marijuana.

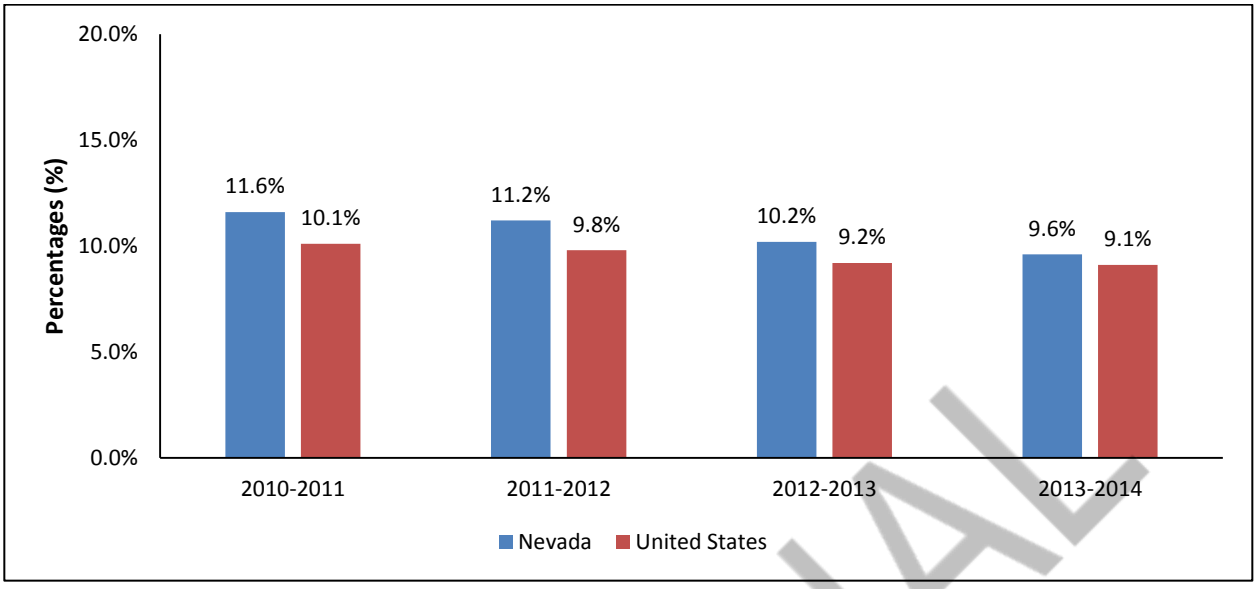
Lifetime Drug Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

In terms of substance abuse among high school students in Nevada, nearly 11% have used synthetic marijuana, the highest percentage of the select substances. About 7% have taken ecstasy, and 7% of students have tried inhalants. About 6% of students have used cocaine, 3% have used methamphetamines, and almost 3% have used heroin.

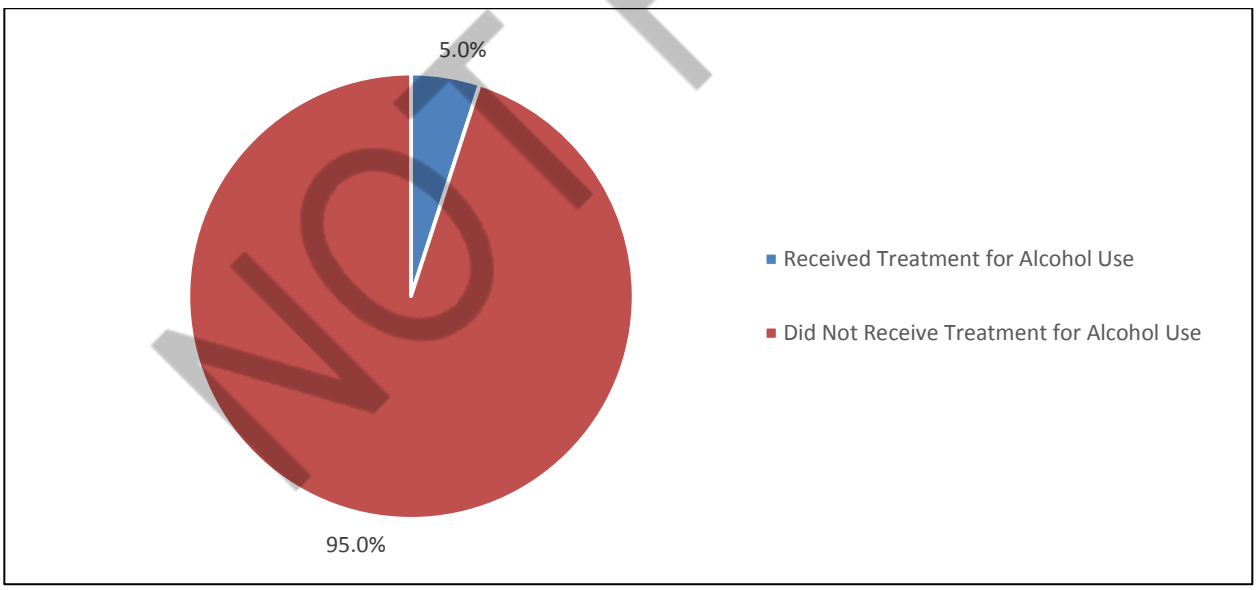
Past Month Illicit Drug Use Among Adolescents Aged 12-17 in Nevada and the United States, 2010-2011 to 2013-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

Adolescent drug use in Nevada is slightly higher when compared to national trends and has seen a recent decrease.

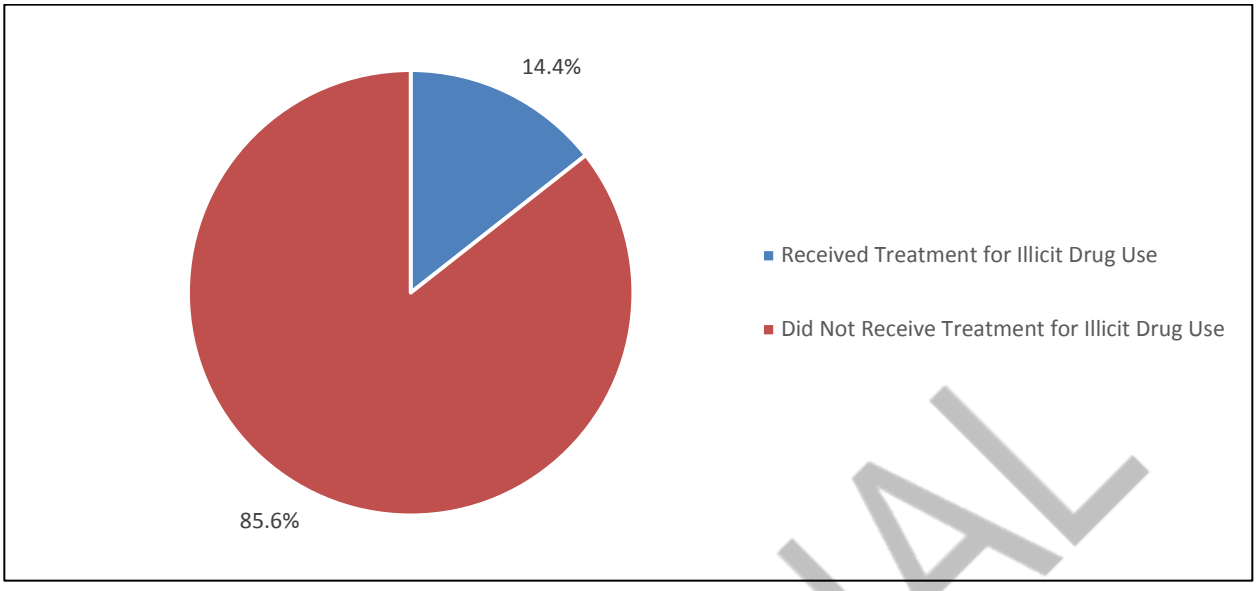
Past Year Treatment for Alcohol Use Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Nevada, 2010-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

In Nevada, individuals aged 12 or older with alcohol dependence or abuse, about 10,000 individuals (5.0%) per year from 2010 to 2014 received treatment for their alcohol use within the year prior to being surveyed.

Past Year Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Nevada, 2010-2014.

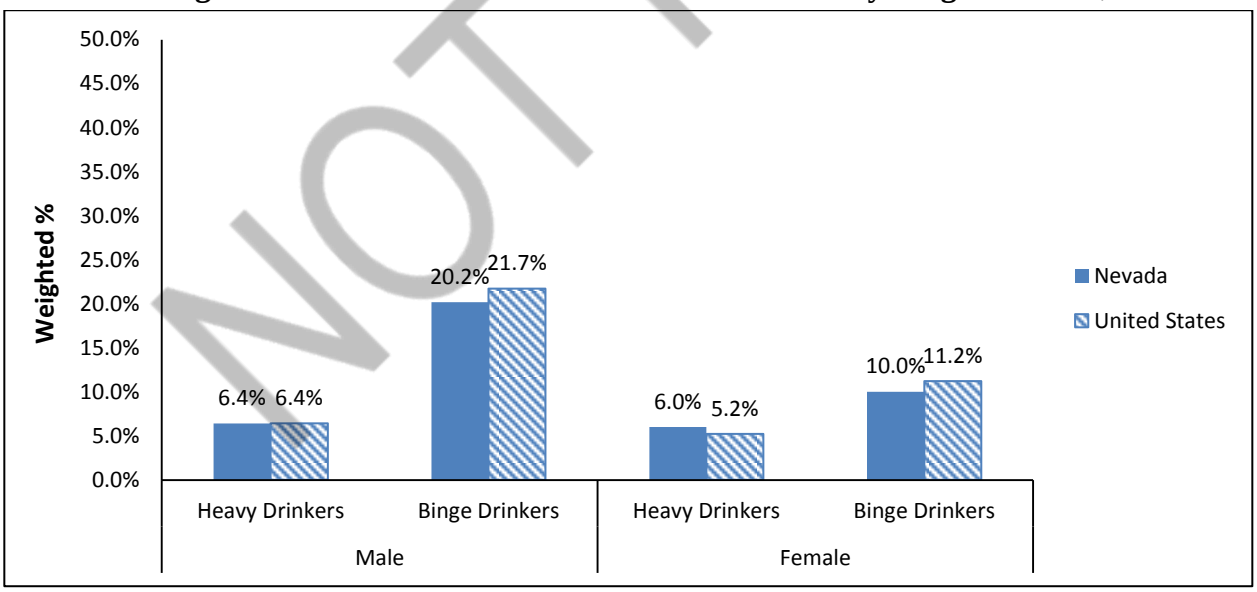


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Between 85-95% of youth in Nevada are not receiving treatment for SUD's that are in need. This is similar to the national average. Building capacity for services and an adequate referral process is a place for improvement within the State.

Adult Rates and Access to Treatment

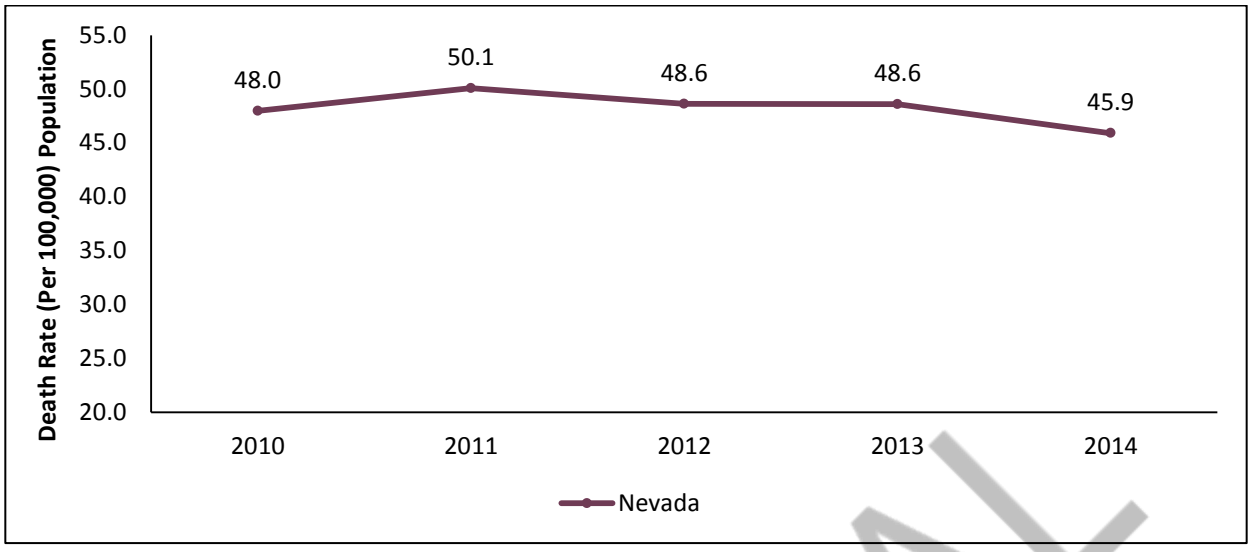
Percentages of Adult Residents Who are Considered Heavy/Binge Drinkers, 2015



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

Over 6% of adult Nevada males and females reported being heavy drinkers. Heavy drinking consists of males consuming more than two alcoholic beverages a day and females consuming more than one alcoholic beverage a day.

Substance-Related Deaths, Nevada, 2010-2014



Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

There were 6,664 substance-related deaths in Nevada between 2010 and 2014. During that timeframe the death rate varied between from 45.9 deaths per 100,000 and 50.1 deaths per 100,000.

Note: the following codes were used to define substance-related deaths: ICD10 codes G312, G621, I426, G721, K292, K70, K860, R78, Y90, Y91, X40-X49, T36-T60, T65, F10, X60-X69, E244, K852, O354, Y10-Y19, P043, Q860, Z721, R781-R786, F11-F16, F18, X85-X90, O355, D521, P961, T96-T97, Y40-Y59, K711, N141, P044.

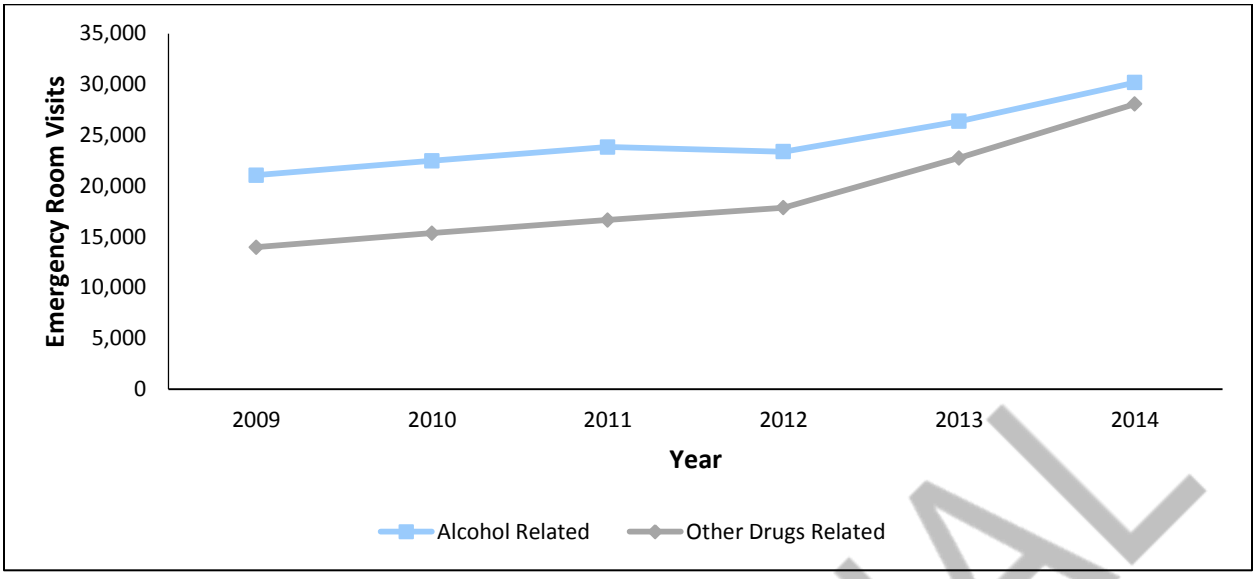
Demographics of Substance Related Deaths, Nevada 2010-2014

	N	Column %
Sex		
Female	2,384	35.8
Male	4,280	64.2
Race		
White	5,317	79.8
Black	423	6.3
Native American	118	1.8
Hispanic	588	8.8
Asian/Pacific	114	1.7
Other	6	0.1
Unknown	98	1.5
Age		
<1	15	0.2
1-4	12	0.2
5-14	12	0.2
15-24	293	4.4
25-34	660	9.9
35-44	974	14.6
45-54	1,899	28.5
55-64	1,700	25.5
65-74	767	11.5
75-84	254	3.8
85+	77	1.2

Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

In Nevada, the most common demographic groups to die of a substance-related death included: males (64.2%), White non-Hispanics (79.8%), and those aged 45 to 64 years of age (54.0%).

Alcohol and Other Drug Related Emergency Room Visits, Nevada Residents, 2009-2014.



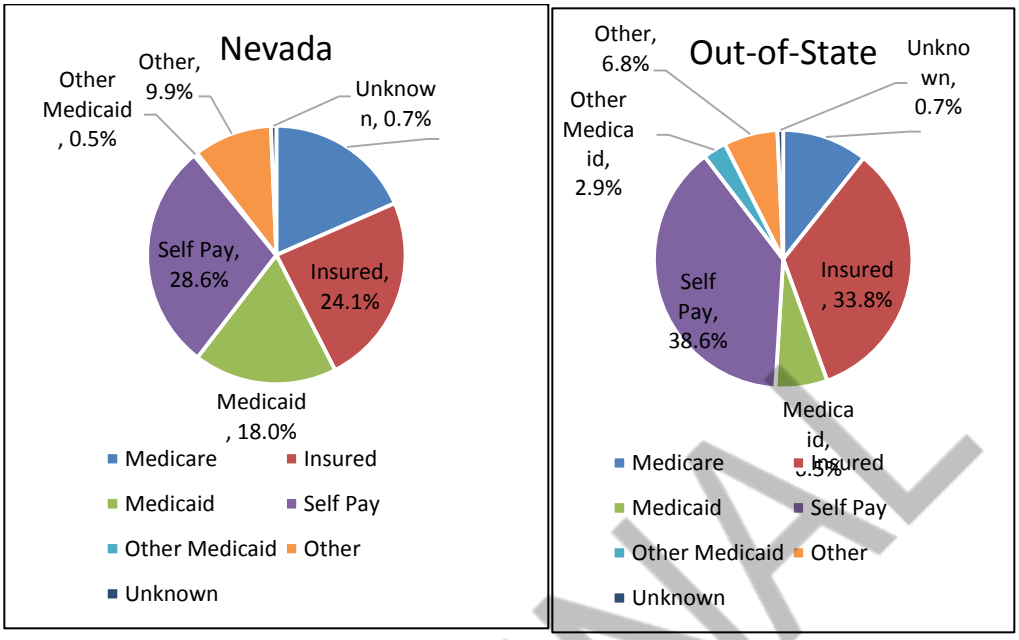
Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

As previously stated, emergency rooms are a highly utilized point of access to treatment for Nevada residents who are in need of services. A steady increase has occurred from 2012-2014. This may have been affected by changes in insurance policies at the national level. Ensuring medical staff is prepared to screen and refer for substance use disorders is crucial to assist the individuals get the proper care they need.

Demographics of Substance Related Emergency Room Visits, Nevada Residents, 2009-2014.

	Alcohol-Related		Other Substance - Related	
	N	Column %	N	Column %
Sex				
Female	45,230	30.7	52,040	45.4
Male	102,078	69.3	62,645	54.6
Race				
White	98,291	66.7	74,686	65.1
Native American	4,409	3.0	1,790	1.6
Hispanic	18,033	12.2	12,566	11.0
Asian/Pacific	2,231	1.5	1,724	1.5
Black	14,937	10.1	17,862	15.6
Other	5,341	3.6	3,921	3.4
Unknown	4,072	2.8	2,140	1.9
Age				
0-14	514	0.3	2,217	1.9
15-24	15,437	10.5	23,250	20.3
25-34	25,137	17.1	30,144	26.3
35-44	29,287	19.9	23,212	20.2
45-54	42,420	28.8	21,411	18.7
55-64	24,248	16.5	10,519	9.2
65-74	7,824	5.3	2,879	2.5
75-84	1,913	1.3	757	0.7
85+	518	0.4	299	0.3

Payer Distribution of Mental Health and Substance Use Related Emergency Room Visits by Residence Status, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Payer was consolidated into the following format:

- Medicare: Medicare, Medicare HMO
- Insured: CHAMPUS OR CHAMVA, Commercial Insurer, Negotiated Discounts e.g. PPO, HMO, All Workers Compensation
- Medicaid: Nevada Medicaid, Nevada Medicaid HMO
- Self-Pay: Self Pay
- Other Medicaid: Out of State Medicaid
- Other: Charity, Miscellaneous, County Indigent Referral
- Unknown: Unknown, Blank

A majority of mental health and substance-related ER visits for Nevada residents was paid by Self-pay (29%), followed by "Insured" (24%), Medicare (18%), and Medicaid (18%).

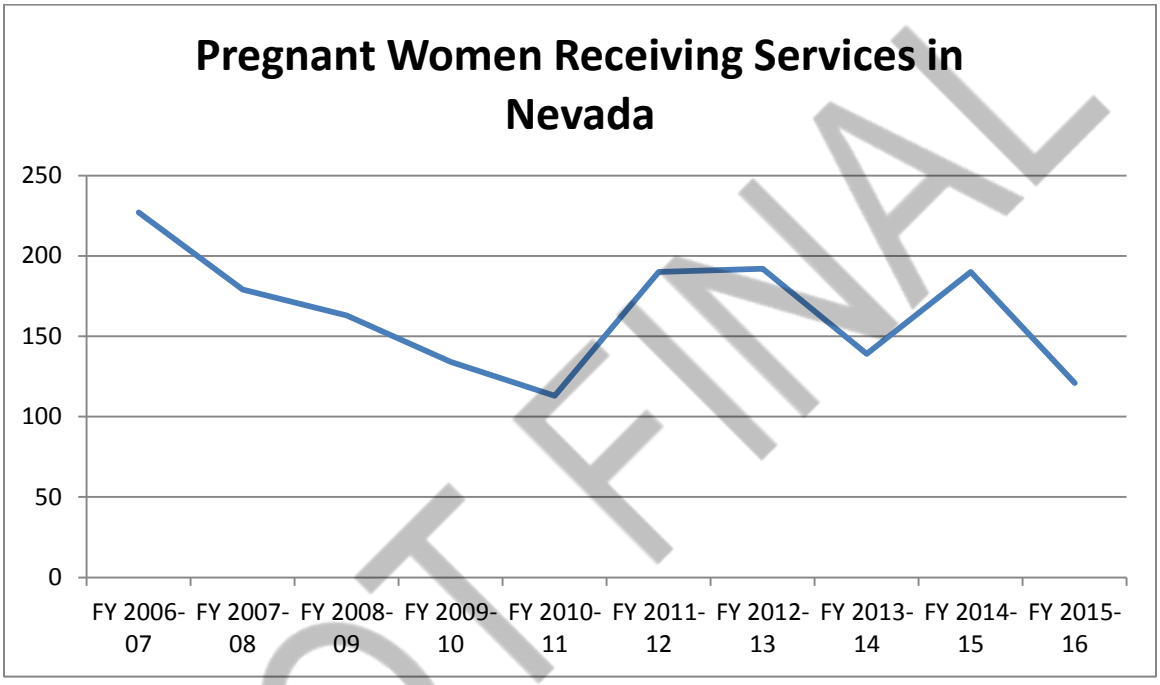
Special Populations

Pregnant Women and Women with Dependent Children

Nevada does not currently have information on women with dependent children, therefore only pregnant women will be addressed.

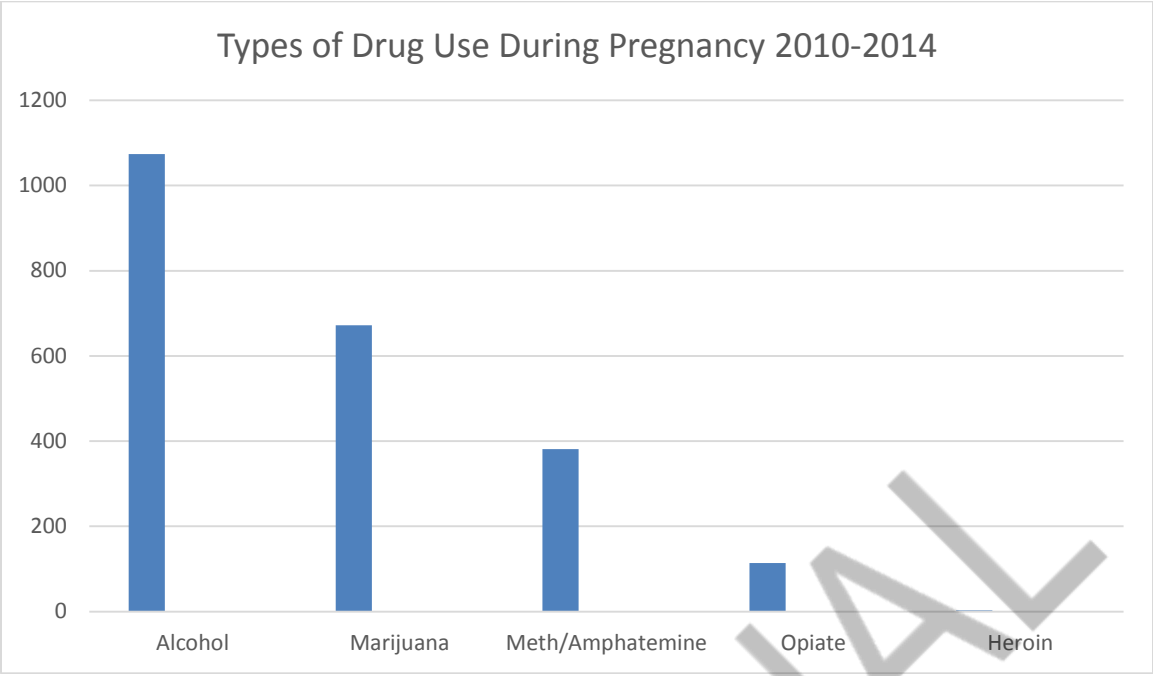
To be able to serve pregnant women in accordance with 45 CFR 96.131, it is vital to understand the population requiring these services, and more importantly, ensure the State has the capacity for

compliance with this regulation. However, data regarding drug use and abuse by pregnant women can be difficult to report accurately. Currently, the state collects data from treatment providers who receive State funding and examines the number of pregnant women receiving treatment. This data collection excludes those pregnant women receiving services from providers that do not receive State funds. It also uses self-reported birth certificate information. Another way to gather information on rates of pregnant women is to take anonymous surveys via telephone and ensure no identifiable information is kept. Although both data sets originate from official sources, each may underestimate the actual number of pregnant women using or abusing drugs in Nevada. In Fiscal Year 2016, the State reported to the Substance Abuse Block Grant reporting system, (WebBGAS) that 121 pregnant women received treatment. A decrease in pregnant women receiving services does not necessarily mean a decrease in women needing them.



Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

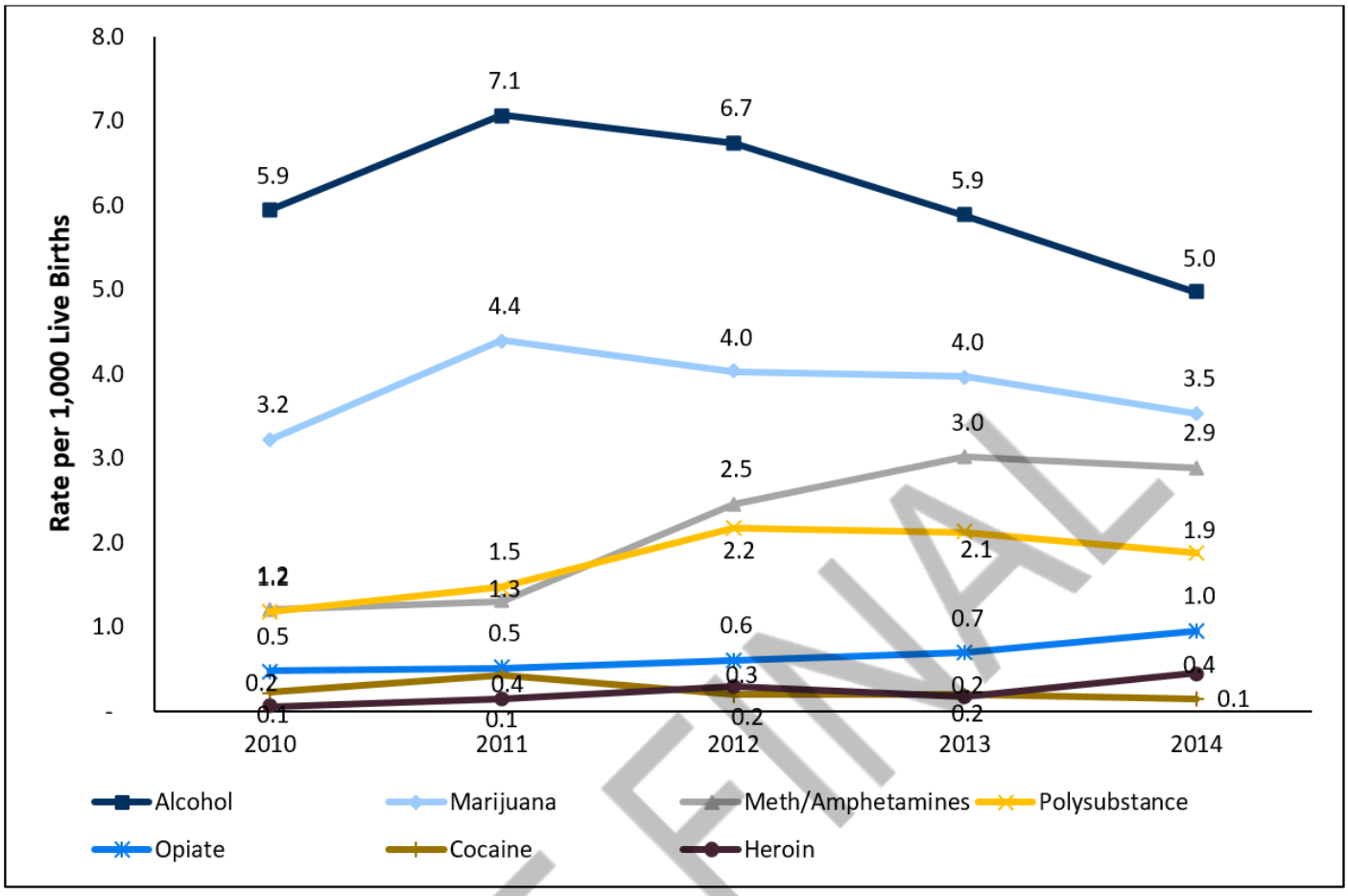
Alcohol was the most used substance during pregnancy, same as the greater population.



Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

On average there are 35,126 live births per year to Nevada residents. From 2010 to 2014, 1,074 had alcohol use indicated on the birth certificate. Additionally, birth certificates indicated 672 for marijuana use, 381 for meth/amphetamine use, 114 for opiate use, and 3 indicated heroin use during pregnancy. Nationally, 122,000 pregnant women (5.4%) self-reported illicit drug use in the last month 2012-2013 with marijuana being the most commonly used drug. The majority of those women were ages 18-25 and non-Hispanic. For the same year, 212,000 pregnant women (9.4%) used alcohol in the last month (2013 National Survey on Drug Use and Health).

Prenatal Substance Abuse Birth Rates (self-reported) for Select Substances, Nevada 2010-2014.



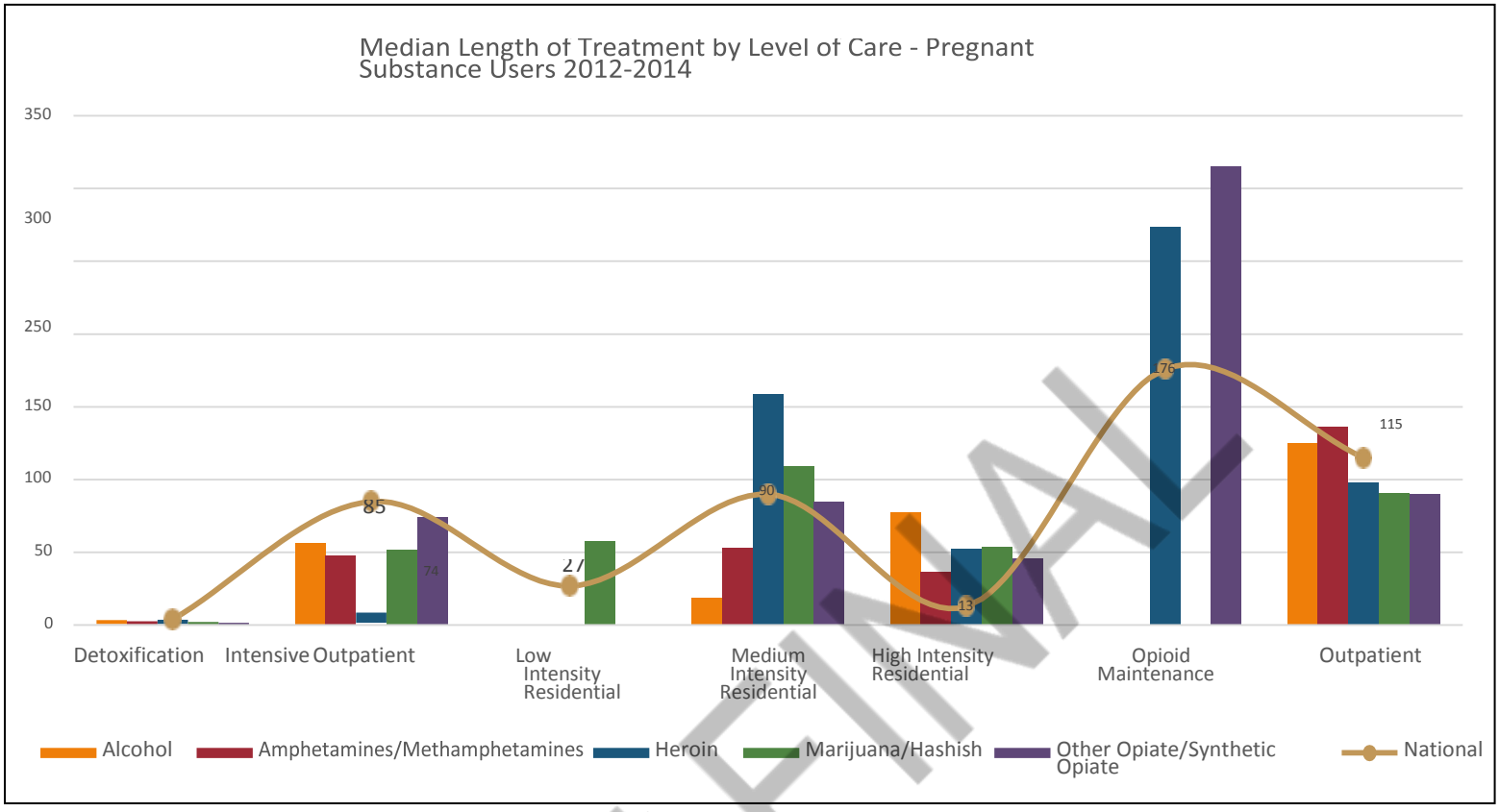
Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

Of the Nevada mothers who gave birth between 2010 and 2014 that self-reported using substances while pregnant, alcohol has the highest prenatal substance abuse birth rate, at 5.0 per 1,000 births in 2014. A rate of 3.5 per 1,000 was reported for marijuana, 2.9 per 1,000 reported for meth/amphetamines, and 1.9 per 1,000 births reported multiple drug use. These numbers are likely significantly underestimated because data is self-reported by the mothers, and they may be reluctant to be forthcoming on the birth record for many reasons.

Treatment Trends of Pregnant Women

For the following table, lengths of treatment by level are charted according to the five primary substances used in Nevada according to the Nevada Health Information Provider Performance System (NHIPPS) between 2012 and 2014. Notable observations include the median length of stay for medium intensity residential is considerably lower for alcohol and amphetamines/methamphetamines and considerably higher for heroin. This observation is interesting since the same level of care has been considerably lower for all substances for the previous priority populations.

Median Length of Treatment by Level of Care-Pregnant Substance Users 2012-2014 in Nevada



Source: Division of Public and Behavioral Health, Web-enabled Vital Records Registry System (WEVRRS)

For all drug categories reported, outpatient treatment was most utilized by pregnant women. In Nevada, opioid maintenance was utilized significantly more than at the national level. SAMHSA's *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare and Collaborating Service Providers,* is an example of a guide that might be used to provide services for pregnant women.

Lesbian/Gay/Bisexual

As shown in the tables below, Nevada's LGB population had higher rates of use among all drugs polled. LGB is recommended as a target population for primary prevention and recovery support services. Nevada does not have adequate data on transgender individuals.

Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation – Nevada Adults, 2014 — 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Binge drinking	22.5%	15.0%	Not significantly different
General health fair or poor	29.9%	18.0%	Significantly Higher
Limited because of physical, mental, or emotional problems	32.2%	21.1%	Not significantly different
Ever told had depressive disorder	37.6%	16.6%	Significantly Higher
Ten or more days of poor mental health	32.8%	13.5%	Significantly Higher
Ten or more days poor mental or physical health kept from usual activities	20.6%	16.3%	Not significantly different

Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation — Nevada High School Students, 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Drove when drinking alcohol.	10.6%	5.9%	Significantly Higher
Did not go to school because they felt unsafe at school or on their way to or from school.	13.1%	6.3%	Significantly Higher
Were ever physically forced to have sexual intercourse	24.4%	6.8%	Significantly Higher
Were electronically bullied	26.8%	11.9%	Significantly Higher
Felt sad or hopeless	63.5%	30.3%	Significantly Higher
Seriously considered attempting suicide	41.5%	13.9%	Significantly Higher
Made a plan about how they would attempt suicide	37.2%	12.7%	Significantly Higher
Attempted suicide	28.5%	6.8%	Significantly Higher
Ever tried cigarette smoking	51.7%	29.6%	Significantly Higher
Currently smoked cigarettes	21.3%	5.1%	Significantly Higher
Ever drank alcohol	78.1%	62.1%	Significantly Higher
Currently drank alcohol	46.8%	28.1%	Significantly Higher
Ever used marijuana	57.1%	37.0%	Significantly Higher
Currently used marijuana	34.7%	17.5%	Significantly Higher
Ever used cocaine	13.8%	4.7%	Significantly Higher
Ever used heroin	7.3%	1.5%	Significantly Higher
Ever took prescription drugs without a doctor's prescription	32.1%	14.5%	Significantly Higher
Currently use prescription drugs without a doctor's prescription	21.3%	7.1%	Significantly Higher

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Nationally, higher drug and alcohol use is also seen within the LGBT population than their peers. Mental health and substance use disorders are part of the myriad of potential characteristics an individual may experience. Training providers to be informed of the additional barriers and experiences someone in the LGBT population may be susceptible to will better prepare professionals to provide an effective person-centered treatment plan. SAMHSA has developed a training through the Addiction Technology Transfer Network (ATTC) specifically for the LGBT population struggling with substance use disorders. It is targeted to clinicians.

American Indian/Alaskan Natives

American Indians and Alaskan Natives in Nevada report higher prevalence rates in every risk behavior indicator in the table below. Most of these differences are not statistically significant due to a small sample size of only 162 participants but additional research may prove to change this. There are over 30 Indian Reservations throughout the State. Currently, there are over 32,000 Native American residents (approximately 1% of the State population), the majority living in Clark County but the greatest proportion of the population relative to other races is Mineral County

Prevalence Estimates of Health Risk Behaviors, by Race/Ethnicity Status — Nevada High School Students, 2015

Indicator	American Indian/Alaska Native (%)	Nevada (%)	Difference*
Drove when drinking alcohol.	30.5%	21.4%	Not significantly different
Did not go to school because they felt unsafe at school or on their way to or from school.	16.2%	7.6%	Not significantly different
Were ever physically forced to have sexual intercourse	12.0%	9.0%	Not significantly different
Were electronically bullied	22.3%	13.8%	Not significantly different
Felt sad or hopeless	36.4%	34.5%	Not significantly different
Seriously considered attempting suicide	21.1%	17.7%	Not significantly different
Made a plan about how they would attempt suicide	16.4%	15.8%	Not significantly different
Attempted suicide	18.0%	9.8%	Not significantly different
Ever tried cigarette smoking	53.1%	32.4%	Significantly Higher
Currently smoked cigarettes	22.4%	7.2%	Significantly Higher
Ever drank alcohol	46.6%	26.1%	Significantly Higher
Currently drank alcohol	44.3%	30.6%	Not significantly different
Ever used marijuana	59.1%	39.4%	Significantly Higher
Currently used marijuana	36.9%	19.6%	Significantly Higher
Ever used cocaine	17.9%	6.1%	Significantly Higher
Ever used heroin	9.2%	6.9%	Not significantly different
Ever took prescription drugs without a doctor's prescription	11.9%	3.6%	Not significantly different
Currently use prescription drugs without a doctor's prescription	28.5%	16.9%	Not significantly different

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Natives had almost double the rates of opioid related inpatient hospitalization than the greater Nevada population. It is not known if this is due to higher rates of opioids use, an over reliance on hospitals to initiate treatment, or other factors

Opioid Related Indicators by Race/Ethnicity Status – Nevada Residents, 2015

Indicator	American Indian/Alaska Native Rate*	Nevada Rate*
Opioid Related Emergency Room Encounter	236.8	244.8
Opioid Related Inpatient Hospitalization	522.9	286.4
Opioid Related Overdose (Death)	21.5	16.2

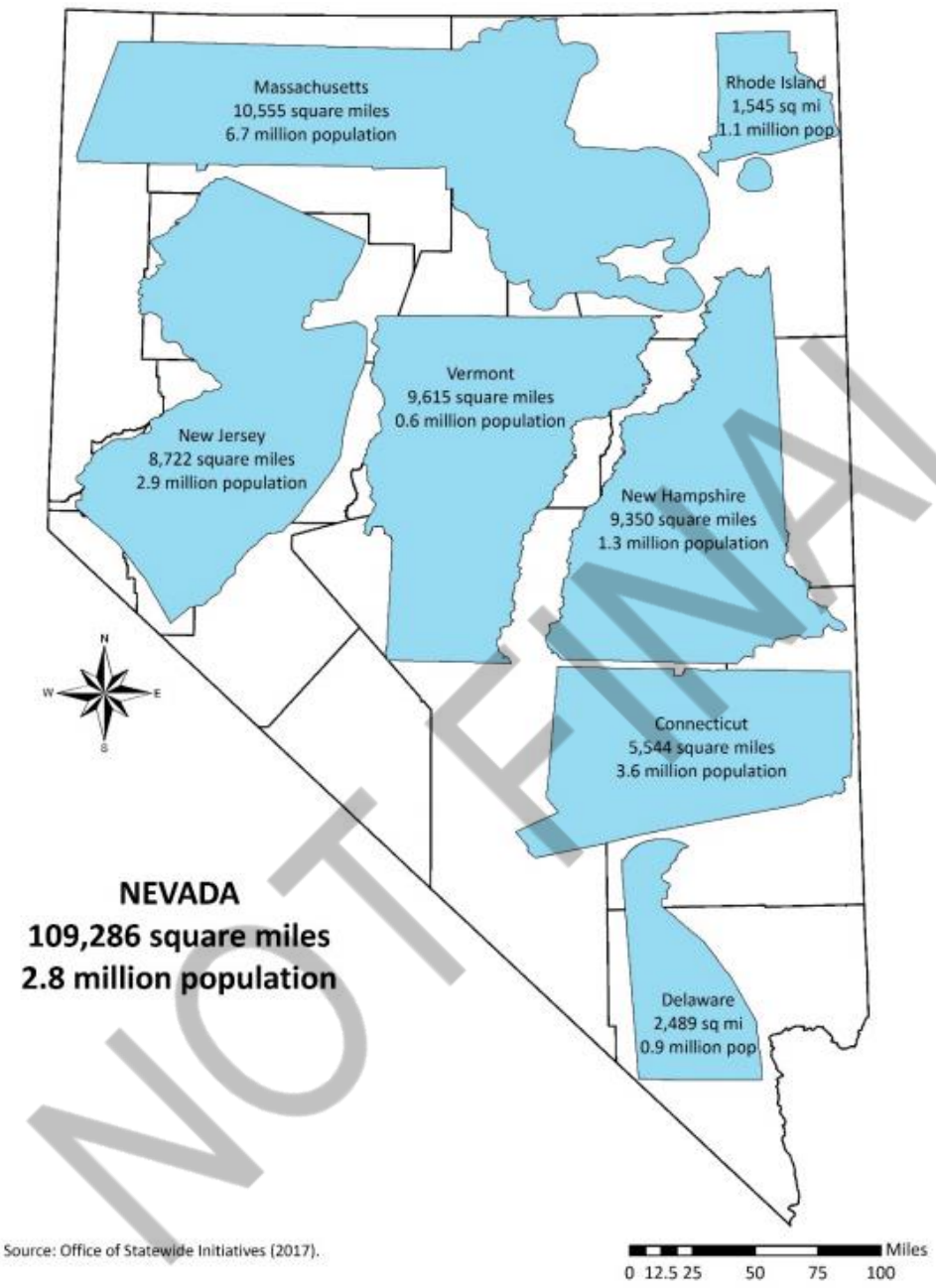
Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge, Hospital Inpatient Billing, WEVRRS
**Rate per 100,000 population*

Persons who Inject Drugs

Nationally, 4.4 million individuals reported injecting drugs via needle in 2013, heroin being the drug most used with this methodology (2013 National Survey on Drug Use and Health). There is no current data on the state of Nevada's IV drug users. This population will be a focus for later data gathering.

Rural Nevada

Rural Nevada counties include Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Nye, Mineral, Pershing, Storey, and White Pine (14 total). Urban counties are Carson City, Clark, and Washoe. A great portion of Nevada is considered rural and frontier, leading to several extra barriers to assist in treatment for behavioral health concerns. Of the 2.8 million people living in Nevada, 281,019 residents live within a rural county and while the rural areas only count for less than 10% of the State's population, these counties cover over 85% of the State's land mass. When it comes to the health of Nevada, there are substantial differences when comparing rural to urban areas. According to the 2017 Nevada Rural and Frontier Health Data Book - Eighth Edition, rural areas have higher rates of obesity, diabetes, physical inactivity, tobacco use and infant mortality. When comparing the ten leading causes of death in Nevada, suicide was listed as number 6 for rural areas; it was not in the top 10 when classifying the entire State.



2017 Nevada Rural and Frontier Health Data Book - Eighth Edition

Insurance Rate in Rural Nevada

Insured residents are comparable across State counties, but uninsured persons range from 10-17% of the State's population.

Insured Population in Nevada by County 2014

Region/County	Estimated Population Under the Age of 65				
	Uninsured Population		Insured Population		Total
	Number	Percent	Number	Percent	
Rural and Frontier					
Churchill County	3,351	13.8	20,989	86.2	24,340
Douglas County	5,198	11.7	40,005	88.5	45,203
Elko County	6,985	14.8	45,460	86.7	52,445
Esmeralda County	121	17.0	692	85.1	813
Eureka County	190	10.1	1,817	90.5	2,007
Humboldt County	2,716	16.6	14,880	84.6	17,596
Lander County	796	12.0	5,233	87.5	5,981
Lincoln County	796	12.0	5,871	88.1	6,667
Lyon County	7,023	13.5	46,328	86.8	53,351
Mineral County	519	11.6	4,051	88.6	4,570
Nye County	5,555	12.3	39,238	87.6	44,793
Pershing County	701	15.7	4,217	85.7	4,918
Storey County	352	11.4	2,763	88.7	3,115
White Pine County	932	11.0	7,939	89.5	8,871
Region Subtotal	35,187	13.3	239,483	87.2	274,670
Urban					
Carson City	6,766	12.6	48,819	87.8	55,585
Clark County	315,827	16.5	1,741,433	84.6	2,057,260
Washoe County	58,428	14.2	388,750	86.9	447,178
Region Subtotal	381,021	16.0	2,179,002	85.1	2,560,023
Nevada — Total	416,208	15.8	2,418,539	85.3	2,834,747

Source: United States Census Bureau (2016).

Professionals in Rural Nevada

In 2015, the number of Nevadans employed in the health sector totaled 102,734 with 7.2% of those located in the rural areas. Included in that total, there were 1,224 licensed alcohol, drug, and gambling counselors in Nevada with 140 in rural counties. Since 2008, the number of licensed alcohol, drug, and gambling counselors in Nevada has decreased by 9 or 0.7% and the per capita number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 42.1 per 100,000 population. Overall, the number of licensed health professionals per 100,000 population is lower in rural Nevada besides a few exceptions. The counties are considered to be in a health professional shortage area in regards to primary care, dental, and mental health. Rural areas were significantly affected by the recent decrease in healthcare professionals.

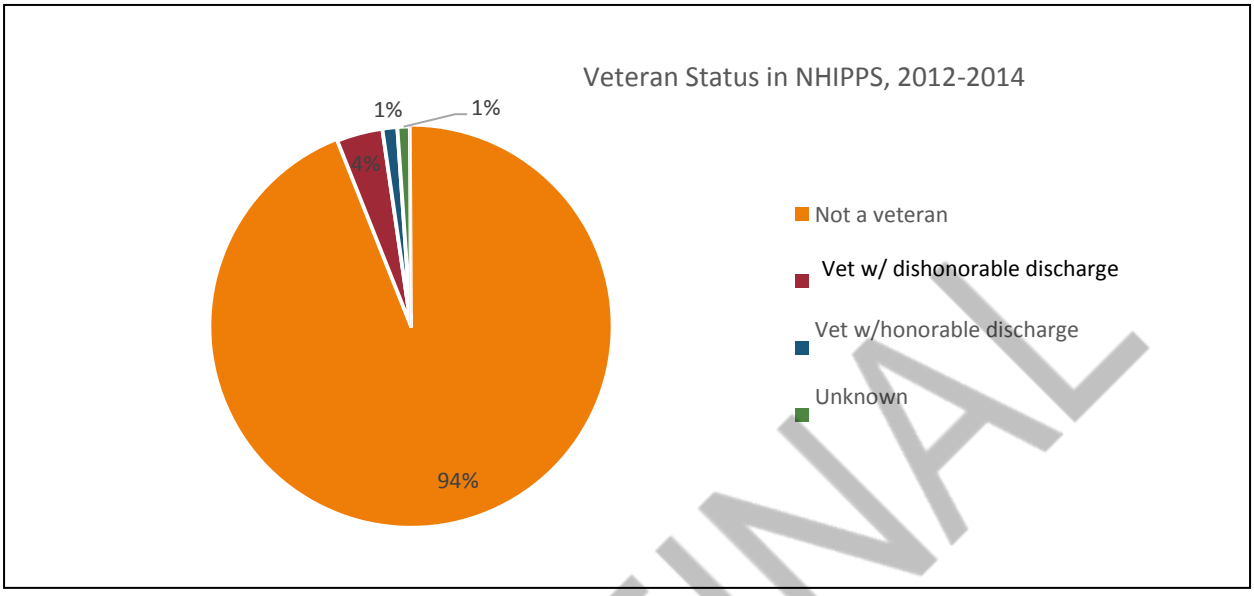
Region/County	Licensed Alcohol, Drug and Gambling Counselors					
	Number		Change — 2008 to 2016		Number per 100,000 Population	
	2008	2016	Number	Percent	2008	2016
Rural and Frontier						
Churchill County	39	32	-7	-17.9	144.5	123.5
Douglas County	30	21	-9	-30.0	57.5	43.9
Elko County	88	21	-67	-76.1	174.0	37.8
Esmeralda County	1	0	-1	-100.0	80.6	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	9	12	3	33.3	50.0	64.9
Lander County	2	3	1	50.0	34.0	44.3
Lincoln County	1	2	1	100.0	23.0	38.9
Lyon County	31	30	-1	-3.2	55.5	55.3
Mineral County	1	0	-1	-100.0	22.7	0.0
Nye County	16	9	-7	-43.8	33.8	19.9
Pershing County	2	3	1	50.0	27.8	42.6
Storey County	2	2	0	0.0	45.6	49.4
White Pine County	4	5	1	25.0	41.3	48.2
Region Subtotal	226	140	-86	-38.1	78.0	48.8
Urban						
Carson City	62	57	-5	-8.1	107.6	103.3
Clark County	619	731	112	18.1	31.5	35.0
Washoe County	326	296	-30	-9.2	76.9	65.7
Region Subtotal	1,007	1,084	77	7.6	41.1	41.5
Nevada — Total	1,233	1,224	-9	-0.7	45.0	42.1

Source: Nevada State Board of Examiners for Alcohol, Drug and Gambling Counselors (2008, 2016).

Veterans

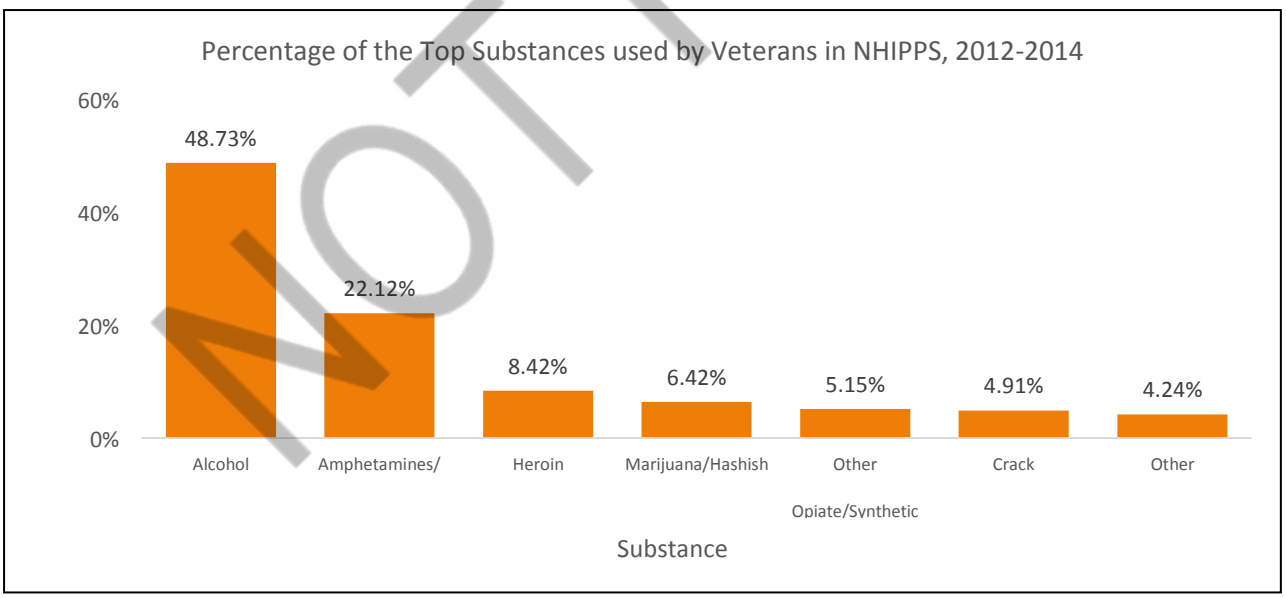
According to the US Census Bureau's American Community Survey, veterans account for 11% of the Nevada population in 2013.

Veteran Status in NHIPPS, 2012-2014



US Census Bureau's American Community Survey 2015

Percentage of the Top Substances used by Veterans in NHIPPS, 2012-2014



US Census Bureau's American Community Survey 2015

Alcohol and amphetamines are the top substances used by veterans, different from the overall population which is alcohol and marijuana. The TEDS excludes admissions to Veterans Affairs (VA) facilities; therefore, the veteran admissions in TEDS represent veterans who chose to seek substance abuse treatment in a non-VA facility. In 2013, there were about 62,000 admissions of veterans nationally.

Persons experiencing Homelessness

The homeless population is tracked by a point in time count monitored by the US Department of Housing and Urban Development (HUD). The data reflects the most current 2016 count. A total of 7,398 individuals are reported homeless, the majority being male and non-Hispanic. Within the homeless population, 1,120 have a chronic substance abuse problem (15.1%). This population may be difficult to reach and provide services to. Utilizing FASST (previously described) is a potential way to interact with this special population as well as mobile crisis intervention teams.

Recommendations for Gaps

There are several gaps in data collection and access to treatment for individuals suffering from a substance use disorder. The priorities of the SABG will be to close some of the gaps found.

A major gap is the lack of providers throughout the State, especially within rural areas of Nevada which comprises a great geographical area within Nevada. Therefore, increasing behavioral health care in Nevada with a specific focus on the rural areas will be a goal for this grant. The objective is to expand access to professionals in areas of need. Some strategies will be to provide additional and adequate trainings, incentivize working in these areas, utilize telehealth when applicable, increase evidence-based practices and provide adequate screenings and referrals at all points of entry for treatment where an individual with a substance use disorder may be seen. Nevada already has the capacity for several of these strategies so effective promotion will be enacted. Equipping providers with the knowledge and skills to work with diverse populations is crucial.

Recovery support is an area where Nevada can expand its services. To be as effective as possible, Nevada strives to provide prevention, intervention, treatment, and recovery support. One way to increase recovery support services is to expand the continuum of care beyond treatment services. SAPTA will facilitate this through several strategies including increasing the use of peer support specialists, providing education on the benefits of holistic wellness and increasing the number of sober living opportunities. Currently, over 1,500 individuals have been certified through various agencies across the State to be peer recovery support specialist. This is no current legislation that requires certification for peers within the state of Nevada so as of now it is done on a voluntary basis. Current work is being done to change legislation by the Nevada Peer Leadership Advisory Council. SAMSHA's Recovery Support Strategic Initiative will be utilized for the planning process. For example, Wellness Recovery Action Plan is an evidence-based

The next priority will be to integrate behavioral health with health promotion and health care delivery. This will improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information throughout the State. A major barrier identified

in the needs assessment was lack of knowledge of resources from the providers and consumers. With Nevada's large geographical size, effective referrals can be difficult. By creating linkages within the State systems, a quicker, smoother transition between different providers may be possible. Also, continuing to meet the diverse cultural and linguistic needs of Nevada residents will help assist individuals get the help they need. A program already in place is 2-1-1 Nevada, developed to provide accurate, well-organized, easy-to-find information within the State and can be accessed by internet and phone. This is just one example of how Nevada will continue to provide better information to resources. Utilization of Electronic Health Records (EHR) may assist in sharing information from one provider to another to have a broader, holistic snapshot of the needs of specific clients.

Supporting earlier access to prevention and early intervention services will assist in getting individuals to services required to prevent escalation of potential problems. As noted, 85-95% of youth needing services are not receiving them. Nevada will utilize universal prevention strategies (designed to reach the entire state population) as well as targeted activities for specific populations such as adolescence, pregnant women, LGBT, and veterans. Some strategies employed will provide education on misuse, alternative activities, and evidence-based intervention practices.

Pregnant women are a special population in need of additional support. As noted, pregnant women receiving services has recently decreased in the state of Nevada. It is estimated that 50% of pregnancies in the U.S. are unplanned so a women might not even be aware she is using substances while pregnant. As Nevada receives federal funds from the Substance Abuse Prevention and Treatment Block Grant, the State must meet the requirements of 45 CFR 96.131, Treatment services for pregnant women, which states: "The State is required to, in accordance with this section, ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admissions to treatment facilities receiving funds pursuant to the grant". Nevada's public health approach to maternal substance misuse aims to prevent substance misuse in pregnant women and provide information to women of childbearing age, providers, and concerned family and friends. Some strategies that will be enacted are the use of SBIRT, specifically in medical settings, dissemination of misuse information, and proper referrals to agencies that provides services for pregnant women.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

- The state of NV currently collects information from provider agencies that is housed in their own private EHR's; primarily myAvatar, AWARDS, and MethaSoft. We are currently collecting NOMs and TEDS data from providers who submit their data through tested systems; however, in 2015, multiple providers changed to new EHR systems. For those providers we are working to ensure they are collecting required NOMs and TEDS data and reporting this data back to the State. We are currently projecting to collect and report all essential data from funded providers by the end of the calendar year 2018. Occasionally, additional data is requested from providers outside of the mandatory TEDS reporting. Each provider is responsible for developing the report in the specified file format and forwarding that information to us by a determined deadline.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

- The state is moving away from housing or requiring just one system specific to substance abuse and/or mental health services. Our state mental health providers and a very small portion of the substance abuse providers are using myAvatar to house their data but on the substance abuse side it is not mandatory that they use myAvatar. Many other providers are using the Awards system or a different EHR that is more suitable to the way they do business.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

- The state is currently able to report at the client level for providers who currently enter data into either myAvatar or NHIPPS. However, requests can be made to providers on external EHR's for adhoc data requests.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

- We are currently projecting to collect and report all essential data from funded providers by the end of the calendar year 2018. In order to ensure accountability and provider compliance, we may withhold provider funds for providers that are not collecting and/or reporting required data.

The Division of Public and Behavioral Health (DBPH), under the Department of Health and Human Services (DHHS), has experience in data collection and performance measurement as demonstrated by several SAMHSA-funded projects, including the State Incentive Grant (SIG), Strategic Prevention Framework State Incentive Grant (SPF-SIG), the State Epidemiological Outcomes Workgroup (SEOW) The PATH program, and the CABHI Program. Nevada has a current state system that is able to report data at the client, program, provider, provider type, and funding level. with plans in the next 6 months to start onboarding the WITS system. The state's data collecting and reporting system for substance abuse and mental health is part of a larger system that include the Division of Child and Family Services (DCFS), the Division of Aging and Disability (ADSD), the Division of Health Care Financing and Policy (DHCFP – Medicaid), and Division of Welfare and Supportive Services (DWSS). The state is able to collect and report on measures at the individual client level, which includes diagnosis, client served, while also protecting and not making client-identification available. Nevada has been collecting client level data and working to improve and expand the ability to ensure validity, reliability, and continuity with data collection and evaluation measures.

Office of Public Health Informatics and Epidemiology

The Office of Public Health Informatics and Epidemiology (OPHIE) records and analyzes reportable disease information, conducts interviews with infected individuals and their contacts, refers individuals for medical treatment, analyzes data from disease investigations, identifies risk factors, provides education and recommendations on disease prevention, and works in conjunction with appropriate agencies to enforce communicable disease laws. Reporting data includes, but is not limited to, vital statistics, morbidity, cancer, demographics, infection disease,

sentinel event, and psychology. This includes a Health Statistics Portal. OPHIE also identifies and manages reportable diseases and Nevada Core Health Indicators. The OPHIE houses over 60 public and behavioral health datasets, including communicable disease (HIV, STD, TB, and others) registries, births, deaths, fetal deaths, abortions, marriages, divorces, cancer, mental health, substance use prevention and treatment, the Behavioral Risk Factor Surveillance Survey, Youth Risk Behavior Surveillance Survey, and others. Common elements between databases enable matching or linking of these databases in order to provide newly accessible and standardized information for analytical and programmatic purposes. Extracted databases derived from each database and linked databases are available for statistical data analysis. Analyses are compiled in a variety of reports, which are posted on the DPBH website, making the data available for program evaluation and planning and policy development.

Center for Health Information Analysis (CHIA)

Nevada implements data measures to improve quality of health, but also to evaluate cost savings from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and group care. Through the Center for Health Information Analysis for Nevada (CHIA), CHIA provides information on over 250 Nevada Healthcare facilitates that submit summary utilization and financial data per state regulation. After all of the facilities have submitted their quarterly data, CHIA aggregates and formats the data. These include acute hospitals, non-acute hospitals, ambulatory surgical centers, skilled nursing/intermediate care facilitate, imaging facilities and hospices. This includes, but is not limited to, emergency department admissions by diagnosis, psychiatric in-patient hospital admission, and residential treatment center out of state placement.

Medicaid Data Collection

The Division of Health Care Financing and Policy (DHCFP) [Nevada Medicaid] – provides baseline data and updates insurance information to ensure that there is no duplication of services; or care being provided for Medicaid eligible recipients. DHHS is able to capture billing date for the managed care organizations (MCOs) that serve both Clark and Washoe County Medicaid recipients; Fee-For-Service (FFS) recipients in rural and frontier Nevada; and Care Management Organization (CMO) information for FFS recipients with identified chronic conditions. This data can capture client level data, provider, type of service provided, and demographics.

Transformation Accountability (TRAC)

Nevada utilizes the Transformation Accountability (TRAC) client-level measures for providing direct services at baseline, 6-month follow up and at discharge. Nevada ensures that data is entered into the Common Data Platform (CDP) web system with seven days of data collection. Specific information will be detailed in the reporting: mental illness symptomatology; employment; education; crime and/or criminal justice; housing; access; age; gender; race; and ethnicity; rate of re-admission to psychiatric hospitals; social support; and client perception of care. Nevada has been expanding use of process and outcome evaluation to guide the development of behavioral health services and the system of care. The Nevada system of care is built on: formative implementation evaluation to monitor the process and success of initiating plans and programs, strengths, needs, culture and gaps analysis to determine how well the current system is addressing the needs of children and families in Nevada. Process and fidelity assessments are used to determine if services and system development meet performance standards and expectations. Outcome evaluation is used to determine the effectiveness and cost impact of the services we provide.

Data-driven Quality Improvement
To ensure continually quality improvement and integrity of the data, DPBH data and evaluation teams verify and ensure that data are synthesized, analyzed, reviewed, and reported on a quarterly basis, with the priority of assessing 1) a) the progress of the state on the development of a plan; b) sustaining and expanding partnerships; c) developing streamlines applications; d) implementing and expanding the peer

navigation network; e) the individuals serviced are transitioning to independence; f) disparities in service access; g) disparities in service use; and h) client outcomes change over time. In addition, DPBH focuses on access to care and if Nevada is improving in mental health or substance abuse.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women Services

Priority Type: SAP, SAT

Population(s): PWWDC

Goal of the priority area:

Target alcohol and other drug use among women of child-bearing years and women currently pregnant

Objective:

Reduce the prevalence of pregnant women or women with dependent children using illicit drugs or abusing alcohol

Strategies to attain the objective:

i. Educational campaigns on available services and consequences of use
ii. Utilize SBIRT
iii. Proper referrals to agencies that provides services for pregnant women

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Pregnant women and women with dependent children receiving treatment for substance use disorder

Baseline Measurement: 121 Pregnant women received services FY 2015-2016

First-year target/outcome measurement: Increase number of pregnant women receiving services by 5%

Second-year target/outcome measurement: Increase number of pregnant women receiving services by 10%

Data Source:

TEDS

Description of Data:

TEDS provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems.
TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.
TEDS does not include all admissions to substance abuse treatment. It includes admissions to facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment (or are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services.
Data updated quarterly

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Workforce Development

Priority Type: SAT

Population(s): Other (Rural)

Goal of the priority area:

Increase behavioral health care in Nevada with a specific focus on rural areas.

Objective:

Expand access to professionals in areas of Nevada that currently have shortages

Strategies to attain the objective:

i. Increase incentives to practice in rural areas
ii. utilize telehealth when needed
iii. increase training opportunities for professionals
iv. increase evidence-based practices
v. provide adequate screening at multiple outlets (hospitals,treatment,etc)
vi. utilize mobile units and first responders
vii. increase Naloxone trainings and availability

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Alcohol and Drug Counselors

Baseline Measurement: 140 Licensed Alcohol and Drug Counselors in 2016

First-year target/outcome measurement: increase substance use professionals in rural areas by 5% or 7 new professionals

Second-year target/outcome measurement: increase substance use professionals In rural areas by 10% or 14 new professionals

Data Source:

8th Edition Nevada Rural Data Book 2017

Description of Data:

Data was gathered from the Nevada State Board of Examiners for Alcohol, Drug and Gambling Counselors.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase the number of telehealth trainings

Baseline Measurement: 1 face-to-face training and 1 webinar in 2016

First-year target/outcome measurement: Complete 2 face-to-face trainings and 2 webinars

Second-year target/outcome measurement: Complete 4 face-to-face trainings and 4 webinars

Data Source:

Center for the Application of Substance Abuse Technologies (CASAT)

Description of Data:

CASAT is the only agency in Nevada completing trainings for telehealth.

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Recovery Support Services

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH, Students in College, Rural)

Goal of the priority area:

Increase recovery support services offered throughout the state

Objective:

Expand continuum of care with support services after treatment

Strategies to attain the objective:

i. Increase the use of Peer Support Specialists
ii. increase the number of sober living opportunities
iii. open a recovery community organization in Northern Nevada
iv. Utilize holistic health and wellness activities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Peer Support Specialists

Baseline Measurement: 1,500 Peers certified as of July, 1017 specifically for SUD

First-year target/outcome measurement: Increase number of peers certified by 50, totally 1,550

Second-year target/outcome measurement: Increase the number of peers certified by 10, totally 1,600

Data Source:

Foundations for Recovery (FFR) and the Center for the Application of Substance Abuse Technologies (CASAT)

Description of Data:

FFR is located in Southern Nevada and CASAT in Northern Nevada.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Develop a training for agencies on how to most effectively utilize Peers and the benefits

Baseline Measurement: None

First-year target/outcome measurement: Develop the training

Second-year target/outcome measurement: Complete 3 trainings

Data Source:

Center for the Application of Substance Abuse Technologies

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Behavioral Health Care

Priority Type: SAP, SAT

Population(s): PP

Goal of the priority area:

Integrate behavioral health with health promotion and health care delivery

Objective:

Improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information and intercommunication throughout the state

Strategies to attain the objective:

i. Create linkages between state systems for access to information
ii. develop culturally and linguistically appropriate services
iii. provide easy access and up-to-date information for providers and consumers
iv. utilize Electronic Health Records
v. Utilize 2-1-1

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Develop a communications plan and engage partners in sharing up-to-date messaging and information.
Baseline Measurement:	N/A
First-year target/outcome measurement:	Develop a statewide communication plan
Second-year target/outcome measurement:	Implement plan

Data Source:

N/A

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Utilize 2-1-1
Baseline Measurement:	N/A
First-year target/outcome measurement:	Require SAPTA funded providers to provide up-to-date information to 2-1-1 about access and availability of services
Second-year target/outcome measurement:	Promote 2-1-1

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Prevention and Early Intervention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Support earlier access to prevention and early intervention services

Objective:

Prevent or delay onset of, and mitigate symptoms and complications from substance use disorders

Strategies to attain the objective:

i. Target high risk populations (adolescents/LGBTQ, pregnant women),
ii. alternative activities
iii. Outreach/education/environmental strategies targeting youth, young adults and adults about how to resist and avoid abuse of alcohol and other drugs
iv. Use of evidence-based practices

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decrease alcohol use in middle school students

Baseline Measurement: 29.4% of middle school students have used alcohol in 2015 survey

First-year target/outcome measurement: Decrease alcohol use to 28% of middle school students

Second-year target/outcome measurement: Decrease alcohol use to 26% in middle school students.

Data Source:

Nevada Youth Risk Behavior Survey

Description of Data:

Nevada Youth Risk Behavior Survey completes it's surveys in the school setting.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase in access to treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse

Baseline Measurement: 85.6% of individuals who needed treatment do not receive it

First-year target/outcome measurement: Increase percentage of individuals who needed treatment aged 12 or older for SUD do not receive it to 16%

Second-year target/outcome measurement: Increase percentage of individuals who needed treatment aged 12 or older for SUD do not receive it to 17.5%

Data Source:

Behavioral Health Barometer 2015

Description of Data:

SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Improve the quality and disorder-relevance of services.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Goal 1–Improve capacity of social institutions within communities (Ex: schools, youth social groups and services organizations, faith-based organizations) to identify, assess, treat and track at-risk and high-risk populations of children and adolescents with the purpose of improving child and adolescent mental health.

Objective:

Objective 1.1: By March, 2018, increase the number of youth serving adults including but not limited to school professionals, social groups and services organizations, faith-based organizations etc. who are trained in recognizing signs and symptoms substance use and mental health disorders.
Objective 2.1: By March 2018 increase the number of referrals from trained community members to behavioral health services.
Objective 3.1: By October 2019 have a statistically significant decrease in percentage of students reporting psychological stress including self harm behaviors, mood symptoms, and suicide attempts on the YRBS.

Strategies to attain the objective:

Activity 1: By March, 2018, solicit competitive bids from community providers statewide to implement mental health training protocols.
Activity 2: By October, 2018, pick an evidence based practice to ensure community members are trained.
Activity 3: By March, 2019, establish database and schedules for long-term tracking of outcomes for each at-risk and high-risk individual who is served in behavioral health protocols.
Activity 4: By October, 2019, establish mechanisms for routine (at least annually) programmatic reviews that are outcomes driven
Activity 5: By March 2018 Develop an evaluation plan.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Statistically significant reduction in the emotional health section of the YRBS
Baseline Measurement:	33% of respondents in 2015 reported feeling sad or hopeless almost every day for 2 or more weeks in a row and stopped engaging in usual activities, and 11% attempted suicide 1 or more times during the 12 months prior to the survey.
First-year target/outcome measurement:	statistically significantly lower health section scores as measured by analysis variance.
Second-year target/outcome measurement:	maintain status of equal to or below the national norm.

Data Source:

2015 Nevada Youth Risk Behavior Survey, which is conducted by the Centers for Disease Control (CDC) and Prevention, and local and state education and health agencies.

Description of Data:

Statewide Youth Risk Behavior Survey Data.

Data issues/caveats that affect outcome measures::

YRBS is only conducted bi annually and methodology is not always consistent across communities. Some communities are active consent, and others are passive consent areas. In small rural and frontier communities it is difficult to survey the students because of the ease of identifying individuals.

Priority #: 7

Priority Area: Unmet Service Need and Critical Gaps. Improve access to services for First Episode of Psychosis (FEP) and Early Severe Mental Illness (ESMI).

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Ensure early intervention services are available statewide for First Episode of Psychosis (FEP), and Early Serious Mental Illness (ESMI).

Objective:

Objective 1.1: Expand capacity to address ESMI in the urban areas.
Objective 2.1: Build capacity in frontier and rural areas to address ESMI

Strategies to attain the objective:

Activity 1.1: By October, 2018, adapt and implement the evidence-based Coordinated Specialty Care (CSC) model in NV's Rural & Frontier communities for First Episode of Psychosis (FEP) and Early Severe Mental Illness (ESMI).
Activity 1.2: By October, 2018, solicit competitive bids from community providers to implement CSC-Rural and Frontier Nevada.

Activity 1.3: By March, 2019, roll out CSC-Rural and Frontier Nevada.
Activity 1.4: By March 2018 work with current providers in urban areas to increase the number of individuals receiving services
Activity 1.5. By March 2018 give technical assistance to providers to enhance current community outreach strategies for identification, recruitment, and increase the number of individuals enrolled in the ESMI programs as a result of the outreach efforts.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	number of persons receiving ESMI services
Baseline Measurement:	40 individuals received ESMI services from july 2015 until May of 2017.
First-year target/outcome measurement:	increase enrollment of ESMI services to 60 by September 2018
Second-year target/outcome measurement:	Increase enrollment of ESMI services to 80 individuals by September 2019

Data Source:

Department of Child and Family Services reports of clients served.

Description of Data:

Actual Client counts.

Using the incidents rate of 15.2 per 100,000 population McGrath etal 2008 it was determined that 456 new cases per year can be expected for Nevada's population. Over a 2 year period the program was able to build capacity to 40 participants. Therefore in the next 2 years Our goal is to continue the trend and reach 80 individuals which would be roughly 20% of the service need. 114 is 25% of 456 individuals.

Data issues/caveats that affect outcome measures::

because of the increase in reliance on private providers the data is fragmented across multiple private providers and no current mechanism to integrate the data sources. therefore technical assistance is needed to integrate the different providers to help the state build a database for providers that is easy to use which can help determine level of needs, and gaps in the services.

Indicator #:	2
Indicator:	outcomes on the semi structured clinical interview (SCID) DX.
Baseline Measurement:	primary diagnoses at time of enrollment DX, medical co morbidity,
First-year target/outcome measurement:	for the 60 individuals planned to be served in 2018 we want a +1 improvement on SCID for all 60 individuals
Second-year target/outcome measurement:	for the 80 individuals planned to be served will have we want a + 1 improvement on the SCID for all 80 individuals

Data Source:

the semi structured clinical interview (SCID) evaluation.

Description of Data:

A plus one on the SCID clinical interview schedule is defined as not currently in an active episode of illness.

Data issues/caveats that affect outcome measures::

inter rater reliability from clinician to clinician

Indicator #:	3
Indicator:	medical status at admission and yearly thereafter.
Baseline Measurement:	primary care physician medical evaluation
First-year target/outcome measurement:	medical status at year 1 is stable
Second-year target/outcome measurement:	medical status at year 2 is stable

Data Source:

Physicians who provide medical exams. Communication is required between the ESMI provider and the physician consistent with the RAISE model.

Description of Data:

data is relevant to medical status. An example is if a patient is diagnosed with diabetes then glucose regulation is maintained.

Data issues/caveats that affect outcome measures::

lack of fidelity and follow up from staff coordinating the expected care necessary.

Priority #: 8

Priority Area: 3-Promote professional competence and development of Nevada's mental health workforce.

Priority Type: MHS

Population(s): Other (Rural)

Goal of the priority area:

Strengthen knowledge and skills of workforce through participation in education and training curricula that are mission-relevant and nationally recognized as evidence-based.

Objective:

Objective 1.1: By March, 2018, increase the number of training offered to provide

Strategies to attain the objective:

Activity 1.1: By March, 2018, develop education and training curricula for staff and community providers.
Activity 1.2: By March, 2018, through the state process solicit competitive bids from community providers statewide for implementation of education and training for staff and community providers.
Activity 1.3: By October, 2018, roll out educational and training curricula for staff and community providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: number of providers who have completed trainings

Baseline Measurement: number of training completed by contracted agencies in 2016

First-year target/outcome measurement: increase the number of training's by 25% from 2016 baseline

Second-year target/outcome measurement: Increase the number of training's from year 2018 by an additional 25%

Data Source:

contracted training's completed.

Description of Data:

Data comes from frequency counts of participants.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Increase the integration of suicide prevention efforts, clinical services and post-mortem reviews within the state's mental health system.

Priority Type: MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military

Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Develop a model of suicide prevention services that integrates community education, clinical intervention and treatment, and continual quality assurance and performance improvement.

Objective:

Objective 1.1: increase participation in training and cross agency collaboration learning through case presentation and analysis and implementing evidence based suicide prevention practices.

Strategies to attain the objective:

Activity 1.1: By March 31, 2018, identify evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.2: By March 31, 2018, solicit competitive bids (RFAs/RFPs) from community providers statewide for implementation of evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.3: By October 31, 2018, roll out evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.4: By March 31, 2019, establish database and schedules for long-term tracking of outcomes associated with each component in the integrated model: suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.5: By October 31, 2019, establish mechanisms for routine (at least semi-annually, initally) programmatic reviews of the integrated model for suicide prevention driven by clinical outcomes related to suicide.
Activity 1.6: By March 31, 2018 host meetings with a minimum of participants from the 3 sectors from the community education component, clinical interventions and treatment component, and post mortem review

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: numbers of meetings held and participants

Baseline Measurement: anything greater than zero

First-year target/outcome measurement: Hold 2 meetings for the year

Second-year target/outcome measurement: Hold quarterly meetings for the year

Data Source:

Office of suicide prevention tracking the number of participants and number of meetings held.

Description of Data:

frequency counts

Data issues/caveats that affect outcome measures::

none

Priority #: 10

Priority Area: Priority 5-Organize clinical data to enable tracking of empirically-based clinical outcomes

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goal of the priority area:

To have health information technology and measurement methodology that support Nevada's current mental health care system, including its community providers.

Objective:

Improve capacity for monitoring and evaluating programmatic efficacy by enable tracking empirically-based clinical outcomes.

Strategies to attain the objective:

Activity: 5.1: By March 31, 2018, Implement the WITS system and integrate it with other data tools.
Activity: 5.2: By March 31, 2019, establish an inner- agency planning committee to identify common outcome measurements
Activity: 5.3: By October 31, 2019, Develop a pilot group of participants to roll out database for health information technology and measurement protocol.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	ability to longitudinally track individual outcomes of treatment recipients.
Baseline Measurement:	we currently do not have a mechanism to measure clinical outcomes.
First-year target/outcome measurement:	a battery of standardized tools have been formally adopted for measuring behavioral health clinical outcomes.
Second-year target/outcome measurement:	the standardized tools have been implemented and data being collected.

Data Source:

Medicaid behavioral health dashboard reports and claims data, Avatar reports. WITS system reports, and other electronic health record systems that providers are currently using.

Description of Data:

standardized functional analysis scores.

Data issues/caveats that affect outcome measures::

dependent on tools that are selected. The ability to come to a collective solution on standardized data tools will be difficult.

Footnotes:

We would like technical assistance to address anonymity issues in small rural communities when collecting data.
We would also like technical assistance on data based systems that can help us to gather the data across various providers including non SAPTA funded providers.
The State anticipates a need for technical assistance on the SCID model for providers to build capacity to demonstrate inter rater reliability on the SCID.
Technical assistance may be needed on selecting a standardized evidence based assessment battery for all providers to use.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$11,600,488		$8,037,717	$0	$2,762,564	$0	$119,821
a. Pregnant Women and Women with Dependent Children**	$842,892		$0	$0	$0	$0	$0
b. All Other	$10,757,596		$8,037,717	$0	$2,762,564	$0	$119,821
2. Primary Prevention	$3,371,568		$2,207,505	$0	$2,023,893	$0	$0
a. Substance Abuse Primary Prevention	$3,371,568		$2,207,505	$0	$2,023,893	$0	$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	$200,000		$0	$0	$50,000	$0	$0
5. Early Intervention Services for HIV	$842,892		$0	$0	$15,000	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$842,892		$29,431	$0	$1,589,709	$0	$8,742
10. SubTotal (1,2,3,4,9)	$13,486,272	$0	$8,067,148	$0	$4,417,273	$0	$128,563
11. SubTotal (5,6,7,8)	$0	$0	$0	$0	$0	$0	$0
12. Total	$16,857,840	$0	$10,274,653	$0	$6,441,166	$0	$128,563

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$426,605	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$3,626,145	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)		$213,302	$0	$0	$0	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$213,302	$0	$0	$0	$0	$0
11. SubTotal (5,6,7,8)	$0	$4,052,750	$0	$0	$0	$0	$0
12. Total	$0	$4,266,052	$0	$0	$0	$0	$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	791	112
Women with Dependent Children	2076	1145
Individuals with a co-occurring M/SUD	78986	158
Persons who inject drugs	4396	875
Persons experiencing homelessness	7395	690

Please provide an explanation for any data cells for which the stats does not have a data source.

Footnotes:

The numbers reflected in this chart for treatment are only for SABG funded entities. It is not reflective of the true population being served across Nevada as the data for non funded providers are not currently being gathered or reported to the state.

Data References:
1. Pregnant women: 2015 NSDUH - http://pdas.samhsa.gov/#/

2. Women w/ dependent children:2015 NSDUH: http://pdas.samhsa.gov/#/

3. Individuals w/ a co-occuring M/SUD:
https://www.samhsa.gov/data/sites/default/files/NSDUHsaeStateTabs2015B/NSDUHsaeSpecificStates2015.htm

4. Persons who inject drugs: 2015 NSDUH - http://pdas.samhsa.gov/#/)

5. Persons experiencing homelessness:
(https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_NV_2016.pdf)

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$11,600,488
2 . Primary Substance Abuse Prevention	$3,371,568
3 . Early Intervention Services for HIV*	$842,892
4 . Tuberculosis Services	$200,000
5 . Administration (SSA Level Only)	$842,892
6. Total	$16,857,840

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$549,000
	Selective	$120,700
	Indicated	$170,000
	Unspecified	$10,000
	Total	$849,700
Education	Universal	$211,787
	Selective	$0
	Indicated	$751,455
	Unspecified	$43,500
	Total	$1,006,742
Alternatives	Universal	$275,218
	Selective	$30,064
	Indicated	$151,750
	Unspecified	$10,000
	Total	$467,032
Problem Identification and Referral	Universal	$60,000
	Selective	$0
	Indicated	$34,251
	Unspecified	$0
	Total	$94,251

Community-Based Process	Universal	$185,000
	Selective	$30,000
	Indicated	$78,000
	Unspecified	$5,400
	Total	$298,400
Environmental	Universal	$157,618
	Selective	$22,541
	Indicated	$81,205
	Unspecified	$6,000
	Total	$267,364
Section 1926 Tobacco	Universal	$225,000
	Selective	$123,079
	Indicated	$40,000
	Unspecified	$0
	Total	$388,079
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$0
Total Prevention Expenditures		$3,371,568
Total SABG Award*		$16,857,840
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$1,247,718
Universal Indirect	$415,905
Selective	$332,648
Indicated	$1,375,297
Column Total	$3,371,568
Total SABG Award*	$16,857,840
Planned Primary Prevention Percentage	20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	þ
Inhalants	¢
Methamphetamine	þ
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	þ
Military Families	þ
LGBT	þ
American Indians/Alaska Natives	þ
African American	¢
Hispanic	þ
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	þ
Underserved Racial and Ethnic Minorities	¢

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems				$200,000
2. Infrastructure Support				$140,000
3. Partnerships, community outreach, and needs assessment				$349,928
4. Planning Council Activities (MHBG required, SABG optional)				$40,000
5. Quality Assurance and Improvement				$360,000
6. Research and Evaluation				$250,000
7. Training and Education				$150,000
8. Total	$0	$0	$0	$1,489,928

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[37] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

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[40] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[41] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

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[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☐ No

   and Medicaid? ☐ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☐ Yes ☐ No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ☐ Yes ☐ No

   b) Health risks such as

      i) heart disease ☐ Yes ☐ No

      ii) hypertension ☐ Yes ☐ No

viii) high cholesterol — Yes / No

ix) diabetes — Yes / No

c) Recovery supports — Yes / No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? — Yes / No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? — Yes / No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

    a) Race ( ) Yes ( ) No

    b) Ethnicity ( ) Yes ( ) No

    c) Gender ( ) Yes ( ) No

    d) Sexual orientation ( ) Yes ( ) No

    e) Gender identity ( ) Yes ( ) No

    f) Age ( ) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ( ) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ( ) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

    Throughout the state, there are groups working on disparity impact statements for various grant projects. These groups have recently come together to collaborate on addressing statewide disparities in a coordinated effort. The partners include the Department of Education, the Nevada State Division of Public and Behavioral Health, and the University of Nevada Reno. Plans are in place to expand the teams working on disparities and utilize the data better to drive decision making.

    Please indicate areas of technical assistance needed related to this section

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

   Integration of value based purchasing decisions.

Footnotes:

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ( ) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ( ) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

In July 2015, Nevada introduced a newly established service of early interventions for residents experiencing a first episode of psychosis (FEP). This service is supported with the 10 percent MHBG set aside, which is sub-contracted through Nevada Division of Child and Family Services to private sector entities, including The Children's Cabinet and its community partners. This service offers interventions for individuals diagnosed with FEP in the urban counties of Washoe and Clark in northern and southern Nevada. Known as Enliven, the service involves a team-based, multi-component approach that includes intensive case management, education and supported employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy for patients and family members. An array of social supports services is also provided, including housing assistance, access to food banks, and financial, transportation and clothing assistance. Enliven may be regarded at this stage as a developing or emerging service. While Enliven includes many of the key components of the coordinated specialty care model that was developed by the National Institute of Mental Health (NIMH) through the RAISE initiative (Heinssen, Goldstein and Azrin, 2014), it is still evolving in terms of workforce training, evidence-based resilience-training psychotherapy, community outreach (population identification/program recruitment and enrollment) and statewide access.

Heinssen R, Goldstein AB, and Azrin ST (2014): Evidence-based treatments for first episode psychosis: Components of coordinated specialty care. Recovery after an initial schizophrenia episode. Bethesda, MD: National Institute of Mental Health.

for additional information See page 2 of attached document titled Nevada_4_ESMI_Environmental_Factors_Plan_ffy2018-2019.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   See attached document titled

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ( ) Yes ( ) No

5. Does the state collect data specifically related to ESMI? ( ) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ( ) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

   The state will expand the evidence-informed service currently in place for individuals with first episode of psychosis (FEP), and extend it to individuals diagnosed with early serious mental illness (ESMI). (Please see response to Question #8 below.) As described in the response to Question #2 above, Nevada's Enliven service provides early interventions for FEP that align with the coordinated specialty care model developed by the National Institute of Mental Health (Recovery After an Initial Schizophrenia Episode (RAISE): Heinssen et al., 2014). A team-based, multi-component framework has been developed to treat Nevada's FEP population that includes intensive case management, education and supported employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy services for patients and family members. A broad range of social supports services is also provided. Enliven is regarded as a developing or emerging service. As discussed for Question #2 above, this constellation of interventions is still evolving in terms of workforce training, evidence-based resilience-training psychotherapy, community outreach (population identification/program recruitment and enrollment) and statewide access.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

   See page 4-14 of attached document titled Nevada_4_ESMI_Environmental_Factors_Plan_ffy2018-2019. to show narrative charts and data points.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

   • Current data collection and reporting mechanisms: Data collection and reporting mechanisms are already in place for the National Outcomes Measures (NOMs) that are supported by SAMHSA.
   • Planned data collection and reporting for Early Intervention Services Model: The existing database that includes the SAMHSA NOMs indicators will be expanded to include data recorded from evaluations that capture the unique characteristics of the FEP and ESMI populations. A repeated measures design will be used for the purposes of identifying trends over time, and estimating the impact of early intervention services provided to these populations. Baseline and periodic evaluations will assess the following factors: DSM-5 diagnoses, medical health examination results, duration of untreated psychiatric illness estimated by age at onset of FEP/ESMI and date of enrollment in first services, duration of lifetime antipsychotic medication at enrollment, medication regimen at enrollment, severity of illness, positive and negative symptoms, social and cognitive functioning, and quality of life.
   NOTE: The state anticipates that training of staff and technical assistance will be required to implement this strategic objective.

10. Please list the diagnostic categories identified for your state's ESMI programs.

    DSM-5 Diagnostic Categories for Nevada's Early Serious Mental Illness program:
    • First Episode of Psychosis (FEP): Non-affective and Affective Psychoses
    o Schizophrenia Spectrum and Other Psychoses, including:
    ? Delusional Disorder
    ? Schizophreniform Disorder
    ? Schizophrenia
    ? Schizoaffective Disorder
    ? Other specified/unspecified Schizophrenia Spectrum and Other Psychotic Disorders
    • Early serious mental illness (ESMI)
    o Bipolar I and II Disorders
    o Depressive Disorders
    ? Major Depressive Disorder
    ? Dysthymia (persistent depressive disorder)
    o Anxiety Disorders
    o Substance-Related and Addictive Disorders, including:
    ? Substance Use Disorders
    ? Gambling Disorder (non-substance-related disorder)

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

• Training and technical assistance to increase the capacity of providers to deliver the diagnostic and clinical evaluations described in the response to Question #9 above. Areas in which training and staff development will be most needed include capacity to distinguish the psychosis prodrome from the onset of a first episode of psychosis, and to estimate duration of untreated illness.

• Training and technical assistance to increase the capacity of providers to deliver the key components of the identified evidence-based program, the Coordinated Specialty Care (CSC) services model, for treating FEP and ESMI, which are described in the responses to Questions #2 and #8.
• Training and technical assistance are necessary to increase the capacity of the state's dedicated resources for maintaining and upgrading its electronic record(s) (i.e., electronic health record(s); electronic medical record(s)). See the description of the planned data collection and reporting activities that are described for Questions #8 and #9 above.
• Training and technical assistance will be needed for anticipated program evaluation and quality assurance.

Footnotes:

References for Environmental Factors and Plan
4. Evidence-based practices for Early Interventions
to Address Early Serious Mental Illness (ESMI), 10 percent set aside, Required MHBG

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Woodard S (lead author) (October 31, 2016): Application to Participate in the Section 223 Certified Community Behavioral Health Clinics Demonstration Program. Nevada Department of Health and Human Services, Division of Public and Behavioral Health.

Environmental Factors and Plan

4. Evidence-based practices for Early Interventions to Address Early Serious Mental Illness (ESMI), 10 percent set aside, Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.*

*States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.*

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

** MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may* precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1.
Does the state have policies for addressing early serious mental illness (ESMI)?
__ Yes
✓ No

2.
Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
✓ Yes
__ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

In July 2015, Nevada introduced a newly established service of early interventions for residents experiencing a first episode of psychosis (FEP). This service is supported with the 10 percent MHBG set aside, which is sub-contracted through Nevada Division of Child and Family Services to private sector entities, including The Children's Cabinet and its community partners. This service offers interventions for individuals diagnosed with FEP in the urban counties of Washoe and Clark in northern and southern Nevada. Known as *Enliven*, the service involves a team-based, multi-component approach that includes intensive case management, education and supported

employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy for patients and family members. An array of social supports services is also provided, including housing assistance, access to food banks, and financial, transportation and clothing assistance. *Enliven* may be regarded at this stage as a developing or emerging service. While *Enliven* includes many of the key components of the coordinated specialty care model that was developed by the National Institute of Mental Health (NIMH) through the RAISE initiative (Heinssen, Goldstein and Azrin, 2014), it is still evolving in terms of workforce training, evidence-based resilience-training psychotherapy, community outreach (population identification/program recruitment and enrollment) and statewide access.

Heinssen R, Goldstein AB, and Azrin ST (2014): Evidence-based treatments for first episode psychosis: Components of coordinated specialty care. Recovery after an initial schizophrenia episode. Bethesda, MD: National Institute of Mental Health.

Table 8.1 (below) shows the number of individuals served by the *Enliven* service since its inception in July 2015 and through May 2017.

Table 8.1: Number of Nevada Residents Served by Enliven, 2015-2017	
Northern Nevada, Washoe County	***Nevada Residents Served (n)***
Brief Contact	25
Screening and Evaluation: Pending Referred Out	 0 43
Excluded (Did not meet criteria)	0
Active Cases of FEP	31
Southern Nevada, Clark County	***Nevada Residents Served (n)***
Brief Contact	5
Screening and Evaluation: Pending Referred Out	 6 0
Excluded (Did not meet criteria)	6
Active Cases of FEP	9

Source: *Enliven Service, The Children's Cabinet, Nevada Division of Child and Family Services, May 18, 2017*

3.
How does the state promote the use of evidence-based practices for individuals with an ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

In addition to the newly established service of early interventions for individuals with first episode of psychosis (FEP), the state currently supports the following evidence-based programs for the treatment of serious mental illness (SMI):

- *Assisted Outpatient Treatment (AOT)*: Also known as involuntary civil commitment, AOT delivers comprehensive community-based treatment to individuals with persistent and serious mental illness. Individuals receiving AOT services participate in a civil court process. To receive AOT services, individuals must have a history of non-compliance with voluntary treatment for their mental health issues, as well as have failed attempts in less restrictive treatment programs. Goals of the involuntary civil commitment AOT program include: preventing harmful outcomes, such as illness relapse that results in hospitalization, incarceration or trauma; supporting individuals in maintaining stability and achieving personal goals; assisting individuals to attain positive relationships with family, friends and other social supports. AOT services include intensive case management; psychiatric services; medication management and support; life skills, job, and vocational support and development; peer and professionally led recovery groups; and financial assistance and housing support.
- *Clinical Program for Assertive Community Treatment (PACT)*: PACT involves a multi-disciplinary team that delivers comprehensive, intensive and integrated care for individuals with serious and persistent mental health disorders. This program is designed to support individuals with serious mental illness in their efforts to live within their community.

Although not included in SAMHSA's National Registry of Evidence-Based Programs and Practices (https://www.samhsa.gov/data/evidence-based-programs-nrepp), community outreach and crisis intervention services are supported by the state through the following program:

- *Mobile Outreach Safety Team (MOST)*: The MOST program is a partnership between public mental health providers and local law enforcement agencies that works to identify individuals who are better served by direct mental health services instead of the criminal justice system.

4.
Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with an ESMI?
✓ Yes
__ No

5.
Does the state collect data specifically related to ESMI?
__ Yes
✓ No

Currently, the state collects the National Outcomes Measures (NOMs) supported by SAMHSA, which do not specifically target the unique clinical symptom profiles, or the distinct patterns of cognitive and social functioning that characterize the FEP and ESMI populations. For a description of the data collection and analyses planned for these specific populations, please see response to Question # 9 below.

6.
Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?
__ Yes
✓ No ?

7.
Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The state will expand the evidence-informed service currently in place for individuals with first episode of psychosis (FEP), and extend it to individuals diagnosed with early serious mental illness (ESMI). (Please see response to Question #8 below.) As described in the response to Question #2 above, Nevada's *Enliven* service provides early interventions for FEP that align with the coordinated specialty care model developed by the National Institute of Mental Health (Recovery After an Initial Schizophrenia Episode (RAISE): Heinssen et al., 2014). A team-based, multi-component framework has been developed to treat Nevada's FEP population that includes intensive case management, education and supported employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy services for patients and family members. A broad range of social supports services is also provided. *Enliven* is regarded as a developing or emerging service. As discussed for Question #2 above, this constellation of interventions is still evolving in terms of workforce training, evidence-based resilience-training psychotherapy, community outreach (population identification/program recruitment and enrollment) and statewide access.

8.
Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis.

A. *The existing early intervention service for individuals with first episode of psychosis (FEP) will be expanded in scope and capacity to include individuals with early serious mental illness (ESMI), and extended geographically throughout the state to include Nevada's rural counties and frontier regions.*

(1) Background and Significance

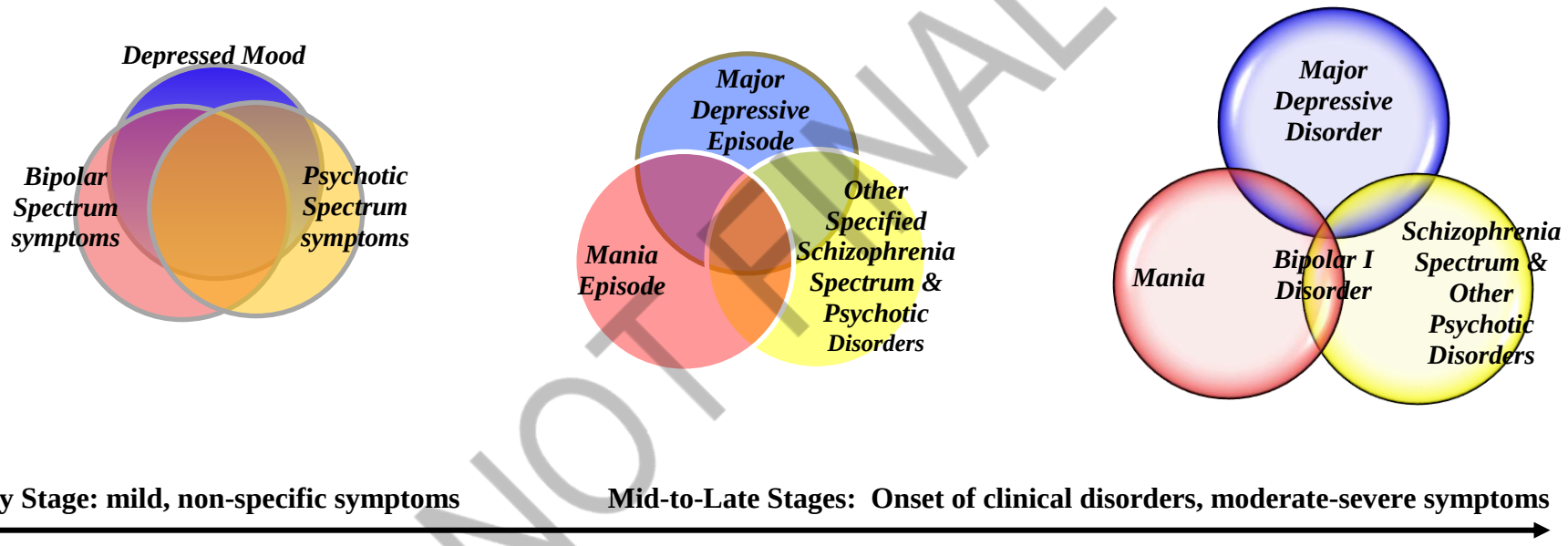
(a) Staging of Clinical Interventions for Early Serious Mental Illness in Nevada's Residents:
The objective of providing effective early interventions for individuals who are at risk for progression from an early stage of serious mental illness to more persistent and debilitating stages of illness has a long history in clinical science and practice. While a discussion of the conceptual development of this work is beyond the scope of this application, it is important to emphasize several conceptual underpinnings. Firstly, the importance of the timing of clinical interventions that are tailored to stage of illness was emphasized relatively recently in this body of work by the

proposal of early psychosis as a critical period during which treatment efforts are more likely to yield positive outcomes (Birchwood and MacMillan, 1993; Birchwood, Todd and Jackson, 1998; McGorry et al., 1996). In parallel, a series of theoretical advances were made in which psychosis is viewed as a dynamic process that progresses over time, with the window for positive outcomes narrowing as the clinical syndrome becomes more organized and fixed (McGorry et al., 1996; McGorry et al., 2010). **Figure 8.1** below (adapted from McGorry et al., 2010) illustrates the idea of chronic ***serious mental illness (SMI)*** as a dynamic process that emerges over time, and which begins as a diffuse constellation of features, characteristics and mild symptoms that gradually cohere within syndromal boundaries.

Offering early interventions for first episode of psychosis (FEP) and early serious mental illness (ESMI) among children, adolescents and young adults represents an optimal strategy for reducing the duration of untreated illness, a factor known to be associated with treatment response and clinical course of psychotic disorders (Addington et al., 2015; Kane et al., 2016). However, as detailed in **Table 8.2** (below), later ages of onset occur for some disorders, including schizophrenia. Therefore, the state's clinical program includes recognition of first episode of psychosis and early serious mental illness as the initial or first manifestations of these illnesses, regardless of chronological age of onset.

(b) Feasibility and Clinical Efficacy of RAISE within Community-based Health Clinics: The RAISE approach involves a comprehensive team-based, recovery-oriented evidence-based intervention originally designed for individuals diagnosed with first episode of psychosis (FEP). Findings from the RAISE initiative lead by NIMH demonstrated the feasibility of implementing its comprehensive coordinated specialty care model within community-based mental health clinics in the United States. Findings from the RAISE research initiative have also provided an evidence base that establishes its clinical efficacy for the population of individuals with FEP. Importantly, in a multi-center comparison of comprehensive coordinated specialty care (CSC) and usual community care for individuals with FEP, Kane et al. (2016) observed greater improvements in clinical and functional outcomes for participants who received the comprehensive multidisciplinary, team-based CSC treatment.

Figure 8.1: The Trajectory of Serious Mental Illness (SMI) as a Dynamic, Emerging Process (*adapted from* McGorry et al., 2010)



(c) Expected Rates of Early Serious Mental Illness (ESMI), including First Episode of Psychosis (FEP), Among Nevada's Residents: Prevalence rates reflect the proportion or total number of individuals in a population who have a disease or characteristic at a distinct point in time or for a defined for period of time. Prevalence can supply valuable information to guide planning and implementation of health care programs and services. This section presents prevalence estimates for SMI and SED among Nevada's residents for 2015 and 2016.

Table 8.1 provides prevalence rates for Serious Mental Illness (SMI) among Nevada residents aged 18 and older for calendar years 2015 and 2016. Prevalence was estimated as the proportion of cases of SMI in the State's population for each year. Rates were determined using methods described for the 2015 SAMHSA Uniform Reporting System (URS) Output Tables for Nevada (https://www.samhsa.gov/data/sites/default/files/Nevada-2016.pdf).

Table 8.1: Rates of Serious Mental Illness (SMI) Among Adults Aged 18 and Older Nevada, 2015 and 2016

Number of Nevada residents with SMI, aged 18 and older [1]	2015 Nevada Civilian Population, aged 18 and older [2]	Estimate of 2015 Nevada Civilian Population, aged 18 and older, with SMI (5.4%) [4]	Lower Limit of Estimate (3.7%) [5]	Upper Limit of Estimate (7.1%) [6]
	2,210,608	119,373	81,792	156,953
Number of Nevada residents with SMI, aged 18 and older	**2016 Nevada Civilian Population, aged 18 and older [3]**	**Estimate of 2016 Nevada Civilian Population, aged 18 and older, with SMI (5.4%) [4]**	**Lower Limit of Estimate (3.7%) [5]**	**Upper Limit of Estimate (7.1%) [6]**
	2,262,631	122,182	83,717	160,647

[1] Estimates for 2015 were prepared by NRI for SAMHSA, November 2016

[2] Population Data Source, 2015: Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2015. U.S. Census Bureau. Release Date: June 2016.

[3] Population Data Source, 2016: Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016. Source: U.S. Census Bureau, Population Division. Release Date: June 2017.

[4] 5.4% prevalence rate for Serious Mental Illness (SMI) adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

[5] Lower Limit of Estimate (5.4% - (1.96 * .8673)): 95% Confidence Bound

[6] Upper Limit of Estimate (5.4% + (1.96 * .8673)): 95% Confidence Bound

Thus, an estimated 119,373 adults in Nevada suffered from Serious Mental Illness (SMI) during 2015, which represents 5.4% of the state's adult population. A similar rate was observed for 2016, with 122,182 adults estimated to be living with SMI.

Table 8.2 provides prevalence rates for Serious Emotional Disturbance (SED) among Nevada youth aged 9 - 17 for calendar years 2015 and 2016. Prevalence was estimated as the proportion or total number of cases of SED in the State's population for each year. Rates were determined using methods described for the 2015 SAMHSA Uniform Reporting System (URS) Output Tables for Nevada (https://www.samhsa.gov/data/sites/default/files/Nevada-2016.pdf)

Table 8.2: Rates of Serious Emotional Disturbance (SED) Among Children Aged 9 - 17 Nevada, 2015 and 2016

Number of Nevada residents with SED, aged 9 - 17 [1]	2015 Nevada Civilian Population aged 9 - 17 [2]	Estimate of 2015 Nevada Civilian Population, aged 9 – 17, with SED (11%) [4]	Lower Limit of Estimate (10%) [5]	Upper Limit of Estimate (12%) [6]
	338,782	37,266	33,878	40,654
Number of Nevada residents with SED, aged 9 - 17	**2016 Nevada Civilian Population aged 9-17 [3]**	**Estimate of 2016 Nevada Civilian Population, aged 9 – 17, with SED (11%) [4]**	**Lower Limit of Estimate (10%) [5]**	**Upper Limit of Estimate (12%) [6]**
	341,224	37,535	34,122	40,947

[1] Estimates for 2015 prepared by NRI for SAMHSA, November 2016

[2] Population Data Source, 2015: Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2015. U.S. Census Bureau. Release Date: June 2016.

[3] Population Data Source, 2016: Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016. Source: U.S. Census Bureau, Population Division. Release Date: June 2017

[4] 11% is mid-point of 9 - 13% range of prevalence rates for children adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

[5] Lower Limit of Estimate (Level of Functioning <= 60) and (State Tier for % in Poverty = Mid) = 10%

[6] Upper Limit of Estimate (Level of Functioning <= 60) and (State Tier for % in Poverty = Mid) = 12%

Thus, an estimated 37,266 children in Nevada suffered from serious emotional disturbance (SED) during 2015, which represents 5.4% of the state's adult population. A similar rate was observed for 2016, with 37,535 children estimated to be living with SED.

(d) Age Cohorts and Community Outreach Planning for Population Identification and Program Recruitment and Enrollment: The prevalence rates observed for Nevada's residents with SMI and SED in 2015 and 2016 are comparable to the range of prevalence estimates of 8.1-11.6% for ***major depressive episode (MDE)*** among adolescents aged 12 to 17 in Nevada and the United States, which were obtained through the National Surveys on Drug Use and Health (NSDUH) for 2010-2011 to 2013-2014. Moreover, the median rate of new cases of ***schizophrenia*** each year (*incidence*) is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). Moreover, as shown in **Table 8.3** below, although a number of serious mental disorders first appear during childhood, adolescence and early adulthood, the age of onset distributions for many disorders extends into middle age. The age of onset for specific mood disorders are included to emphasize this fact. Therefore, the patterns of age of onset identified in these data are important for considerations in designing community outreach efforts directed to identifying and recruiting individuals for potential enrollment in early intervention services for FEP and ESMI.

Table 8.3: Prevalence Rates and Age of Onset Distributions for Select Categories of DSM-IV Mental Disorders [1]

DSM-IV Mental Disorders Aged 18 years and older	Lifetime prevalence *% (SE)* [1]	Age of onset (yrs) (Median) [1]	Age of onset (yrs) (25^{th}–75^{th} percentiles) [1]
Any anxiety disorder	28.8 (0.9)	11	6-21
Any mood disorder	20.8 (0.6)	30	18-43
Major depressive disorder	16.6 (0.5)	32	19-44
Dysthymia	2.5 (0.2)	31	17-43
Bipolar I and II disorders	3.9 (0.2)	25	17-42
Any impulse-control disorder	24.8 (1.1)	11	7-15
Any substance use disorder	14.6 (0.6)	20	18-27

[1] *Adapted from* Kessler et al., 2005a.

(e) Individuals with and FEP and ESMI in Rural Nevada: Details concerning the scarcity of resources and health care services that characterizes rural and frontier Nevada have been included throughout the needs assessment performed for the targeted populations in this application. An important focus here is the major strategic priority for FFY 2018 and FFY 2019 to expand the scope and capacity of the early interventions service for individuals with first episode of psychosis (FEP) to individuals with early serious mental illness (ESMI). Extending this service to Nevada's residents in the State's rural and frontier counties represents an urgent need that is included in that strategic plan. **Table 8.4** below presents the population distribution by age category and geographical regions of the State.

Region	Table 8.4: Population Estimates by Age Category and Region in Nevada, 2017		
	17 and under	**18 to 64**	**65 and over**
Rural and Frontier Region	**58,663**	**164,242**	**56,885**
Urban Region	634,358	1,635,315	367,204
Nevada – Total	693,021	1,799,557	424,089

Source: *Adapted from Griswold, T. et al. (2017) and Nevada State Demographer's Office (2016)*

For the approximately 280,000 individuals who reside in the State's rural and frontier counties, which are highlighted for easy identification in the table above, access to health care services is limited, and this is especially so for mental health services. As discussed in earlier sections, there are *less than 1 psychiatrist and only 4.2 psychologists per 100,000 population for all of the rural and frontier counties combined.* Using the prevalence rates adopted by SAMHSA of 5.4% for Serious Mental Illness (SMI) among adults, and 11% for Serious Emotional Disturbance (SED) among children, the expected rates of SMI and SED are summarized in **Table 8.5** below.

Table 8.5: Rates of Serious Mental Illness and Serious Emotional Disturbance, Rural Nevada, 2017		
Number of Nevada residents with SED, aged 17 and younger	**2017 Rural Nevada Population, aged 17 and younger [1]**	**Estimate of 2017 Rural Nevada Population, aged 17 and younger, with SED (11%) [2]**
	58,663	**6,453**
Number of Nevada residents with SMI, aged 18 and older	**2017 Rural Nevada Population, aged 18 and older [1]**	**Estimate of 2017 Rural Nevada Population, aged 18 and older, with SMI (5.4%) [3]**
	221,127	**11,941**

[1] Population Data Source, 2017: Griswold, T. et al. (2017) and Nevada State Demographer's Office (2016)

[2] 11% is mid-point of 9 - 13% range of prevalence rates for children adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

[3] 5.4% prevalence rate for Serious Mental Illness (SMI) adopted by SAMHSA, NRI, National Association of State Mental Health Program Directors Research Institute.

(2) Access to Services

Numbers of Nevada's Residents with Serious Mental Illness (SMI) Served, 2015: Data presented in earlier sections indicate deficiencies in access to services for individuals with serious mental illness (SMI) and serious emotional disturbance (SED). **Table 8.4** summarizes these circumstances. An estimated 119,373 adults in Nevada suffered from serious mental illness (SMI) during 2015, which represents 5.4% of the state's adult population; and an estimated 37,266 children and adolescents experienced serious emotional disturbance (SED) during that same period, which represents 11% of the state's youth population (SAMHSA, Uniform Reporting System (URS) Output Tables-Nevada 2016). Moreover, the percent of children aged 5–17 in poverty in 2015 (17.3%) placed Nevada in the mid tier for percent in poverty (SAMHSA, URS Output Tables-Nevada 2016.) However, the proportions of these populations served by the State Mental Health Authority were 9% of the SMI population and 8% of the SED population.

Table 8.4: Persons with Serious Mental Illness and Serious Emotional Disturbance Served by Nevada State Mental Health Authority (SMHA)

Adults with Serious Mental Illness (SMI), Age 18 and older	**2015 Civilian Population Aged 18 +**	**2015 Civilian Population Aged 18 + with SMI (5.4%)**	**Number of Adults with SMI Served in 2016 by Nevada SMHA [1]**
	2,210,608	119,373	**10,400 (9% of SMI population)**
Children with Serious Emotional Disturbance (SED), Age 9 to 17	**2015 Civilian Population Youth Aged 9 to 17**	**2015 Civilian Population Age 9 to 17 with SED (11%)**	**Number of Children with SED Served in 2016 by Nevada SMHA [1]**
	338,782	37,266	**3,035 (8% of SED population)**

Adapted from: SAMHSA, Uniform Reporting System (URS) Output Tables-Nevada 2016, prepared by NRI for SAMHSA: November 2016

[1] SAMHSA National Outcomes Measures (NOMs)

B. ***Methods and Procedures: Planned Activities for FFY 2018 and FFY 2019***

(1) Planned activities for FFY 2018 and FFY 2019 for Nevada's Early Intervention Programs designed for Early Serious Mental Illness (ESMI) and First Episode of Psychosis (FEP):
The state's strategic priority for FFY 2018 and FFY 2019 is to improve access to evidence-based mental health services that are optimal for first episode of psychosis (FEP) and for the early stages of severe mental illness (ESMI). An important goal is to ensure that early interventions are available ***statewide*** for individuals who are experiencing a first episode of illness (FEP), and for those who are in the initial stage of serious mental illness (ESMI). Early interventions for FEP have been initiated through the *Enliven* service in the urban counties of Washoe and Clark in northern and southern Nevada. The state's ***Certified Community Behavioral Health Clinics Program (CCBHC)*** (S. Woodard and Nevada Department of Health and Human Services, 2016) will serve as the principal mechanism for achieving this goal and its objectives in the rural and frontier regions. Nevada's ***CCBHC Program*** was launched in July 2017, and includes ***brick-and-mortar facilities that include residential treatment facilities in rural Elko and Churchill Counties, with satellite outpatient offices planned for the less densely populated frontier regions.*** The following *Activity Objectives* were developed to advance this strategic priority and plan:

- *Activity Objective 1:* By October 2018, adapt the evidence-based ***Coordinated Specialty Care (CSC)*** treatment model for implementation in Nevada's rural and frontier communities to serve individuals experiencing a first episode of psychosis (FEP) and individuals experiencing early severe mental illness (ESMI).

  CSC-Rural and Frontier Nevada will be designed to follow the CSC model developed at NIMH through the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative for treating first episode of psychosis (FEP) in community settings. CSC is team-based and recovery-oriented, and involves clients, treatment team members, and when appropriate, relatives, as active participants. The essential components of CSC include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents.

- *Activity Objective 2:* By October 2018, solicit competitive bids (RFAs/RFPs) from community providers statewide for implementation of ***CSC-Rural and Frontier Nevada***.
- *Activity Objective 3:* By March 2019, roll out ***CSC-Rural and Frontier Nevada.***
- *Activity Objective 4:* By March 2019, establish database and schedules for long-term tracking of clinical and functional outcomes for each individual with first episode of psychosis (FEP) or early severe mental illness (ESMI) who is served by ***CSC-Rural and Frontier Nevada***. The aim of this planned activity is to evaluate the impact of these early intervention services.
- *Activity Objective 5:* By October 2019, establish mechanisms for routine (at least semi-annually) programmatic reviews of ***CSC-Rural and Frontier Nevada*** that are driven by clinical status and social functioning outcomes.

(2) ***The state's Early Intervention Services Delivery Model will be solidified and refined through additional planned activities, including the following:***

- Articulate, operationalize and implement the definition of *"active case"* that reflects a minimum number of specific types of service contacts per month, with the number and type of services specified.
- Articulate, operationalize and implement a comprehensive, integrated services delivery model that coordinates mental health *and* primary medical care of individuals with first episode of psychosis (FEP) and early serious mental illness (ESMI). Benchmark indicators of this services model will include baseline and yearly medical evaluations performed for each "*active case."* This services model will also include identification and training of personnel dedicated to coordinating and tracking this domain of care for "*active cases."*
- Articulate, operationalize and implement the definition of "*safety net"* for this vulnerable population. Specification of this "*safety net*" will include mechanisms to address missed appointments, and to provide welfare checks for individuals who have missed multiple, successive appointments.
- Advance the development and implementation of Community Outreach that targets two groups and levels of engagement: (i) professionals through fellowships, internships and externships; (ii) patients and family members through school settings and public health information campaigns. An important goal is to enhance the identification and program recruitment and enrollment of the FEP and ESMI populations.
- Plan and implement workforce development activities to increase the capacity of providers to deliver evidence-based interventions related to FEP and ESMI.
- Enhancing the state's data collection and reporting capacity is necessary to implement an ongoing quality and performance improvement process that is driven by outcomes data. Activity objectives are twofold:
    - increase capacity for capturing the clinical and functional characteristics that are unique to the FEP and ESMI populations;
    - utilize outcomes data to evaluate the impact of the state's ***Early Intervention Services Delivery Model***.

9.
Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

- Current data collection and reporting mechanisms: Data collection and reporting mechanisms are already in place for the National Outcomes Measures (NOMs) that are supported by SAMHSA.
- Planned data collection and reporting for ***Early Intervention Services Model:*** The existing database that includes the SAMHSA NOMs indicators will be expanded to include data recorded from evaluations that capture the unique characteristics of the FEP and ESMI populations. A repeated measures design will be used for the purposes of

identifying trends over time, and estimating the impact of early intervention services provided to these populations. Baseline and periodic evaluations will assess the following factors: DSM-5 diagnoses, medical health examination results, duration of untreated psychiatric illness estimated by age at onset of FEP/ESMI and date of enrollment in first services, duration of lifetime antipsychotic medication at enrollment, medication regimen at enrollment, severity of illness, positive and negative symptoms, social and cognitive functioning, and quality of life.

NOTE: The state anticipates that training of staff and technical assistance will be required to implement this strategic objective.

10.
Please list the diagnostic categories identified for your state's ESMI programs.

DSM-5 Diagnostic Categories for Nevada's Early Serious Mental Illness program:

- *First Episode of Psychosis (FEP): Non-affective and Affective Psychoses*
  - Schizophrenia Spectrum and Other Psychoses, including:
    - Delusional Disorder
    - Schizophreniform Disorder
    - Schizophrenia
    - Schizoaffective Disorder
    - Other specified/unspecified Schizophrenia Spectrum and Other Psychotic Disorders
- *Early serious mental illness (ESMI)*
  - Bipolar I and II Disorders
  - Depressive Disorders
    - Major Depressive Disorder
    - Dysthymia (persistent depressive disorder)
  - Anxiety Disorders
  - Substance-Related and Addictive Disorders, including:
    - Substance Use Disorders
    - Gambling Disorder (non-substance-related disorder)

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

- Training and technical assistance to increase the capacity of providers to deliver the diagnostic and clinical evaluations described in the response to Question #9 above. Areas in which training and staff development will be most needed include capacity to distinguish the psychosis prodrome from the onset of a first episode of psychosis, and to estimate duration of untreated illness.

- Training and technical assistance to increase the capacity of providers to deliver the key components of the identified evidence-based program, the Coordinated Specialty Care (CSC) services model, for treating FEP and ESMI, which are described in the responses to Questions #2 and #8.
- Training and technical assistance are necessary to increase the capacity of the state's dedicated resources for maintaining and upgrading its electronic record(s) (i.e., electronic health record(s); electronic medical record(s)). See the description of the planned data collection and reporting activities that are described for Questions #8 and #9 above.
- Training and technical assistance will be needed for anticipated program evaluation and quality assurance.

References for Environmental Factors and Plan

4. Evidence-based practices for Early Interventions

to Address Early Serious Mental Illness (ESMI), 10 percent set aside, Required MHBG

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? [x] Yes [ ] No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized Treatment Plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers shall provide advocacy for the recipient's goals and independence, supporting the recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

4. Describe the person-centered planning process in your state.

   the following website http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_17_02_23.pdf is the site with the service manual which medicaid enforces related to person centered planning. The 117 page manual outlines the services available in Nevada and what each service entails. Person centered planning is essential for service delivery in Nevada. A recent Department of Health and Human Services Behavioral health needs in nevada meta-analysis summary report outlined 10 guiding principals to recovery and number 2 states that recovery is person and family -driven. This means Individuals and families optimize their autonomy to the greatest extent possible by making decisions and playing a central role in determining which services and supports will best assist their recovery and resilience. Services and supports need to be provided in the least restrictive, most appropriate community-based setting in order to support independence. Such services and supports allow families to remain intact and recognize that children, youth, and families thrive in the context of their homes, communities, and schools.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

      no current plan to implement in the future

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

The Sate has assurances in all sub grants that include the federal program requirements as listed in sections A, and G below. These policies are reviewed on a regular basis to include changes and all recipients of funds are required to abide by them. Technical assistance is provided ongoing to providers through provider calls, monitors, site visits, monthly requests for reimbursement reviews, and occasionally formal audits as needed or required by law.

Assurances

As a condition of receiving subgranted funds from the Nevada State Division of Public and Behavioral Health, the Subgrantee agrees to the following conditions:

1. Grant funds may not be used for other than the awarded purpose. In the event Subgrantee expenditures do not comply with this condition, that portion not in compliance must be refunded to the Division.

2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in denial of reimbursement.

3. Approval of subgrant budget by the Division constitutes prior approval for the expenditure of funds for specified purposes included in this budget. Unless otherwise stated in the Scope of Work the transfer of funds between budgeted categories without written prior approval from the Division is not allowed under the terms of this subgrant. Requests to revise approved budgeted amounts must be made in writing and provide sufficient narrative detail to determine justification.

4. Recipients of subgrants are required to maintain subgrant accounting records, identifiable by subgrant number. Such records shall be maintained in accordance with the following:

a. Records may be destroyed not less than three years (unless otherwise stipulated) after the final report has been submitted if written approval has been requested and received from the Administrative Services Officer (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.
b. In all cases an overriding requirement exists to retain records until resolution of any audit questions relating to individual subgrants.

Subgrant accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this subgrant award. Records required for retention include all accounting records and related original and supporting documents that substantiate costs charged to the subgrant activity.

5. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee on the grounds of actual or apparent conflict of interest. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of funding.

6. To comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offeror for employment because of race, national origin, creed, color, sex, religion, age, disability or handicap condition (including AIDS and AIDS-related conditions).

7. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations

8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. 160, 162 and 164, as amended. If the subgrant award includes functions or activities that involve the use or disclosure of protected health information (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed then a Confidentiality Agreement will be entered into.

9. Subgrantee certifies, by signing this notice of subgrant award, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pr. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp. 19150-19211). This provision shall be required of every subgrantee receiving any payment in whole or in part from federal funds.

10. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the “PRO-KIDS Act of 1994,” smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children’s services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

11. Whether expressly prohibited by federal, state, or local law, or otherwise, that no funding associated with this subgrant will be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:

a. Any federal, state, county or local agency, legislature, commission, council, or board;
b. Any federal, state, county or local legislator, commission member, council member, board member, or other elected official; or
c. Any officer or employee of any federal, state, county or local agency, legislature, commission, council or board.

12. Division subgrants are subject to inspection and audit by representative of the Division, Nevada Department of Health and Human Services, the State Department of Administration, the Audit Division of the Legislative Counsel Bureau or other appropriate state or federal agencies to:

a. Verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations and procedures;
b. Ascertain whether policies, plans and procedures are being followed;

c. Provide management with objective and systematic appraisals of financial and administrative controls, including information as to whether operations are carried out effectively, efficiently and economically; and
d. Determine reliability of financial aspects of the conduct of the project.

13. Any audit of Subgrantee's expenditures will be performed in accordance with generally accepted government auditing standards to determine there is proper accounting for and use of subgrant funds. It is the policy of the Division, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending $750,000 or more in federal funds have an annual audit prepared by an independent auditor in accordance with the terms and requirements of the appropriate circular. A COPY OF THE FINAL AUDIT REPORT MUST BE SENT TO:

Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. To acknowledge this requirement, Section E of this notice of subgrant award must be completed.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION
NOTICE OF SUBGRANT

SECTION G

In addition to the Division of Public and Behavioral Health Sub-grant Grant Assurances, the sub-grantee and all organizations or individuals to whom the sub-grantee passes through funding (subrecipients) must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State award flow down to the sub-grantee and to subrecipients unless a particular section specifically indicate otherwise.

GENERAL REQUIREMENTS

Applicability: This section is applicable to all sub-grantees who receive finding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention. The sub-grantee agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards

2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.

3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants & / or Projects for Assistance in Transition from Homelessness

4. NRS 218G - Legislative Audits

5. NRS 458 - Abuse of Alcohol & Drugs

6. NRS 616 A through D Industrial Insurance

7. GAAP - Generally Accepted Accounting Principles and/or GAGAS Generally Accepted Government Auditing Standards

8. GSA - General Services Administration for guidelines for travel

9. The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention Policies and guidelines.

10. State Licensure and certification

a. The Sub-grantee is required to be in compliance with all State licensure and/or certification requirements.

b. The Sub-grantee's Certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Sub-grants cannot be issued unless certifications are current.

11. The Sub-grantee's commercial general or professional liability insurance shall be on an occurrence basis and shall be at least as broad as ISO 1996 form CG 00 01 (or a substitute form providing equivalent coverage); and shall cover liability arising from premises, operations, independent Sub- grantees, completed operations, personal injury, products, civil lawsuits, Title VII actions,

and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

12. To the fullest extent permitted by law, Sub-grantee shall indemnify, hold harmless and defend, not excluding the State's right to participate, the State from and against all liability, claims, actions, damages, losses, and expenses, including, without limitation, reasonable attorneys' fees and costs, arising out of any alleged negligent or willful acts or omissions of Sub-grantee, its officers, employees and agents.

13. The sub-grantee shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.

14. The sub-grantee agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed;

15. The sub-grantee will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).

16. The sub-grantee is required maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the sub-grantee serves minors with funds awarded through this sub-grant.

17. Application to 211
o As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 211 system.

18. The Sub-grantee agrees to fully cooperate with all Bureau of Behavioral Health Wellness and Prevention sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.

19. The Sub-grantee must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.

20. The Sub-grantee acknowledges that to better address the needs of Nevada, funds identified in this sub-grant may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The Division may reallocate funds to other programs to ensure that gaps in service are addressed.

21. The Sub-grantee acknowledges that if the scope of work is NOT being met, the Sub-grantee will be provided a chance to develop an action plan on how the scope of work will be met and technical assistance will be provided by Division staff or specified sub-contractor. The Sub-grantee will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, the Division will provide a written notice identifying the reduction of funds and the necessary steps.

22. "The Sub-grantees will NOT expend Division funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health services Block Grant Funds for any of the following purposes:
a. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
b. To purchase equipment over $1,000 without approval from the Division.
c. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
d. To provide in-patient hospital services.
e. To make payments to intended recipients of health services.
f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
g. To provide treatment services in penal or correctional institutions of the State.

23. Failure to meet any condition listed within the sub-grant award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

24. For sub-grantees of the program who expend less than $750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.

25. For sub-grantees of the program who expend $750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

Year-End Financial Report

26. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.

27. The non-federal entity financial statements may also include departments, agencies, and other organizational units.

28. Year-End Financial Report must be signed by the CEO or Chairman of the Board.

29. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.

30. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:

a. List individual federal and State programs by agency and provide the applicable federal agency name.
b. Include the name of the pass-through entity (State Program).
c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
d. Include the total amount provided to the non-federal entity from each federal and State program.

31. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at the following address.

Behavioral Health, Prevention and Treatment
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

Limited Scope Audits

32. The auditor must:
a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

33. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

34. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:
a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

35. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

Behavioral Health, Prevention and Treatment
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

Amendments

36. The Division of Public and Behavioral Health policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the Bureau of Behavioral Health Wellness and Prevention prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via e-mail.

37. For any budgetary changes that are in excess of 10% of the total award, an official amendment is required. Requests for such amendments must be made to the Bureau of Behavioral Health Wellness and Prevention in writing.

38. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.

39. Any significant changes to the Scope of Work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all Scope of Work amendments.

40. The Sub-grantee acknowledges that requests to revise the approved sub-grant must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.

41. Final changes to the approved sub-grant that will result in an amendment must be received 60 days prior to the end of the sub -grant period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60 day deadline will be denied.

Remedies for Noncompliance

42. The Division reserves the right to hold reimbursement under this sub-grant until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

SUBSTANCE USE TREATMENT SERVICES

Applicability
This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The Sub-grantee, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.

a. The Sub-grantee must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee's organization as applicable.

b. The client has the right to be referred to another Division funded provider that is not faith-based or that has a different religious orientation.

2. Priority Groups – The sub-grantee agrees to prioritize admission to treatment, except for Civil Protective Custody Services, for priority populations in the following order:

a. Pregnant injecting drug users;
b. Pregnant substance abusers;
c. Injection drug users;
d. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
e. All others.

3. The sub-grantee agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90% capacity or greater in accord with the Division's Wait List and Capacity Management policy.

4. A sub-grantee who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division's Wait List and Capacity Management policy.

5. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.

6. The sub-grantee must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons

may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.

7. The sub-grantee is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.

8. The sub-grantee is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

Capacity of treatment for intravenous substance abusers

9. A sub-grantee must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the sub-grantee must contact the Bureau of Behavioral Health and Wellness according to the Division's Capacity Management and Wait List policy.

10. The sub-grantee who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The sub-grantee must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the Bureau of Behavioral Health Wellness and Prevention. All outreach activities will be reported to the Division quarterly. The model shall require that outreach efforts include the following at a minimum:

a. Selecting, training and supervising outreach workers;
b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
d. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
e. Encouraging entry into treatment.

Treatment services for pregnant women (45 CFR § 96.131)

11. All sub-grantees who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.

12. Sub-grantees who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.

13. Sub-grantees who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed in target areas, and frequent notification of availability of such treatment services distributed to the network of community based organizations, health care providers, and social services agencies.
Records
14. All sub-grantees will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.

15. The system to protect confidentiality shall include, but not be limited to, the following provisions:
a. Employee education about the confidentiality requirements, to be provided annually;
b. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.
Reporting
16. The sub-grantee is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The sub-grantee is also required to submit any other reporting as defined and requested by the Bureau of Behavioral Health Wellness and Prevention.

17. The sub-grantee agrees to participate in reporting all required data and information through the authorized Bureau of Behavioral Health Wellness and Prevention data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.
Fee for Service requirements
18. Sub-grantees that have been awarded a fee for service sub-grant must comply with the Division's Utilization Management policy and the following billing and eligibility rules for claims processing.

a. The service must be delivered at a Division certified facility.
b. The certifications must cover the service levels under which the qualified service was delivered.
c. The service must be provided by an appropriately licensed/certified staff member.

d. The service delivered must be a Division qualified service which is NOT reimbursable by Medicaid or other third party insurance carrier.
e. The rate of reimbursement will be based on the Division approved rates (available upon request).
f. The sub-grantee agrees to accept the Division reimbursement rate as full payment for any program eligible services provided.
g. The Sub-grantee is responsible for ensuring that all third party liabilities are billed and collected from the third party payers and are NOT billed to the Division.
h. Division funds will NOT be used to fund the services for self-pay clients or clients who elect not to use their insurance coverages. This includes clients that elect not sign up for insurance under the Affordable Care Act or clients that have existing insurance and choose not to use their insurance for treatment services. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
i. Division funds will NOT be used to reimburse Medicare claims.
j. Division funds will NOT be used to reimburse claims for which the client is pending eligible for insurance coverage.
k. Division funds will NOT be used to reimburse for claims denied by Medicaid or other insurance carriers unless the claim was denied as “not a covered benefit”.
a. Claims denied as “not a covered benefit” and billed to the Division must have the accompanying denial attached in order to guarantee payment.
l. Division funds will NOT be used to cover any unpaid costs that Medicaid and/or other insurance carriers may not reimburse (i.e. copayments, deductibles).
m. The Sub-grantee agrees to use Division funds as the “payer of last resort” for all services provided to clients. If an undue barrier to treatment exist, a written request to the Division may be submitted for review and some services may be covered upon written permission from the Division.

19. The Sub-grantee must establish policies, procedures, and the systems for eligibility determination, billing, and collection to:
a. Ensure that all eligible clients are insured and/or enrolled in Medicaid in accord with the Affordable Care Act.
b. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical assistance, any grant program, any private health insurance, or any other benefit program; and secure from client’s payment for services in accordance with their ability to pay.
c. And prohibits billing the Division for a service that is covered by Medicaid or any other insurance carrier. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
Billing the Division

Fee for Services only:
20. The sub-grantee agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Sub-grantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.

21. Upon official written notification from the Bureau of Behavioral Health Wellness and Prevention, prior authorizations will be required for all residential and transitional housing services being billed to the Division.

22. The Sub-grantee agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.

23. The Sub-grantee understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.

24. The Sub-grantee understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.

25. The Sub-grantee understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706.
d. The invoice must show the total number of services by CPT or HCPS code, the rate being charged, the total amount charged to that CPT or HCPS code line and summarize the totals by level of care.
e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this invoice."
PREVENTION SERVICES

Applicability

This section is only applicable to primary prevention coalitions and programs.

1. The sub-grantee will implement the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework Planning Process.

2. If the sub-grantee is a certified prevention coalition, it will solicit representatives from local substance abuse prevention programs and treatment providers to become coalition members and assist with efforts to implement the CSAP's Strategic Prevention Framework Planning Process.

3. The sub-grantee representatives are required to attend prevention training as listed below if applicable to provide prevention services:

a. All fulltime staff must annually complete a minimum of twenty (20) hours of prevention training.
b. All part-time staff must annually complete a minimum for ten (10) hours of prevention training.
c. Participate in the implementation of evidence-based prevention programs, strategies, policies, and practices, and use the Prevention Program Operating and Access Standards as the basis for program, workforce, and agency development.

REQUESTS FOR REIMBURSEMENTS (All non-fee for service sub-grants):

1. A Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.

2. Reimbursement is based on actual expenditures incurred during the period being reported.

3. Requests for advance of payment will not be considered or allowed by the Division.

4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.

5. Payment will not be processed without all programmatic reporting being current.

6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.

7. The sub-grantee is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the CLOSE OF THE SUB-GRANT PERIOD. All remaining balances of a federally funded sub-grant revert back to the Division 30 days after the close of the sub-grant period.

8. The Request for reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY which occurs on June 30. All remaining balances of the State funded sub-grants revert back to the State after the close of the SFY.

9. The sub-grantee must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

The sub-grantee agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

Please indicate areas of technical assistance needed to this section

Footnotes:

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The State of Nevada Department of Health and Human Services conducts a tribal consultation on a quarterly basis. This is a government-to-government relationship with Nevada's 27 tribes. Within federal fiscal year 16, four consultations were conducted.

2. What specific concerns were raised during the consultation session(s) noted above?

   Within the four tribal consultations, topics included were: Certified Community Behavioral Health Centers; Electronic Visit Verification systems for personal care services; managed care expansion and delivery models; provider rate realignments; targeted case management; dispensing fees; maternal and child health services; the sequential intercept model for justice involved individuals; and Opioid-related hospitalizations and deaths among American Indians and Alaskan Natives in Nevada. In addition, a regulation change for tribal evaluation centers who choose to be certified by the State was discussed during the tribal consultation in July 2017. Information was shared on the various topics with tribes and feedback was obtained and documented. No major concerns were addressed that affect the block grant.

   Does the state have any activites related to this section that you would like to highlight?

   The State of Nevada Department of Health and Human Services holds tribal consultation meetings with all 27 tribal entities whenever policy or proposed rules, regulations, or laws affect the tribes are being created or revised. The Department of Health and Human Services has a total of 7 tribal liaison's. These liaisons come from the Department of Health and Human Services Director's office, the Division of Aging and Disability Services, the Division of Public and Behavioral Health, the Division of Welfare and Supportive Services, the Division of Health Care Financing and Policy, and the Division of Child and Family Services.

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ( ) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ( ) Yes ( ) No

   - þ Data on consequences of substance using behaviors
   - þ Substance-using behaviors
   - þ Intervening variables (including risk and protective factors)
   - é Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   - þ Children (under age 12)
   - þ Youth (ages 12-17)
   - þ Young adults/college age (ages 18-26)
   - þ Adults (ages 27-54)
   - þ Older adults (age 55 and above)
   - þ Cultural/ethnic minorities
   - þ Sexual/gender minorities
   - þ Rural communities
   - é Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- ☐ Archival indicators (Please list)
- ☐ National survey on Drug Use and Health (NSDUH)
- ☐ Behavioral Risk Factor Surveillance System (BRFSS)
- ☐ Youth Risk Behavioral Surveillance System (YRBS)
- ☐ Monitoring the Future
- ☐ Communities that Care
- ☐ State - developed survey instrument
- ☐ Others (please list)

Clark County Coroners report.

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ☐ Yes ☐ No

If yes, (please explain)

Based on the data that is collected from the sources identified above and local data (if available), each coalition creates a Community Coalition Prevention Plan (CCPP) every three years. This allows the coalitions to identify their greatest needs, set priorities, and allot their fiscal resources to address those needs. This is accomplished through environmental strategies and primary prevention programs. SAPTA also uses the data collected in the sources above to create and update its strategic plan. SAPTA recently conducted a situational analysis and strategic plan to assist in developing key strategies over the next 5 years. Whenever new reports are generated related to mental health, substance use prevention, and treatment across the state SAPTA reviews the data and attempts to utilize it in planning for the future and reports are shared with all partners. We utilize data from results of the various state surveys, data from billing codes, and any other sources available throughout the State which provides insight into the issues affecting consumers. These plans include the 3 consortium plans, and individual agency plans within the Division of Public and Behavioral Health which all utilize consumer input and stakeholder feedback prior to being published.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Our state is very unique in how it has coalitions representing all counties that utilize the strategic prevention framework and are highly trained in that model. The coalition structure is such that there is representation from a minimal of 12 sectors of participants in each community, and all communities are represented in a lead from the middle framework which helps partners feel they are a part of the whole process. This avoids a top down approach, or a bottom up approach but a true partnership between the communities and the State. Coalitions provide sub grants to various community partners through an open bid process to ensure the prevention priorities are implemented well and that the experts from the proper sectors are utilized. For example, If a media campaign is needed then they partner with a local or national media company that meets their needs. Furthermore if educational materials are needed to run groups such as parenting classes, or refusal skills training, then coalitions partner with the right community experts to provide the training and can provide funding to purchase necessary curriculum materials. The coalitions ensure that services span the whole state and are tailored to the needs of the individual community but also align with state priorities and that duplication of services are not occurring with the same funding sources and same community.

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (•) Yes ( ) No

   If yes, please describe

   Our State offers a certification in prevention which is not mandated, but encouraged by all prevention providers to have a minimum of one staff who is certified in prevention. This certification started in 2016. Many of the providers sought national prevention certifications previously.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (•) Yes ( ) No

   If yes, please describe mechanism used

   Our State has ongoing communication with providers through monthly provider calls, and a state liaison to the providers that can be contacted for technical assistance needs. When training needs are identified the State works with providers to try and find solutions, and at times hosts collaborative training's for state staff and community prevention partners. Attempts are made whenever possible to communicate training's that are being held that will be mutually beneficial and can serve the needs of all who participate in the field. Also the coalitions provide information to the State regarding training's they are holding and invite state staff to participate when appropriate.

   SAPTA has relied on the CAPT West RET along with the Center for Addiction Technology (CASAT) and Community Anti Drug Coalitions of America (CADCA) to provide training and technical assistance to SAPTA staff as well as all of the state's prevention workforce. All of these entities offer live trainings, webinars, and conferences. SAPTA makes every effort to notify prevention and treatment providers of any pertinent training opportunities of which it becomes aware.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (•) Yes ( ) No

   If yes, please describe mechanism used

   Our State has a request for qualification application. In the application are agency capacity questions including policies and procedures for managing funds properly, maintaining the proper staffing ratio's needed to manage projects, and demonstrating an understanding of the federal rules and regulations. There have been times in the past where agencies struggled to maintain the proper capacity to perform duties of the grants and requirements of the projects and have closed their doors. This typically happened after many supportive interactions with the State providing technical assistance as well as peers providing supportive services. Most State partners are willing to mentor other providers as needed to help them be successful as Nevada struggles with keeping professionals of all backgrounds in the workforce.

Does the state have any activities related to this section that you would like to highlight?

Most of the twelve coalitions have served their community for many years and have a keen sense of their community's challenges. During the economic downturn, several of the rural and frontier communities were greatly affected. Unemployment in some counties was as high as 20%, and the ability to buy food for families was on the decline. In response to this turn of events, several of the coalitions applied for grants from other sources such as the FDA in an effort to expand their reach and available resources. Because of the leadership of these coalitions, food banks and thrift stores were created. Some of the communities experienced an increase in mental health and crime related issues. The Coalitions began to broaden their membership to include businesses, schools, law enforcement, physicians, and dentists to assist their underserved. In addition some coalitions have now expanded through other grant resources to include assisting with mental health capacity building and have increased their partnerships with the schools to build referral systems and decrease mental health stigma. This broadened approach allows for a coordinated, focused, intentional response to community challenges. With the funding and technical assistance from SAPTA, the coalitions will continue to grow their agencies.

The issue of workforce development has been a challenge for SAPTA for many years. Workforce development is a topic of concern from every state agency and community agency that provides care. One of the goals in SAPTA's Strategic Plan is to engage with educational partners including higher education and secondary education partners to create a pipeline of qualified workforce to address community needs. Building capacity in the workforce is mentioned in most strategic meetings across the state and is being addressed on a continual basis until there is no longer a shortage in professionals. With Nevada's growing population and increased need, based on population growth it is unlikely the need will go away soon.

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ( ) Yes ( ) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ( ) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

   a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) ☐ Timelines
   c) ☐ Roles and responsibilities
   d) ☐ Process indicators
   e) ☐ Outcome indicators
   f) ☐ Cultural competence component
   g) ☐ Sustainability component
   h) ☐ Other (please list):
   i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ( ) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ( ) Yes ( ) No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   N/A

   Does the state have any activities related to this section that you would like to highlight?

   Nevada's Five-Year Strategic Prevention Plan was created in May, 2017. This plan outlines SAPTA's vision for prevention efforts in

Nevada and goals going forward, the priorities that were established based on available data and the principles underlying Nevada's Prevention System. The plan is to be revised ongoing as needed and reviewed at a minimum of 1 time per year by the Behavioral health Planning and Advisory Council (BHPAC). The coalitions, as the Block Grant's primary prevention recipients, were instrumental in developing the plan and will use it to guide their environmental strategies and primary prevention programming including the 12 state priorities that they use to build all of their goals and activities for their prevention plans.

The SAPTA evidence-based workgroup was created in 2013 and consists of coalition members, members of Child and Family Services, Mental Health, the CAPT West RET, Center for the Application of substance Abuse Technologies (CASAT). With turnover in staff the EBP workgroup lost ground but was reintroduced in 2015 after obtaining the Safe Schools and Healthy Students (SS/HS) and the Partnership for Success (PFS) grants from SAMHSA. Since then the evidence-based workgroup (EBPW) has adopted new members including the Department of Education which brought the additional resources of Now Is the Time Project AWARE (AWARE), and The School Climate Transformation Project (SCTG) and recently the System of Care grant (SOC) from the Department of Child and Family Services. The collaborative efforts have led to a workgroup that is moving forward with developing an official protocol for vetting programs through the committee, and training people in evidence based practices. This workgroup will continue to collaborate in an effort to create additional shared prevention strategies throughout the state and move to being an effective body that can assist in making decisions about effective use of SABG primary prevention funds.

Please indicate areas of technical assistance needed related to this section.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ☐ SSA staff directly implements primary prevention programs and strategies.

   b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ☐ The SSA funds regional entities that provide training and technical assistance.

   e) ☐ The SSA funds regional entities to provide prevention services.

   f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☐ The SSA funds community coalitions to provide prevention services.

   h) ☐ The SSA funds individual programs that are not part of a larger community effort.

   i) ☐ The SSA directly funds other state agency prevention programs.

   j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   • Health Fairs-Nevada's rural and frontier regions rely on these types of community gatherings to get the word out about substance abuse and underage drinking.
   • Printed Material-When coalitions make presentations to parents, bartenders, or students, often they take home printed materials with information and phone numbers or referrals for future reference.
   • PSA Development- PSA's are a part of coalitions regular operation. Many new PSA's are being developed to address marijuana use and build traffic to sites like knowmj.org where people can learn more about marijuana, and coalition prevention work including the harmful effects of various substances. Other uses are when coalitions want to announce their events to draw community members to attend.
   • Speaking Engagements Email requests- Because the coalitions have a long history of serving their communities, they are often called upon to make presentations to the public or speak at conferences and events about strategies and the latest trends in use and prevention efforts.
   • Coalitions are frequently called upon to provide information to legislative bodies who use the information to make

informed decisions about issues facing their community.
• Social Media Dissemination- All of the coalitions have websites and most have Facebook pages or Twitter accounts. These social media outlets help to attract youth to their activities and mission. This is also true for the State partners including Maternal and Child Health which promotes the website sobermomshealthybabies.org, and the Department of Health and Human Services Tobacco prevention control program which both provide appropriate prevention information.

b) Education:

• Education for Youth Groups-Presentations to youth K-12 related to substance abuse. Many coalitions engage youth to conduct peer-to-peer educational presentations.
• Education to parents-Coalition staff or guest speakers from the community present to parents at high schools. In this way, parents are engaged in the prevention process and can reinforce and support information youth are receiving regarding substance use and abuse.
• Education and information to medical providers- Multiple resources are available to help providers do a better job at detecting and making referrals to the proper places. Prevention partners come together to ensure resources are shared and utilized by providers.
• Education to Treatment and Prevention providers on addiction- in an effort to assist prevention and treatment providers with information to hone their skills or keeping abreast of current trends.
• Education to bartenders and servers on the importance of carding their customers before serving them alcohol to reduce underage drinking. Additional focus is placed on responsible beverage service to address binge-drinking and other hazards such as alcohol poisoning.
• Education to tobacco sales merchants about carding customers before selling.
• Education to Marijuana dispensaries about the laws associated with sales. Focus is also placed on harm to minors, and assistance given to help avoid access to minors.

c) Alternatives:

• Recovery picnic which is held every September in northern Nevada in an effort to normalize the decision to be drug-free and support those in recovery.
• Safe and Sober graduation parties are held in many of Nevada's high schools. Block grant funds are often combined with the Safe and Sober organizations throughout the state to offer a safe, drug-free
graduation experience.
• Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups offer youth a safe, constructive and meaningful way to spend their time.

d) Problem Identification and Referral:

Most of the coalitions in the state fund direct service programs that address high risk youth: incarcerated, on probation, parents are incarcerated. In some of the counties, Signs of Suicide (SOS) is being conducted as well as Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) where there are increases in number of referrals to services taking place across the State, and an annual increase in trainers who help communities know signs and symptoms and make referrals to triage centers to get people the proper help. Some communities are mapping out their resources and deliberately creating a formalized triage process that all community partners can follow giving it a no wrong door approach to closing the service gaps.

e) Community-Based Processes:

This is the most powerful strategy used in Nevada and it begins within the twelve community coalitions. Attending the coalition meetings, one sees members of the community from all walks of life and business including the 12 sectors from the SPF SIG model. Included but not limited to are food banks, domestic violence agencies, law enforcement, farmers, ranchers, health care providers of mental health as well as medicine, tribal entities, government agencies, schools, students, youth, parents, and clergy all working together to improve their community. Again with the various sectors working together and seeking to solve problems as a group rather than in silo's they are able to close the service gaps more efficiently.

The Statewide partnership and a select few coalitions are tasked with mentoring new and existing coalitions to improve their practices, and build capacity to serve their perspective communities better which includes sharing experiences, managing grants, building lasting relationships with community members, understanding reporting, evaluation, community outreach techniques and following proper state processes.

f) Environmental:

Service and Actions oriented Initiatives:
• RX Round-ups which are held semi-annually. These events highlight the issue of availability to youth of prescription medication for non-medical purposes, as well as bring
awareness to misuse/abuse of these medications.
• Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups are working towards shifting social
norms regarding drug use among youth.
• Media campaigns which focus:
o on the need to limit the over-prescribing of opioids
o locking up prescriptions from youth

o dangers of second hand smoke especially around children
o Governor's campaign to improve birth outcomes
o Substance use including Marijuana, alcohol, and Opioids.

Legal and regulatory initiatives:
• Quarterly compliance checks especially during Reno's Pub Crawls. These checks spread the word that the community will not tolerate underage drinking and/or misuse of
alcohol.
• Working with Nevada's legislators and local city councils to inform policies:
• Coalition Youth participate in legislation days and attend hearings on important issues that affect youth in Nevada related to substance use and mental health, and offer their
voice and are heard. Typically when youth speak the adults listen.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ( ) Yes ( ) No

If yes, please describe

Our state has a no supplanting requirement in place for all sub recipients. While braiding is encouraged for sustainability purposes it is to be done within the proper parameters that avoid duplication of efforts or supplanting. There are two federal substance abuse-related grants DPBH oversees (Block, and PFS) and two state grants awarded to the prevention coalitions, and monitored by SAPTA. Each funding source has its priorities, thus complimenting or enhancing the other funding streams. The Coalitions report on each grant's quarterly activities separately, so as to maintain separate scopes of work and avoid any supplanting of funds. Additionally, a monitor is conducted annually to include a fiscal review to ensure all sources are accounted for separately as well as whether each is complying with federal and state regulations.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ( ) Yes ( ) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a) [ ] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) [ ] Includes evaluation information from sub-recipients
   c) [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) [ ] Establishes a process for providing timely evaluation information to stakeholders
   e) [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) [ ] Other (please list:)
   g) [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) [x] Numbers served
   b) [ ] Implementation fidelity
   c) [ ] Participant satisfaction
   d) [x] Number of evidence based programs/practices/policies implemented
   e) [x] Attendance
   f) [x] Demographic information
   g) [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

   a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Our state has requested that up to 5% of coalitions' budgets reflect an evaluation component for this funding cycle. We are beginning to add evaluation into all of our projects, and recommend that if a particular evidence based program is implemented that they use the evaluation tools associated with that program and report back. The new evaluation component will further the ability of both the State and the coalitions to make informed decisions on funding, and outcome based projects that make the most sense and provide the most effective outcomes. Further we hope to implement strategies in our evaluation plans that Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks. It will also include evaluation information from all sub-recipients, Includes SAMHSA National Outcome Measurement (NOMs) requirements, establishes a process for providing regular reports back to the providers and subrecipients, and fully formalizes processes for incorporating evaluation findings into resource allocation and decision-making.

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   Nevada's Behavioral Health System is comprised of Federal, state and local resources with a variety of funding sources, priorities and mandates from the Department of Health & Human Services. Within the Department of Health and Human Services there are four agencies that provide behavioral health services who play a part in managing and implementing services across the State to keep people functioning at their highest potential and divert away from residential services as much as possible.
   1. Director's Office, Aging and Disability Services Division (ADSD)
   2. Division of Health Care Financing and Policy (DHCFP)
   3. Division of Public and Behavioral Health (DPBH)
   4. Division of Child and Family Services (DCFS)
   Almost all of Nevada qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2017, Map 5.3, p. 148). The state's geography and its low population density in rural and frontier counties amplify the challenges associated with this critical health care shortage. The current population of Nevada is 2,940,058
   Medicaid covered services include:
   1.: Healthcare Home/Physical
   General and Specialized Outpatient Medical Services
   Acute Primary Care
   General Health Screens, Tests, and Immunizations
   Comprehensive Case Management
   Care Coordination and Health Promotion
   Comprehensive Transitional Care
   Individual and Family Support
   Referral to Community Services

   2. Community Support (Rehabilitative)
   Parent/Caregiver Support
   Skill Building (social, daily living, cognitive)
   Case Management
   Behavior Management
   Supported Employment
   Permanent Supported Housing
   Recovery Housing
   Therapeutic Mentoring
   Traditional Healing Services

   3. Prevention Including Promotion
   Screening, Brief Intervention and Referral to Treatment Recovery Supports
   Brief Motivational Interviews
   Screening and Brief Intervention for Tobacco Cessation
   Parent Training Facilitated Referrals
   Relapse Prevention/Wellness Recovery Support
   Warm Line

   4. Recovery Supports
   Peer Support

Recovery Support Coaching
Recovery Support Center Services Supports for Self-directed Care

5.Substance Abuse Primary Prevention
Classroom and/or small group sessions (education
Media campaigns (Information Dissemination) Systemic Planning/coalition and Community Team
Parenting and family management (Education) Education programs for youth groups (Education)
Community Service Activities (Alternatives) Student Assistance Programs (Problem Identification and Referral)
Employee Assistance Programs (Problem Identification and Referral)
Community Team Building
Promoting the Establishment or review of alcohol, tobacco, and drug use policies (Environmental)

6. Other Supports Habilitative
Personal Care Homemaker
Respite
Supported Education Transportation
Assisted Living Services Recreational Services
Trained Behavioral Health Interpreters
Interactive Communication Technology Devices

7. Intensive support Services
Substance Abuse Intensive Outpatient (IOP) Partial Hospital
Assertive Community Treatment Intensive Home-based Services
Multi-systemic Therapy
Intensive Case Management

8. Engagement Services.
Assessment
Specialized Evaluations (Psychological and Neurological)
Service Planning (including crisis planning) Consumer/Family Education
Outreach

9. Intensive Support Services
Substance Abuse Intensive Outpatient (IOP) Partial Hospital
Assertive Community Treatment Intensive Home-based Services
Multi-systemic Therapy Intensive Case Management

10.Outpatient Services
Individual Evidenced-based Therapies Group Therapy
Family Therapy
Multi-Family Therapy Consultation to Caregivers

11. Out of Home Residential Services
Crisis Residential/Stabilization Clinically Managed 24-hour Care (SA)
Clinically Managed Medium Intensity Care (SA)
Adult Mental Health Residential Services Children's Residential Mental Health Services Therapeutic Foster Care

12. Medication Services
Medication Management
Pharmacotherapy (including MAT)
Laboratory Services

13. Acute Intensive Services
Mobile Crisis
Peer-based Crisis Services
Urgent Care
23-hour Observation Bed Medically Monitored Intensive
24/7 Crisis Hotline Services

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) Physical Health ( ) Yes ( ) No

b) Mental Health ( ) Yes ( ) No

c) Rehabilitation services ( ) Yes ( ) No

d)	Employment services	Yes No
e)	Housing services	Yes No
f)	Educational Services	Yes No
g)	Substance misuse prevention and SUD treatment services	Yes No
h)	Medical and dental services	Yes No
i)	Support services	Yes No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes No
k)	Services for persons with co-occuring M/SUDs	Yes No

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

there are 10 guiding principles to recovery and case management services link individuals to care in a manner that helps individuals meet recovery.
1. recovery emerges from hope
2. recovery is person and family driven
3. recovery occurs via many pathways
4. recovery is holistic
5. recovery is supported by peers and allies
6. recovery is supported through relationships and social networks
7. recovery is culturally based and influenced
8. recovery is supported by addressing trauma
9. recovery involves individual , family and community strengths and responsibilities
10. recovery is based on respect.

4. Describe activities intended to reduce hospitalizations and hospital stays.

All our services are designed to serve clients at the lowest level of care and escalate only when medically necessary to a higher level of care. Most of the State is designated as a health professional shortage area which makes it extremely difficult to provide the proper lower levels of care, such as outpatient therapy services, to the high number in need. When new therapist serve rural areas of the state, their caseloads quickly fill up, making it difficult to get services. Nevada is working to increase the number of peer support specialists and family support specialists on the ground to help individuals navigate the service system. Nevada is working to increase the number of community members who interact with youth and at risk adults who can recognize signs and symptoms of potential mental health and substance use needs and make early referrals to services where available.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	119373	
2.Children with SED	37266	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

We obtain our rates from NRI, and are using the NRI calculated prevalence rates for 2015. Currently Nevada does not currently collect data on statewide incidence that would enable accurate calculation of incidence rate. Per SAMHSA guidance in an email from Cathleen Crowley July 31st 2017 statewide incidence rates are not reported in this table.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Nevada receives the PATH and CABHI grants to assist in managing the homeless population. These grants allow outreach case workers to serve individuals in the North, South, and rural regions of the State. They make referrals when needed and assist individuals to get care. Medicaid has started to place eligibility workers within local agencies that serve the targeted populations including rural, homeless, and older adults. The workers are able to get necessary services and assistance to families and individuals who are struggling with finances, and mental health or substance use needs.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Footnotes:

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	Yes No
ii)	Education	Yes No
iii)	Brief Intervention	Yes No
iv)	Assessment	Yes No
v)	Detox (inpatient/social)	Yes No
vi)	Outpatient	Yes No
vii)	Intensive Outpatient	Yes No
viii)	Inpatient/Residential	Yes No
ix)	Aftercare; Recovery support	Yes No

b) Are you considering any of the following:

	Targeted services for veterans	Yes No
	Expansion of services for:	
(1)	Adolescents	Yes No
(2)	Other Adults	Yes No
(3)	Medication-Assisted Treatment (MAT)	Yes No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ( ) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? ( ) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ( ) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ( ) Yes ( ) No

5 Are you considering any of the following:

a) Open assessment and intake scheduling ( ) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes ( ) No

d) Inclusion of recovery support services ( ) Yes ( ) No

e) Health navigators to assist clients with community linkages ( ) Yes ( ) No

f) Expanded capability for family services, relationship restoration, custody issue ( ) Yes ( ) No

g) Providing employment assistance ( ) Yes ( ) No

h) Providing transportation to and from services ( ) Yes ( ) No

i) Educational assistance ( ) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Programs that provide services to PW and PWWDC are instructed to give priority treatment. Although SAPTA only has jurisdiction over programs that receive funding, every effort is made to encourage non- funded entities to follow the same best practice. Site visits are planned at a minimum of one time per year but are sometimes more frequent. Program monitors for funded providers are also conducted at a minimum of one time per year. When problems are identified, every attempt is made to correct the issue on site immediately. If time is needed then a corrective action plan is written and the provider given a timeline to complete the corrective action. Once completed, the issue is reexamined for compliance on the next site visit or formal program monitor.
In addition, Nevada has just moved to an active monitoring system. According to the Capacity Management and Wait List policy, all providers who treat PW and PWWDC are required to immediately contact the State for assistance. This information is collected and managed by the State program. The State is also collecting information on the numbers of PW and PWWDC on a quarterly basis. In order to increase the number of PW and PWWDS, the Maternal and Child Health program is expanding outreach efforts. The State is also planning to provide a PW and PWWDC tool box available on the State's website. In addition to the scheduled annual monitors, the State is expanding informal visitation efforts. If data anomalies or direct observations identify any compliance issues, they will be addressed with technical assistance as soon as an issue is identified.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

   a) 90 percent capacity reporting requirement — Yes / No

   b) 14-120 day performance requirement with provision of interim services — Yes / No

   c) Outreach activities — Yes / No

   d) Syringe services programs — Yes / No

   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — Yes / No

2. Are you considering any of the following:

   a) Electronic system with alert when 90 percent capacity is reached — Yes / No

   b) Automatic reminder system associated with 14-120 day performance requirement — Yes / No

   c) Use of peer recovery supports to maintain contact and support — Yes / No

   d) Service expansion to specific populations (military families, veterans, adolescents, older adults) — Yes / No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Programs that provide services to PWID are required to give priority treatment. They are also required to conduct outreach to persons who inject drugs. Although SAPTA only has jurisdiction over programs that receive funding every effort is made to encourage non-funded entities to follow the same best practice. Site visits are planned at a minimum of one time per year but are sometimes more frequent. Program monitors for funded providers are also conducted at a minimum of one time per year. When problems are identified, every attempt is made to correct the issue on site immediately. If time is needed then a plan is written and the provider given a timeline to complete the corrective action and communication as to when the action is completed is requested and reviewed again for compliance on the next site visit or formal program monitor.
   The State also requires federally required interim services to be provided any time a person who injects drugs is placed on a waiting list. Waiting lists are monitored actively by State staff. Quarterly reports will be required from all funded providers to monitor outreach efforts and the numbers of persons who inject drugs receiving services. The State may also fund specific programs to conduct outreach to persons who inject drugs throughout this grant period.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — Yes / No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers — Yes / No

   b) Cooperative agreement/MOU with public health entity for testing and treatment — Yes / No

   c) Established co-located SUD professionals within FQHCs — Yes / No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Programs that provide substance use services are required to make TB services available. The State has changed methodology and policy to allow this testing to occur on sight at the substance use treatment provider's facility. This program is managed by the States TB program who also collects all data. Site visits are planned at a minimum of one time per year but are sometimes more frequent. Program monitors for funded providers are also conducted at a minimum of one time per year. When problems are identified, every attempt is made to correct the issue on site immediately. If time is needed then a plan is written and the provider given a timeline to complete the corrective action and communication as to when the action is completed is requested and reviewed again for compliance on the next site visit or formal program monitor. The State's Substance Use Prevention and Treatment program and the TB program will collaborate on this monitoring process.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes ( ) No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes ( ) No

   b) Establishment or expansion of tele-health and social media support services ( ) Yes ( ) No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ( ) Yes ( ) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ( ) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ( ) Yes ( ) No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ( ) Yes ( ) No

   If yes, plese provide a brief description of the elements and the arrangement

   Nevada does not allow purchase of syringes with public funds. We allow supplies like band aids, cotton swabs, and bleach. The State, through the State's HIV Treatment and Prevention program in collaboration with the Substance Abuse Prevention and Treatment program fund HIV and IDU outreach programs. Services are IDU outreach, HIV testing, and or testing for other STD's as necessary and referral to substance abuse treatment facilities or to referrals syringe exchange programs may be made.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — Yes / No

2. Are you considering any of the following:

   a) Workforce development efforts to expand service access — Yes / No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — Yes / No

   c) Establish a peer recovery support network to assist in filling the gaps — Yes / No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — Yes / No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — Yes / No

   f) Explore expansion of service for:

      i) MAT — Yes / No

      ii) Tele-Health — Yes / No

      iii) Social Media Outreach — Yes / No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — Yes / No

2. Are you considering any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — Yes / No

   b) Establish a program to provide trauma-informed care — Yes / No

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — Yes / No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — Yes / No

2. Are you considering any of the following:

   a) Notice to Program Beneficiaries — Yes / No

   b) Develop an organized referral system to identify alternative providers — Yes / No

   a) Develop a system to maintain a list of referrals made by religious organizations — Yes / No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes / No

2. Are you considering any of the following:

   a) Review and update of screening and assessment instruments — Yes / No

   b) Review of current levels of care to determine changes or additions — Yes / No

c) Identify workforce needs to expand service capabilities — Yes / No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes / No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes / No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — Yes / No

b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes / No

c) Updating written procedures which regulate and control access to records — Yes / No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — Yes / No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes / No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Approximately four to eight sub-recipients will receive peer review over the grant period.

3. Are you considering any of the following:

a) Development of a quality improvement plan — Yes / No

b) Establishment of policies and procedures related to independent peer review — Yes / No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — Yes / No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — Yes / No

If YES, please identify the accreditation organization(s)

i) € Commission on the Accreditation of Rehabilitation Facilities

ii) € The Joint Commission

iii) € Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No

2. Are you considering any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state Yes No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No

   c) Preformance-based accountability Yes No

   d) Data collection and reporting requirements Yes No

2. Are you considering any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs Yes No

   b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women Yes No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis Yes No

   b) Early Intervention Services Regarding HIV Yes No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment Yes No

   b) Professional Development Yes No

   c) Coordination of Various Activities and Services Yes No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

http://admin.nv.gov/Documents/Policies/Procedures/

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ( ) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

The Nevada Department of Health and Human Services Division of Public and Behavioral Health Bureau of Behavioral Health Wellness and Prevention works together with the Division of Child and Family Services which published an annual quality Assurance Program Report in February 2017. This plan is included in the attachments. When these plans are shared and recommendations are made, attempts are made to implement changes, and improve services on an ongoing basis.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

ANNUAL QUALITY ASSURANCE PROGRAM REPORT

Division of Child and Family Services

Prepared by DCFS Planning and Evaluation Unit
February 28, 2017

Contents

DCFS Children's Mental Health Services (CMHS) is a Behavioral Health Community Network (BHCN) provider under Nevada Medicaid. As a BHCN under Nevada Medicaid, DCFS must adhere to all applicable requirements under the Medicaid Services Manual. Nevada Medicaid requires a BHCN to have a structured, internal monitoring and evaluation process designed to improve quality of care. This report describes the major quality assurance activities of 2016 for DCFS CMHS and an updated Performance and Quality Improvement Plan for 2017 (see Appendix A)

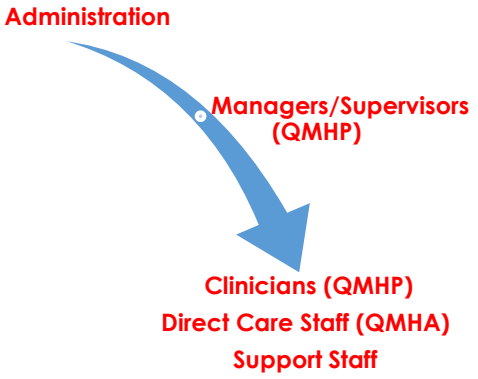
DCFS provides a number of behavioral health programs that serve children and families in Northern and Southern Nevada (see Table 1).

Table 1. DCFS Child and Adolescent Services Mental Health Programs

Southern Nevada	Northern Nevada
Community Based Programs	
Children's Clinical Services (CCS)	Children's Clinical Services (CCS)
Early Childhood Mental Health Services(ECMHS)	Early Childhood Mental Health Services(ECMHS)
Wraparound In Nevada (WIN)	Wraparound In Nevada (WIN)
Mobile Crisis Response Team (MCRT)	Mobile Crisis Response Team (MCRT)
Treatment Homes	
On-Campus Treatment Homes (Oasis)	Family Learning Homes (FLH)
	Adolescent Treatment Center (ATC)
Residential Facility and Acute Care Psychiatric Hospital	
Desert Willow Treatment Center (DWTC)	
Quality Assurance, Program Planning, and Program Improvement	
Planning and Evaluation Unit (PEU) and System of Care Unit (SOC)	

Supervisory Structure and Training

DCFS Children's Mental Health clinical programs are structured as follows:



- Administrator
- Deputy Administrator
- Clinical Program Manager II
- Clinical Program Manager I or Psychologist (Supervisors are Qualified Mental Health Professionals)
- Various state job classifications- Mental Health Counselors or Clinical Social Workers (both are QMHPs), QMHAs such as Psychiatric Case Workers, Developmental Specialists, as well as Child Care Workers, Public Service Interns, Treatment Home Staff

Additionally, Desert Willow and Adolescent Treatment Center have medical staff positions such as Psychiatrists, Nursing staff, and Mental Health Technicians. NNCAS and SNCAS have Psychiatrists who are Medical Directors as well. Organizational charts are available upon request.

DCFS Children's Mental Health programs also offer clinical supervision and post-doctoral hours for those seeking licensure as a Marriage and Family Therapist, Clinical Professional Counselor, Licensed Clinical Social worker, or Psychologist.

Residential programs and Desert Willow staff have their own trainings related to licensing and The Joint Commission requirements. Children's Mental Health community based programs have established training academies for new hires and ongoing training for staff.

Clinical content covered during standard training includes but is not limited to:

- Utilizing the electronic health record program Avatar and the UNITY program (Nevada's Statewide Automated Child Welfare Information System)
- Medicaid Chapters 400 and 2500
- Completing a comprehensive assessment, SED determination, CASII, functional assessments, and diagnosis using DSM V and DC:0-3
- Wraparound Training
- Targeted case management and how to complete an assessment
- Writing progress notes
- Conducting a Child and Family Team
- Treatment planning and Care Coordination
- System of Care Values and Principles (partnering with family organization)
- Trauma Informed Care
- Recognizing signs of suicide
- Mood disorders in children
- ADHD, Anxiety, Sensory Deficits
- Introduction to infant and early childhood mental health
- Various treatment modalities and approaches, e.g., Motivational Interviewing, art therapy and play therapy, Solution Focused Brief Therapy, Family Check Up, Everyday Parenting, Aggression Replacement Training (ART), Positive Behavior Supports, Trauma Focused Cognitive Behavior Therapy (TF-CBT), Psychological First Aid, Psychoeducational Model (PEM), Conflict Prevention and Response (CPAR)

Staff also attend Defensive Driving, HIPAA training, Security Awareness Training, Sexual Harassment, and other Department of Health and Human Services or Department of Personnel trainings as required.

New hires typically shadow seasoned peers for a month or more. In addition to regular staff meetings, staff on probation and interns receive at least weekly supervision, those who have been in their position a year or more receive formal supervision at a minimum of once a month. Supervisors typically have an open door policy and are accessible for crises, questions, or concerns and administrative issues. In addition, supervisors may use group supervision, direct observation, record review

utilizing the supervisor checklists, approving documentation in the clinical record, and viewing video tapes of client sessions or Child and Family Team to monitor their supervisee. Supervision is to be documented and supervisors must review and approve assessments, treatment plans, and care coordination plans prior to their being finalized.

Employee performance reviews are conducted at 3 months, 7 months and 11 months after the initial date of hire and annually on the employee's anniversary. DCFS follows the disciplinary procedures outlined by the Department of Personnel.

Goals and Objectives/Services and Programs

The goals and objectives of DCFS Children's Mental Health programs and methods are to ensure that the children and families served receive a thorough intake, diagnostic and biopsychosocial assessment, and that they begin least restrictive, individualized treatment in a timely manner in accordance with SOC values and guiding principles (see Appendix B). This comprehensive assessment builds on strengths and identifies needs resulting in a treatment plan that is developed in partnership with the family or caregiver. The ultimate goal is that the child and family will participate in individualized, coordinated services that improve their functioning and reduce symptoms. DCFS strives to provide services in a culturally and linguistically competent manner. This is often a challenge due to the shortage of a diverse workforce statewide.

Practitioners in DCFS Children's Mental Health treatment programs are trained in numerous evidence based practices in order to improve the functioning of children and adolescents determined to be Severely Emotionally Disturbed (SED). A list of evidence based practices and treatment models utilized can be found at the end of this report. (see Appendix C)

Community Based Programs- These programs are located in Northern Nevada and in four neighborhood centers in Southern Nevada. Wraparound and Mobile Crisis Response Teams (MCRT) are located in the rural regions as well. Rural MCRT is operated by the Division of Public and Behavioral Health in consultation with DCFS.

- Children's Clinical Services (CCS) - This program serves children ages 6-17 years old (18 if still in high school) who are primarily

severely emotionally disturbed. Services include individual, family, and group therapy as well as clinical case management services, psychological evaluation, and referral for psychiatric care and medication management if needed. The children served are in the custody of their parents or they may be in the foster care system.

- Early Childhood Mental Health Services (ECMHS) - Serves children between birth and six years of age with emotional disturbance or high risk factors for emotional and behavioral disturbance and associated developmental delays. The goal of services is to strengthen parent-child relationships, support the family's capacity to care for their children and to enhance the child's social and emotional functioning. Services include behavioral and psychological assessments, Individual, family, and group therapies and behavioral management, psychiatric services, day treatment, in-home crisis intervention, clinical case management, as well as childcare and pre-school consultation, outreach, and training.

- Wraparound In Nevada (WIN) - With locations in Reno, Las Vegas and communities in the rural regions, this program provides intensive targeted case management services to children with SED in foster care or the custody of their parents. In addition to addressing mental health needs, these services support the achievement of permanency for foster care youth through reunification with their families, guardianship with relatives, adoption or successful emancipation in all three regions statewide. WIN staff use a nationally recognized, strengths based and collaborative approach to help families overcome barriers to caring for children with SED at home.

- Mobile Crisis Response Team (MCRT) - The Mobile Crisis Response Teams (MCRT) provide crisis intervention and support to Nevada families dealing with a behavioral or mental health crisis. MCRT serves youth under the age of 18 showing signs of behavioral or mental health issues that pose a threat to the child's stability within their home, school or community. MCRT responds to youth and families of youth in crisis, over the phone or in person, in order to

reduce emergency room visits and ensure everyone receives the proper care. MCRT conducts triage over the telephone in order to evaluate, prevent or resolve a crisis and decide if a referral will be made to a community resource or if care is needed beyond a phone call. A response team will go to the youth and their family and work to resolve the crisis. MCRT offers short-term assistance and case management services inside and outside of the home through a Child and Family Team process. In addition to stabilization services, MCRT also provides referrals to additional community-based services. The youth and family can access MCRT in the future should another crisis should arise. Follow-up and referral care through community partners, including family support through Nevada PEP, is available to the youth and their family. MCRT ensures a smooth transition to any support and services that may be necessary. Since its inception MCRT services have resulted in significant diversion from emergency room and acute care services. Since its inception, the percentage of youth served who have avoided hospitalization has been at 85% or above.

Treatment Homes – Located in Southern and Northern Nevada

- On-Campus Treatment Homes (Oasis) in Las Vegas and Family Learning Homes (FLH) in Reno- These programs are residential homes providing intensive highly structured treatment for children and adolescents 7-17 years of age determined to be severely emotionally disturbed. Services within this program include individual, family, and group therapies and behavior management, clinical case management, psychological, psychiatric assessment and evaluation as well as parent training.

- Adolescent Treatment Center (ATC)- Located in Reno, ATC is a 16-bed residential program providing staff secure, 24-hour supervised treatment for adolescents, 12-17 years of age with severe emotional disturbance and behavioral disorders. Service provided within the program include psychiatric evaluation and medication management, individual, family, and group therapies, psychological assessment and evaluation, special education and

regular education services on site through Washoe County School District, nursing care and emergency evaluation and stabilization.

Acute Care Psychiatric Hospital Residential Facility – Located in Southern Nevada

- Desert Willow Treatment Center (DWTC) - Desert Willow Treatment Center is a licensed psychiatric hospital accredited by The Joint Commission that provides mental health treatment to children from throughout the state. The facility consists of acute psychiatric units and three residential treatment units serving kids 12-17. These programs provide psychiatric care to youth with the most severe emotional disturbances representing the most restrictive service alternatives in the state. Many of the children served present risks to themselves and/or their community. The services include crisis intervention and stabilization, individual, family, and group therapies and behavior management, clinical case management, psychological evaluation and consultation, psychiatric evaluation and medication management, nursing care, recreational therapy, and special education on site through the Clark County School District.

Quality Assurance, Program Planning, and Program Improvement – Located in Reno and Las Vegas

- Planning and Evaluation Unit (PEU) - Within DCFS, quality assurance, program planning, and program improvement responsibilities are primary roles of the Planning and Evaluation Unit (PEU). PEU staff also monitor compliance to policies and conducts special investigations when requested.

- System of Care Unit (SOC) - DCFS was awarded a System of Care (SOC) Expansion Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015. Staff have been hired to develop priorities for grant funded initiatives and implementation in conjunction with DCFS stakeholders with the goal of improving access to care across Nevada. SOC staff have begun to initiate quality assurance

activities with community providers who receive funds from the grant.

Treatment Population

A detailed Descriptive Summary is available upon request. This annual report describes the youth and families served by DCFS Children's Mental Health programs during Fiscal Year 2016. Consumer demographics and highlights from this report can be found in Appendix D.

Service Effectiveness

DCFS Children's Mental Health programs collect and report numerous performance measures to various state and federal entities on an annual basis at a minimum.

One of the performance measures reported that demonstrates effectiveness of clinical services includes the change in scores on the Child and Adolescent Functional Assessment Scale (CAFAS) as well as the Preschool and Early Childhood version (PECFAS). The CAFAS and the PECFAS are standardized instruments commonly used across child-serving agencies to guide treatment planning and as clinical outcome measures for individual clients and program evaluation (Hodges, 2005). Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. For the PECFAS clinically significant improvement is considered if there is a 17.5 point drop in total score in subsequent ratings. The following table contains information reported in detail in the 2016 Descriptive Summary which is available upon request.

Percent of children served in State Fiscal Year 2016 who show improved functioning on CAFAS/PECFAS ratings at discharge

Performance Measure	Program- Statewide	Number with Clinically Significant Improvement (%)
CAFAS	Children's Clinical Services	267 (51%)
CAFAS	Wraparound In Nevada	168 (53%)
CAFAS	Mobile Crisis Response Team	174 (36%)

PECFAS	Early Childhood Mental Health Services	142 (54%)
CAFAS	Treatment Homes (Oasis, FLH, ATC)	37 (61%)
CAFAS	DWTC Acute	95 (85%)
CAFAS	DWTC Residential	34 (92%)

Additional performance measures collected and reported include data from the DCFS Consumer Satisfaction Surveys that are conducted annually for community based programs and at discharge for residential programs and Desert Willow Treatment Center. Results from these surveys will be discussed elsewhere in this report (see page 13l). The performance measures from the surveys include consumers' perceptions of the youth's ability to cope, interact socially with friends, and function at school since participating in DCFS services. Further performance measures reported from the survey include items related to the quality and appropriateness of the services received. These measures are compared to National Outcome Measures denoted in the Federal Mental Health Statistical Improvement Program (MHSIP) developed by the Center for Mental Health Services to improve quality of mental health service delivery.

DCFS Children's Mental Health programs utilize two checklists to assure staff's procedures and documentation are in compliance with the Medicaid Services Manual Chapter 400 and Chapter 2500. The DCFS Planning and Evaluation Unit (PEU) conducts periodic audits of client files including entries into Avatar, the DCFS electronic health record and billing system. Clinical supervisors are also required to review and approve assessments, treatment plans, and targeted case management plans prior to them being finalized in Avatar. Copies of the checklists are in Appendix E. Plans are also reviewed with the client and family as well as the rest of the Child and Family Team at least every thirty days for clients being served by Wraparound In Nevada and formally updated at a minimum of every 90 days for those clients receiving therapy.

PEU also audits Avatar for cases that are inactive (have no service entries) for 90 days and 180 days so that program managers can prompt staff to close them thus improving accuracy related to client counts, caseloads, and reducing liability. Clients who fail to show for two appointments, don't respond to phone calls, or have otherwise lost contact with their provider are sent letters advising them that their case will be closed if there is no response within 10 calendar days.

The Planning and Evaluation Unit also conducts audits in DCFS residential programs in order to monitor compliance to the DCFS Medication Administration and Management for Residential Programs Policy as well as

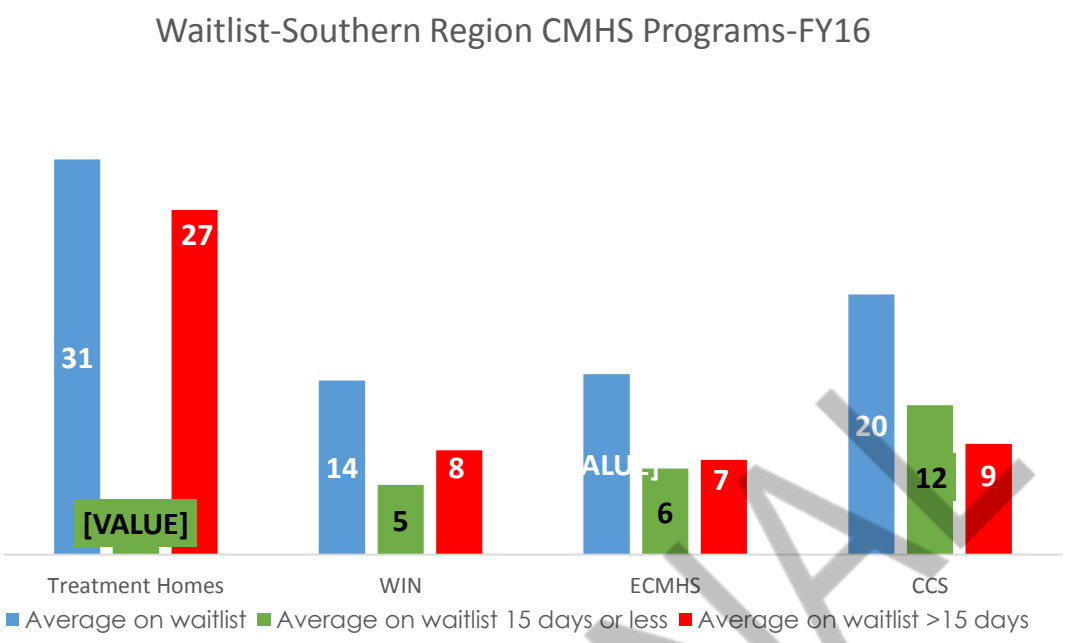
other policies related to consent to treat, safety, the physical plant, documentation, etc.

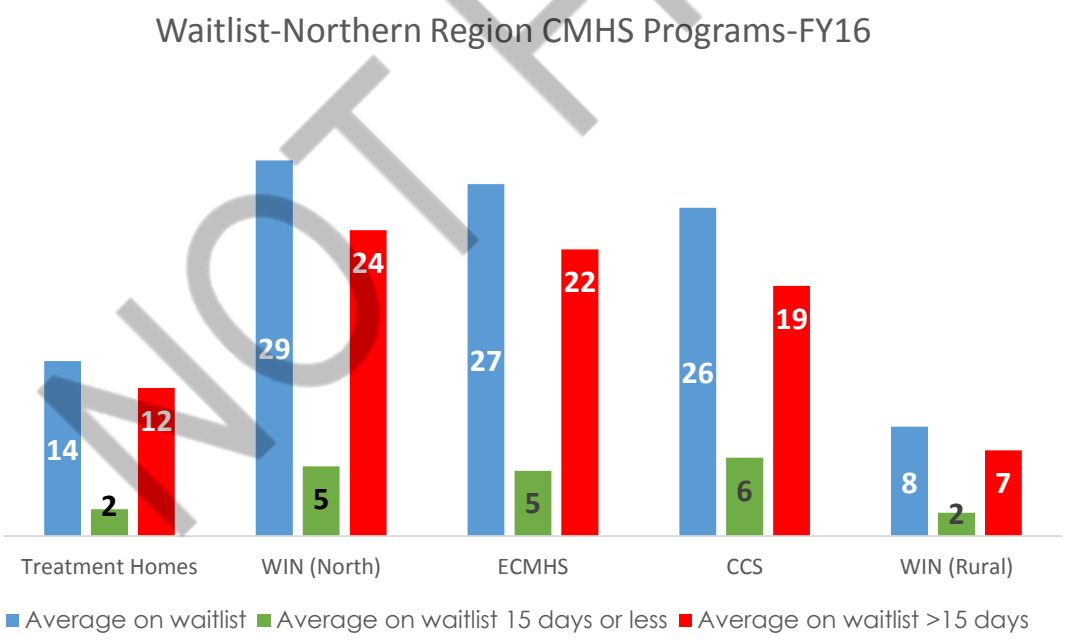
DCFS PEU also conducts special investigations and reviews incidents and consumer complaints upon request of the Administrator and is also responsible for monitoring Children's Mental Health programs' compliance to the Health Insurance Portability and Accountability Act (HIPAA).

Access and Availability of Care

DCFS Children's Mental Health programs are to maintain up-to-date waitlists in Avatar. These waitlists are submitted monthly to the state of Nevada Department of Health and Human Services, are reviewed in DCFS management team meetings, and reported to the Nevada Commission on Behavioral Health.

The following are the average waitlist data for Southern and Northern Children's Mental Health programs. Clients are placed on the waitlist at their/or a referral source's first call to an Intake Coordinator. The client is to be removed from the waitlist when the Intake Coordinator assigns the client to a practitioner in Avatar. Some programs such as the Southern WIN program report having no waitlist for a number of years so it is hypothesized that these averages in the charts below may be the result of clients not being actually removed from the waitlist after assignment, thus inflating the numbers.





DCFS, as a state entity, acts as a safety net providing services regardless of ability to pay or insurance status. Children may be Medicaid Fee for Service recipients, uninsured, underinsured, and in some cases undocumented.

Since January 2014, DCFS has provided Mobile Crisis Response Teams (MCRT) designed to assist youth who are experiencing a mental health crisis. This service has improved access to care and resulted in youth being diverted from unwarranted acute hospitalization. MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department regardless of insurance coverage. The Southern Nevada team has recently begun responding twenty-four hours, 365 days a year. MCRT began in October 2014 in Northern Nevada and in November 2016, DCFS began supporting crisis services in the rural regions through a subgrant with the Department of Public and Behavioral Health.

Consumer Satisfaction

Community Based Programs-

DCFS conducts an annual survey of consumers who are in community-based mental health services (see statewide report and survey instruments in Appendix F). The survey typically takes place in the spring and is anonymous. Parents/caregivers with children in treatment and the youth themselves (if age 11 or older) are solicited to voluntarily participate in completing the survey instrument. Participants are asked to disagree or agree with a series of statements relating to seven "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness.
These domains include:

- Ease of Access
- Functioning
- Social Connectedness
- Participation in Treatment
- Positive Outcomes
- General Satisfaction
- Cultural Sensitivity

Responding to the survey from spring of 2016 were 454 parents/caregivers and 232 youth in program services. This was an increase of 22% from participation the year prior. Of the 454 parent/caregiver surveys, 60 respondents chose to complete the Spanish language survey. Survey participation, although voluntary, was solicited by clerical/other office staff at the locations providing the clients' mental health services. Survey questionnaires were self-administered and, when completed, put into

closed collection boxes, or completed at home and mailed to Planning and Evaluation Unit offices. Items that require a plan for improvement are those that have a positive response rate of 60% or below. None of the domain items met that criteria so no specific improvement plans were created. However, in order to report more timely results and improve response, the survey is going to be available more frequently. A different process is being piloted and if proven to be successful will be implemented throughout DCFS Children's Mental Health. Criteria has been established that the survey will be offered to clients who have been in services at least 30 days and have had at least four sessions and also at discharge. The clients who meet that criteria will be selected by the Planning and Evaluation Unit however their survey will be collected electronically whenever possible. Secured computers will be available in the lobby for confidential survey completion via Survey Monkey. Initially this will be piloted in Reno and at the West Neighborhood Family Service Center. The annual survey will also likely take place in the spring as usual at least for 2017 while the viability of the new process is evaluated.

Parents/guardians whose children were served by the Mobile Crisis Response Team reported being extremely satisfied with the services and supports they received. The greatest areas of satisfaction are in agreeing that the Mobile Crisis Response Team was able to help quickly (97%); the team was professional, friendly, and respectful (99%); and that they received the help they needed from the Mobile Crisis Response Team (94%). Parents/guardians also reported that the Mobile Crisis Response Team was able to de-escalate the situation (90%) and provide resources (93%). Nearly all parents reported that overall, they were satisfied with the Mobile Crisis Response Team (98%). Additionally, when asked how likely they were to recommend the Mobile Crisis Response Team to a friend in need of similar help, 94% of parents/guardians reported that they were very likely or extremely likely to do so.

Residential programs and Desert Willow Treatment Center-

Oasis, Family Learning Homes, Adolescent Treatment Center, and Desert Willow Treatment Center collect surveys at discharge. For fiscal year 2016 the responses received were from 106 parents/caregivers and 159 youth, resulting in a 51% decrease in response rate from the previous fiscal year. A workgroup with program managers will be formed to determine what can be done to increase the response rate.

Oasis On-Campus Treatment Homes' highest positive responses for Parents/Caregivers were in the areas of Access to Services (91%) and Cultural Sensitivity (88%). The highest positive responses for Youth were in the areas of Positive Outcomes (88%), Cultural Sensitivity (88%), Functioning (91%), Interest Items (87%), and Psychiatrist/MD (89%). The areas with the lowest responses for Parents/Caregivers were Positive Outcomes (58%) and Functioning (51%). The areas with the lowest responses for Youth were Access to Services (70%), General Satisfaction (79%) and Participation in Treatment (79%).

The Family Learning Home's highest positive responses by Parents/Caregivers were in the areas of Access to Services (100%), General Satisfaction (95%), Positive Outcomes (94%), Functioning (91%) and Interest Items (95%). The highest positive responses by Youth were in the areas of General Satisfaction (86%), Positive Outcomes (90%), Participation in Treatment (94%), Functioning (89%) Interest Items (89%), and Psychiatrist/MD (91%). The area with the lowest responses by Parents/Caregivers was Participation in Treatment (80%). The area with the lowest responses for Youth was Cultural Sensitivity (79%). No responses were less than 60% positive.

Adolescent Treatment Center's highest positive responses by Parents/Caregivers were in the areas of Access to Services (97%), General Satisfaction (92%), Cultural Sensitivity (98%), and Interest Items (92%). The highest positive responses by Youth were in the areas of Access to Services (86%), General Satisfaction (92%), Positive Outcomes (90%), Cultural Sensitivity (88%), and Functioning (93%). The lowest positive response by Parents/Caregivers were in the areas of Positive Outcomes (75%) and Functioning (71%). The lowest positive response by Youth was in the areas of Psychiatrist/MD (83%).

Desert Willow Treatment Center's highest positive responses for Parents/Caregivers were in the areas of Access to Services (88%), General Satisfaction (86%), Cultural Sensitivity (93%), and Interest Items (87%). The highest positive responses for Youth were in the areas of Cultural Sensitivity (88%), Interest Items (92%), and Psychiatrist/MD (86%). The areas with the lowest positive responses by Parents/Caregivers were Positive Outcomes (69%) and Functioning (67%). The areas with the lowest positive responses by Youth were Positive Outcomes (82%) and Participation in Treatment (82%). No responses were less than 60% positive.
For residential programs who have parents expressing views that differ significantly from their children concerning outcome of treatment, improved functioning, etc., improving parent participation and

engagement in treatment would likely improve the parent perspective on these particular items. In order to address these items, the parent management training program Family Check Up and Everyday Parenting will be implemented when appropriate. This program is shown to improve family functioning, parenting skills, monitoring, as well as improve relationships. This program has been challenging for staff to become certified in and implement; however, managers will be more vigilant about supporting this evidence based initiative.

Grievances/Consumer Complaints

Managers of DCFS Children's Mental Health programs have developed a policy to address consumer complaints (Appendix G). This policy is currently being updated to reflect system of care values and principles. Copies of all complaints will be forwarded to the Planning and Evaluation Unit and maintained in a database.

Desert Willow and residential program complaints are reported monthly to the Legislative Counsel Bureau (LCB). For calendar year 2016, Desert Willow clients had 179 complaints. Complaints against staff, peers, and rules made up more than 50% of the concerns reported to LCB.

Complaints reported to LCB regarding Oasis, FLH, and ATC during calendar year 2016 were 2, 0, and 8 respectively. Complaints were primarily about rules, food choices or taste, and peers.

Conclusion

The DCFS Planning and Evaluation Unit is tasked with developing plans for quality assurance and measuring service delivery impact upon outcomes. PEU researches best practices and works with DCFS managers to improve the understanding of the components that lead to effective programs. PEU also partners with community stakeholders, such as the three regional consortia in developing quality assurance and quality improvement standards. The 2017 CMHS QA/PQI Plan incorporates quality assurance and quality improvement efforts that continue to address system of care operations at the child and family level, at the supervisory level and at the managerial and community stakeholder level and includes revisions of methods and standards required in order to gain a better understanding of service delivery and outcomes.

We endorse the Annual Quality Assurance Program Report and are pleased to submit it to DHCFP on behalf of DCFS Children's Mental Health Services program managers and staff.

Approved by:

_____ _____

Katherine Mayhew LMFT
Clinical Program Planner III
Planning and Evaluation Unit, DCFS

Date

_____ _____

Ryan Gustafson, Deputy Administrator
Children's Mental Health, DCFS

Date

_____ _____

Michelle Fontenelle-Gilmer, M.D.
Medical Director, Southern Nevada Child and Adolescent Services, DCFS

Date

_____ _____

Darryl McClintock, M.D.
Medical Director, Northern Nevada Child and Adolescent Services, DCFS

Date

_____ _____

Kelly Wooldridge
Administrator
Division of Child and Family Services

Date

References

Center for Mental Health Services. (1996). The MHSIP consumer-oriented mental health report card: The final report of the Mental Health Statistics Improvement Program (MHSIP) task force on a consumer-oriented mental health report card. HHS Pub. No. MC96-60. Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

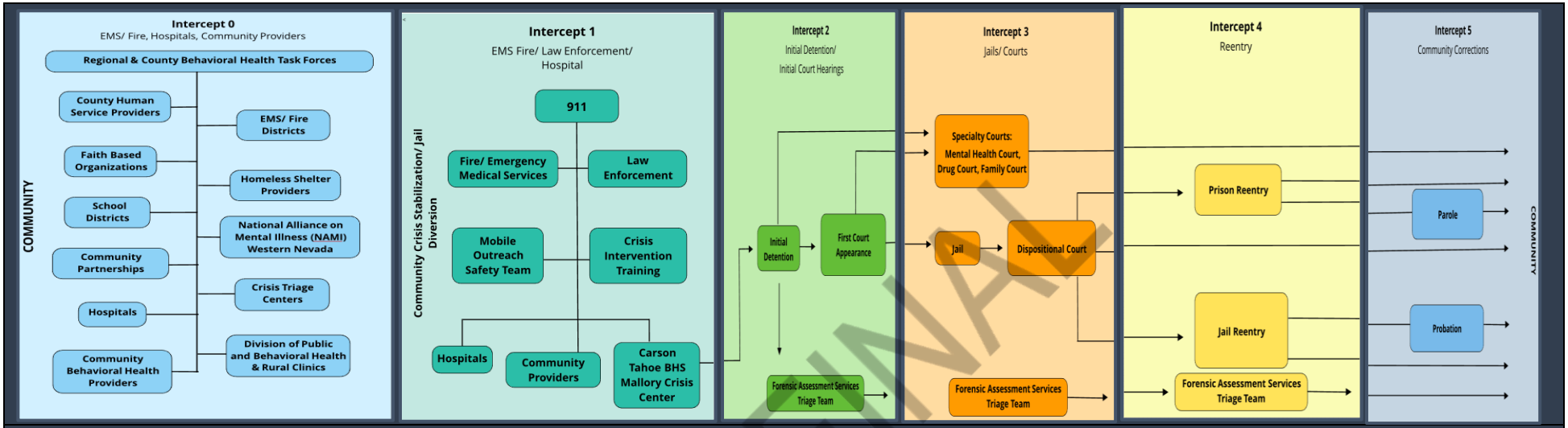
   During the past year 1 regional coordinator brought several counties together to create plans in the individual counties, and develop sequential intercept models. The coordinator also created a regional behavioral health task force which brings multiple counties together to have discussions, create plans, and support one another's efforts. In May 2017 two more regional coordinators were hired to cover other areas of the State and duplicate some of the efforts completed by the first regional coordinator.

   Some counties are now implementing a brief jail mental health screen at the time of booking to help triage getting services in place when needed to help prevent future incidents.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Regional Sequential Intercept Model for Crisis Prevention, Crisis Stabilization, and Jail Diversion: Lyon, Churchill, Carson, and Douglas Counties



Identified Action Steps for Change:

Community Collaboration:
Formalize relationships and partnerships through inter-local agreements and Memorandum of Understanding (MOU's)
- Develop police and EMS/ Fire friendly policies and procedures to ensure easy access to needed community services
-Identify information sharing strategies that are informed by law
- Develop and implement EMS/Fire/ law enforcement/ community provider cross training
-Develop community resource protocol

Treatment:
Development of in-home rehabilitation

Housing:
Create housing steering committee to identify strategies to develop affordable housing, transitional housing, and crisis housing opportunities

Database for Collaboration and Data Collection: Use Community Management Information System (CMIS) to collaborate on super-utilizers and track community initiatives

Develop/ formalize community Case management:
To stabilize super-utilizers and individuals in chronic crisis.

Community Discharge:
Create community task force to develop community discharge planning policies and procedures

Community
Mental Health EMS Fire/ Law Enforcement Crisis Teams available during expanded hours (Ideally 24/7)

Jail
Implement universal mental health screening using Brief Jail Mental Health Screen and Medicaid eligibility at booking

Policy and Procedure:
-All EMS/ Fire and Law enforcement providers have a clear process for mental health evaluations and voluntary and involuntary behavioral health admission

Data Sharing:
EMS/ Fire and Law enforcement will form data sharing agreements with state epidemiology office for data collection and analysis of MOST and FASTT program progress

Training:
-Development of 40-hour crisis intervention training
-Development/ identification of mental health training provided to all EMS/Fire and law enforcement
-All dispatchers are trained to recognize when mental illness is a factor

Courts
Develop Justice Court diversion initiatives and resources
-Increase mental health diversion program options in the county

Lawyers:
Local bar association obtains continuing education on mental illness, community resources, alternatives to incarceration, and related legal issues

Database:
Criminal Justice and Mental Health information will be matched to identify and respond to behavioral health needs with privacy mandates

Jail
-Increase access to mental health support groups, peer support programs in jail (FASTT)
-Treatment needs are assessed to inform placement and in- custody care
-Jail Staff are provided with specialized training to supervise inmates with mental illness

Courts:
-Identify and develop policies and procedures to develop jail discharge coordination between courts, alternative, parole and probation, and FASTT

Community Collaboration:
MOU's and inter-local agreements will be developed to formalize agreements between jail, behavioral health, and local community providers (FASTT)

Community Re-entry:
-Jail case managers are trained assess risk and needs to match individuals to appropriate services
-Transition plans are consistently developed
-Medicaid/ SSI/ SSDI enrollment is facilitated for eligible individuals before release
-Reentry plans are based on assessments and include key supports such as housing

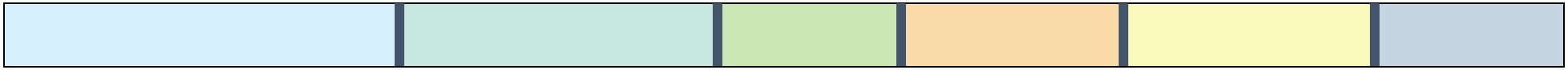
Develop/ formalize community case management:
-Strengthen connections to community providers and EMS/ Fire for individuals released from jail and hospitals

Treatment:
-Develop opportunities to develop domestic violence counselors

Community Discharge
-Develop community discharge planning policies and procedures

- Probation:
Develop a system in which supervision plans based on assessed risk/ needs are coordinated with local probation parole
-Develop transition plans and coordinate with community agencies
-Development of policies where collaborative case management is used by probation and behavioral health agencies
-Probation officers are given specialized caseloads for overseeing individuals with mental illness
-Cross training is offered for community corrections officers and community providers

Regional Sequential Intercept Model for Crisis Prevention, Crisis Stabilization, and Jail Diversion: Lyon, Churchill, Carson, and Douglas Counties



Intercept 1: Law enforcement/ Emergency Services

	Don't have but want	In progress	Complete
Policies	-(1*) Mobile Crisis Unit is available to law enforcement	-(3*) All emergency service providers have a clear process for mental health evaluations and involuntary/voluntary commitment -(1*)"Premise Alert" information is provided to law enforcement to assist in response to a call for service (currently for Alzheimer's and autism)	-Law enforcement and emergency services agencies document all calls for service when mental illness is a factor -Law enforcement at the scene helps the subject of the call for service connect to community services -(1*) Department policy enables officers to implement an appropriate response based on the nature of the incident, the behavior of the person, and available resources
Programs and Treatment	-(1*)Crisis intervention teams (CIT) are established -Mental health/police co-responder teams are available (days/times or for certain call types (8*?) -Crisis receiving centers at local hospitals or other 24/7 facility are accessible (want but do not have in Lyon County/ have in region)	-(2*) Case management teams are used particularly for high utilizers of emergency services -(6*) In home rehabilitation	
Training	-(3*) Training is available for behavioral health care providers taking referrals from police and other emergency service providers-	-Mental health training module is provided for all new officers -(2*) Dispatchers are trained to recognize when mental illness is a factor for all calls	-(2*) CIT or other in-service law enforcement training is offered- Lyon County Sheriff's Department has trained most their deputies in a 16-hour training

Intercept 2: Initial detention/ Initial court hearings

	Don't have but want	In progress	Complete
Policies	-(2*)Criminal justice and behavioral health databases are matched to help identify behavioral health needs in compliance with privacy mandates -Defense counsel is quickly appointed and made aware of identified mental health needs	-(2*) Jail intake personnel conduct behavioral health screenings and screen for Medicaid eligibility to increase connection to treatment on release -1*)Pretrial decisions are informed by assessments on behavioral health needs and risk of reoffending or failure to appear (prison?) -(2*)Defense counsel or staff screen for mental illness and advocate for referral/diversion when appropriate (?)	
Programs and Treatment	-(3*)Mental health diversion programs are available[8] -A court-based clinician(s) is available for consultation, referrals, and client engagement	-Defendants with serious mental illnesses are included in alternative-to-incarceration programs	
Training	-Local bar association does continuing legal education on mental illness, community resources, alternatives to incarceration, and related legal issues	-Judges are trained on recognizing mental health needs -Pretrial services officers are trained on mental health issues (recognition of when mental illness may be a factor in offense or arrest, options for diversion or special supervision, etc.)	

Intercept 3: Jails/ Courts

	Don't have but want	In progress	Complete
Policies	-Reviews are conducted with legislator on what charges qualify for diversion -Assessment on treatment needs inform placement and in-custody care	-(1*)There are regular reviews of release alternatives for people who are unable to make bail (In municipal court?) -(1*)Alternatives to incarceration are used when possible (need more alternatives) -Assessment on treatment needs inform placement and in-custody care -Jail staff provides an opportunity for family/caregivers to communicate medication and treatment needs for individuals who remain in custody -There is access to mental health support groups, peer support programs, and dual recovery groups in jail	-There are regular reviews of release alternatives for people who are unable to make bail (In district court?) -(1*)Alternatives to incarceration are used when possible -There are clear processes for modifications to condition of release to take circumstances into consideration
Programs and Treatment	-Non-problem solving court diversion is available -(1*) Jail has information-sharing agreement with local behavioral health and reentry service providers to facilitate uninterrupted treatment and supports	-Problem-solving courts use an application process to match individuals with appropriate programming (municipal court)	-Problem-solving courts use an application process to match individuals with appropriate programming (district court)
Training		-Jail staff receive special training on supervising inmates with mental illnesses	

Intercept 4: Reentry

	Don't have but want	In progress	Complete
Policies	-(5 *) Transition plans are consistently developed (in jail) -(2*) Risk/needs related to reoffending are assessed using validated tool and consistent process and inform program- and service-matching (in jail- ORAS) -Release notice is given to community supervision and agencies responsible for ongoing services (jail) -(7*) Medications in sufficient supply are provided upon release, along with connection to doctor / clinic for future prescriptions -Mental Health gets updates on who is coming back into the community	-(5*) Transition plans are consistently developed (in prison) -(3*) In-reach or other mechanism is used to ensure "warm hand-off" to community-based treatment providers -(3*) Reentry plans are based on assessments and include key supports such as housing[6] -(4*) Medicaid / SSI-SSDI enrollment is facilitated for eligible individuals before release -Connections to supportive family members and other networks are encouraged	-(2*) Risk/needs related to reoffending are assessed using validated tool and consistent process and inform program- and service-matching (prison) -Release notice is given to community supervision and agencies responsible for ongoing services (prison)
Programs and Treatment		-Transition Case Management is available for high-need individuals -(2*) Mental health and substance use treatment providers can provide timely access -Access to Health Homes is provided to people after release to enable integrated care	

Training	-(2*) Training is available for mental health care providers and social service providers -(2*) Jail case managers, transition staff, and program staff are trained on how to match individuals to appropriate services and supports available in the community for both transitional and long-term care, effective communication techniques for engaging clients, [9] and information -sharing protocols (in progress)		

Intercept 5: Community corrections/ Community support

	Don't have but want	In progress	Complete
Policies	-Supervision plans are based on assessed risks / needs (prioritizing high-risk/need individuals for intensive supervision and ensuring low-risk/need individuals are receiving light touches) -(2*) Collaborative case management is used by probation and behavioral health agencies	-Community supervision requirements and responses are appropriate for the mental health population and encouraging success	-Conditions of supervision modifications are available as needed -Supervision plans are based on assessed risks / needs (prioritizing high-risk/need individuals for intensive supervision and ensuring low-risk/need individuals are receiving light touches) (prison) -Probation officers are provided training for responding to people with mental health needs (?)
Programs and Treatment	-(3*) Trained probation officers are given specialized, smaller caseloads for overseeing individuals with mental illnesses -Mental health professionals are embedded in probation units -(1*) "Modified" Therapeutic Community and other evidence-based treatment is available for individuals with co-occuring substance use disorders		
Training	-Specialized training and cross-training is available for community corrections officers and treatment providers	-(1*) Community-based organizations provide training on available resources	

Douglas County Stepping Up Initiative Workshop

CVIC Hall
1604 Esmeralda Ave, Minden, NV 89423
March 28th, 2017, 8:00 am-12:00 pm

Introduction:

The Douglas County Stepping up Workshop was held on March 28th, 2017 at the CVIC Hall in Minden, Nevada and facilitated by Steve Lewis of Douglas County University of Nevada Reno, Cooperative Extension. The primary goal of this workshop was to develop a county plan to collaborate in building healthy communities though stabilizing individuals in chronic crisis in the community and diverting individuals with behavioral health issues from the criminal justice system. This workshop focused on the following objectives aligned with the Stepping up Initiative using the Sequential Intercept Model:

- Examine treatment and service capacity in the county
- Identify state and local policy that could be changed to enhance efforts toward stabilization and diversion of individuals in chronic crisis.
- Identify funding barriers to minimize involvement with the criminal justice system
- Provide treatment and supports in the community

Partners in attendance:

Douglas County Sheriff Pierini, Captain Halsey, Sergeant Savage, Judge Perkins, East Fork Fire Deputy Chief Fogerson, Tahoe Fire Chief Scott Baker, Probation and Parole officers, Douglas County Counseling and Supportive Services Clinic Director Jenni Johnson, Douglas County Counseling and Supportive Services DPBH Rural Clinics Director Tina Gerber Winn, DPBH Program Developer Dana Walburn, Tahoe Youth and Family Director Christopher Croft, Suicide Prevention Network Executive Director Debbie Posnien, Partnership of Community Resources Director Cheryl Bricker, Douglas County Social Services Director Karen Beckerbauer, Regional Behavioral Health Coordinator, Jessica Flood, and NAMI representative Sandie Draper.

Intercept 0: Community Prevention

Strengths:

Douglas County's stakeholders at the Stepping up Initiative Workshop, identified Intercept 0 and initiatives established within it as the most important part of the Sequential Intercept Model. Community prevention and intervention efforts prior to crisis or risk of arrest, are viewed as most effective and least disruptive when working to stabilize and integrate individuals with mental health issues back into the community. Intercept 0

consists of the network of community providers, including Douglas County Social Services, National Alliance on Mental Illness, East Fork Fire, Tahoe Douglas Fire, Counseling and Supportive Services, Suicide Prevention Network, Partnership of Community Resources, Tahoe Youth and Family, Carson Valley Medical Center, and more.

Douglas County has made great strides in enhancing collaboration and reducing silos between agencies. This strong network allows agencies to assist individuals who are at risk of crisis to connect to community treatment and services. Douglas County stakeholders are in the process of formalizing relationships and processes through development of polices procedures and interagency agreements.

Anticipated Next Steps

- Develop emergency responder friendly policies and procedures with training throughout the community
- Develop cross-training
- Develop community resource protocol and processes for youth and adults
- Develop county based policies and procedures for FASTT, MOST, CIT, and other initiatives
- Develop MOU's and interagency agreements as needed based upon collaborative initiatives
- Further explore and identify legal foundations of mental health-involved issues such as legal holds, Multi-disciplinary Teams, HIPPA, and releases of information.

Identified Priorities

- Development of law enforcement and EMS/Fire friendly policies and procedures including community training and education was the second highest priority identified for the entire workshop.
    - Development of community resource protocol was included in priority of developing policies and procedures friendly to emergency responders.
- Identify and formalize information sharing strategies was included as one of the top 5 priorities of the workshop as well.

Intercept 1: Law enforcement / Emergency services

Strengths

Douglas County has several important policies in place that support emergency responders in defusing and preventing crises in the community. Douglas County developed and implemented a multi-disciplinary 40-hour Crisis Intervention Training, developed from guidelines of Memphis Model CIT, in the Spring of 2017 to provide first responders with training on effective responses to behavioral health issues and community resources. Additional policies are in place that support appropriate responses to individuals at risk of or currently experiencing behavioral health crisis. EMS/ Fire and law enforcement agencies all have policies in place that enable first responders to implement appropriate responses based upon the situation, behavior of the individual, and available resources Emergency responders at the scene are also able to help individuals connect with needed community services. Douglas County emergency responders also use a Premise Alert system to obtain forewarning on potential situations that could involve individuals who have autism or mental health issues.

Anticipated Next Steps

- Develop protocols for community crisis triage system

- Development of behavioral health dispatch training to complement Crisis Intervention Training so dispatchers can determine whether mental illness is a factor for all calls.
- Develop system that allows data to be collected regarding calls for service where mental illness in a factor. This information is currently being collected, but is not able to be obtained for data purposes.
- Explore options and resources to develop system for increased availability of mental health/ EMS/Fire/ law enforcement first responder teams
- Formalize crisis management teams for high utilizers of emergency services and for follow up in the community post crisis or reentry.
- Develop crisis receiving center at local hospital or other 24/7 facility for emergency responders and individuals in community to access.
- Identify/ develop mental health module that is provided for all new EMS/Fire and law enforcement officers
- Develop training for behavioral health providers accepting referrals from emergency responders and law enforcement

Identified Priorities

- Expansion of mental health/ EMS/Fire/ law enforcement co-respond teams was the identified as the highest priority of the workshop.

Intercept 2: Initial detention/ Initial court hearings

Strengths

Like community prevention efforts in Intercept 0, Douglas County's Jail was one of the strongest areas their system in the Sequential Intercept Model. The Douglas County Jail is nationally certified _____, and has many process in place that are aligned with national best practices. Jail intake personnel conduct behavioral health and Medicaid eligibility screens to increase connection to treatment upon release. The court system is also able to to provide appropriate response to individuals with mental illness: Pre-trial decisions are informed by behavioral health needs and risk of reoffending, defense council is quickly appointed, screen for mental illness and advocate for referral/ diversion when appropriate, and a Medicaid outreach worker is available in detention to connect individuals with Medicaid upon release.

Anticipated Next Steps

- Develop system in which criminal justice and mental health databases are matched to identify behavioral health needs in compliance with privacy mandates
- Develop/ enhance mental health diversion programs in Intercept 2
- Have court based clinician available for consultation, referrals, and client engagement
- Discuss possibility of local bar association in engaging in continuing legal education in mental illness, community resources, alternatives to incarceration etc.
- Train pre-trial officers, judges, court personnel on mental health issues (when they may be a factor in arrest, offense, and options for diversion and/ or special supervision)

Intercept 3: Jails/Courts

Strengths

In the Douglas County Jail, all inmates are assessed for medical and mental health needs which inform placement in custody, and jail staff allow for family and caregivers to provide information regarding medication and treatment needs. Jail staff receive special training on supervising inmates with mental illness, and healthcare providers within the jail are trained in responses to mental illness as well as treatment and placement options. The jail is also supported by the FASTT program. The Forensic Assessment Services Triage Team (FASTT) is a multi-disciplinary in-reach case management team provides weekly substance use and employment groups in the jail, and meets with inmates once per week to provide assessment and case management services.

In the court system, there are regular reviews of release alternatives for people who are unable to make bail, alternatives are used to incarceration when possible. Problem solving courts use an application process to match individuals with appropriate programming, and non-problem solving courts use diversion for first time drug offenders. Douglas County is supported by the Carson City Mental Health Court, whose team regularly attends problem solving court conferences and training.

Anticipated next Steps

- Explore/develop information sharing agreement between jail and local behavioral health and service providers to facilitate uninterrupted treatment and supports at reentry.

Identified Priorities

- Access to mental health support groups and peer support programs in jail was one of the top 5 priorities identified in the workshop/

Intercept 4: Reentry

Strengths

Reentry from the Douglas County Jail is supported by the Douglas County FASTT program. FASTT provides jail in-reach services through a multi-disciplinary team of community providers to ensure that transition plans are consistently developed in jail and that there is a “warm hand off” to community based treatment. Members of the FASTT team are trained on how to match individuals to appropriate and/or available services and supports in the community to support a successful reentry into the community. This program conducts an assessment that includes key supports such as food, transportation, housing, medication management, and treatment, and works to ensure that inmates have information to connect to a treatment provider in the community. FASTT also facilitates Medicaid enrollment for individuals upon release. The Jail releases inmates with the rest of the supply of medications that were prescribed in jail, and FASTT works to get inmates connected to services as soon as possible. Douglas County Social Services works closely with the jail and community deputies to place individuals in temporary housing on a case by case basis.

It was reported at that transition plans are consistently developed in prison as well. The prison is currently working with Nevada DPBH Rural Clinics to develop and in-reach process by community mental health professional to assist in the development of transition plans. The prison is also working to adopt a process in which key supports such as housing are considered when developing transition plans. The prison releases inmates with sufficient supplies of medication, and is in the process of increasing written prescriptions upon release to 60 days in response to long waits to connect with providers in the community.

Next Steps

- Develop processes that encourage connections from family members and other networks for inmates in jail.
- Douglas County FASTT will adopt and implementing the ORAS Community Supervision Tool Assessment and Screen to assess the risk and needs of the inmate to inform discharge plans.
- Identify high risk/ high needs individuals using ORAS in FASTT to assess the need for transition case management and develop resources accordingly.
- Develop increased support for inmates to obtain housing and employment after release from jail.
- Douglas County Social Services, through the FASTT team, is in the process of implementing employment groups in jail
- Douglas County Social Services will identify community providers who are willing to train inmates as well.
- The need for affordable and transitional housing at reentry was discussed
- Address existing gap in community mental health and substance use treatment provider ability to provide timely access to treatment.

Intercept 5: Community corrections/ Community support

Strengths:

In Douglas County, collaborative case management is used by probation and mental health agencies in jail through the FASTT Team. Additionally, evidence based treatment for individuals with co-occurring substance use disorders is available in multiple agencies in the community.

Next steps:

- Parole and Probation is in the process of enhancing mental health programs and officer mental health response through multiple initiatives.
- Parole and probation is developing systems in which supervision plans as based on assessed risks/ needs where, those with high risk/ high needs are prioritized for intensive supervision and low risk/ needs receive a “light touch”.
- Parole and Probation is working to provide their officers with training to respond to individuals with mental illness, and to establish community supervision requirements and responses that appropriate for the mental health population.
- The prison is also incorporating collaborative case management with probation and mental health agencies.

Top 5 Priorities

1. Mental Health/ police/ EMS/ Fire Responder Teams available

2. Police EMS Fire friendly policies and procedure/ education & training

    a. Develop community resource protocol/ triage flowchart

b. Develop flowchart on decision making process for resources

- during business hours, and after hours
- Incorporate “no wrong door”
- Develop community map
- Provide signage at community agencies in window that signifies if the agency can assist.
- Establish protocols , pilot protocols and feedback, train and communicate protocols

3. Identify information sharing strategies:

- Include parameters for ROI and information sharing in accordance with federal and state law

4. Access to mental health support groups, peer support programs in jail:

- Develop peer groups in jail where there is no contractual obligation
- Obtain peer group recommendations
- Develop peer network
- Develop Behavioral Health Task Force to provide informational incentive on why to engage- what’s in it for them.

-

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No

   a) é Methadone

   b) é Buprenophine, Buprenorphine/naloxone

   c) é Disulfiram

   d) é Acamprosate

   e) é Naltexone (oral, IM)

   f) é Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   See the attached document entitled updated information bulletin on MAT 08 2017 for additional information about current work related to MAT services in Nevada.

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Informational Bulletin on Medications and Services for Substance Use Disorders

This bulletin is informational only and does not supersede any policy or information documented in the Fee for Service (FFS) or Managed Care Organization (MCO) policy, billing manuals.

Nevada Medicaid consists of four different health care plans:

1. Fee for Service
2. Health Plan of Nevada (HPN) (MCO)
3. Amerigroup (MCO)
4. Silver Summit Health (MCO)

Recipients will be enrolled in one of these plans. It is important to know what plan recipients are enrolled in. In some situations recipients can transfer to a different health care plan. Recipients must also be Medicaid eligible at the time of service.
All pharmacies and medical prescribers and servicing providers must be enrolled as billing/servicing providers in the Medicaid health care plan. Just because a provider is enrolled with FFS does not mean they are enrolled as providers with the MCO plans.

Medicaid Covered Outpatient Drugs used for Opiate Addiction

These drugs may be subject to prior authorization (PA) approval and /or quantity limits (QL) and Preferred Drug List (PDL) status.
Refer to MSM Chapter 1200, Prescribed Drugs, at the following web address for more FFS information:
http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/
Refer to the following website for more HPN information: http://www.myhpnmedicaid.com/PrescriptionCoverage.htm
Refer to the following website for more Amerigroup information: https://www.myamerigroup.com/Documents/NVNV_CAID_PDL_ENG.pdf
Refer to the following website for more Silver Summit Health information:
https://www.silversummithealthplan.com/content/dam/centene/Nevada/Medicaid/PDFs/NV_SilverSummit-PDL.pdf

Drug	Fee For Service (FFS)	Health Plan of NV (HPN)	Amerigroup	Silver Summit Health
Drugs Used for Opioid Overdose:				
Naloxone (Narcan®)	**X**	**X**	**X** (Has QL†)	**X** (Has QL†)
Naloxone Auto-Injector (Evzio®)	**X**	**X** (NP**)	**X** (NP**Requires Clinical PA* & QL†)	**X** (NP**/ Requires Clinical PA*)
Naloxone Nasal Spray (Narcan®)	**X**	**X** (NP**)	**X**	**X**
Drugs Used for Opioid Dependence:				
Naltrexone ER Susp (Vivitrol®)	**X** (Requires Clinical PA* & QL†)	**X** (Requires Clinical PA*)	**X** (Requires Clinical PA*)	**X** (Requires Clinical PA*)
Naltrexone (ReVia®)	**X**	**X** (Generic Preferred)	**X** (Generic Preferred)	**X** (NP**/ Requires Clinical PA*)
Buprenorphine/naloxone (Suboxone®, Zubzolv®, Bunavail®)	**X** (Requires Clinical PA* & QL†)	**X** (Requires Clinical PA* & QL†)	**X** (Requires Clinical PA* & QL†)	**X** (Requires Clinical PA* & QL†)
Buprenorphine (Subutex®)	**X** (Requires Clinical PA* & QL†)	**X** (Requires Clinical PA* & QL† Generic Preferred))	**X** (Has QL†)	**X** (Requires Clinical PA*)
Drugs Used for Detoxification/Withdrawal:				
Methadone (Dolphine®, Methadose®)	**X** (NP‡)	**X**‡PA requirement can be overridden when prescribed for treatment of detoxification/withdrawal.	**X** (Requires Clinical PA* & QL†)	**X** (NP**/ Requires Clinical PA*/QL†)
Abuse Deterrent Opioids: (Drugs with physical barriers that can prevent chewing, crushing, cutting, grating, or grinding of the dosage form. Dosage forms with chemical barriers that resist extraction of the opioid through use of common solvents including water, alcohol or other organic solvents.)				
Oxycodone ER Tab (OxyContin®)	**X** (NP**)	**X** (NP**)	**X** (Requires Clinical PA* ST & QL†)	**X** (NP**)
Morphine/Naltrexone (Embeda®)	**X (**QL†)	**X** (NP**)	**X** (Requires Clinical PA* ST & QL†)	**X** (Has QL†)
Hydrocodone ER (Hysingla ER®)	**X** (QL†)	**X** (NP**)	**X** (Requires Clinical PA* ST & QL†)	**X** (Has QL†)
Oxyconde ER Cap (Xtampza ER®)	**X** (QL†/NP**)	**X** (NP**)	**X,** NP, QL†, ST	

Drugs for Alcohol Dependence				
Acamprosate	**X**	**X** (NP**)	**X** (Has QL†)	**X** (NP**)
Naltrexone (ReVia®)	**X**	**X** (Generic Preferred)	**X**, NP, QL†,‡	**X** (NP**)
Naltrexone ER Susp (Vivitrol®)	**X**	**X** (Requires Clinical PA*)	**X**(NP*‡)	**X** (Requires Clinical PA*)
Alcohol Sensitizing Drug:				
Disulfiram	**X**	**X**	**X**	**X**

Methadone Clinics: Payment for the direct observation of oral medications to treat opioid dependence/withdrawal given at methadone clinics.				
Direct Observation	**X**	**X**	**X**	**X**

Lock-In: When a recipient has demonstrated drug seeking behaviors they are locked in to one specific pharmacy for controlled substance scripts.				
Lock-In Program	**X**	**X**	**X**	**X**

*Clinical PA = PA required
QL† = Quantity Limit
NP = Nonpreferred.
‡PA requirement can be overridden when prescribed for treatment of detoxification/withdrawal.
**Requires a Standard Preferred Drug List Exception Criteria Prior Authorization.
ST = Step Therapy
OON=Out of Network
X = Covered

Medication Assisted Treatment

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). MAT is a combination of medications and services that are provided in concert to assist recipients with a substance use disorder (SUD).
Refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services, at the following web address for more FFS information:
http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_16_5_1_BHCN_Packet.pdf
Refer to the following website for more HPN information: https://www.healthplanofnevada.com/Member/Mental-Health
Refer to the following website for more Amerigroup information: https://www.myamerigroup.com/NV/Pages/medicaid.aspx

Behavioral Therapies/Services				
Service	**Fee For Service (FFS)**	**Health Plan of NV (HPN)**	**Amerigroup**	**Silver Summit Health**
Individual Therapy: 90832, 90834, 90837	**X** (Requires Clinical PA*, †QL)	**X**	**X** (Requires Clinical PA* for OON provider only)	**X** (Requires Clinical PA* & †QL for OON provider only)
Family Therapy: 90846, 90847, 90849	**X** (Requires Clinical PA*, †QL)	**X**	**X** (Requires Clinical PA* for OON provider only)	**X** (Requires Clinical PA* & †QL for OON provider only)
Group Therapy: 90853	**X** (Requires Clinical PA*, †QL)	**X**	**X** (Requires Clinical PA* for OON provider only)	**X** (Requires Clinical PA* & †QL for OON provider only)
Therapy in Home or Community Setting: H004, H004 HQ	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*,†QL)	**X** (Requires Clinical PA* for OON provider only)	**X** (Requires Clinical PA* & †QL for OON provider only)
Skills Training & Develop.: H2014, H2014 HQ	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*,†QL)	**X** (Requires Clinical PA*)	**X** (Requires Clinical PA*,†QL)
Psychosocial Rehabilitation: H2017, H2017 HQ	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*,†QL)	**X** (Requires Clinical PA*)	**X** (Requires Clinical PA*,†QL)
Self-Help/Peer-Support: H0038, H0038 HQ	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*,†QL)	**X** (Requires Clinical PA* for OON provider only)	**X** (Requires Clinical PA*,†QL)

Medications
Review covered medications identified previously in this bulletin.
NV Physician Administered Drugs (NVPAD): These outpatient drugs are administered in places such as physician's office, outpatient clinics, End-Stage Renal Disease (ESRD) facilities, etc. These drugs are not subject to PDL requirements.

Screening, Brief Intervention and Referral to Treatment (SBIRT) - SBIRT is an evidence based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.				
Services	**Fee For Service (FFS)**	**Health Plan of NV (HPN)**	**Amerigroup**	**Silver Summit Health**
Alcohol and/or substance (other than tobaccos) abuse structured screening (e.g. AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes: 99408	**X**	**X**	**X**	**X**
Greater than 30 minutes: 99409	**X**	**X**	**X**	**X**
Brief face-to-face behavior counseling for alcohol misuse; 15 minutes: G0443	**X**	**X**	**X**	**X**

Detoxification - Inpatient substance abuse services are those services delivered in freestanding substance abuse treatment hospitals or general hospitals with a specialized substance abuse treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance abuse professionals and a structured multidisciplinary clinical approach to treatment. These hospitals provide medical detoxification and treatment services for individuals suffering from acute alcohol and substance abuse conditions.				
Services	**Fee For Service (FFS)**	**Health Plan of NV (HPN)**	**Amerigroup**	**Silver Summit Health**
Inpatient detoxification	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*)	**X** (Requires Clinical PA*)
Outpatient Observation (not to exceed 48 hrs.)	**X** (Requires Clinical PA*, †QL)	**X** (Requires Clinical PA*, †QL)	**X**	**X**

Resources and Links:

Quantity Limits and Policy Guidelines:

MSM Chapter 400: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C400/Chapter400/

MSM Chapter 600: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C600/Chapter600/

MSM Chapter 1200: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/

Provider Billing Guides for Quantity Limits:
https://www.medicaid.nv.gov/providers/BillingInfo.aspx

Preferred Drug List (PDL):
https://www.medicaid.nv.gov/providers/rx/PDL.aspx

Citations:

Information Bulletin on MAT
https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf

Fact Sheet for SBIRT:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

Resources:

Crisis Call Center – 24-hour crisis line is here to provide a safe, non-judgmental source of support for individuals in any type of crisis. In addition to a 24-hour crisis hotline, Crisis Call Center also offers crisis intervention through text messaging.

- http://crisiscallcenter.org/
- 1-775-784-8090
- 1-800-273-8255
- Text "ANSWER" to 839863
- Medicaid District Office staff can assist with recipient benefit questions or problems.

Nevada 2-1-1 Services – Nevada 2-1-1, a program of the Financial Guidance Center, is committed to helping Nevada citizens connect with the services they need. http://www.nevada211.org/

Substance Abuse Prevention and Treatment Agency (SAPTA) – The Substance Abuse Prevention & Treatment Agency (SAPTA) administers programs and activities that provide community-based prevention and treatment. http://dpbh.nv.gov/Programs/ClinicalSAPTA/Home_-_SAPTA/

Medicaid District Office Staff Assistance:

Carson City District Office
1000 East William Street, Suite 118
Carson City, NV 89701
Telephone: (775) 684-3651

Elko District Office
1010 Ruby Vista Drive, Suite 103
Elko, NV 89801
Telephone: (775) 753-1191

Las Vegas District Office
1210 S. Valley View, Suite 104
Las Vegas, NV 89102
Telephone: (702) 668-4200

Reno District Office
560 Hammill Lane
Reno, NV 89511
Telephone: (775) 687-1900

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) þ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) þ Psychiatric Advance Directives
   - c) þ Family Engagement
   - d) þ Safety Planning
   - e) ¿ Peer-Operated Warm Lines
   - f) ¿ Peer-Run Crisis Respite Programs
   - g) þ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) þ Assessment/Triage (Living Room Model)
   - b) þ Open Dialogue
   - c) ¿ Crisis Residential/Respite
   - d) ¿ Crisis Intervention Team/Law Enforcement
   - e) þ Mobile Crisis Outreach
   - f) þ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) þ WRAP Post-Crisis
   - b) þ Peer Support/Peer Bridges

c) é Follow-up Outreach and Support

d) þ Family to Family Engagement

e) é Connection to care coordination and follow-up clinical care for individuals in crisis

f) é Follow-up crisis engagement with families and involved community members

g) þ Recovery community coaches/peer recovery coaches

h) þ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

We have a plan to implement a peer-oriented warm line within the next year which will enhance the support services to the adult population in need. The State recently implemented a mobile crisis unit as part oft he system of care expansion grant. The information listed below demonstrates what the mobile crisis team does for Nevada, and as a result of implementation 85% of youth who have been served have avoided hospitalization which is helping to allow the additional funds to be utilized in other places and serve more individuals.

Nevada Mobile Crisis Response Teams

VALUES –
• Respond immediately to children and families during times of crisis.
• Provide services that are family driven, culturally competent, community based and consistent with Nevada System of Care principals.
• Assure safety and continuity of care through wraparound – based team approach.

GOALS –
• Maintain youth in their home and community environment.
• Promote and support safe behaviors in youth in their home and community.
• Reduce admissions to Emergency hospitals due to the crisis.
• Facilitate short-term inpatient hospitalization when needed.
• Assist youth and families in accessing and linking to on-going support and services.

SERVICES
• Telephone Triage – Staff provide support over the phone to assist in resolving or preventing a crisis situation. After the screening, a referral will be made to a community resource or the MCRT will respond.

• Crisis Response – If it is determined that further care and support is needed, a response team will be dispatched to the youth and family in crisis. The response team will work to de-escalate the crisis by providing behavioral health intervention and support. The team will develop a crisis plan with the family and youth to facilitate safety.

• Crisis Stabilization – Short-term behavioral health interventions will be provided in or outside of the youth's home. It is designed to assess, manage, monitor, stabilize and support the youth and families well-being. The team will develop an on-going safety plan with the youth, family and other support services.

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

   b) Required peer accreditation or certification? ( ) Yes ( ) No

   c) Block grant funding of recovery support services. ( ) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

      Consumers and family members are a part of several state coalitions and advisory boards. One example being NPLAC (Nevada Peer Leadership Advisory Council).

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Recovery from serious mental illness is not only possible, but for many people living with mental illness today, probable. The notion of recovery involves a variety of perspectives. Recovery is a holistic process that includes traditional elements of physical health, and aspects of recovery extend beyond medication. Recovery from serious mental illness also includes the idea of attaining and maintaining physical health as another cornerstone of wellness. People in recovery make important contributions to their communities. Hope for recovery should be reflected in all treatments, services, and supports.

   The recovery journey is unique for each individual. There are several definitions of recovery; some grounded in medical and clinical values, some grounded in context of community and successful living. One of the most important principles of recovery is this: recovery is a process, not an event. The uniqueness and individual nature of recovery must be honored.

   For NAMI, recovery is a foundational principle. While serious mental illness impacts individuals in many challenging ways, the concept that all individuals can move towards wellness is paramount. A strengths-based approach is a cornerstone for NAMI initiatives, activities, and efforts. Many, many NAMI members living with mental illness have benefited from the various opportunities within the organization. NAMI has become a vehicle for recovery, and a pathway towards wellness.

   Specific NAMI initiatives developed to help the process of recovery are:

   The Peer-to-Peer Recovery Education Course: a 9-week, experiential, illness management and wellness educational course taught by people in recovery, for people living with mental illness.

   In Our Own Voice: a public awareness project built around a one-hour presentation by a person living with mental illness. An 11-minute video frames the presentation around dark days, acceptance, treatment and medications, and hopes and dreams.

   NAMI-C.A.R.E. (Consumers Advocating Recovery through Empowerment): a mutual self-help support group model.

   Hearts and Minds: Learn about healthy, accessible and affordable lifestyle changes designed to reduce cardiac risk among people with mental illness.

   The Provider Education Course: a 10-week initiative developed to raise awareness with mental health providers of the perspective of the impact mental illness has on the family and the individual. A team of persons living with mental illness, family members of a person living with mental illness, and a consumer- or family member-provider teaches the course.

   National Consumer Council: the only nationally convened representative body of persons living with mental illness. The Council serves in an advisory capacity to the NAMI National Board of Directors, and includes subcommittees on the issues of Restraint and Seclusion; Ethics; and Education, Mentoring, and Outreach.

   State level Consumer Councils: similar in structure and purpose to the National Consumer Council; but established as advisory bodies to some state NAMI Boards of Directors.

Leadership development opportunities are emerging as an important mechanism to help in the recovery process. The Consumer Councils are one important opportunity supported by NAMI. Experiential knowledge is a common theme in both leadership and recovery, and NAMI provides those experiences.

In summary, NAMI is dedicated to improving the lives of all those affected by mental illnesses. Whether by providing support, education, advocacy, or leadership experiences, all levels of NAMI are working every day to help. Recovery is possible, and people no longer need be defined by their illness, but rather by the goals, hopes, and dreams so vital to each of us.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

In Washoe and Clark counties, several different recovery support services are available in various agencies. Rural Nevada is lacking this support and is a place for expansion.

Some examples of opportunities available to individuals in recovery are:
collegiate recovery community
recovery houses
recovery support groups
recovery advocacy groups

5. Does the state have any activities that it would like to highlight?

Foundation for Recovery (FFR) is an independent, non profit organization and the only peer-run Recovery Community Organization in the state of Nevada. FFR's mission is to promote the positive impact of addiction recovery in the community and the lives of individuals and families affected by the disease of addiction. The programs, services and partnerships open pathways to recovery by removing social barriers and creating opportunities for those seeking recovery. Some activities within FFR to note are the peer support specialist training, specialized women's services, a Nevada resource directory and a location made available for various support groups to met.

Nevada's Recovery and Prevention (NRAP), a peer-driven and faculty over seen program, is located on the University of Nevada, Reno campus. NRAP provides a nurturing and affirming environment where students choosing a substance-free lifestyle can successfully pursue academic and professional goals while enhancing their personal resiliency, quality of life, and positive college experiences. It is a place to connect with other students, a place to grow in sobriety, and to thrive as an individual. Through faculty and peer support, NRAP members create a family to assist them during their college career. Some activities within NRAP to note are a collegiate peer mentor training, a on-campus dedicated space for various support groups, events aimed at stigma reduction of celebration of recovery.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   - housing services provided. ( ) Yes ( ) No
   - home and community based services. ( ) Yes ( ) No
   - peer support services. ( ) Yes ( ) No
   - employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   Nevada is currently in the development stages of creating an updated Olmstead plan. One of the recent tools developed as a part of the development of the Olmstead plan is Nevada's Olmstead community integration self-assessment data summary report from may 2017. This report includes 5 goals. 1. fund and implement an integrated, high-quality, person-centered service delivery system. 2. facilitate timely, responsive services to achieve person-directed goals. 3. Increase opportunities and supports that promote social connection and enhance self- determination and personal dignity. 4. expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice. 5. Establish and report on Nevada's progress to implement an integrated, high quality, person centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address unmet need for services. Goal 5 also includes a need to use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for implementation of the plan.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Nevada Division of Public and Behavioral Health
Olmstead Decision Implementation

Community Integration Self-Assessment Data Summary Report

May 4, 2017

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BACKGROUND

Since the 1999 Olmstead decision, Nevada has made significant progress to ensure persons with disabilities are able to live in the community setting of their choice. Nevada developed a statewide plan to address the need for community supports for people with disabilities who are in segregated settings and to prevent future unnecessary segregation. The 10-year plan was approved by the Legislature in 2003 and expired in 2013.

The Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) has just completed the process of creating a framework for further Olmstead Plan development in the state. The State of Nevada Aging and Disability Services Division (ADSD) is a lead entity for implementation of the plan. As a result of discussions with key stakeholders in Nevada, a decision was made to integrate behavioral health into the evolving Olmstead Plan framework. This decision was informed by notable data points, including:

- In 2015, the prevalence rate of adults age 18 or older with a serious mental illness (SMI) was 4.3 percent or 91,893 individuals, slightly higher than the U.S. rate of 4.0 percent. [1]
- 28,589 persons were served by State Mental Health Agencies (SMHA) in Nevada during 2015 which equates to 31 percent of the adult population with SMI.[2]
- The largest adult housing support in 2016 was intermittent support (547 persons served), followed by shelter plus care (283), and group homes (281).[3]

What is the Olmstead Decision?

On June 22, 1999, the US Supreme Court ruled in the landmark Olmstead v. L.C. decision that unnecessary segregation and institutionalization of people with disabilities is a form of discrimination and prohibited under the Americans with Disabilities Act (ADA).

To remedy or avoid such discrimination, states are required to provide integrated community services and supports for people with disabilities who are otherwise entitled to segregated services, when:

1. **The state treatment professionals reasonably determine that community placement is appropriate;**
2. **The person does not oppose such placement; and**
3. **That placement can be reasonably accommodated, taking into account resources available to the state and the needs of others receiving state disability services.[1]**

[1] Substance Abuse and Mental Health Services Administration (SAMHSA). 2015. Serious Mental Illness in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2014 and 2015.
[2] Center for Mental Health Services (CMHS) Uniform Reporting System. 2015. Total Clients Served by SMHA System.
[3] Nevada Department of Health and Human Services (DHHS). October 2016. Behavioral Health Chart Pack.

Interest from the Department of Justice (DOJ) has elevated Olmstead as a priority nationally, and statewide within Nevada. The DOJ conducts investigations to determine why people are institutionalized, and if institutionalization is needed, whether they are receiving adequate and appropriate care to ensure timely return and integration back to the community. Their approach includes examining discharge planning, as well as community capacity to ensure adequate and appropriate services and supports in an integrated setting.[4]

Through a convening of SMHA, national experts and other stakeholders, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a self-assessment tool to measure community integration by proactively identifying states' strengths and weaknesses around integrations for persons with behavioral health issues.

The Community Integration Self-Assessment (CISA) tool was piloted by eight states over a span of two years, and was also reviewed by the US DOJ, the Department of Housing and Urban Development (HUD), and the National Disability Rights Network on behalf of state protection and advocacy organizations.[5] It provides an evaluation of Olmstead as it stands related to child and adult behavioral health, including:

- Current state of the state in policy and practice
- What policies are supportive of Olmstead or that could be strengthened related to Olmstead

The CISA tool requires a cross-system collaborative approach within state agencies that offer community services and supports. The tool suggests collecting data not only from mental health client data systems, but from Medicaid, health, housing, social services, and criminal justice agencies.[6] DPBH has begun gathering data from a number of sources to complete the CISA. This document summarizes the results of the data collection process.

[4] Ted Lutterman. Development of a Community Integration Self-Assessment (CISA) tool for State Governments. November 14-15, 2016.
[5] Ibid.
[6] Ibid.

METHODS

To develop this report, a set of methods were used to obtain the data necessary to complete the CISA. These included technical assistance in the form of a two-day policy academy to conduct a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, outreach to key data stakeholders, and lastly data collection for the CISA.

TECHNICAL ASSISTANCE

SAMHSA approved a technical assistance (TA) request from DPBH and Behavioral Health Community Services to support state staff by increasing understanding of the Olmstead decision and its implications for state action, and creating a framework for Olmstead Plan development in the state.

The Nevada Behavioral Health Community Integration Mini Policy Academy was held in Carson City, NV on November 14th and15th, 2016 with representatives participating from the Nevada DHHS, including DPBH, Community Services, Division of Health Care Financing and Policy (DHCFP), Division of Child and Family Services (DCFS), and the Director of the National Alliance on Mental Illness Nevada. Social Entrepreneurs, Inc. participated in the Policy Academy, as they are working with the Aging and Disability Services Division (ADSD) on the development of their Olmstead/community integration plan. The TA was provided by the National Association of State Mental Health Program Directors Research Institute (NRI) and a consultant from Healthcare Systems Consulting, Inc.

State Goals for TA

1. Stakeholder understanding of the Olmstead Decision and integration mandate and how it relates to behavioral health services in Nevada
2. Identification of a plan for assessing the state system and determining Olmstead risks, including coordinating a two-day policy academy for creating a comprehensive Olmstead Plan
3. Development of a framework for an Olmstead Plan in Nevada

Participants at the Mini Policy Academy reviewed quantitative and qualitative data and discussed a common vision, the Olmstead planning process, and how systems work together to support community integration for individuals with disabilities.

A decision was reached early in the discussion that behavioral health would become integrated into the Olmstead Plan being developed by ADSD. The guiding principles and goals identified by the ADSD planning group align well with the behavioral health system. This collaborative effort should result in one unified comprehensive Olmstead/community living plan for Nevada.

The ADSD Strategic Plan identifies the following guiding principles:

Independence
- People should have options and the ability to select the manner in which they live

Access
- People's needs are identified and met quickly

Dignity
- People are viewed and respected as human beings

Integration
- People can live, work, and play as part of their community

Quality
- Services and supports achieve desired outcomes

Sustainability
- Services and supports can be delivered over the long term so individuals can be self-sufficient

The ADSD strategic plan also identifies five goals to achieve over the next five years:

Goal #1 **Strong, Supportive Systems**
- Fund and implement an integrated, high-quality, person-centered service delivery system

Goal #2 **Access and Engagement**
- Facilitate timely, responsive services to achieve person-directed goals

Goal #3 **Meaningful Community Integration**
- Increase opportunities and supports that promote social connection and enhance self-determination and personal dignity

Goal #4 **Strengthening Other Systems to Address Barriers**
- Expand systems and supports to ensure that older adults and persons with disabilities have the opportunity to achieve optimal quality of life in the community of their choice

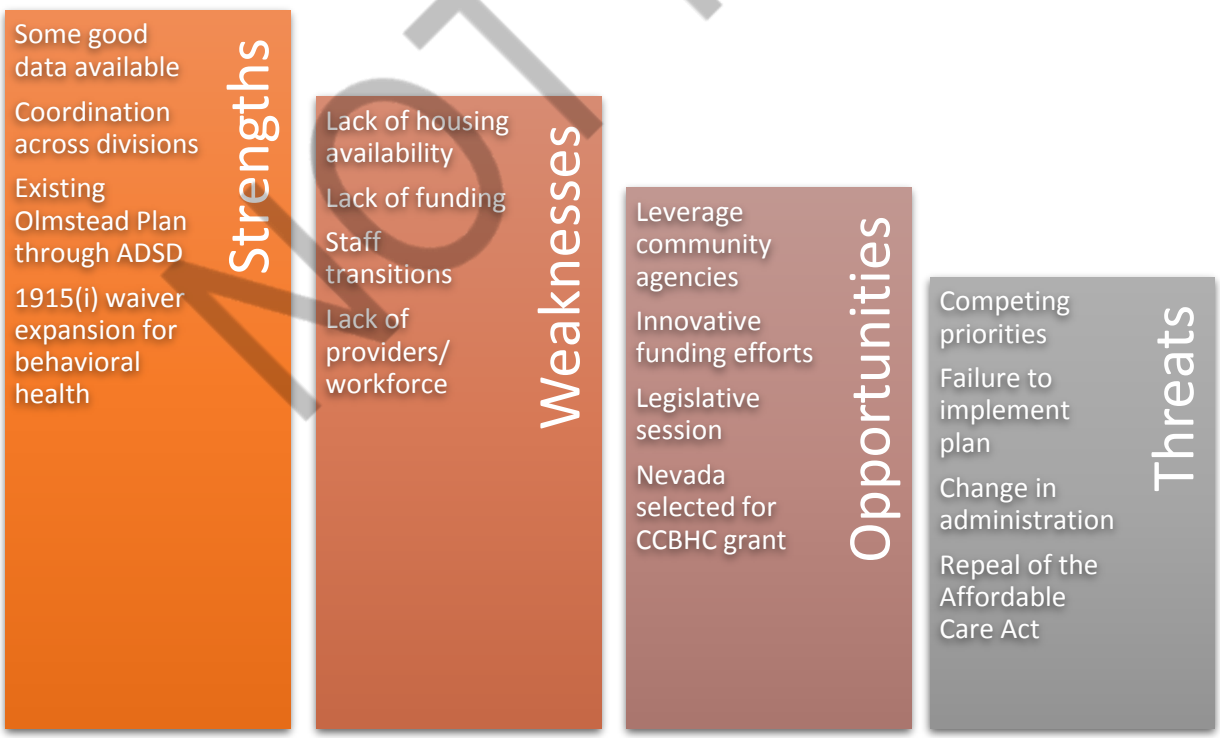
Goal #5 Accountability

- Establish and report on Nevada's progress to implement an integrated, high quality, person centered service delivery culture across systems throughout the state with measurable indicators and outcomes that address unmet need for services
- Use data to drive quality improvement and decision making regarding resource allocation and policy within the state to meet the needs of Nevadans while upholding guiding principles and ensuring accountability for the implementation of the plan

SWOT Analysis Results

During the Mini Policy Academy, a SWOT analysis was conducted. As Nevada moves forward with implementing the Olmstead plan, the SWOT analysis can help guide strategic efforts to develop and support community integration for individuals with behavioral health disorders and other disabilities. The analysis includes both internal and external factors that may influence the planning efforts as well as the execution of the plan over time.

The results of the analysis, as seen below, can be leveraged over time to use strengths to capitalize on opportunities, and address weaknesses to decrease threats and promote opportunities. The full results of the SWOT analysis can be found in Appendix B.



The process for the development of the CISA was also shared during the Mini Policy Academy and included an overview of the CISA. The CISA provides a menu of indicators states can use to conduct a self-assessment of their current performance related to the degree of community integration across the following domains:

The goal of the CISA tool is for all states to assess where there are statewide service gaps through an Olmstead lens and ultimately, improve the individualized level of community integration.

Developed by SAMHSA, the CISA was a collaborative effort guided by a Policy Expert Panel consisting of state staff, consumers, federal representatives, and a Technical Expert Panel who had expertise in state behavioral health data systems, performance measurement, planning, Olmstead, and state community integration efforts. It was designed to provide measures for states to use to assess their performance related to community integration. After two years of pilot testing within eight states, SAMHSA worked with the pilot states, DOJ, and U.S. Department of Housing and Urban Development (HUD) to finalize the tool.[7]

Participants reached consensus that integrating behavioral health into the ADSD plan is the desired pathway for developing a single state Olmstead plan. Integrating behavioral health

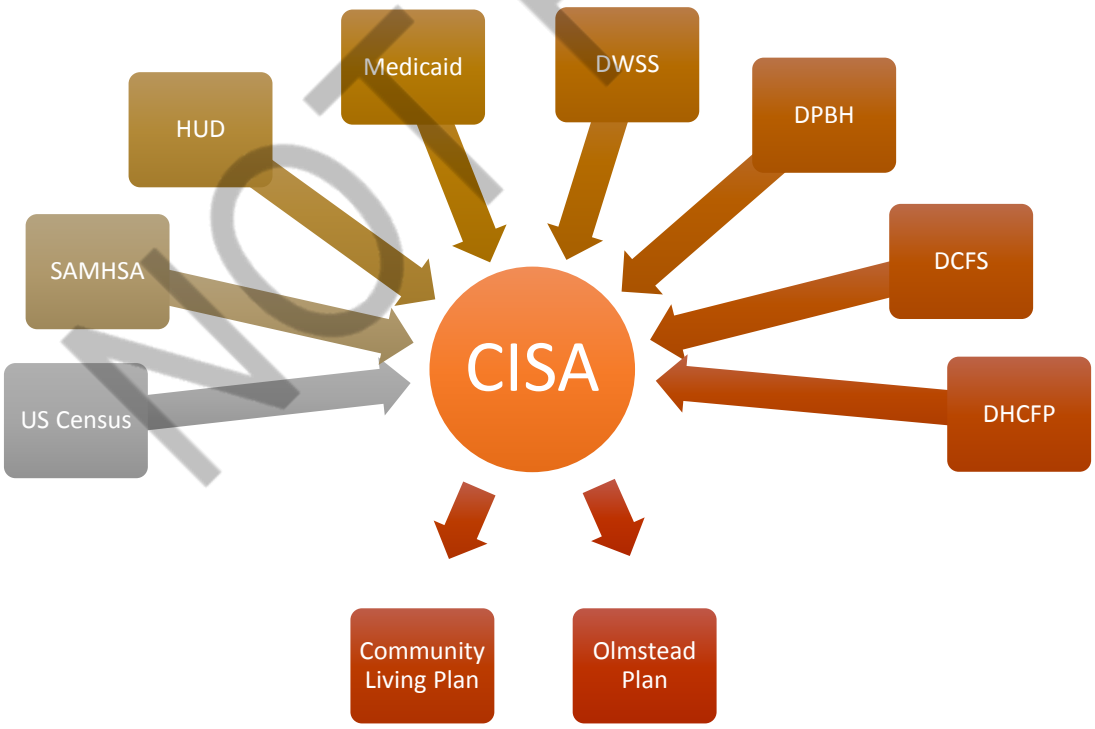
[7] Ted Lutterman. Development of a Community Integration Self-Assessment (CISA) tool for State Governments. November 14-15, 2016.

with the guiding principles and critical issues identified by the ADSD planning group appeared to make sense given how well they align with behavioral health priorities. It was determined that other key stakeholders such as those from vocational rehabilitation, education, law enforcement, etc. will be engaged in the implementation planning process as needed.

Steps were developed to immediately begin examining some multi-year trend data based on the indicators from the CISA, focusing on the domains of **1) Financing and Resources, 2) Movement to the Community and Recidivism, 3) Community Capacity, and 4) At-Risk Population** within the recommended settings (e.g., state hospitals, nursing homes, adult care homes, residential treatment centers, jails, and other settings). These domains were selected by participants at the Mini Policy Academy based on the availability of data collected in the state of Nevada.

Data Collection

The data collected to inform the four domains were obtained from a number of sources including the U.S. Census Bureau, SAMHSA, HUD, Medicaid, the Nevada Uniform Reporting System (URS), the Nevada Division of Welfare and Supportive Services, the Nevada Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy (DHCFP), and DPBH through the Office of Public Health Informatics and Epidemiology (OPHIE).



When possible, data were collected directly from the federal or state source if they were publicly available. For cases where data were tracked within a state management information system (MIS), the Division was provided with a copy of the data needed within each of the four domains.

A webinar was held in December 2016 to review the CISA with the Division stakeholders and identify what data could be provided. A follow-up call and meetings were held in January 2017 between DPBH and the Divisions to provide context and better understanding of the specifics of the available data, including caveats and limitations.

If the data were available, they were documented directly into a spreadsheet version of the CISA tool. The outcomes from the report will be used to inform implementation of Nevada's Olmstead plan and to create a Community Living Plan for DPBH.

CONTEXTUAL FRAMEWORK

Information has been gathered to provide context to the indicators of community integration. This information will help the state better analyze and understand the trend and values of the indicators as they relate to the overall state system of behavioral health service delivery and Olmstead activities. The following summarizes contextual information specific to Nevada:

1. **Role of SMHA/Behavioral Health Authority in Olmstead Implementation:** The state of Nevada is currently developing an Olmstead plan that addresses mental health. ADSD recently completed their statewide Olmstead plan, of which the mental health plan will be a subset. The SMHA played a major role in the development of the plan including initiating planning activities, requesting technical assistance, and facilitating the data collection process. The plan will contain evaluation and progress reporting once implementation begins. Specific populations will also be identified in the plan.
2. **State Olmstead Investigations:** Nevada is not currently under an Olmstead investigation.
3. **Interagency Collaboration to Promote Community Integration**: The SMHA works with a number of other state agencies, providers, and community partners to promote community integration. For example, DPBH worked with ADSD during the development of their statewide Olmstead plan to ensure integration between their plan and the implementation plan specific to behavioral health. In addition, supportive housing, intensive case management, and home visitation are current

strategies the SMHA utilizes with other agencies to promote community integration.[8] In 2017, Nevada received the Certified Community Behavioral Health Clinics (CCBHC) demonstration approval from the SAMHSA to promote integration of behavioral and physical health, as well as introduce value-based reimbursement for CCBHC clinics. Nevada's Medicaid through DHCFP participated in Track 2: State Medicaid-Housing Agency Partnerships through the Medicaid Innovation Accelerator Program (IAP) in April 2016. The track was designed to assist in building collaborations with key housing partners within the state, such as Medicaid agencies, state housing finance agencies, public housing agencies, and others.

4. **Use of Medicaid to Fund Services that Promote Community Integration:** The Nevada DHHS represented by the DHCFP (Medicaid) has been working with stakeholders to develop a proposal to identify funding sources to create a tiered level of service for Medicaid habilitation services for permanent supportive housing, under the authorization of the Medicaid State Plan 1915(i) authority. Medicaid is working with Clark, Washoe, and rural counties to attempt to find local match funding and address issues concerning the program plan.[9]
5. **Use of Housing and Urban Development Programs to Fund Housing or Housing Support Services that Promote Community Integration:** Permanent support housing recipients of HUD Continuum of Care funds in Nevada are required to practice a Housing First approach. Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible and then providing voluntary supportive services as needed.[10] This includes mental health consumers. Additionally, Nevada was the recipient of the CABHI-States grant in 2013-2016, which provided case management to homeless individuals with co-occurring disorders. Permanent supportive housing was provided through the HUD CoC grants.
6. **Follow-up Activities to Sustain Community Transition/Integration:** Currently, the state does not have an assessment to determine the client's readiness for discharge and transition to the community. This is an area of opportunity as it will help track consumers who have transitioned back to the community, and potentially identify any specific indicators as to how well consumers have transitioned.
7. **Diversion Programs and Related Activities to Keep Consumers in Integrated Settings and Prevent Unnecessary Institutionalization:** The State's SMHA identified and uses

[8] Mental Illness in Nevada: Screening, Intervention, and Intercepts to Avoid System Failure. Presented by Dr. Tracey Green and Dr. Linda White. Nevada Division of Public and Behavioral Health. Accessed online on March 16, 2017 at http://dpbh.nv.gov/uploadedFiles/03%202014-01-29_DPBHmentalIllnessInNV.pdf.
[9] DHHS DHCFP Summary of Medicaid Expansion of Habilitation Services – Housing Supports.
[10] National Alliance to End Homelessness. Housing First. Accessed online on March 9, 2017 at http://www.endhomelessness.org/pages/housing_first.

a number of diversion strategies to prevent unnecessary institutionalizations. Crisis Intervention training is offered to law enforcement, and the state funds mobile crisis units and mobile outreach. Supportive housing is also available, as well as intensive case management and home visitation.

8. **Budget Development to Finance Community Integration:** Nevada ADSD includes programs that address community integration to facilitate transition and diversion in their budget. Clinical behavioral services are also included in DPBH's budget. These include Southern Nevada Adult Mental Health, Northern Nevada Adult Mental Health, Lake's Crossing Center, and Rural Counseling and Supportive Services. The DHHS Plan for Older Nevadans and Persons with Disabilities calls for a variety of financing strategies to support waivers, services, and supports.
9. **Affordable Housing:** According to the Nevada Housing Divisions 2016 Annual Affordable Apartment Survey, there has been a shortage of affordable housing in Nevada. Nearly half (46 percent) of households in Nevada are renters and 17 percent are extremely low income. There is a shortage of affordable housing opportunities for the extremely low income, estimated at 65,000 units. The vacancy rate for 2016 was 4.1 percent, nearly unchanged since 2015.[11] Due to the high cost of rents, and low vacancy rates, the number and availability of housing and housing vouchers available to persons with mental illness in Nevada is very low.
10. **Use of Peer Services**: Individuals with appropriate training who have significant life-altering experiences are used to assist other individuals with behavioral health issues. Peer support services are available in the community through several private and public organizations. Additionally, peer support was provided through the now expired Cooperative Agreements to Benefit Homeless Individuals (CABHI-States) grant to assist consumers with co-occurring disorders to find housing and supports and transition into the community. In 2013, DPBH applied for and received a Bringing Recovery Supports to Scale Technical Assistance Center (BRSS TAC) Award from SAMHSA to assist in developing a mental health, substance use disorder, and co-occurring Peer Support Specialist Program and Initiative in Nevada. The award supported the development of a statewide Peer Support Academy Team who focused on developing training curriculum. The Team identified Peer Certification and development of a Statewide Peer Leadership Council as priorities.[12] A Bill Draft Request (BDR), Assembly Bill (AB) 194 was presented to the Nevada Legislature and

[11] Nevada Housing Division. 2016 Affordable Apartment Survey. Accessed online on March 9, 2017 at http://housing.nv.gov/uploadedFiles/housingnvgov/content/Public/2016TakingStock20170209.pdf.

[12] Nevada Department of Health and Human Services – Division of Public and Behavioral Health. New Legislator Training Presentation. 2014. Accessed on March 23, 2017 at http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/About/Budget/FY16-17/FY16-17_DPBH_Overview.pdf.

provides for the certification of behavioral healthcare peer recovery support specialists.[13]

DATA ISSUES AND LIMITATIONS

During the data collection process, a number of issues and limitations of the data were identified. They are presented in the following sections.

ISSUES

Information presented in this document was intended to inform the CISA tool. For some data provided, a number of elements were identified that should be considered when reviewing the data:

- The URS was utilized for many of the data points collected. URS is intended to provide uniform reporting of state-level data to describe the public mental health system and the outcomes of its programs. These data can be used to track individual state performance over time and to develop a national picture of public mental health systems of the state.[14]
- For many of the data points collected, URS methodology was utilized. The scope of reporting data to the URS includes any part of the mental health system that comes under the auspices of the state mental health agency. There is specific methodology that details how to count people for inclusion in the URS and report related data.[15]
- For all data collected, fiscal year was utilized instead of calendar year. Additionally, data from FY2015 and FY2016 are both used in the tool.
- Data were collected from multiple information databases across Divisions, each with their own data collection methodology.
- Nevada has identified the need for a master client index that spans across Divisions to better track data and reduce duplication.

LIMITATIONS

For the data collected, there are limitations. Caution should be used when interpreting data, as various factors can contribute to the result. Limitations that particularly affect the interpretation and presentation of the data may include (but are not limited to):

- Some data are preliminary or are estimates, particularly Medicaid data.
- Data gaps exist due to limited data available.

[13] Assembly Bill No. 194 – Assemblymen Monroe-Moreno; Joiner, Miller and Sprinkle. Accessed online on March 23, 2017 at https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB194.pdf.
[14] Office of Disease Prevention and Health Promotion. Healthy People 2020. Uniform Reporting System. Accessed online on March 9, 2017 at https://www.healthypeople.gov/2020/data-source/uniform-reporting-system.
[15] Ibid.

- Reports from state data systems typically collect and compile information for a particular purpose and may not be comprehensive. For example, for many of the data requested, a statewide data source that includes information directly from facilities does not exist and the only data available was Medicaid recipient specific. If the indicator was not referencing Medicaid data, these data were omitted from the CISA tool. Similarly, URS data only provides State Psychiatric hospitals data, so some of the readmissions data are in reality lower than what is reported.

- Expenditure data from Medicaid are not specific to community based programs, as the ability to filter for these programs is limited.
- Definitions of behavioral and mental health were adjusted by Medicaid to provide data that fit the needs of this project. Because of this adjustment, estimates provided in this report cannot be compared with other behavioral health analyses that may be based on different criteria.

SUMMARY RESULTS

In their investigation of Olmstead issues, the DOJ posted two questions about community integration:

1. Why are people in the hospital?
2. If they need to be in the hospital, is the care adequate and appropriate to ensure a timely return to the community?[16]

During the two-day Mini Policy Academy, DPBH and stakeholders selected four domains to measure where Nevada is currently positioned to ensure community integration for persons with behavioral health issues. The following indicators from those selected were used to guide data collection efforts for completion of the CISA tool:

The following sections detail the data availability for the four domains, the suggested and actual sources of the data, and the trends of the available data.

[16] Ted Lutterman. Development of a Community Integration Self-Assessment (CISA) tool for State Governments. November 14-15, 2016.

DOMAIN: FINANCING AND RESOURCES

The domain of Financing and Resources examines one indicator and corresponding data points that are used to inform the State's current status:

1. Increase in funding for community-based programs

- State mental health expenditures
- Number of home and community based services (HCBS) slots available
- State SMI/Severe Emotional Disorders (SED) population

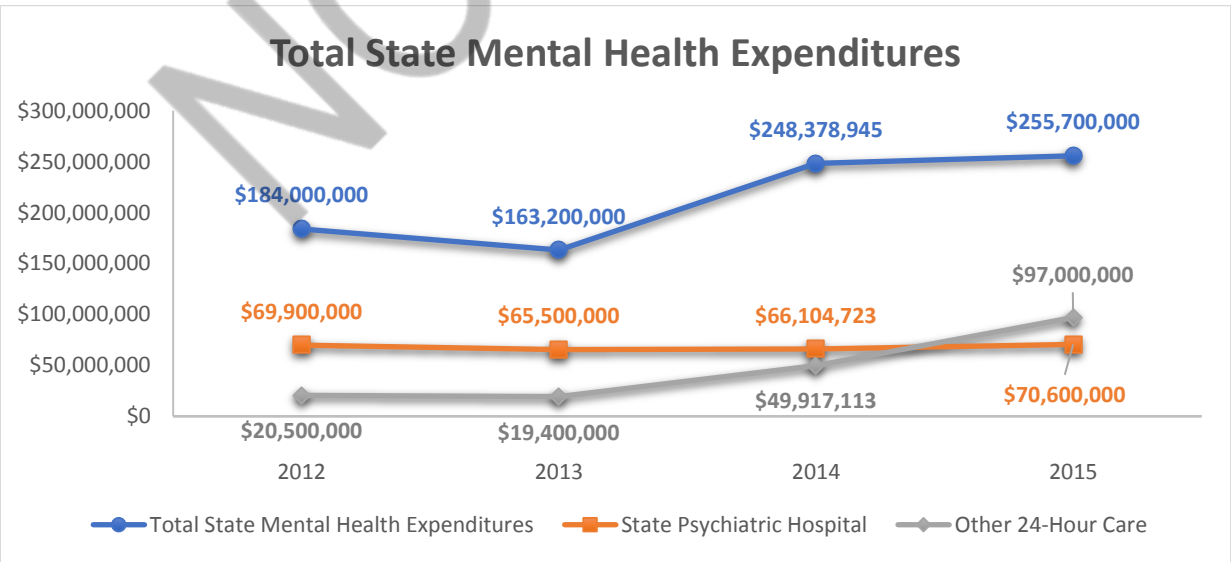
Potential data sources as suggested by the CISA tool are shown below, along with the actual sources that were able to provide data for this domain.

CISA Suggested Data Source	Actual Nevada Data Source
✓ Revenues and Expenditures	✓ URS
✓ Medicaid Claims Data	✓ DHCFP: Medicaid
✓ NDS for Nursing Homes	✓ ADSD
✓ SMHA MIS	

SUMMARY RESULTS

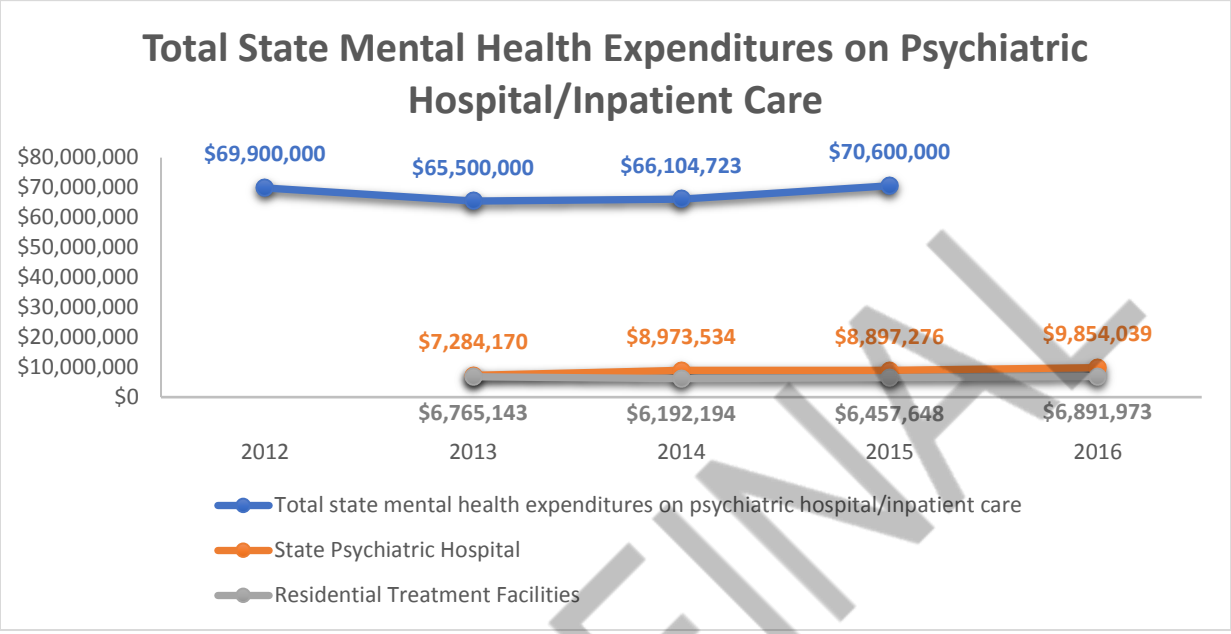
Of the data collected, total state mental health expenditures have increased between 2013 and 2014. State psychiatric hospital expenditures have remained relatively stable between 2012 and 2015, and other 24-hour care has increased during that same time period.

Figure 1 Total State Mental Health Expenditures



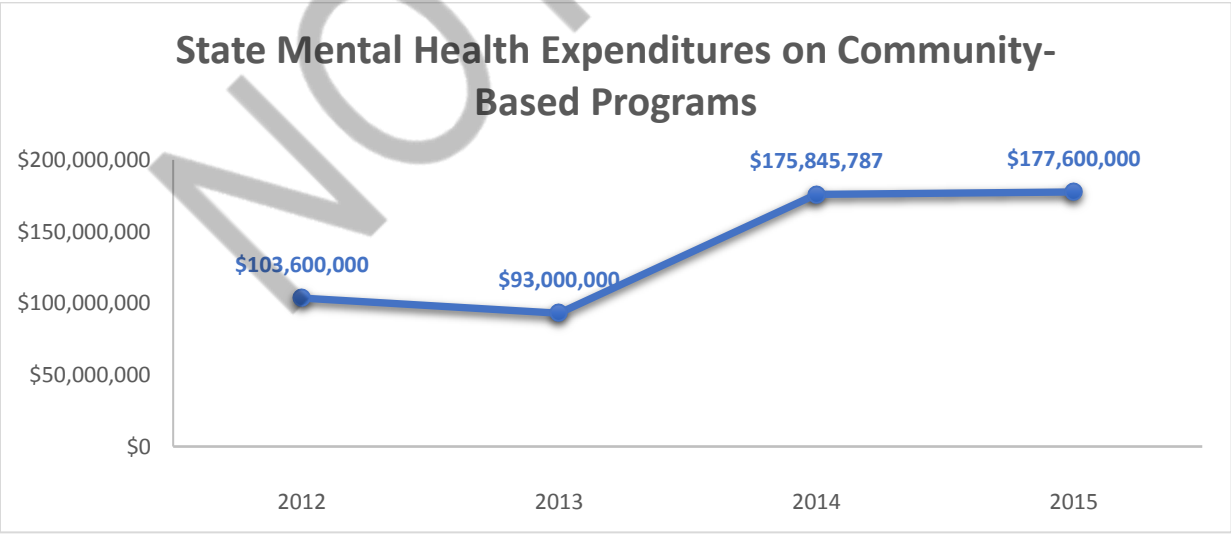
Total state mental health expenditures have remained relatively constant between 2012 and 2016.

Figure 2 Total State Mental Health Expenditures on Psychiatric Hospital/Inpatient Care



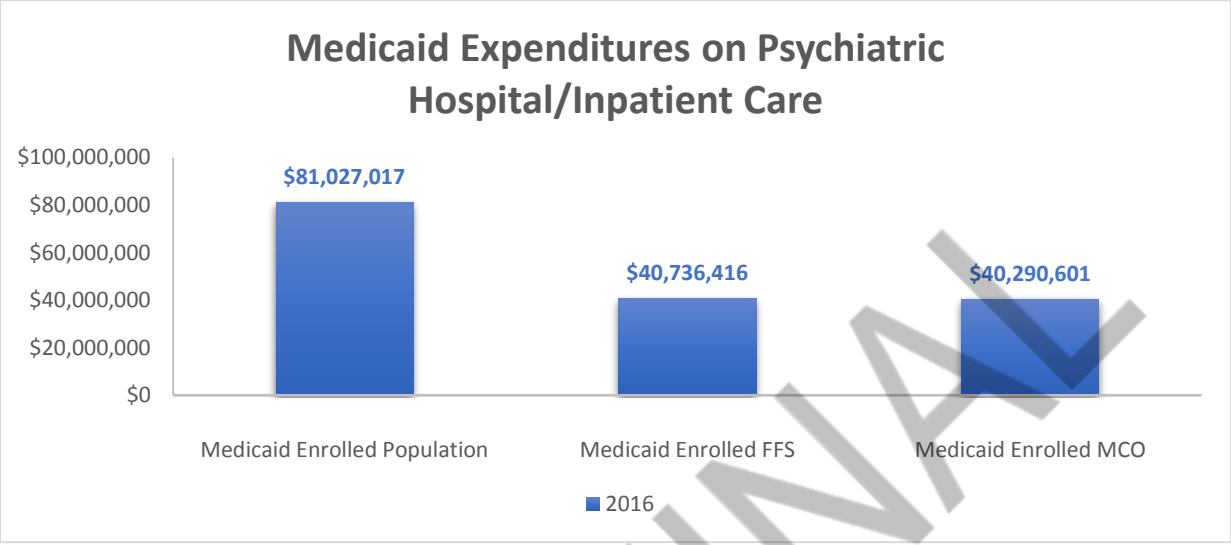
State mental health expenditures on community-based programs has increased by 71 percent since 2012.

Figure 3 State Mental Health Expenditures on Community-Based Programs



Data for Medicaid expenditures on psychiatric hospital and inpatient care was only available for 2016 and will serve as a baseline for measuring progress in the future.

Figure 4 Medicaid Expenditures on Psychiatric Hospital/Inpatient Care



DOMAIN: MOVEMENT TO THE COMMUNITY & RECIDIVISM

The domain of Movement to the Community and Recidivism examines four indicators and corresponding data points that are used to inform the State's current status:

1. Decrease in length of time waiting for discharge

- Persons awaiting discharge/discharged
- Persons with SMI/SED
- Standardized assessment for discharge
- Institutional census

2. Decrease in length of stay

- Persons in instituion for more than one year
- Institutional census
- Persons discharged

3. Decrease in readmission rate

- Persons with SMI/SED readmitted
- Institutional Census
- Persons discharged

4. Decrease in utilization rate of institutional settings

- Persons with SMI/SED admitted to institutional care
- Institutional occupancy rate
- Licensed psychiatric beds available
- Persons with SMI/SED declining transfer to community
- Persons with SMI admitted to nursing homes

Potential data sources as suggested by the CISA tool are shown below, along with the actual sources that were able to provide data for this domain.

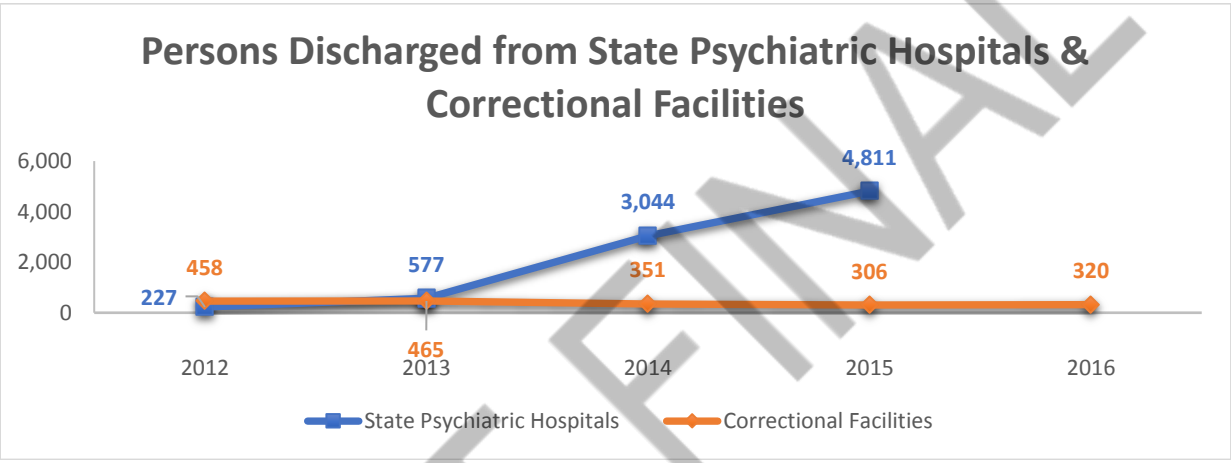
CISA Suggested Data Source	Actual Nevada Data Source
✓ Institutional databases ✓ SMHA MIS ✓ Preadmission Screening and Resident Review (PASRR) Assessments ✓ Centers for Medicare and Medicaid's (CMS) minimum data set	✓ DPBH OPHIE

Summary Results

This particular domain requested data for a nursing home census, of which none was available. Additionally, because the state does not have a standardized assessment that is updated regularly to assess readiness for discharge, many of the indicators pertaining to discharge were not applicable.

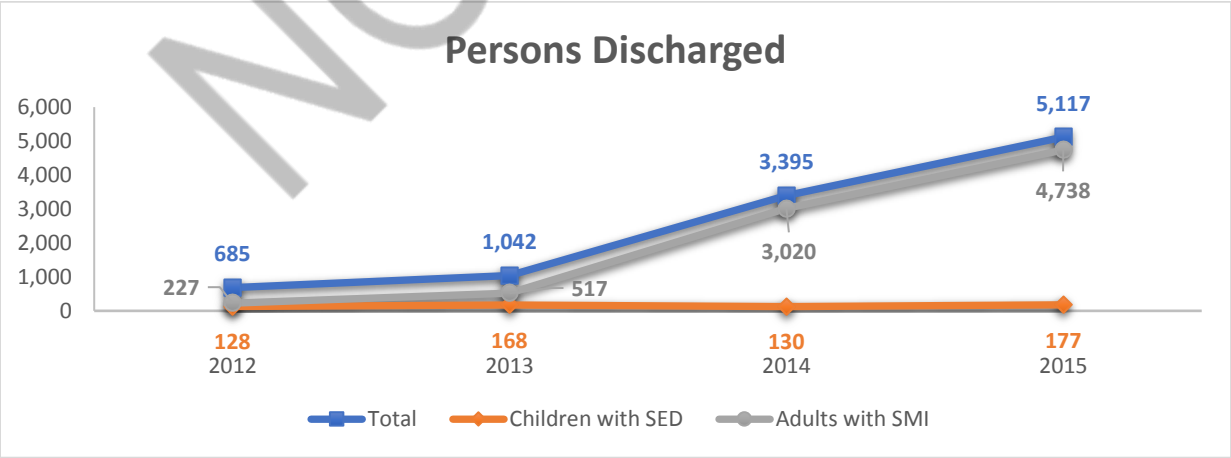
The number of persons discharged from correctional facilities declined slightly from 2012 to 2016, while the number of persons discharged from state psychiatric hospitals increased from 227 in 2012 to 4,811 in 2015. 2016 data for state psychiatric hospitals was not available.

Figure 5 Persons Discharged from State Psychiatric Hospitals and Correctional Facilities



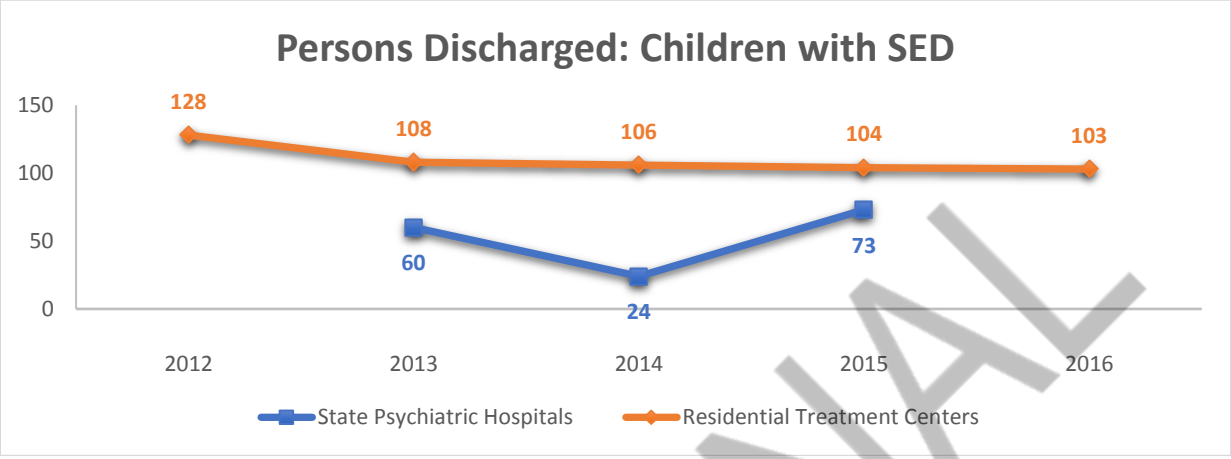
Similarly, total persons discharged increased from 2013 to 2015. Full data for 2016 was not available and is not presented in the figure.

Figure 6Total Persons Discharged in Nevada



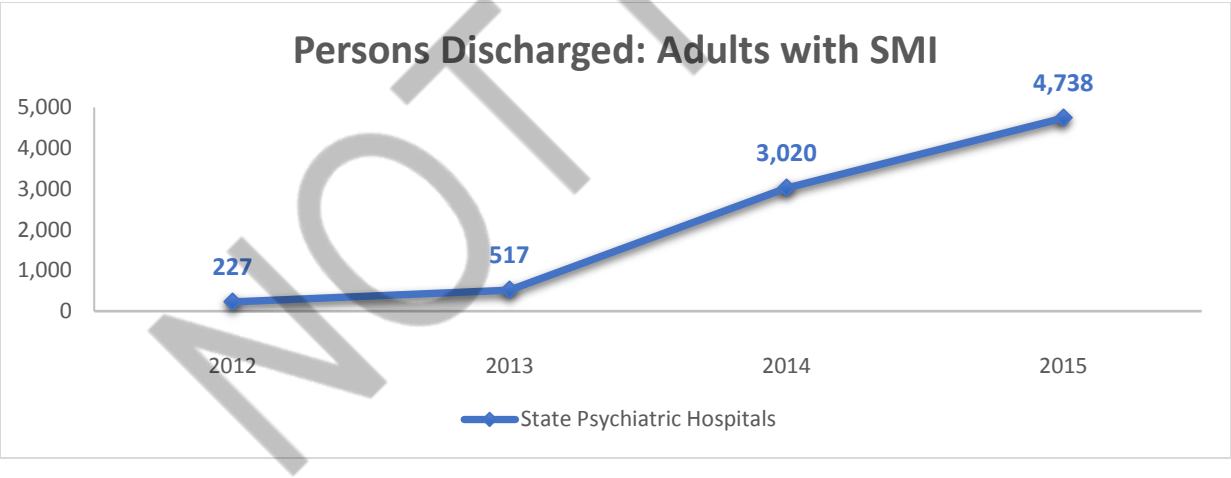
The number of children with SED discharged from residential treatment centers declined slightly from 2012. A decline of discharges from state psychiatric hospitals was seen in 2014, but numbers increased in 2015.

Figure 7 Persons Discharged: Children with SED



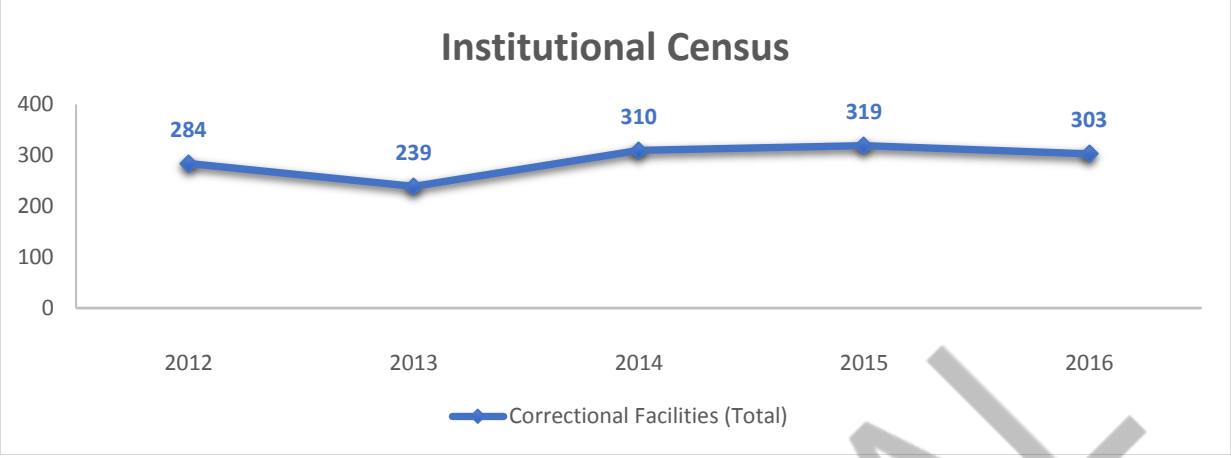
Data for discharges of adults with SMI was only available from state psychiatric hospitals. An increase was seen from 2012 to 2015.

Figure 8 Persons Discharged: Adults with SMI



Data for the aggregate institutional census were gathered from correctional facilities. Numbers have remained relatively stable from 2012 to 2016.

Figure 9 Institutional Census



Institutional census numbers for adults with SMI were not available. Data for the institutional census for children with SED were obtained for state psychiatric hospitals and residential treatment centers. 2016 reflects lower census numbers for state psychiatric hospitals, while numbers in residential treatment centers has remained constant.

Figure 10 Institutional Census: Children with SED

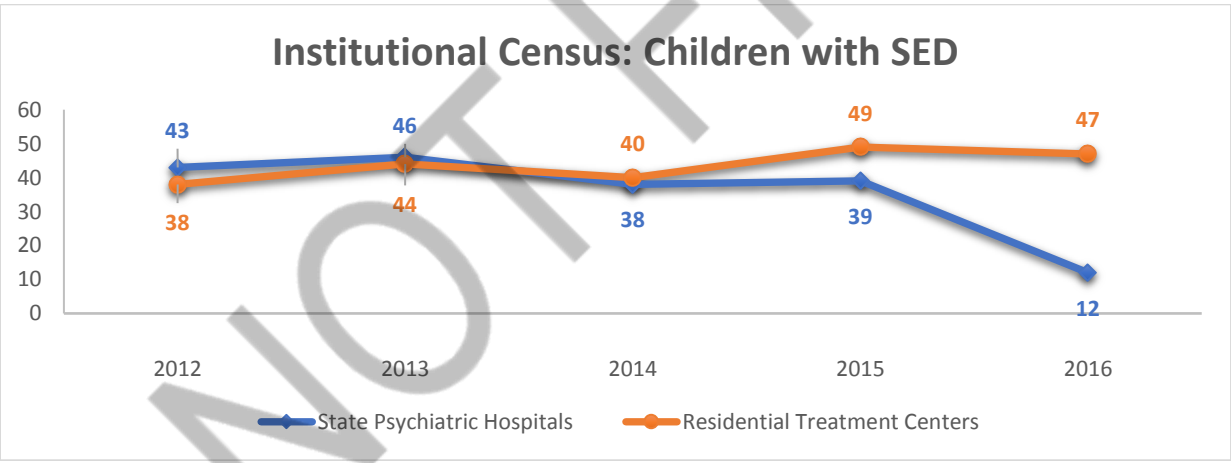
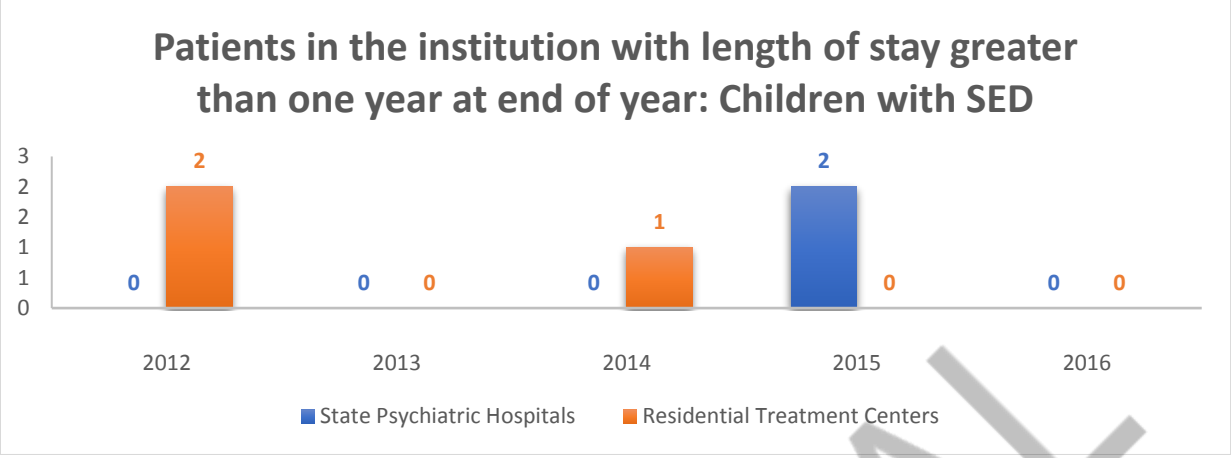


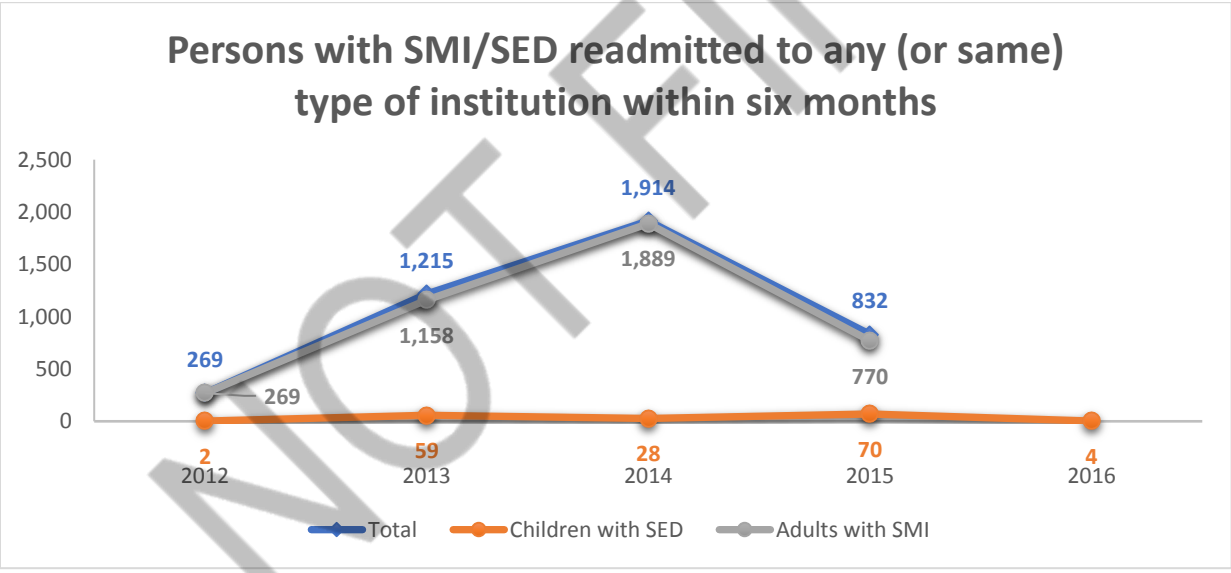
Figure 11 shows children with SED in the institution with a length of stay that is greater than one year. Data for this indicator reflect that few children have been institutionalized for a year or more.

Figure 11 Patients in Institutions with Length of Stay Greater than One Year at End of Year: Children with SED



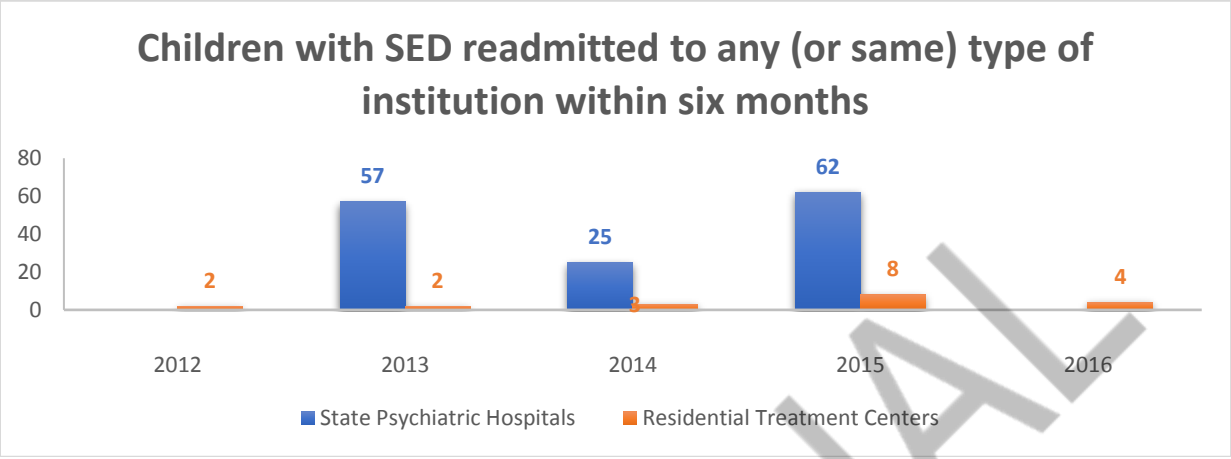
Readmissions are also reviewed under this domain. The persons with SMI/SED readmitted to any institution within six months declined considerably from 1,914 in 2014 to 832 in 2015.

Figure 12 Persons with SMI/SED Readmitted to Any (Or Same) Type of Institution Within Six Months



Readmissions for children with SED in residential treatment centers remained relatively low, compared to the number of readmissions to state psychiatric hospitals.

Figure 13 Children with SED Readmitted to Any (or Same) Institution Within Six Months



Readmissions for adults with SMI peaked in 2014 at 1,889 readmissions but declined to 770 in 2015.

Figure 14 Adults with SMI Readmitted to Any (or Same) Type of Institution Within Six Months

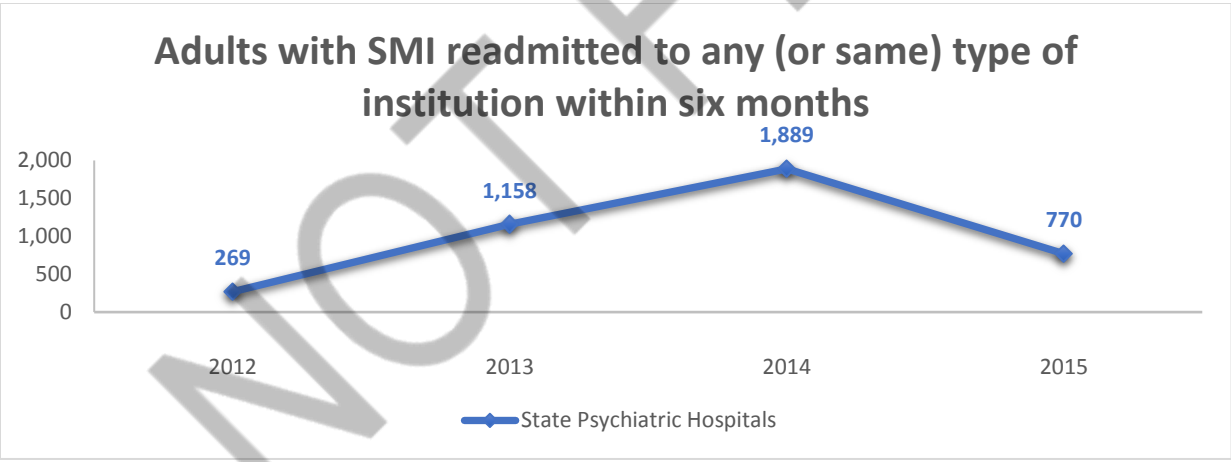
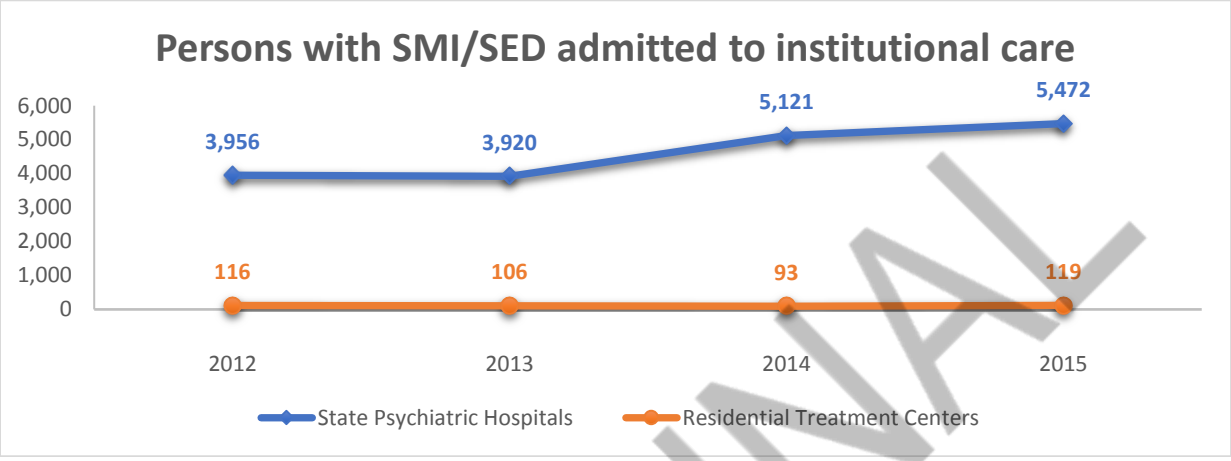


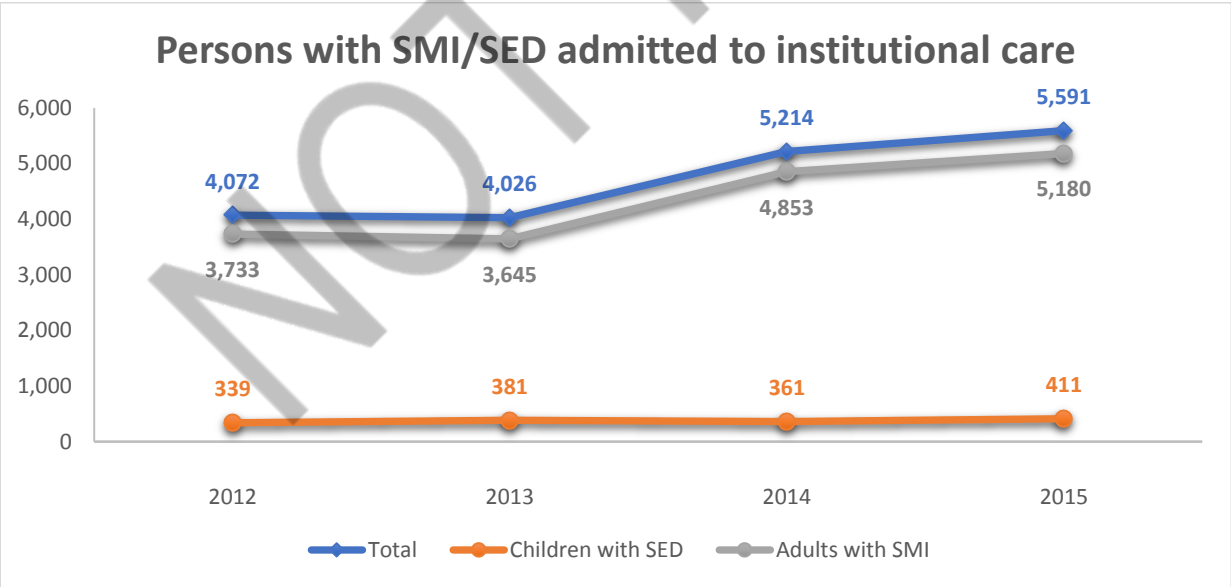
Figure 15 shows that persons with SMI/SED admitted to institutional care at state psychiatric hospitals increased over time from 2012 to 2015. On the contrary, the number of persons admitted to residential treatment centers has remained relatively unchanged during that time period.

Figure 15 Persons with SMI/SED Admitted to Institutional Care



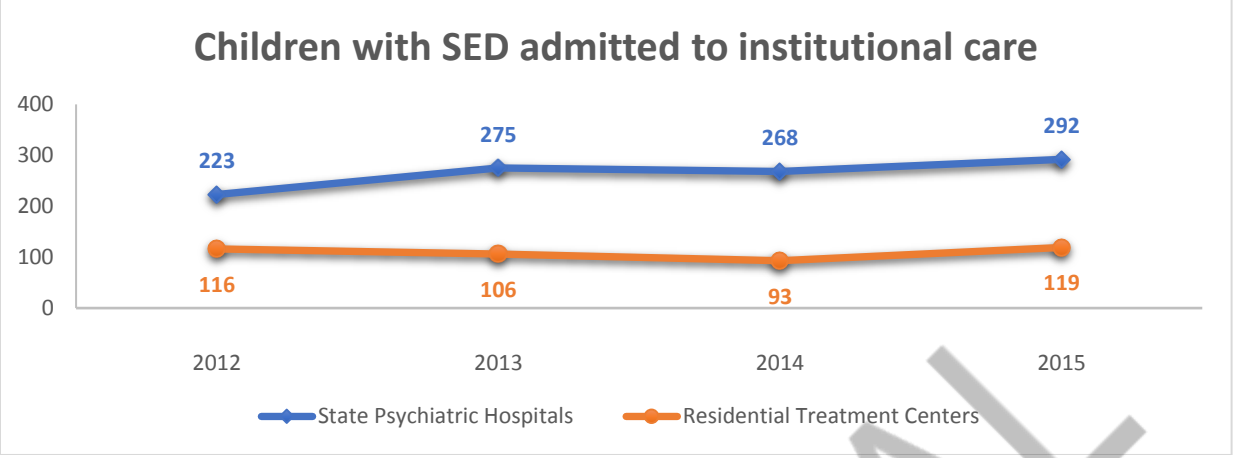
The total number of persons with SMI/SED admitted to institutional care increased from 2012 to 2015, corresponding with a large increase of adults with SMI, as seen in Figure 16.

Figure 16 Persons with SMI/SED Admitted to Institutional Care



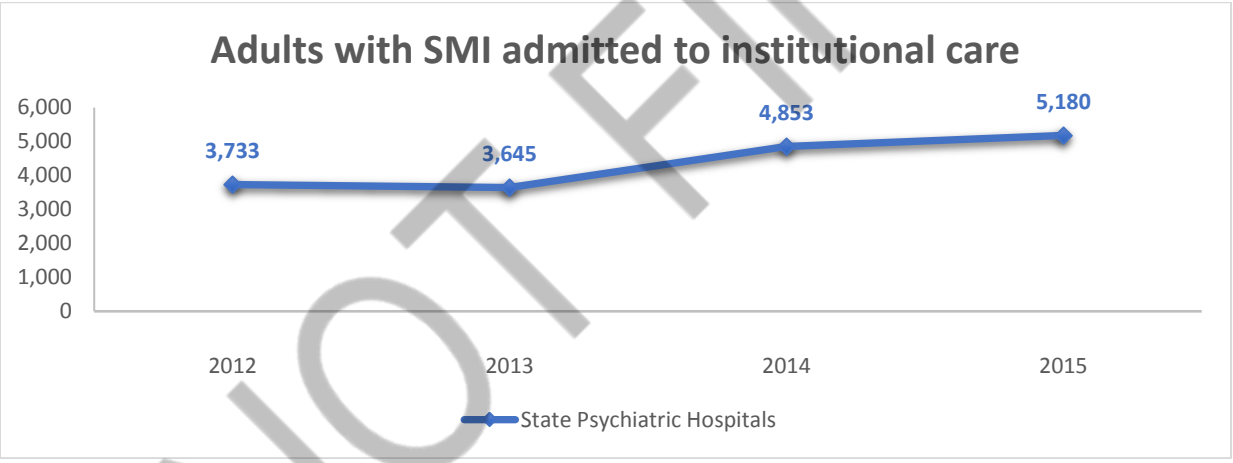
The number of children with SED admitted to institutional care both in state psychiatric hospitals and residential treatment centers has remained stable between 2012-2015.

Figure 17 Children with SED Admitted to Institutional Care



Only data from state psychiatric hospitals were available for adults with SMI admitted to institutional care.

Figure 18 Adults with SMI Admitted to Institutional Care

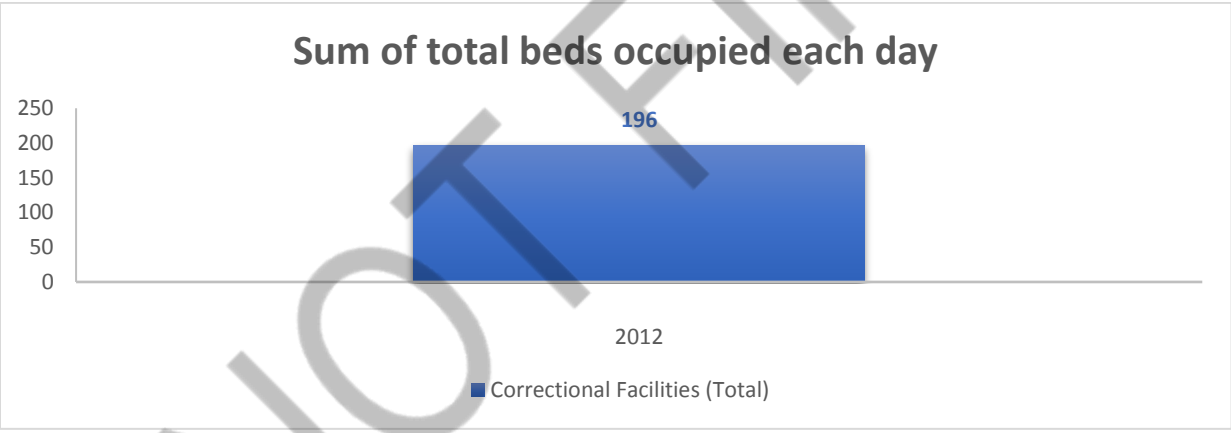


This domain also has indicators pertaining to occupancy rates and availability of beds. For the sum of total beds available each day, only correctional facility data was available.

Figure 19 Sum of Total Beds Available Each Day

Only data from 2012 was available for the total beds occupied each day from correctional facilities. Comparing beds occupied to beds available for correctional facilities yields a 73 percent utilization rate for 2012.

Figure 20 Sum of Total Beds Occupied Each Day



Figures 21 and 22 show that more state psychiatric hospital and residential treatment beds for children with SED are occupied each day than are available.

Figure 21 Sum of Total State Psychiatric Hospital Beds Occupied and Available Each Day: Children with SED

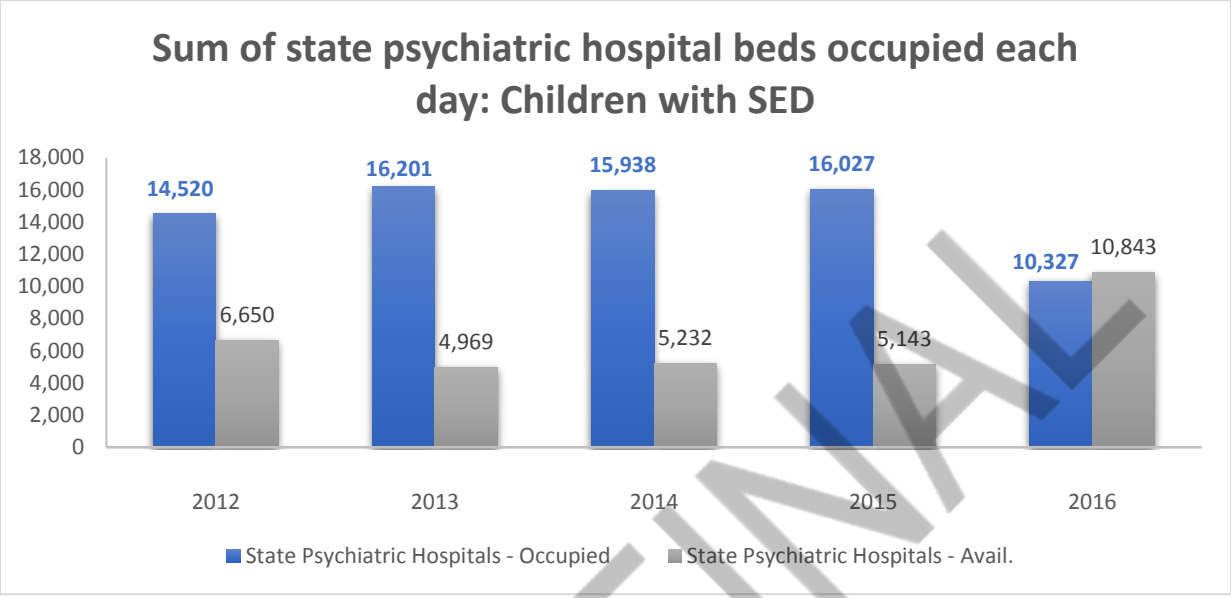
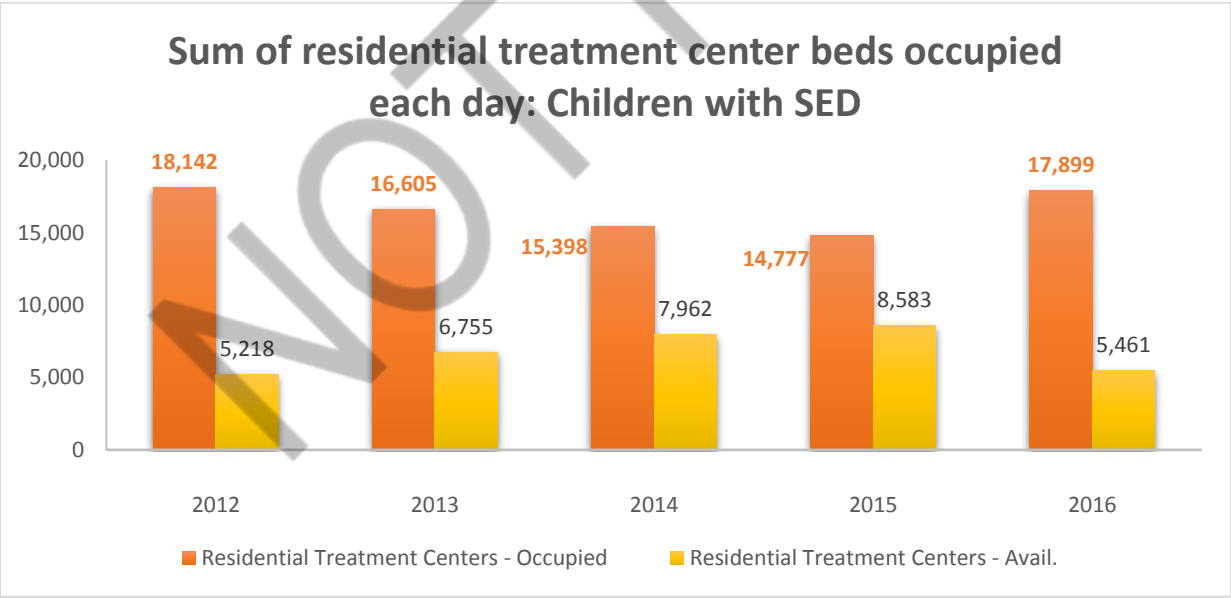
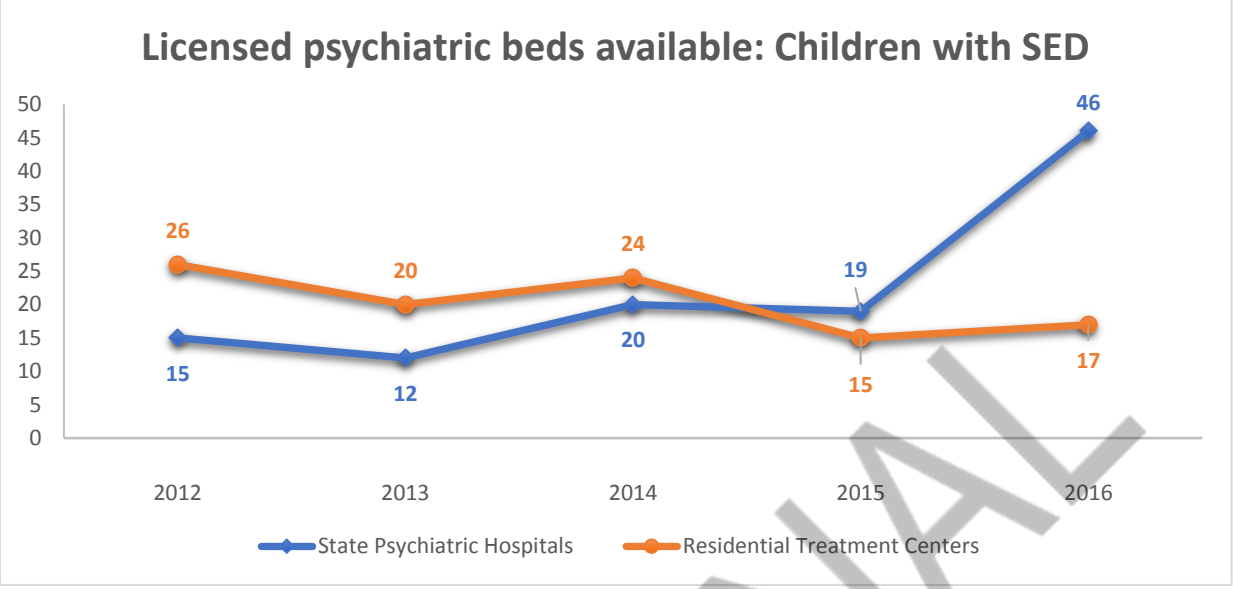


Figure 22 Sum of Total Residential Treatment Center Beds Occupied and Available Each Day: Children with SED



The number of licensed psychiatric beds available for children with SED doubled from 2015 to 2016. Most of the increase was due to the number of state psychiatric hospital beds available.

Figure 23 Licensed Psychiatric Beds Available: Children with SED



DOMAIN: COMMUNITY CAPACITY

The domain of Community Capacity examines one indicator and corresponding data points that are used to inform the State's current status:

1. Increase in utilization rates of community-based services

- Persons with SMI/SED receiving intensive targeted case management
- Persons with SMI receiving Assertive Community Treatment
- Persons with SMI enrolled in supported employment
- Persons with SMI employed or served by SMHA who are employed
- Children with SED receiving wraparound services
- Number of crisis residential beds available/persons receiving institutional diversion services
- Persons receiving in-home services
- Persons receiving family support services
- ER visit for primary mental health condition
- Admissions to general hospitals for psychiatric treatment

Potential data sources as suggested by the CISA tool are shown below, along with the actual sources that were able to provide data for this domain.

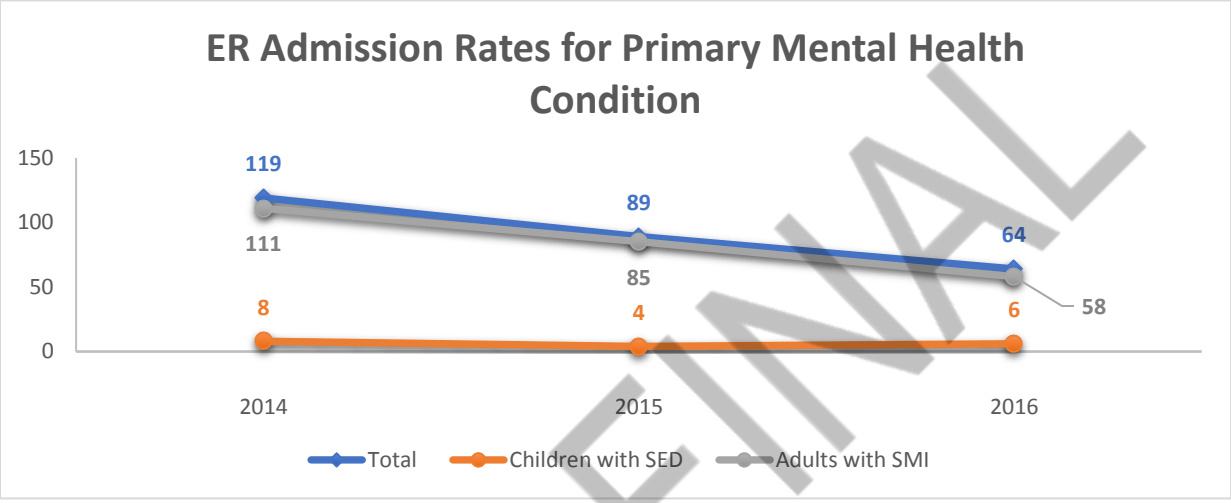
CISA Suggested Data Source	Actual Nevada Data Source
✓ SMHA MIS	✓ DPBH OPHIE ✓ URS ✓ DCFS

SUMMARY RESULTS

Nevada-specific data were limited for this domain. Data collection efforts yielded some data which are presented in this section.

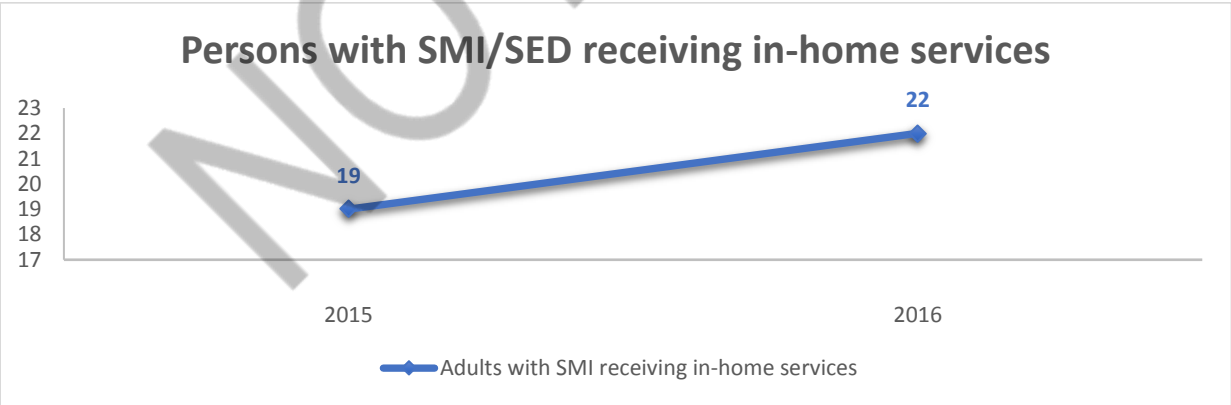
The number of ER visits for a primary mental health condition is available and shows that the number has decreased since 2014

Figure 24 ER Admission Rates for Primary Mental Health Condition



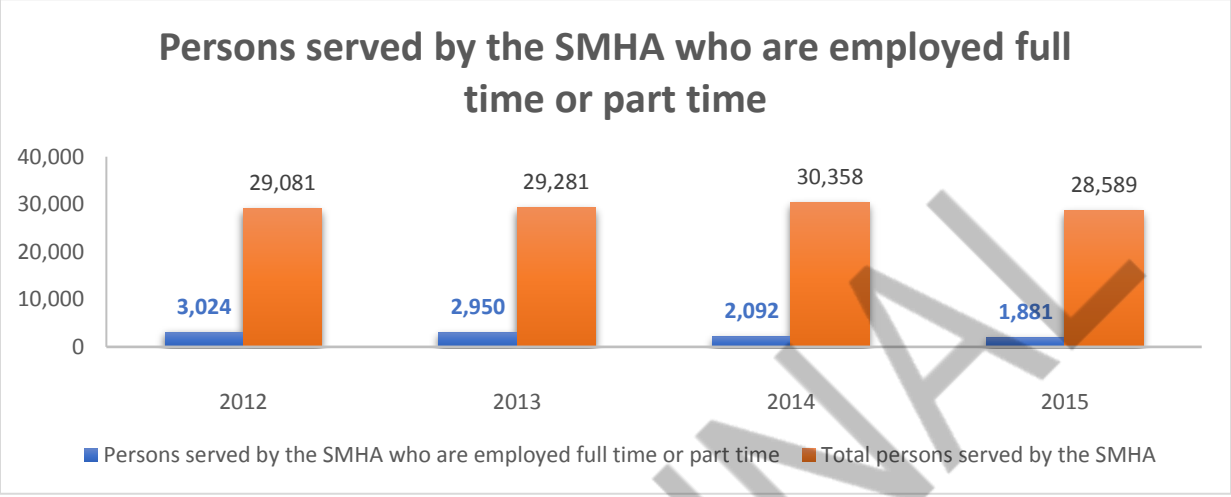
Only data for 2015 and 2016 was available for persons with SMI/SED receiving in-home services, reflecting an increase over the one-year period.

Figure 25 Persons with SMI/SED Receiving In-Home Services



Data for persons served by the SMHA who are employed is available for 2012 to 2015; the numbers have slightly declined over the four-year period. About 6.6 percent of population served by the SMHA were employed in 2015, compared to 10 percent in 2012.

Figure 26 Persons Served by the SMHA Who Are Employed (Full Time or Part Time)



DOMAIN: AT-RISK POPULATIONS

The domain of At-risk Populations examines two indicators and corresponding data points that are used to inform the State's current status:

1. Measures of early intervention services to avoid institutionalization

- 24-hour crisis hotline and number of calls
- Warm lines operated by mental health consumers, and number of peer staff and calls
- 24/7 mobile crisis teams, and people who received services

2. Measures that help define the size of the at-risk population

- Persons who are homeless and mentally ill
- Persons who are mentally ill involved in the criminal justice system
- Repeat psychiatric users of the emergency department
- Individuals with non-fatal suicide attempts
- Persons with co-occurring substance abuse disorders
- Adults with mental illness in board and care homes
- Children with SED in State Foster Care
- Children with SED suspended from school
- Children with SED who have been subject of a police referral at school
- Children with SED who have been arrested

Potential data sources as suggested by the CISA tool are shown below, along with the actual sources that were able to provide data for this domain.

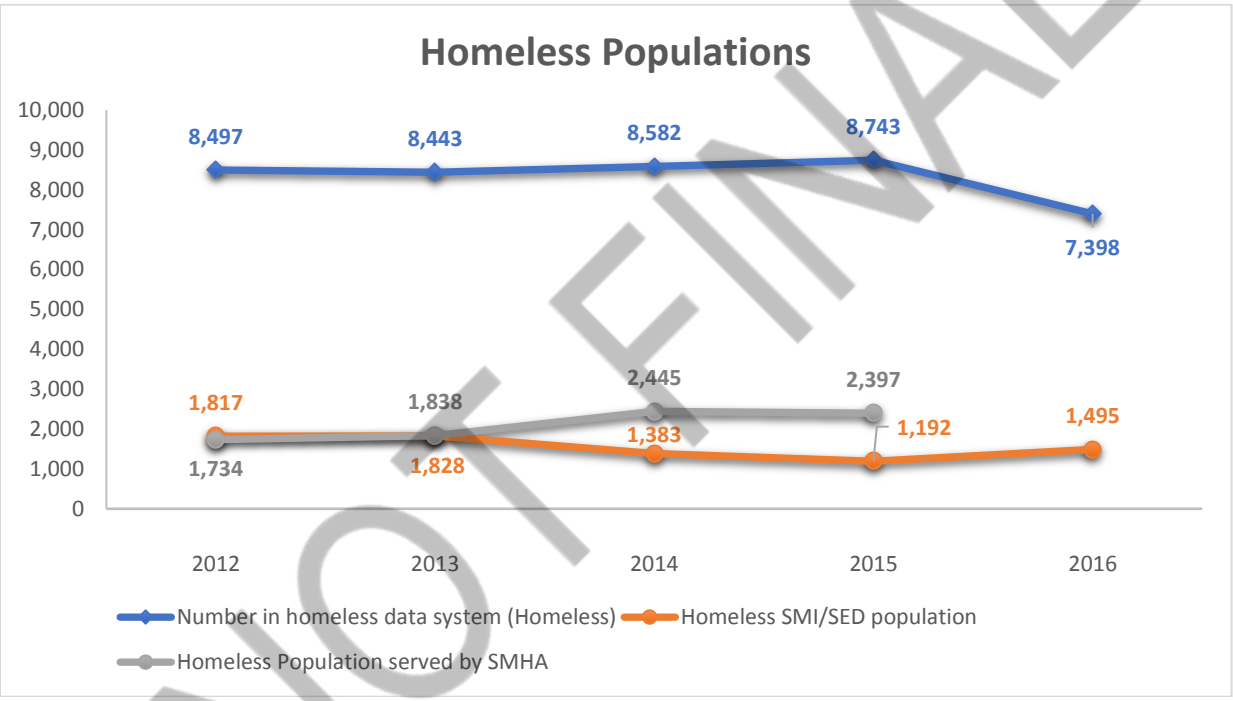
CISA Suggested Data Source	Actual Nevada Data Source
✓ SMHA MIS	✓ HUD
✓ State Criminal Justice	✓ URS
✓ Medicaid Paid Claims	✓ DCFS
✓ Medicaid Healthcare Cost and Utilization Project (HCUP) Files	✓ Crisis Call Center
✓ State Substance Abuse Agency Data	✓ Department of Education
✓ State Child Welfare Agency Data System	

Summary Results

Some requested data under this domain was not available, including data on warm lines which Nevada does not have and discharges from correctional facilities, prisons, and jails. The state does have some data on populations that have been identified as at-risk such as the homeless (including those with SMI/SED), youth in the juvenile justice system, those served by the SMHA, and those in foster care.

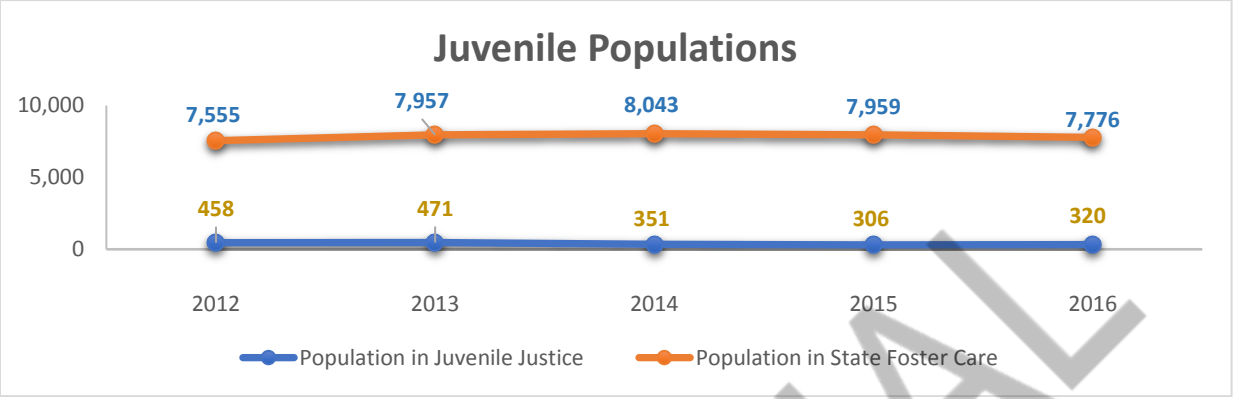
The number of individuals in the homeless data system declined in 2016, while the number with SMI/SED increased slightly. About 20 percent of the number in homeless data systems had SMI/SED. 2016 homeless population served by SMHA data was not available.

Figure 27 Homeless Populations



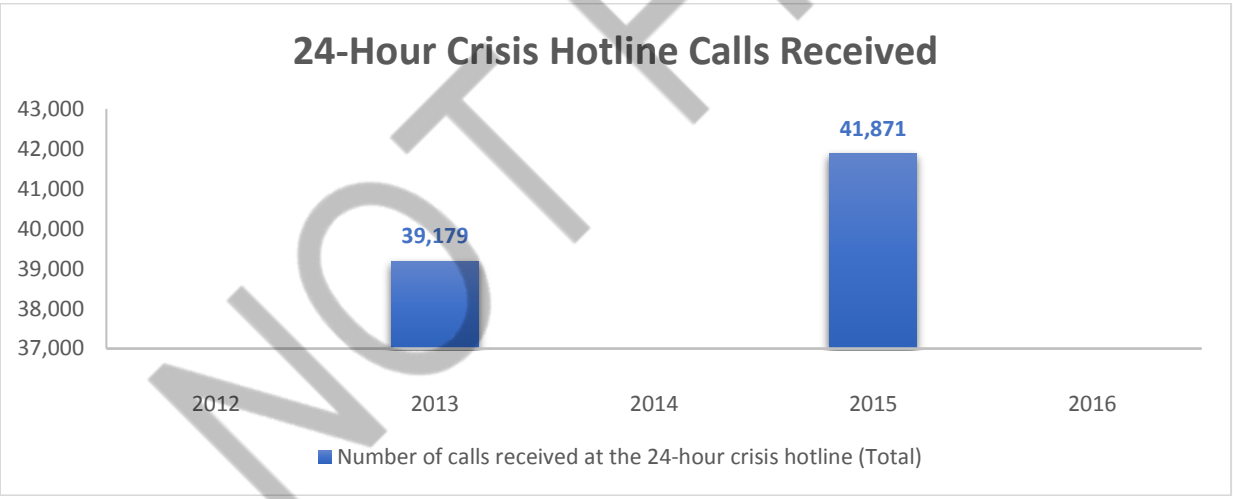
At-risk populations served by Juvenile Justice and in the State Foster Care system have remained constant between 2012-2016.

Figure 28 Juvenile Populations



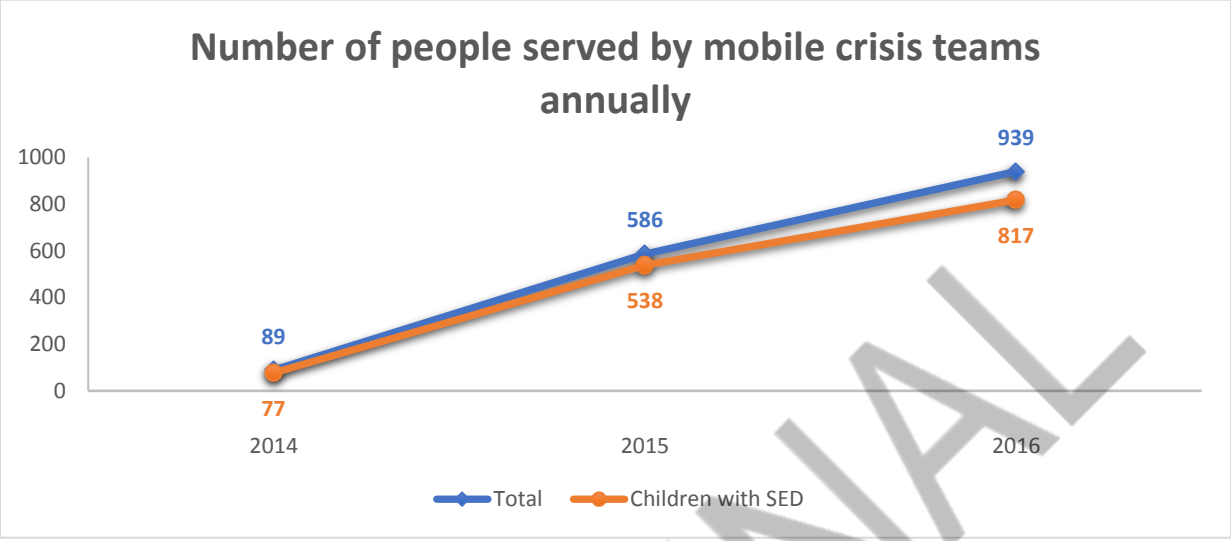
The state does have a 24-hour crisis hotline through Crisis Call Center. Data on the number of calls received were provided for 2013 and 2015. Specific data, such as the number of calls placed by individuals with SMI/SED, are not tracked.

Figure 29 Number of Calls Received by 24-Hour Crisis Hotline



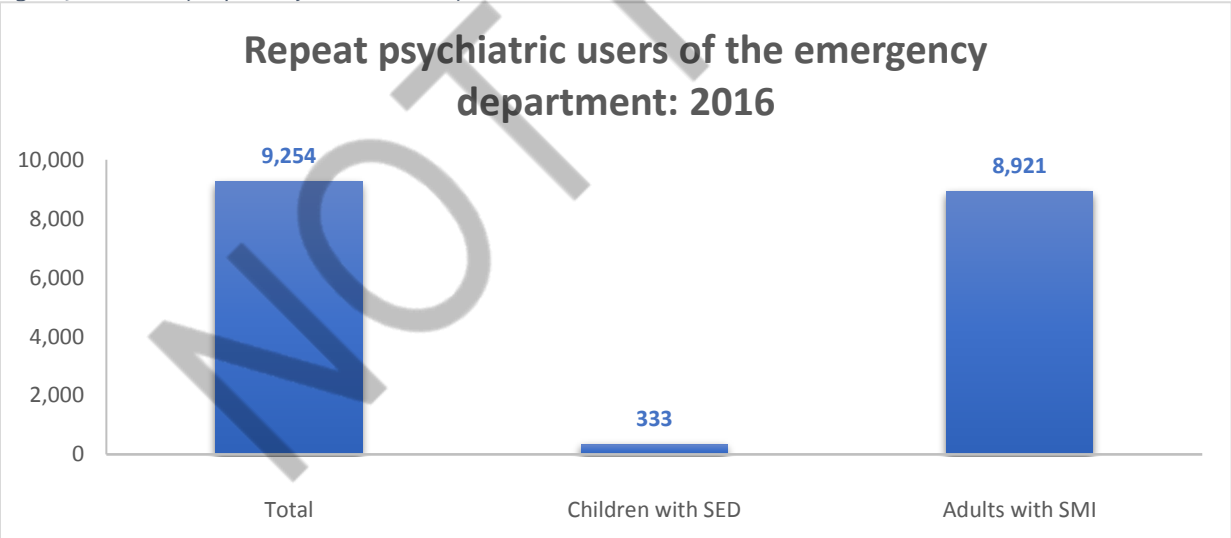
Data for the number of persons served by the mobile crisis teams show an increase from 2014 through 2016.

Figure 30 Numbers Served Annually by Mobile Crisis Teams



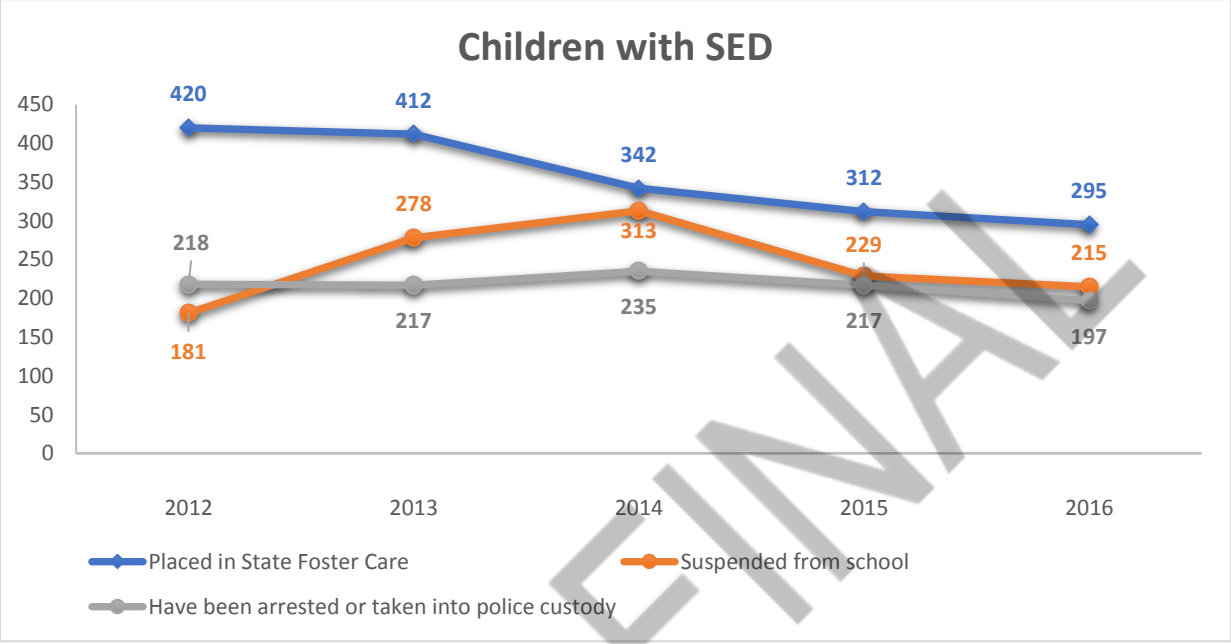
Data for Nevada show that the majority of repeat psychiatric users were adults with SMI. Some children with SED were also reported as repeat users.

Figure 31 Number of Repeat Psychiatric Users of ER



The CISA tool utilizes data on children with SED in various situations. Figure 32 shows the number of children with SED placed in state foster care, suspended from school, and arrested or taken into custody.

Figure 32 Children with SED in Situations



CONCLUSION AND RECOMMENDATIONS

The data collection process to complete the CISA tool has resulted in identification of a key issue with reporting in Nevada, namely that much of the data requested are not actually collected or only partial data are collected for Medicaid clients. As Nevada moves forward in implementing the statewide Olmstead plan, it will be critical that the priorities be set and agreed to across DHHS regarding the type of data to be collected and reported.

Additionally, the results of this data collection effort have highlighted the need for cross-system communication between the various agency databases. In some cases, numbers may be duplicated or under-reported due to the methodology of the particular system used to collect the data.

An area of opportunity that will continue to improve community integration efforts is through the IAP, whose goal is to improve health and health care for Medicaid beneficiaries by supporting states' ongoing efforts related to payment and delivery system reform. One program priority area is focused on physical and mental health integration. The goals for this priority program area are:

1. Improve the behavioral and physical health outcomes and experience of care of individuals with a mental health condition;
2. Create opportunities for states to link payments with improved outcomes for beneficiaries with these co-morbid conditions;
3. Expand and/or enhance existing state physical and mental health integration efforts to:
    a. Customize for specific populations; and/or,
    b. Spread integration efforts to new areas of the state; and/or,
    c. Spread integration efforts to new types of health professionals;
4. Identify and spread innovations to the field that improve and expand physical and mental health integration initiatives in various settings and for various populations.[17]

The IAP will work to support integration across varied settings (e.g., primary care, community mental health centers, school-based health centers), for different populations (e.g., adults and children, individuals with serious mental illness), and/or a variety of evidence-based models of integrated care (e.g., collaborative care, co-location, primary care-oriented, etc.).

[17] Medicaid.Gov. Innovation Accelerator Program – Physical and Mental Health Integration accessed on March 16, 2017 at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/physical-and-mental-health-integration/physical-and-mental-health-integration.html.

In 2016, Nevada was selected as one of the eight state Medicaid agencies chosen by CMS to receive technical assistance from its IAP. The initiative promotes community integration for Medicaid beneficiaries through public/private partnerships and collaborations with housing and development agencies. The six-month training began in May and included intensive, hands-on approaches to building collaborative relationships with key housing partners. The program concluded at the end of 2016.

Focusing on collecting data about community capacity would align with the ADSD plan and demonstrate the state's progress toward community integration. For that reason, the domain of community capacity could be considered a priority for data collection.

APPENDIX A. DATA DICTIONARY

Adult Care Homes and Other Congregate Living Settings: Each state has different nomenclature for adult care homes. For the purposes of this Community of Practice, adult care homes are defined as any congregate residential settings targeted toward people with low income, where more than half of the residents have psychiatric disabilities. This setting includes group homes for persons with mental illnesses funded by state or county funds.

Jails and Prisons: Many persons with mental illnesses end up in jails or prisons due to a lack of alternative (diversionary) community services and other supports.

Nursing Homes: Nursing Homes provide services to persons with significant medical conditions who have been assessed as needing nursing-level care, but who are not acutely ill enough to require treatment in a hospital. Nursing homes provide on-site access to staff 24 hours per day. The majority of nursing home residents tend to be older adults; however, children and younger adults with disabilities are also sometimes served by nursing homes. Studies estimate that nearly 50 percent of those receiving care in a nursing home have a mental illness (Mental Health and Aging, 2012).

Residential Treatment Centers: Residential Treatment Centers are often used to provide services to children; however, these facilities sometimes provide services to adults and older adults. All licensed residential treatment facilities should be included in the Community of Practice.

State Psychiatric Hospitals: State Psychiatric Hospitals provide services to consumers with high levels of need, including those who are a threat to themselves or others. These facilities provide acute care services, long-term treatment, and forensic services to mental health consumers. Although protected under *Olmstead* and the Americans with Disabilities Act, for the purposes of the Community of Practice, long-term forensic patients and persons admitted for pretrial competency evaluations (including sexually violent predators) are excluded to the extent they can be identified. Long-term, forensic patients include defendants in legal cases who were acquitted not guilty for reason of mental insanity (NGRI); defendants convicted as guilty, but mentally ill; persons transferred from prison to the state hospital for mental health treatment; and persons who have been determined Incompetent to Stand Trial. Additionally, states that have Sexual Offender or Sexual Predator laws that allow for a civil or criminal commitment to psychiatric facilities of convicted sex offenders deemed to need treatment should exclude these patients from the census for this Community of Practice.

Supported Housing: Supported Housing is a specific program model in which a consumer lives in a house, apartment, or similar setting; alone or with others; and has considerable responsibility for residential maintenance; but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities.

Criteria identified for Supported Housing programs include: housing choice, functional separation of housing from the provision of services, affordability, integration with persons who do not have mental illnesses, right to tenure, service choice, service individualization, and service availability.

Supervised Housing: Supervised Housing provides the most care for its residents. Residents generally share another room with at least one other person. Residents have their own bed, dresser, and closet space. Bathrooms and common areas are shared. Depending on the level of supervision these programs provide, supervised housing programs may include: 24-hour (or less) supervision and assistance; assistance in performing basic daily living skills; assistance with medication; food and meals (no less than three per day); assistance with paying bills and managing money; company from other residents and house managers, which can help to ease loneliness; assistance with making doctors' appointments; assistance with transportation; and day programs. These facilities must be licensed by the state.

APPENDIX B. SWOT ANALYSIS RESULTS

Strengths	Weaknesses

• Lots of available data
• Office of Public Health and Epidemiology will likely be able to gather some additional data, including the Planning and Evaluation unit through DCFS. Internal structures in place that will assist with drilling down into the existing data
• Size in Washoe and the rural counties – flexible and able to make decisions quickly
• Renewed effort and energy tied to the divisions working together – top down support from leadership vs. trying to push something up to the divisions. This planning effort came from the director
• Currently have an Olmstead plan – ADSD is working on it, as well as this current group. Potential to bring these groups together and have a united front.
• Communications between agencies in DHHS
• Part of the communication that has improved due to complex cases
• Benefit of crafting the plan as it needs to be vs. trying to craft it around a preconceived notion of what it must be
• Other states have gone through; Nevada is never the first to go through it (always the middle or last, which can also be a weakness)
• Resources, technical assistance support
• Broad commitment to the planning process
• Doing the right thing before Department of Justice (DOJ)
• 1915 c waiver – good programs that could serve as models (doesn't have it for mental health)
• No Wrong Door implementation in Nevada – predicated on a lot of the basic philosophies of community integration
• Work on the 1915i specifically to expand what's reimbursable so that it fits within behavioral health and addresses clients within the mental health side
• State transition plan – good time to look at Olmstead as many of the key areas in Olmstead are within the transition plan
• Housing Shortage - Southern Nevada is implementing a program working with real estate agents to work with landlords
	• Housing availability
	• Funding and staff
	• Staff transitions, lack of staff
	  ○ Loss of institutional knowledge due to changes
	  ○ Restrictive professional reciprocity rules in Nevada – those who have been practicing in other states, come into Nevada and need additional education/training/internships
	• Lack of providers/workforce issues
	• Lack of evidenced based practices and fidelity monitoring, for practices such as Assertive Community Treatment and Supported Employment
	• Lack of residential treatment for all ages
	• Transportation issues
	• Have to send some clients out of state for treatment (mainly children)
	• Data (not sure what data is out there that we don't know about)
	  ○ Lacking a great deal of outcome data
	  ○ Haven't prioritized being data-driven or good quality data that is reviewed consistently to measure outcomes or do anything more than collect frequencies
	  ○ Data sharing with non-government entities that aren't linked to the Division of Public and Behavioral Health (DPBH), makes it difficult to understand client level data. Could work more collaboratively to address issues within the community.
	• Behavioral health has never looked at the systems through the critical lenses of community integration and Olmstead. If they have, it wasn't coordinated.
	• Competing priorities for staff
	• Complicated insurance – transition to managed care, trouble for providers getting approval
	• State can change policies to reflect an Olmstead planning process, but don't have a monitoring and oversight arm over community providers to ensure policies are replicated at the community level and are enforced/supported

	• Limited SAPTA (Substance Abuse Prevention and Treatment Agency) Block grant funding and some general funding for providers • Communication breakdown, even with the greatest intentions and a communication plan
Opportunities	**Threats**
• Centralizing and consolidating licensing boards • Increase performance management/QI • Identification of service needs through planning • BHC needs assessment, Clark County is doing a BH assessment in southern Nevada – reviewing access to behavioral health and services available (other assessments could inform efforts) • Explore and leverage of community agencies ○ Grant specific reporting metrics • ADSD and Vocational (Voc) Rehab are working on a Memorandum of Understanding (MOU) to ensure funding is stretched further • Working with Center for Excellence to blend funding from the regional center, Voc Rehab, and a private provider (collaborate & remove siloes) • Leverage existing groups/community coalitions to get the word out about community integration and community health • More data about the economic benefit of integration. Other states quantify the benefit of investing in community integration not only in cost savings (ROI) but in overall well-being. • Legislative session – Governor's strategic framework has language that aligns with community integration, increasing employment opportunities, about people with disabilities, reducing suicide, eliminating wait list, improving state service and customer satisfaction. Number of sweet spots that an Olmstead plan around behavioral health would hit (sellable) • Lot of emphasis on jail diversion, one of the key strategies throughout the Intercept model. Natural touchpoints with Olmstead planning • Rural communities have signed on at the county level for the Stepping Up initiative. More counties are becoming aware of the number of individuals who are incarcerated, who have untreated or undertreated mental health issues. • Increase in evidence-based practices and fidelity • Quality insurance plans through Medicaid, value based payments, able to do outcomes measures. • Efforts to train/provide whole health care	• Risk of lawsuit • Scope creep • Competing priorities • Failure to implement as having a plan doesn't put one in compliance with Olmstead. It's only compliance with the Americans with Disabilities Act. There isn't an Olmstead Act. Trying to move towards compliance with ADA and community integration. Can you demonstrate that you've made progress? Could be false sense that we have the plan and therefore in compliance. It's just the starting point, not the end. • Change in administration – will the new administration change the priority in funding? Loss of housing resources. Change in funding priorities • Bureaucracy slows change opportunities • Scarcity mentality – if different factions advocate in opposition to each other, would pose a threat (could be an opportunity as well, could push prioritization of community integration efforts) • Naysayers, stakeholders who object against the process • With more people gaining coverage, infrastructure in behavioral health to serve those individuals, everyone wants to work with the one provider they have always worked with (state mental health system) vs. community based providers • Affordable housing crisis/Housing shortage – elderly are going to be priced out. Seen more in the north and rural areas. • Repeal of the Affordable Care Act – not sure what parts will be repealed, especially in a Medicaid expansion state (sustainability) • Loss of provider base to work with population

• Currently developing the next integrated behavioral health plan for the block grant – will be going in late summer, early fall of 2017 ○ Good opportunity to look at early intervention and prevention services • Nevada is in the running for the next phase of CCBHC – their CQI plan includes several different elements including fidelity measures	

Nevada and Olmstead

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Executive Summary

The 1999 Olmstead decision by the U.S. Supreme Court established that the unnecessary segregation of people with disabilities in institutions is a form of discrimination under Title II of the Americans with disabilities Act of 1990 (ADA) and set the responsibility to states to provide services to individuals with disabilities in the most integrated setting appropriate to their needs. In 2001 the "New Freedom Initiative" affirmed the nation's commitment to the provision of publicly financed community based services and supports to individuals with disabilities fostering independence and community participation.

Nevada consumers, family members, advocates and government entities became very involved in driving toward implementation of community based services and supports for individuals with disabilities. In 2003, the Nevada Strategic Plan for People with Disabilities was submitted and approved for implementation to the Nevada Department of Health and Human Services. The Plan, also known as the Nevada Olmstead Plan, included nine primary goals and more than 200 strategies to resolve the numerous barriers to the provision of appropriate community supports and services to Nevadans with disabilities.

Nevada has participated in compliance reviews of their adherence with Title II of the Americans with Disabilities Act (ADA) and the Olmstead decision periodically throughout the last twelve years with recommendations provided to the oversight committees. The Nevada Strategic Planning and Accountability Committee and the Commission on Services for Persons with Disabilities monitor and review the plan implementation and issue annual reports regarding progress and obstacles to providing integrated services.

The purpose of this report is to provide an update to the 2003 Nevada Strategic Plan for People with Disabilities and Older Adults to set the foundation for a new Strategic Plan for People with Disabilities across the Lifespan. The report provides a review by Tony Records of compliance to the federal ruling, a review of current legal perspectives regarding the inclusion of seniors under the Olmstead decision, and additional recommendations for seniors, behavioral health populations and service gaps that create inclusion barriers for Nevada citizens.

Context of the Report

The state's Olmstead Plan provides the framework through which it intends to comply with its obligation to ensure people with disabilities have access to opportunities to live, work and receive supports in integrated settings. The integration mandate obligates the state to:

- Furnish supports and services to individuals with disabilities in integrated settings that offer choices and opportunities to live, work and participate in community activities along with individuals without disabilities at times and frequencies of the person's choosing.
- Afford choice in their activities of daily life and the opportunity to interact with non-disabled person to the fullest extent possible.
- Provide individuals with an assessment of their needs and the supports necessary for them to succeed in integrated settings by professionals who are knowledgeable about the variety of services available in the community.
- Enable people with disabilities to make informed choices about the decision to reside in the most integrated settings by furnishing information about the benefits of integrated settings, facilitating on-site visits to community programs and providing opportunities to meet with other individuals with disabilities who are living, working and receiving supports in integrated community settings, with their families, and in other arrangements.
- Protect people with disabilities from the risk of institutionalization resulting from service or support reductions or reconfigurations as a result of state funding reductions through the provision of support alternatives that do not result in institutionalization.

In 2015, Aging and Disability Services Division undertook the task of updating the 2003 plan and created an Olmstead Subcommittee. The Olmstead Subcommittee, a collaboration of members of the Commission on Aging and the Commission on Services for Persons with Disabilities embraced the Olmstead decision as a key component of achieving a better Nevada for all Nevadans, and strive to ensure that Nevadans with disabilities regardless of age will have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life. This includes:

- The opportunity and freedom for meaningful choice, self-determination, and increased quality of life, through: opportunity for economic self-sufficiency and employment options; choices of living location and situation, and having supports needed to allow for these choices.
- Readily available information about rights, options, and risks and benefits of these options, and the ability to revisit choices over time.
- Systemic change supports self-determination, through revised policies and practices across state government and the ongoing identification and development of opportunities beyond the choices available today.
- Services and Supports are available at the time the person requests the service. Funding and the availability of a choice of service providers requires the state address the

approach used to fund services sufficiently as to eliminate wait time and engage quality provider organizations.

The Olmstead Subcommittee desires to be inclusive of all ages and populations and thus has added to the recommendations provided by Mr. Tony Records. The additional recommendations have been provided by consumers, family members, community advocacy groups, professionals in fields supporting the aforementioned consumers and information gleaned from the review of recent reports on Nevada's system of care.

The Olmstead Decision of 1999 definition of qualified individuals has expanded over the last 16 years. Individuals have challenged states regarding who is covered by the mandate to provide services in the least restrictive setting. Nevadans of any age who require assistance in their daily activities due to a disability are included as a covered individual.

Aging and Disability Services Division, Elder Rights Attorney, Sally Ramm has researched cases brought by the United States Department of Justice, Civil Rights Division involving older people and provided a legal perspective.

THE OLMSTEAD DECISION OF 1999 – A CURRENT LEGAL PERSPECTIVE BASED ON AGE, Prepared by Sally Ramm

The Americans with Disability Act of 1990 (ADA) prohibits discrimination against what it terms a "qualified person with a disability." The term "disability" means, with respect to an individual: "a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.[1]

The legal requirements of the ADA and the United States Supreme Court Olmstead decision of 1999, which is based on the ADA, contain no exclusions based on age. While the Olmstead decision was about a case involving institutionalization of two people who were in a mental health institution, the decision does not pertain only to mental health issues and developmental disabilities. It specifically requires states to provide integrated community services and supports for people with disabilities who are otherwise entitled to segregated services under the definition contained on page one of Mr. Tony Records' report entitled "Nevada and Olmstead – A Continuous Examination."

[1] ADA.gov website: US Department of Justice, Civil Rights Division

Therefore, Nevadans of any age who require assistance in their daily activities due to a disability are entitled to those services required by the Olmstead decision, and must be included in any Olmstead planning that is required by the federal government.

Additionally, since 1999 courts have been finding that Olmstead applies to individuals living in the community who are at risk of institutionalization. A federal appellate court decision from the 10th Circuit held that the protections in Olmstead would be meaningless if men and women with disabilities "were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." In that case, the individuals stated that they would rather die than enter nursing facilities.[2]

Following are cases involving older people that were brought by the United States Department of Justice, Civil Rights Division: [3]

United States v. Marion County Nursing Home District - (E.D. Mo. 2013)
On March 14, 2013, the parties in *United States v. Marion County Nursing Home District d/b/a Maple Lawn Nursing Home* filed a Settlement Agreement. The Agreement addresses whether residents of the nursing home are being served in the most integrated setting appropriate to their needs. The Agreement also addresses basic elements of residents' care and treatment. Maple Lawn is required to develop numerous improvement measures. An independent monitor has been selected to monitor the Settlement Agreement.

Darling v. Douglas – 09-CV-3798 – (N.D. Cal. 2009) (Formerly Cota v. Maxwell-Jolly)
The United States filed a Statement of Interest on July 12, 2011 and October 31, 2011 in support of Plaintiffs' challenge to the manner in which the State plans to eliminate the Adult Day Health Care (ADHC) service, which enables elderly individuals and individuals with physical and mental disabilities to live in the community and avoid hospitalization and institutionalization. The United States argued that the State's plan to eliminate ADHC without ensuring sufficient alternative services are available will place thousands of individuals who currently receive ADHC services at serious risk of institutionalization, in violation of the ADA. Approximately 35,000 Californians would be affected by the proposed ADHC elimination.

Hiltibran v. Levy – 10-CV-4185 – (W.D. Mo. 2010)
In a suit brought by individuals who need incontinence supplies to live in the community, the court issued an order on June 24, 2011 requiring the State of Missouri to provide Medicaid-funded incontinence supplies to individuals who need those supplies to prevent their placement in nursing facilities. The United States filed a Statement of Interest supporting Plaintiffs' Motion for Preliminary

[2] Disability Integration Project; OlmsteadRights.org; "From Olmstead to the Present."
[3] ADA.gov website: US Department of Justice, Civil Rights Division

Injunction and Motion for Summary Judgment arguing that Missouri's policy not to provide the necessary supplies placed individuals at risk of institutionalization in violation of the ADA.

Lee v. Dudek – 4:08-CV-26 – (N.D. Fla. 2008)
This class of plaintiffs—consisting of all Medicaid-eligible adults with disabilities who currently, or at any time during the litigation, are unnecessarily confined to a nursing facility and desire to and are capable of residing in the community—claims that the State of Florida's refusal to provide services in the community to these individuals violates the ADA's integration mandate.

In a 2011 case in Georgia, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) investigated a complaint filed by Atlanta Legal Aid on the part of an "Affected Party," and concluded that the Department of Community Health (DCH) violated Title II of the ADA based on its failure to place a 79 year old person in the most integrated setting appropriate to this person's needs and its refusal to make reasonable modifications in its policies, practices or procedures to avoid discrimination on the basis of disability. A synopsis of the facts:

The affected party was admitted to a nursing facility for rehabilitation services 17 years before the complaint was filed. This person never intended to stay there, and has persistently sought to leave the facility and live in a community setting. This person has left-side paralysis which affects speech. A February 2011 medical assessment found the person oriented to person, place and time of day, able to self-feed with supervision, and to propel the wheelchair using the right leg and arm. This person did not need skilled nursing other than medication administration.

In 2009, DCH had noted the resident's longstanding desire to move into the community, but noted that there might not be a personal care home able to care for the resident because the reimbursement for such homes was only $12,789.60 a year. All nine providers declined to accept the resident for various reasons, including that the reimbursement rate does not match the level of service required.

OCR found that DCH violated the ADA based on its failure to place the affected party in the most integrated setting appropriate to needs and its refusal to make reasonable modifications in its policies, practices or procedures to avoid discrimination on the basis of disability. The full text of the findings and recommendations can be found at the U.S. Department of Health and Human Services website (link below).[4]

There are numerous other cases from around the country that have been decided in the last five years that prove that the legal provisions of the ADA and the Olmstead decision

[4] U.S. Department of Health & Human Services; Office for Civil Rights; OCR Olmstead Enforcement Success Stories; "Georgia Department of Community Health" Letter of Findings
http://www.hhs.gov/ocr/civilrights/activities/examples/Olmstead/successstoriesolmstead.html

apply to people of all ages and forms of disability. People are successfully bringing suits against states that do not acknowledge this.

Nevada and Olmstead – A Continuous Examination

July 17, 2015

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Introduction

This report is submitted at the joint request of the Nevada Department of Human Services, Aging and Disability Division and the Olmstead Subcommittee of the Committee on Strategic Planning and Accountability. TRA, Inc. (hereinafter referred to as the Consultant) is the contractor. Tony Records, President of TRA, Inc. performed all of the tasks and activities associated with this report.

On June 22, 1999, the US Supreme Court ruled in the landmark Olmstead v. L.C. decision that unnecessary segregation and institutionalization of people with disabilities is a form of discrimination and prohibited under the Americans with Disabilities Act (ADA). To remedy or avoid such discrimination, states are required to provide integrated community services and supports for people with disabilities who are otherwise entitled to segregated services, when:

1. The state treatment professionals reasonably determine that community placement is appropriate;
2. the person does not oppose such placement; and
3. that placement can be reasonably accommodated, taking into account resources available to the state and the needs of others receiving state disability services.[1]

This civil rights ruling has resulted in numerous federal initiatives and policy changes nationwide designed to increase services and supports in the

[1] US Supreme Court (1999) Olmstead v. L.C. (98-536) 527

community for people with disabilities living in segregated settings, such as institutions and nursing facilities. More recently, there has also been increased emphasis of ensuring that non-residential supports are also provided in the most integrated setting.

In response to the Olmstead decision, most states, including Nevada, have engaged in developing statewide plans to address the need for community supports for those people with disabilities who are in segregated settings and to prevent future unnecessary segregation. Specifically, Nevada, over a two year period, developed the October 2002 *Strategic Plan for People with Disabilities*. A broadly representative stakeholder task force of people with disabilities, service providers, advocates, national consultants, state and county officials and state legislators were involved in this planning process. The meeting planners held 45 meetings and training sessions and three public hearings to develop and review the plan. Members and participants initially identified 185 perceived barriers to community services, independence and inclusion. The Consultant also provided technical assistance and training to the planning group on Olmstead related issues. This plan was approved by the state legislature in 2003. The ten-year timeframe for implementation of this plan expired in 2013.

This report provides a narrow snapshot at how well Nevada's efforts to support people with disabilities in the community over the past nine years comport with the basic principles, as well as the basic requirements of Olmstead and the community integration mandate of the ADA. This report is not to be in anyway considered as legal findings of fact or opinion of law. Rather, it is designed to provide a broad assessment of Nevada's efforts in providing services and supports to people with disabilities in the most integrated setting.

Although a preliminary overview of the findings and recommendations was provided to the Olmstead Subcommittee on April 30, 2015, no prior draft of this report was provided to the Committee or anyone else.

Methodology

In order to obtain information and viewpoints from a variety of sources, the Consultant used several methods toward collecting a broad set of information to formulate the findings and recommendations. These methods included the following:

- **Stakeholder Interviews.** The Consultant made five trips to Nevada (two trips to southern Nevada and three trips to northern Nevada) to facilitate face-to-face interviews with various stakeholders, including people with disabilities, families, advocacy organizations, community service providers, state and county administrators and policy staff, as well as advocacy professionals. These interviews included one-on-one interviews as well as six "town-hall" meeting formats in northern and southern Nevada. There were also observations and interviews with people with disabilities in programs and facilities in southern Nevada.

- **Document Review.** More than 100 various plans, reports and documents were reviewed to obtain a broad analysis of information, to facilitate interview questions and clarify conflicting information.

- **Internet Research**. Extensive internet research from federal agencies, Nevada websites, as well as national and state disability research agencies was conducted to obtain the most up-to-date and accurate information available.

Evaluation Questions. The Consultant approached this review utilizing the following evaluation questions:

1. Is there a statewide effectively working plan to ensure that people with disabilities are being, and will be, served in the most integrated setting?

2. Are policies and procedures in place or being proposed that promote and facilitate services in the most integrated settings?

3. Is Nevada making effective efforts to identify and assess people with disabilities who may be unnecessarily served in segregated settings?

4. For people who are waiting for community living supports and services, are they receiving these services with reasonable promptness?

5. Are there activities or initiatives occurring to adequately expand community supports and services in order to avert unnecessary segregation?

Acknowledgements

The Consultant experienced full cooperation and support from all individuals and organizations involved in the review. There were also numerous individuals with disabilities, and their families, that took time off of their busy schedules to participate in one-on-one interviews.

There were also numerous advocates and service organizations that participated in this review. In particular, the Consultant would like to thank the following organizations and for their invaluable contributions to this review.

Northern Nevada Independent Living Center
Southern Nevada Independent Living Center
Nevada Partners in Policy Making
Nevada Center for Excellence in Disabilities, UNLV
People First of Nevada (Las Vegas and Reno Chapters)
State of Nevada: Department of Human Services

- Aging and Disability Services Division
- Mental Health and Developmental Services
- Division of Health Care Financing and Policy
- Sierra Regional Center
- Department of Employment, Training and Rehabilitation

Clark and Washoe County Administration
Governor's Council on Developmental Disabilities
Nevada PEP
Nevada Disability Advocacy and Law Center
Sierra Nevada Quality Care
Southern Nevada Health District
Washoe Legal Services
Life Planning Services of Nevada
Leadership Education Advocacy Designs
Opportunity Village
American Association of Retired Persons, Nevada Chapter

A Nationwide Look at Olmstead

Although the Olmstead decision is nearly 16 years old, the Obama administration has continued to demonstrate heightened attentiveness to monitoring and enforcement of the ADA integration mandate and how well states offer services to people with disabilities. In 2009 the President marked the 10th anniversary of Olmstead by launching "The Year of Community Living," which included several initiatives through many federal agencies and departments over a five year period. These initiatives were designed to enhance interagency coordination and provide structures to better understand the needs of people with disabilities.

In addition, the US Department of Justice (DOJ) has demonstrated a renewed commitment to ADA and Olmstead enforcement. DOJ has intervened on numerous federal cases involving people with disabilities to ensure that Olmstead compliance is given high priority. DOJ has also transformed the manner in which it is enforcing the Civil Rights of Institutionalized Persons Act (CRIPA) by placing high priority on questioning the appropriateness of the presence of people with disabilities in publicly operated institutions. DOJ has also demonstrated that they will seek remedies through CRIPA by making Olmstead claims only, and not being necessarily dependant upon claims about conditions of the institution. DOJ has taken a much more aggressive attitude in enforcing the ADA and Olmstead decision as a matter of civil rights. In the past two years, for example, DOJ has entered in to settlement agreements with Oregon and Rhode Island to ensure that these states are providing work programs and daytime supports in the most integrated settings.

Another example of the new federal attitude and perspective is the recently (2014) promulgated rulemaking by the US Centers for Medicare and Medicaid Services (CMS) regarding its Home and Community-Based Services (HCBS) program. These new rules are designed to ensure that individuals receiving long-term services and supports through home and community based service (HCBS)

programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. These new requirements also establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences. The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting.

Despite these efforts, however, states across the country have continued to struggle mightily in their attempts to keep up with the rapidly growing need for community integrated supports and services. Collective lists of people nationally waiting for services are measured in the hundreds of thousands. Many states, including Nevada, are facing unprecedented budget problems and deficits at levels never experienced before. Competition for any available funding is fierce. In some states, current services are being reduced. In others, new services are only made available to people who are in a crisis situation. Sadly, some states are now admitting people into institutions that are appropriate for community services because "that's where the money is." There are, however, many pockets of notable progress across the country.

What does the Olmstead decision mean for states?

Olmstead is often misunderstood by the public to have many different meanings. Some see Olmstead as an entitlement to community services. Others see it as a Medicaid requirement for states to maintain a "continuum" of residential services and supports. In most states, however, the impetus of Olmstead has resulted in: 1) fewer people with disabilities being admitted to public and private institutions; 2) substantial growth in community residential and non-residential services and supports and; 3) reductions in the number of people with disabilities in public and private institutions. Many of these changes are the direct result of statewide collaborative planning. In some instances these changes were the direct result of litigation, or the threat of litigation.

The Olmstead decision made it quite clear that, under Title II of the ADA, states have an affirmative responsibility to operate programs and provide services in a manner that ensures that people with disabilities receive services in the most integrated setting appropriate to their needs. The Olmstead decision established this integration premise as a minimum standard and benchmark for publicly supported programs. The Olmstead decision also established a firmly grounded expectation that states have a clear and unambiguous responsibility to assist people with disabilities in transitioning from segregated settings to community supports.

The Consultant has visited twenty-three states and reviewed their activities pursuant to Olmstead. Although it is clear that much has been accomplished as a result of these activities, it is also clear that no state has completely fulfilled its obligations under Olmstead, to serve people with disabilities in the most integrated setting in accordance with individual need. In many instances, states are working diligently to serve some segments of the disabilities groups while almost ignoring others. In other states, funding problems and state budget deficits have compelled them to curtail previous planning actions due to lack of resources.

Over the past 15 years, federal agencies have provided states with several new funding mechanisms and tools to assist people with disabilities in the community. In order to utilize these tools, however, the state legislative branch, as well as the executive leadership within the state, must work together to embrace the fundamental principles and commitment to community that Olmstead requires.

Overall Findings

Since the beginning of the development of its *Strategic Plan for People with Disabilities* fifteen years ago, in 2000, it is the opinion of the Consultant that Nevada has been one of the leading states in the country in its commitment to Olmstead. It is important to note here that the development of this plan is not the primary reason for this opinion. More important , was the continuous diligence of the state to implement the plan and, when necessary and appropriate, to modify the plan to achieve its primary goals and objectives. Throughout the full ten years of plan life, close attention was given to implementation strategies and achievement of its objectives. The Consultant believes that this is exactly what the US Supreme Court intended when they indicated compliance might be demonstrated through the development of a "comprehensively working plan to increase community based services and reduce institutionalization, and by ensuring that waiting lists for services move at a reasonable pace.[2]"

Like many states, Nevada found many barriers to implementation of it plans and promoting integration of people with disabilities. Funding constraints and biases, regulatory barriers, local political considerations and disparities between geographic regions have often interfered with solid plans and intentions. These barriers notwithstanding, however, Nevada has indeed taken the Olmstead mandate seriously. It is clear that most of the goals and action plans led to the reduction of unnecessary institutionalization and maintaining many people in community settings.

Paradoxically, Nevada historically allocated few new resources for people with disabilities. One positive result of this history is the fact that significant resources were not allocated to statewide institutional care as had been the case in many other states. As a result Nevada did not need to "undo" a large system of institutional care. On the negative side, this situation also required Nevada to

[2] US Supreme Court (1999) Olmstead v. L.C. (98-536) 527 U.S. 581

provide new funding and structural resources to support the much needed growth in community service. The strategy of shifting resources from institution to community, used by many states, was not a viable one for Nevada. Below are more specific findings of strengths and areas of concern as well as corresponding recommendations designed to address the needs to more fully comply with the Olmstead requirements.

Strengths in Nevada

With an overall population of 2,839.098 people,[3] Nevada is the lowest (50th) of federal per capita spending of any other state at $7,580.[4] Yet, despite this low spending rate, Nevada is among the leaders in the country in minimizing unnecessary segregation.

With regard to people with developmental disabilities for example, Nevada has continued to reduce the number of people in institutional settings. Between 1988 to 2014, Nevada reduced the number of people in facilities larger than 16 people by more than 70%, which is a higher than average rate nationwide. Today, Nevada has fewer than 50 people with developmental disabilities remaining in one remaining state facility. Conversely, the number of people with developmental disabilities living at home, or in small community homes, increased by more than 700% during the same period[5]. Nevada is heading in the direction to be an institution-free state for people with developmental disabilities. There are currently only 13 states, most of which have a smaller population base than Nevada, in that category currently.

For adults with mental illness, Nevada also has among the nations lowest number of people in public long term psychiatric hospitals and other large

[3] Resident estimated populations as of July 1, 2014, US Census Bureau
[4] US Census Bureau, Consolidated Federal Funds Report for Fiscal Year 2014.
[5] Lakin, K.C., Larson, S.A. , Salmi and Scott, *Residential services for persons with developmental disabilities: Status and trends through 2012*, University of Minnesota, 2014

institutions. The average length of stay at state hospitals remains among the lowest in the nation. There are also continued efforts to reduce the number of long term hospital beds statewide.

For people in nursing facilities, Nevada has a proactive program to identify people who want to live in the community, as well as a support system to assist them in moving to the community. Through a collaborative effort between the Centers for Independent Living and the FOCIS program, hundreds of people with disabilities statewide have transitioned from nursing facilities to the community over the past ten years.

The positive indicators listed above are attributable to several factors. First and foremost has been the planning activities developed over the past 15 years that focused heavily on increasing community capacity and the reduction of the size of institutional settings. This success is not just attributable to the planning documents themselves, but, most importantly, to the commitment of the state to implement the plan and, in many instances revising the plan to address specific needs as they change. The wisdom of the planners to continue with the Strategic Planning Accountability Committee (now the Nevada Commission on Services for Persons with Disabilities) has made a difference, which is unmatched in most state Olmstead plans and plan implementation.

Areas of Concern

Statewide Understanding of Olmstead

While some of the stakeholders demonstrated a clear understanding of Olmstead during the review, many did not. Olmstead remains to be one of the most misunderstood US Supreme Court decisions and has often been used to support different social agendas. In interviews with various stakeholders across the state, the understanding of Olmstead and its requirements were varied and inconsistent. It is important for state policy makers, as well as advocacy organizations, to have a clear understanding of Olmstead and the integration mandate.

Also, it is clear that public human services agencies conduct informal self evaluations of Olmstead compliance, but most do not. It is important for the decision makers to be proactive on an ongoing self assessments to ensure that the ADA integration requirements are being followed, and when they are not, take steps to remediate the situation.

People with Disabilities Living in Institutions in Nevada

As stated earlier, Nevada is among the states with the lowest per capita number of people with disabilities in long-term public institutions. There are still many Nevadans with disabilities, however, who may be unnecessarily in large private institutions. These include private nursing facilities and out-of-state placements.

Primary Barriers to Increasing Community Capacity

The Consultant found the primary barriers to expansion of community capacity for people with disabilities to include deficiencies, or lack of adequate quantity in at least the following areas:

1. **Lack of Available and Accessible Transportation -** Transportation was, by far, the number one concern expressed by people with disabilities and their families as a barrier to accessing the community. This sentiment was expressed across the state and in urban, suburban and rural settings. Reported problems included non-accessible vehicles, limited bus routes, Para-transit schedule limitations and overall unreliable bus services.

2. **Lack of Affordable and Accessible Housing -** A large number of adults with disabilities expressed the need to expand affordable housing opportunities. In some instances, funding for services and supports was available, but the lack of housing resulted in the individual staying in a nursing facility or another in appropriate setting.

3. **Inadequate Employment Supports and Opportunities -** Among young adults with disabilities, particularly those who recently left the school system, this was a widely reported problem. This includes the need for supported employment funding, as well as job training and job development supports.

4. **Lack of Community Behavioral Health/Psychiatric Supports Capacity** This problem was reported as particularly acute in rural and frontier regions, but was listed as a concern statewide.

5. **Growing Waiting Lists that Move Slowly -** Many people reported that funding for community supports was made available, but there was no service provider who was willing to support the individual.

6. **Insufficient Person-Centered Planning Supports -** There was broad concern that there is a lack of infrastructure and support to implement the person-centered planning that is now required by Federal rules.

7. **Shortage of Skilled Staff and Clinicians -** Families reported an insufficient supply of Home health aides, personal support professionals, nurses and physical therapists, even when funding for these services is available. Reportedly, this shortage of help is particularly problematic.

8. **Lack Community Dental Supports -** This problem was reported statewide and focused on the unwillingness of community dentists to accept Medicaid and, in some instances, treat a person with severe disabilities.

9. **Shortage Sign Language Interpreters and other Supports for People who are Deaf or Hard of Hearing -** Many deaf adults simply cannot access the community and are significantly isolated without the needed communication and other ancillary supports.

10. **Lack of Specialized Services to Children and Adults with Autism -** Many families of children and adults with Autism expressed frustration with how few specialized services are available for this rapidly growing population.

11. **Insufficient Services for People who are Blind or Visually Impaired -** These services include orientation and mobility training, assistive technology, transportation, life skills and employment.

12. **Proposed possible budget cuts!** The Consultant has reviewed several documents describing significant, and, in some instances, devastating budget cuts for the upcoming biennial cycle. While it is impossible to measure the impact of these budget cuts until they are finalized, it is clear that, if enacted, these budget cuts will have a significant negative impact on providing adequate supports for people with disabilities in the community.

    Since the specific proposed budget cuts have not yet been finalized it is not possible that any specific analysis can be conducted at this time. The Consultant recommends, therefore, that the Olmstead Subcommittee keep a vigilant watch on the state budget, and its implications, and maintain this review as part of the ongoing planning process. The likelihood of any major positive change in the budget crisis over the next several years is small. It appears that the Committee has already given the budget cuts a high priority. The Consultant recommends that its impact on compliance with Olmstead and the ADA be considered on an ongoing basis.

Recommendations

As stated earlier, Nevada has maintained a statewide commitment to follow the basic tenants of the ADA and Olmstead decision for the past ten years. As a result, the overall picture of residential supports in the most integrated setting is positive, especially in comparison to the rest of the country. The state of Nevada should be congratulated for its accomplishments in this regard.

That does not mean however, that 100% compliance has been achieved. There is still much to be done. The following recommendations are offered to support continuous improvement in offering services and supports in the most integrated setting consistent with the ADA and Olmstead.

Recommendation #1: Nevada should develop at 10-year community integration plan for Nevadans with disabilities and those with age-related conditions. The plan should include:

- Gubernatorial and Legislative Support
- Statewide Comprehensive Stakeholder Involvement
- Measurable Strategies and Outcomes
- Long-Term Budget Assumptions and Projections

Recommendation #2: Nevada public agencies should establish an internal mechanism to evaluate ongoing compliance with Olmstead and the ADA integration mandate.

Recommendation #3: Nevada should develop policies and oversight mechanisms for waiting lists prioritization and corresponding reasonable pace standards.

Recommendation #4: Nevada should develop mechanisms to directly engage consumers and families in planning and designing supports.

Recommendation #5: Nevada should conduct a specialized needs assessment in rural and frontier areas in order to identify services gaps in these areas, and develop a plan to address these gaps.

Additional Recommendations and Service Gaps

1. Eliminate all inappropriate out-of-state placements by seeking remedies to keep people in the least restrictive setting that is person centered. Each case where a person is placed out-of-state, such as a person with mental health or behavioral health issues, should be reviewed quarterly with the intent the person will return to a local community placement.

2. Services and support are provided at the time the service need is identified. Providing services and supports early will prevent or delay the costly chronic illnesses which develop when individuals are forced on lengthy wait list.

3. "Resources available" is not adequate reasoning for not funding state services to keep from placing people in the most restrictive settings.

4. Wait Lists need to move at a reasonable pace, accessed frequently, and across all demographics.

5. Budget cuts that force institutionalization are discriminatory. Eliminating services without ensuring sufficient alternative services are available that will place people at serious risk of institutionalization is an Olmstead violation. (Darling v. Douglas – 09-CV-3798 (N.D. Cal. 2009)

6. Increase the number of providers skilled with caring for individuals with high need. Adjust the reimbursement level based on the needs of the individual.

7. Elimination of Medicaid services because they are optional in the state plan that put people at risk of institutionalization is an Olmstead violation. (Hiltibran v. Levy – 10-CV-4185- W.D. Mo. 2010)

8. If one is living in an institutional and they are able and agree to transition to a community setting, efforts must be undertaken. (Lee f. dudek – 4:08 – CV – 26 – (N.D. Fla. 2008)

9. Support the development of affordable, available housing for all populations. Both temporary and permanent supportive housing must be obtained and maintained especially for persons with mental illness.

10. Increase the Evidenced-Based Practices available across Nevada. This will require the collaboration of licensing boards and higher education to work with community to expand the number of persons skilled in the delivery of evidenced-based practices.

11. Develop multiple types of programs that allow a person to receive the level of service required without being placed in a nursing facility. Acute psychiatric hospitals are meant to be

temporary; a drop down program would allow individuals to receive support while they recover.

12. Establish a statewide workgroup to ensure planning, support, and evaluation of on-going efforts to address community integration to include individuals with behavioral health disabilities.

13. Request technical assistance from SAMHSA to ensure efforts to address BH within State Olmstead Plan is consistent with other states.

14. Develop an environmental survey to determine the strengths and challenges in implementing community integration precepts within the community behavioral health system of care across settings including residential, educational, employment/vocational, recreational, treatment, and support settings. Include individuals with lived experience, family members, providers, policy makers, and community stakeholders.

15. Coordinate efforts with Medicaid to ensure equal access to Long Term Services and Supports (LTSS), habilitation, and rehabilitation services and supports available under the current state plan to assist individuals to live as independently as possible in their communities and prevent unnecessary institutionalization. Disseminate knowledge about access to LTSS, habilitation, and rehabilitation options to community providers, individuals needing services, and family members/primary support providers.

16. Promote core concepts of cultural competency, person-centered care planning, and trauma-informed care across the behavioral health field and continuum of care.

17. Support local and regional efforts to develop and provide individuals with behavioral health disabilities opportunities for meaningful participation in their communities.

18. Support the Governor's Office to assure the Insurance Division has sufficient authority to oversee and enforce parity in employer sponsored plans.

19. Assure that Medicaid takes steps to enforce parity in any managed care contracts.

20. Develop a program for individuals who are blind or visually impaired which supports adaption to living and working in integrated community settings. This is a major service gap in Nevada and will require a commitment in funding, service types and supports for all ages.

21. Address the communication needs for individuals that are Deaf or hard of hearing. The needs for individuals living with a hearing impairment must begin early and continue across the lifespan to address the changing needs of the person. This will include the development of highly trained educators and communication specialist, interpreters and medical providers. A

special emphasis must be made to educate the public on communicating with individuals who are Deaf and/or hard of hearing.

22. Support the implementation of the system of care for Nevada's Children's Mental Health system. Create outcomes to ensure services and supports are available in the most integrated setting based on the needs of the individual child and family.

23. Support a comprehensive supported employment program across all disability groups.

24. Implement a No Wrong Door approach to service access. Assess the needs of the individual and wrap all needed services around the person and their support system.

25. Assure that all services and supports available in the Nevada system of care support the needs of veterans. This includes medical, mental health, work supports, housing and life skills.

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   The State of Nevada's Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) provides a wide range of services for children, youth and families in Nevada.

   DCFS program areas include Rural Child Welfare, Youth Parole, as well as Children's Mental Health Services. DCFS also provides severely emotionally disturbed children and youth direct services as well as oversight for the programs administered at the state and county level. In recognizing the important role the State has to protect and provide services to Nevada's vulnerable children, the Governor and Legislature passed and enacted Nevada Revised Statute (NRS) 433B to provide additional provisions related to children. NRS 433B mandates that any county, whose population is 100,000 or more establish a Mental Health Consortia. Nevada's vast geographic area required that a consortia be created in Washoe County (Reno/Tahoe), Clark County (Las Vegas and area), and Rural Nevada (15 of 17 Nevada counties in rural/frontier Nevada). Each consortium is mandated to include partners from the local, county and regional level including school districts, chambers of commerce and business community, state agencies, juvenile probation, community behavioral health care providers, foster care providers, a parent of a child with an emotional disturbance, substance abuse agencies, advocates and provider organizations.

DCFS serves as Nevada's Mental Health System of Care (SOC) expert and manages Nevada's Children's Mental Health System of Care Subcommittee as part of the Governor's Wellness and Behavioral Health Council. Nevada is committed to statewide implementation to create sustainable infrastructure and services as part of the Children's Mental Health Initiative (CHMI). The State of Nevada was recently awarded the Substance Abuse and Mental Health Services Administration System of Care- Expansion and Sustainability Grant for youth with Serious Emotional Disorders. This grant will support efforts to further establish and monitor a comprehensive system of care for seriously emotionally disturbed children, youth and their families as well as young adults, who age out of the foster care system in Nevada. Nevada's focus of the SOC expansion and sustainability is to improve mental health outcomes for children and youth (birth to 21 years of age) with serious emotional disturbances (SED) and their families.

To strengthen Children's Mental Health Services, Nevada's plan focuses on prevention and treatment and builds on SAMHSA's Theory of Change. Nevada shares the fundamental belief that prevention, early intervention and treatment for SED, and appropriate family, peer and support services are essential components of a system of care and impact and improve the quality of life. The Nevada Strategic Priorities, as evidenced through the Clark County, Rural and Washoe County Children's Mental Health Consortium Strategic Plans and the Nevada Children's Mental Health System of Care Subcommittee align and ensure a wide range of activities, programs, results- oriented and evidence-based goals are in the SOC.

DCFS will ensure Nevada's children and families benefit from evidence informed services and supports that are delivered within a SOC framework by assuring coordinated, accessible, community-based, individualized services that are culturally and linguistically competent. DCFS will provide infrastructure and sustainable funding for services by establishing standards, setting policy and monitoring quality of care. This will require programs to integrate mental health, social services, educational, health care, substance abuse, vocational, recreational and juvenile justice services when necessary for each client. Nevada's plan for a SOC is an organizational framework for system reform based on strategic plans of behavioral health initiatives across the State. Nevada's program activities focus on community-based services that are delivered at a local level; family driven and youth guided; culturally and linguistically competent; individualized and strength based; with measures and metrics that ensure the SOC is data driven and accountable.

Nevada's plan emphasizes expansion and adoption of the SOC approach through dissemination of training and knowledge that focuses on capacity building and implementation of programs to ensure SED youth and their families are engaged in effective services and have greater access to innovative and evidence based, trauma informed practices. The Nevada plan incorporates workforce development, governance and accountability for publicly funded children's mental health providers and maintains the safety net for those youth who are uninsured, underinsured, or undocumented. The plan relies heavily on technical assistance, collaboration with stakeholders, consumers and community partners and rigorous evaluation and quality assurance. Statewide adoption of the proposed activities will result in unprecedented changes in how funding is utilized to develop an effective SOC for children's mental health services in Nevada.

Nevada's framework supports SAMHSA's Theory of Change through an expansion and improvement of policy, both administrative and regulatory, focused on the gaps and needs assessments that turn strategic plans into widely adopted action plans. This supports the expansion of services and supports at the community and local levels, based on the SOC philosophy and approach and targets SED youth ages 0-21. Nevada's established teams will utilize evidence-based practices, enhanced youth and family support networks, direct and community service providers to provide training, technical assistance and coaching to ensure continuity and expansion of services.

To enhance the workforce throughout the state, DCFS has collaborated with the University of Nevada, Las Vegas and direct service providers to identify and develop curriculum for behavioral health providers. DCFS will continue to collaborate to align mental health training with community, technical, and the State University system to develop comprehensive programs for training, infrastructure development, and workforce expansion

Innovative programs that have been developed to enhance the System of Care include addressing the need for a system of early mental health identification. The First Episode Psychosis (FEP) model has been developed and is ready to begin serving families in Clark and Washoe Counties. Nevada has also successfully implemented Mobile Crisis Response Teams in northern and southern Nevada. This program has resulted in fewer youth being hospitalized and instead acts as a "no wrong door" avenue to access stabilization and other services at lower levels of care. Further evaluation of these services and outcomes will support the identification of technical assistance and supports needed at all levels of service delivery.

Outreach, collaborative efforts, and support from stakeholders and community partners will ensure backing at all levels of government for the SOC structure. This will facilitate change in financial strategies and result in blended and expanded funding streams.
Monies can be utilized more efficiently since the services will be in place to address the needs of SED youth at less costly lower levels of care. Furthermore, DCFS Children's Mental Health transitioning to the children's mental health authority rather than primarily a direct service provider will allow for more accountability and oversight in the care that children receive from publicly funded community providers. Policy development and procedural changes and the proposed activities in this application will result in a transformation of Nevada's children's mental health services. This will reduce the percentage of children that are provided direct services from DCFS and create a Statewide Children's Mental Health Authority, allowing DCFS to oversee quality

improvement and quality evaluation strategies with the support of an outside evaluator to maintain integrity of the data and supports.

Ultimately, the goal is to work to support the SOC through training, evaluation, utilization management, and quality assurance accompanied by widespread dissemination of system of care values and principles which will lead to effective, qualified children's mental health providers in the jurisdictions targeted. Nevada's plan emphasizes dissemination of training and knowledge of system of care and focuses on capacity

building and implementation of programs so that SED youth and their families are engaged in their services and have better access to innovative, culturally and linguistic appropriate services and evidence based, trauma informed practices.

The goals and strategies of the DCFS plan are as follows:

Policy Leadership & Support
Goal 1: Generate support among families and youth, decision policy makers at state and local levels, providers, managed care organizations and other leaders to support expansion of the SOC approach, including transitioning DCFS from a direct care provider to an agency that primarily provides planning, provider certification, utilization management, oversight and quality assurance.

Through existing efforts in Nevada, the project team will continue to reach out to policy leaders at the state and local level to support policies and practices that create a collaborative network of fiscal and program supports for a comprehensive SOC for youth ages 0-21. With competing priorities and limited resources, a SOC framework ensures the system has the ability to address the most disadvantaged in the community. These strategies and goals will work to advance the SOC in Nevada and engage policy makers at all levels.
• Nevada will synthesize the regional strategic plans by incorporating the Clark County Children's Mental Health Consortium, the Washoe County Children's Health Consortium, and the Rural Children's Mental Health Consortium Strategic Plan 10- Year Strategic Plan into one collaborative document building on the strengths, practices and lessons learned in each region (such as telemedicine for rural families) for SOC Statewide Plan.
• Nevada will implement identified strategies into action plans to increase opportunities for home, community and school success for children with disabilities, including those who are at risk for or who have serious emotional disturbances (SED), their families and service providers, through education, encouragement and empowerment activities through a statewide communication plan.
• Nevada will expand existing state and local level youth support systems to more widely incorporate value-based decision making to strengthen capacity of youth leaders to inform policy and practice.
• Nevada will develop memoranda of understanding to promote flexibility and access to needed services and develop a "no wrong door" approach.
• Nevada will implement a Quality Improvement Program (QIP) to ensure all outcomes are evaluated at the individual, agency and system levels to measure the quality of care, access and any potential gaps. Evaluation and grant monitoring efforts will impact decision-making and creation of policy for the SOC.

Develop and Evaluate Blended Funding and Resources State-wide
Goal 2: Maximize public and private funding at the state and local levels to provide a SOC with accountability, efficiency, and effective statewide funding sources, utilizing blended funding sources and repurposing state and local funds spent on inpatient services for use on community-based services.

• Develop and implement a statewide financing plan to blend funds to provide long- term support for the expansion and sustainability of a statewide SOC approach.
• Implement strategies for policy change as identified through statewide strategic plans and priorities to enhance SOC implementation by maximizing existing revenue sources including the Medicaid; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); 1115 waiver, state block grants and general funding, as well as local and regional funding.
• Identify opportunities for new revenue funding sources for SOC implementation, including Medicaid waivers, private and public health insurance, philanthropic foundations, corporate partnerships, social impact bonds, and other grants or collaborative agreements.
• Repurpose funds currently being used for the State Children's Psychiatric Hospital/Residential Treatment Center to expand non-institutional services in the community.

Increase Readiness to Enhance Implementation and Sustain the SOC Framework.
Goal 3: Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and supports consistent with the system of care approach

• Facilitate and expand community infrastructure through service providers as part of implementation strategies to provide technical assistance and education at all levels of care.
• Target the most disadvantaged populations to advance the SOC readiness and development through dissemination of information and publications.
• Provide mobile crisis intervention and stabilization services to youth in crisis at risk for costly acute and long-term placements.

• Enhance partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health needs; and provide preventive services for those identified with high risk factors.
• Adopt and increase workforce practices that ensure Nevada has the right people, with the right skills, at the right times for evaluation, goal setting, supervision, mentoring/coaching, professional development, training, recruitment, retention, selection, performance appraisals, developing decision making teams, and ensuring organizational readiness. These will build the infrastructure to support Nevada's system moving towards improved services.

Effective Services through Cultural and Linguistic Competence
Goal 4: Expand evidence-based services and supports in Nevada based on the SOC approach, creating a delivery model focused on First Episode Psychosis (FEP) and peer-to-peer, family-to-family, and child-centered care ensuring linguistically and culturally responsive service.

By geographical size, Nevada is the 7th largest state in the nation with a large majority of the state including vast and sparsely populated frontier areas. Although Nevada is not yet a majority-minority state, Nevada has a minority population of 42%.[1] In 2014, 88 percent of the state's population resided in Clark and Washoe Counties.[2] The adoption of linguistically and culturally competent programs promotes family-centered values and decision-making. Services will be responsive with an awareness and respect of values, beliefs, traditions, customs and parenting taking into consideration the specific language, literacy ability, and communication preference of families.
• Establish a culture of collaborative inquiry, shared language and resources for the diverse population in the state of Nevada. Nevada will review all assessment instruments and identify methods and procedures for ensuring that all children will be assessed consistently, regardless of their language, culture, or disabilities, and that the tools provide useful information for fostering development and learning.
• Further enhance the infrastructure to support culturally diverse peer support services for youth and family through training, policy, accountability, and community health services.
• Expand non-traditional services for children with mental health challenges and their families, to include: Behavioral health workers, language services, respite care, family to family support, peer to peer services, transportation and FEP Teams.
• Provide program development, financing and workforce training to expand services and supports for youth transitioning to adulthood.
• Support the implementation of culturally and linguistically competent organizations to serve children, youth and families, by supporting promising practices within communities that address the social-emotional development for youth and young adult populations.

Accountability in Services, Data Collection, Evaluation and Outcomes
Goal 5: Establish an on-going locus of management and accountability for systems of care to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels.

• Define and develop effective data measures and key indicators of the children's mental health system to monitor strengths, needs, outcomes, and trends to be used by local and state decision-makers.
• Involve families and youth in developing evaluation plans, gathering and analyzing data, and reporting and disseminating information on a central site to maximize transparency.
• Strengthen collaborative capacity to ensure continuity in reporting to track and monitor outcomes across child serving systems to understand multi-system impacts and identify gaps.
• Identify and increase the use of evidence-based, strength based models and valid measurement tools for child outcomes and provide training for continuity of use.

[1] Healthy People Nevada, 2010-2020
[2] http://nvdemography.org/wp-content/uploads/2011/05/Clark.pdf

• Increase the use of technology to support data management, information sharing and coordination of services to ensure continuity and consistency within the SOC at all levels from birth to age 21, including collaborations with school-based programs.

Established Guidelines for Individualized Care Planning: The SOC has established guidelines for individualized care planning for children and youth. Upon entering treatment, each child and their caregiver/family undergo a series of standardized structured intake assessments designed to evaluate their individual needs for clinical care, case management, and family support. Following the assessment period, the case manager convenes a child and family team, which consists of the child, the family, family support specialist, other providers, and any other people chosen by the child and family.

The child and family team then collaborate to produce an integrated Care Coordination Plan that addresses each child and family's unique needs via a series of treatment goals. All team members, as well as the child and family, sign the Care Coordination Plan to indicate that they agree with the course of treatment and are committed to working together to achieve the goals. The Care Coordination Plan is reviewed and updated every 90-days and at discharge. These individualized care planning guidelines

will remain in place as the SOC expands to serve more children statewide and will also function as a template for policy as DCFS assumes responsibility for oversight of community providers of mental health/substance use treatment.

The purpose of the Nevada State collaboration is to provide coordinated, accessible, community-based, evidence-informed, individualized services that are culturally and linguistically sensitive through community-based mental health programs, statewide. The importance of and need for increased interagency coordination and a SOC is demonstrated by the gap of mental health services available and/or being utilized by the population aged 0-21. Many children and youth access the mental health system through
various doors including the school system, child welfare, the juvenile justice system, non- profits, pediatrician's offices, and emergency rooms. The continuum of care is currently a fragmented system that poses significant coordination and access of care issues that are funding and policy based, and not family or "person-centered." The systems that serve children, youth and families have become increasingly more complicated, increasing the need for coordination, collaboration and case management to reduce duplication of effort, enhance continuity of care, ensure optimal performance, track outcomes and access across multiple provider systems, and maximize limited fiscal resources.

Training in SOC principles, evidence-based practices, and trauma informed approaches will be enhanced with the implementation of the Nevada SOC and quality improvement measures, which include evaluation and improvement. Nevada will focus on prevention and recovery as well as expansion of innovative programs to improve outcomes for youth experiencing the onset of serious behavioral health disorders, such as programs targeting youth experiencing a first episode of psychosis. Collaborations and coordination with adult-serving agencies will also be a focus to improve transition services for young adults no longer eligible for services through the child-serving system of care. All of these goals focus on a SOC that diverts children and young adults from psychiatric inpatient

and residential treatment facilities, while at the same time achieving positive clinical and functional outcomes through the use of community and direct care service provider supports from family, peer, and community. In addition, Nevada seeks to reduce out-of - home and juvenile correction placements.

Established Collaboration with Child- and Youth-serving Agencies Addressing Behavioral Health: In the state of Nevada, child welfare, juvenile justice, and children's mental health are integrally connected due to the unique structure of its Division of Children and Family Services agency. DCFS has three branches covering the three main child-serving areas of mental health, juvenile justice, and child welfare. The Deputy Administrators overseeing each branch collaborate closely to ensure the service needs of children and adolescents are adequately met, State resources are appropriately allocated, and gaps in the system are addressed. The State is also working closely with the education system to better serve youth who may seek services primarily in a school setting. Planning is actively underway for the creation of school-based health centers, which will provide integrated primary-behavioral healthcare. Additionally, the State- provided Children's Mobile Crisis Response Teams that respond to schools in the Washoe County and Clark County School Districts on a daily or near-daily basis to serve children and adolescents experiencing mental/behavioral health crises at school. DCFS is working actively with the Department of Healthcare Financing and Policy (State Medicaid) to expand the number of providers available for children's mental/behavioral healthcare, including making DCFS a provider for managed care organizations statewide. Finally, DCFS Planning and Evaluation Unit staff provide support and technical assistance including training to Specialized Foster Care providers statewide.

In some of the Southern Nevada DCFS Neighborhood Care Centers and Family Service Centers, Clark County Department of Family Services Child Welfare and Child Protective Services staff are co-located with DCFS programs. This collaboration serves to streamline communication and facilitate services for families. Washoe County Social Services actively collaborates with DCFS in training and initiatives such as Wraparound expansion. Washoe County Social Services and Clark County Department of Family Services are represented on the statewide consortium as well as their local consortia and participate on related workgroups of those consortia.

The following community and state organizations are part of the core that developed the state plans for mental health in Nevada and remain engaged in service delivery and policy development across the state: The Children's Cabinet, Department of Public and Behavioral Health, Department of Employment, Training and Rehabilitation (DETR), Suicide Prevention of Nevada, DCFS, Northern Nevada Adult Mental Health Services, Washoe County School District, University of Nevada School of Medicine, Northern Nevada HOPES, Mojave North, Community Health Alliance, Southern Nevada Adult Mental Health Services, Nevada State Office of Rural Health, Clark County School District, PACT Coalition for Safe and Drug Free, Transparent Mental Health, WestCare Nevada, National Alliance on Mental Illness (NAMI), Rural Nevada Hospital Association, Nevada Healthcare Guidance Program, Rural Community Health Services, Nevada Parents Encouraging Parents (PEP), Aging and Disability Services, Washoe

County Social Services, Clark County Social Services, and the State of Nevada Governor's Behavioral Health and Wellness Council (BHWC) which includes judicial, legislative, law enforcement, community, higher education and private individuals across the State of Nevada. DCFS also worked with SAPTA on developing this joint, integrated Block Grant application.

Tracking and Monitoring Service Utilization, Costs and Outcomes: DCFS Children's Mental Health has a Planning & Evaluation Unit with 11.5 FTE responsible for monitoring service utilization and outcomes across all youth mental/behavioral health programs receiving state funding. This includes monitoring risk measures, admission and discharge conditions as well as policy implementation pertaining to the children and youth in specialized foster care. These providers include privately-operated homes

as well as those who are operated by DCFS. Depending upon the program, staff report service utilization and outcome statistics on a quarterly, semi-annual, or annual basis to administrators and other stakeholders. Logic models and evaluation plans guide data collection and analysis.

In addition, DCFS has a statewide Planning and Evaluation Unit that utilizes existing data collection and analysis methods to obtain information on factors collected as part of the Uniform Reporting System for SAMHSA's Community Mental Health Block Grant. In addition, this Unit works to develop and implement statewide policies for children's mental health as well as monitors residential provider's implementation of policies required by licensing bodies. The Planning and Evaluation Unit collects data from residential providers in the community concerning client demographics, length of stay, medication management, crisis management, suicide attempts, discharge and departure conditions and trauma informed training of staff.

The Division of Health Care Financing and Policy (DHCFP) – Nevada Medicaid – also provides baseline data and updates insurance information to ensure that there is no duplication of services; or care being provided for Medicaid eligible recipients. With the implementation of the SOC Grant, and transition of DCFS from a direct service provider to the children's mental health authority, DCFS will provide oversight and governance to children's mental health providers. Data collection methods, evaluation, and reporting will be developed to be able to report the required performance measures to SAMHSA at all levels throughout the state. Information and feedback available from other state, tribal, and local entities as well as stakeholders and community partners will be utilized in addition to federal government resources and technical assistance. In addition, the State of Nevada will also be incorporating performance measures as part of the National Outcome Measurement Systems (NOMS). Nevada currently gathers client satisfaction surveys.

As part of the Child Outcome Measures for Discretionary Programs, Nevada will utilize the Transformation Accountability (TRAC) client-level measures for providing direct services at baseline, 6-month follow up and at discharge. Nevada is committed to ensuring that data is entered into the Common Data Platform (CDP) web system with seven days of data collection. Specific information will be detailed in the reporting: mental illness symptomatology; employment; education; crime and/or criminal justice; housing; access; age; gender; race; and ethnicity; rate of re-admission to psychiatric hospitals; social support; and client perception of care. Nevada has been expanding use of process and outcome evaluation to guide the development of behavioral health services and the system of care. The Nevada system of care is built on: formative implementation evaluation to monitor the process and success of initiating plans and programs, strengths, needs, culture and gaps analysis to determine how well the current system is addressing the needs of children and families in Nevada. Process and fidelity assessments are used to determine if services and system development meet performance standards and expectations. Outcome evaluation is used to determine the effectiveness and cost impact of the services we provide.

Nevada will establish a data subcommittee to identify and confirm key indicators of system and individual outcomes for children with mental health and address any challenges. This will be done by conducting meetings with child-serving agencies and other stakeholders to identify selected factors for system monitoring. The data subcommittee will identify processes and procedures, with assigned tasks for updating the system and dashboard. The dashboard (data and reports) will be available through the DCFS website. This dashboard will be used to 1) identify a system to share data across state child-serving systems for transparency; 2) implement capacity building technical assistance to cross-system data share; and 3) provide technical assistance to other agencies to support an understanding of the available data and processes for accessing and utilizing the data sources. An important overall guiding principle will be the ability to identify opportunities to reduce policy barriers to information sharing across data management systems and providing the opportunity to use technology to enhance service coordination, data management and system of care activities.

By monitoring the quality and fidelity of the service process in terms of the outcomes it produces, Nevada will focus attention on needs of the children and families. By providing data on needs, gaps, service quality and fidelity, outcomes, and costs to decision makers as part of the ongoing planning process we will achieve better outcomes for children, families, and communities. Evaluation efforts will be centered in the DCFS Planning and Evaluation Unit (PEU). Evaluation staff will work with managers, families, and providers and other stakeholders to develop an integrated data collection plan for measures identified through the system of care. This will build on the data collection that is already ongoing through DCFS staff and the Clark County, Washoe County and Rural Mental Health Consortia. The focus will be for data collection that is integrated within the normal flow of work and documentation and a sampling of this data for verification purposes. Nevada will ensure that information and data is collected by the PEU and provided to the outside evaluator. An outside evaluator with experience in assessing the performance, data measures and compliance with programs will be hired through the MSA process.

Outcomes are evaluated with structured, standardized measures such as the Child and Adolescent Functioning Assessment Scale, Child Behavior Checklist, Crisis Assessment Tool, Strengths and Difficulties Questionnaire, and other well-validated tools. Additionally, client satisfaction is assessed regularly. Program leaders use the results of regular monitoring and reporting to adjust services to best meet the needs of all youth. This includes identifying workforce development initiatives for staff and potential marketing and recruitment strategies for the agency in order to best serve all populations within our state. Depending upon the funding source, Fiscal personnel within DCFS, as well as Nevada Medicaid, monitor expenditures and utilization across the state.

Social workers in schools: The state created a new office at the Department of Education as of October 1st 2015 called the Office of Safe and Respectful Learning Environments. This office coordinates 11 million dollars of annual funding to place professionals

in schools to help manage and triage mental health and substance use needs. To date over 120 new professionals have been placed in schools. This office also works on reducing bullying in schools and conducts training on anti bullying initiatives across the state and works to build capacity to manage mental health referrals in school systems.

Transitioning Child to Adult Behavioral Health Services, including Foster Care: Typically, age 18 is considered the cut-off in the State of Nevada for receiving behavioral health services in the child/adolescent system. In most cases, non-foster youth referred to mental/behavioral health services for the first time between the ages of 18 and 21 would be assisted in transitioning to the adult behavioral health system. If a youth is already receiving services and remains in high school, he/she would continue to be served within the child/adolescent system, unless on a case-by-case basis it was determined that their needs would be better met by the adult system (for example, treatment plan goals would be better addressed by an evidence-based treatment for adults).

When it is time for a non-foster youth to transition from the child to the adult system, one or more staff members working with the youth, which typically includes a case manager, assist the youth in contacting an intake coordinator at the appropriate treatment site in order to set up an initial appointment per Memoranda of Understanding between DCFS and the Division of Public and Behavioral Health, which houses the behavioral health services for adults. The clinician, caseworker, and other staff members from the child/adolescent service system do not terminate services with the youth until they are confident that the transition is successful. When appropriate, peer or family support is engaged to assist with the transition. Youth who meet eligibility criteria for intellectual disability and related conditions would be referred to the appropriate regional centers within the Division of Aging and Disability.

Foster care youth may choose to remain voluntarily in the child welfare system past the age of majority. There are programs related to independent living as well as monetary support for young adults who have been in the foster care system. Collaboration between child and adult serving agencies, regional center services, schools, and vocational rehabilitation services can assist the youth in transition.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NEVADA CHILDREN'S MENTAL HEALTH **NEEDS ASSESMENT**

OCTOBER 3, 2016

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1. INTRODUCTION AND PURPOSE

There is a growing concern for the lack of mental health services in the United States. Mental health disorders are becoming more prevalent yet are being ignored at the simultaneously, particularly amongst our youth. A mental illness is a condition that can affect a person's thinking, feeling, mood and even their day-to-day functions (National Alliance on Mental Illness, [NAMI], 2015). Such disorders can include (but are not limited to):

* Anxiety disorders
* Autism
* Bipolar disorder
* Depression
* Eating disorders
* Obsessive-compulsive disorder (OCD)
* Posttraumatic stress disorder (PTSD)
* Substance use disorders

Research has shown that 1 in 5 children and youth in the United States have a diagnosable mental health disorder (NAMI, 2015). Figure 1 describes some of these statistics of mental health disorders affecting youth across the United States.

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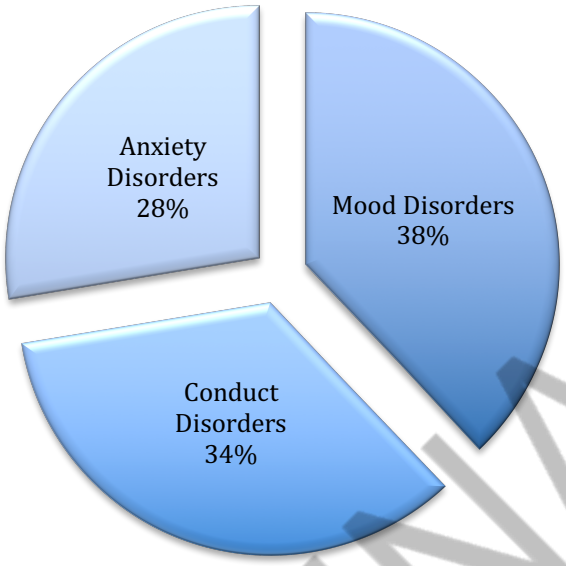
Figure 1. Youth Mental Health Disorders



National Alliance on Mental Illness, Mental Health Conditions, 2015

A recent study done by the Administration for Children and Families, Family and Youth Services Bureau, and the Street Outreach Program, found that out of 875 youth 62% of them experienced symptoms of clinical depression (Whitbeck, Lazoritz, Crawford, & Hautala, 2016). They also found that almost 80% of the participants reported experiencing symptoms of PTSD for more than one month at a time. Violence and trauma are often linked to the development of mental health disorders. During their study, Whitbeck et al., found that 72% of the youth had experienced some form of physical abuse, sexual abuse, or had been a victim of violence at some point in their life (2016).

Studies have also shown that almost 50% of all lifetime mental illness cases begin by the age of 14 and 75% start by the age of 24 (NAMI, 2015). Many mental health disorders go undiagnosed and even if diagnosed: the average delay between the onset of symptoms of an illness and the diagnoses is anywhere between 8 and 10 years (NAMI, 2015). The time between diagnosis and treatment can also be severely delayed. Unfortunately, theses statistics are only becoming more worrisome, particularly in Nevada and Nevada's youth.

Suicide is the *3rd leading cause of death* in youth ages 10-24 and about 90% of cases of suicide in the U.S. are caused by underlying mental illness (NAMI, 2015).

Population of Nevada

Nevada is unique in the fact that the population distribution of the state is very drastic. Southern Nevada has the highest population in Clark County with 2,114,801 people, while Washoe County in Northern Nevada has the second highest population density with 446,903. This report is specific to the mental health challenges facing youth in Nevada but it is important to understand where in the state these populations are and what the distribution of children in the state looks like.

Table 1 is Nevada's population by county with the total population of the county, and the percentage of the state's population that county contains. Table 2 is Nevada's population of kids divided into three areas: Clark County, Washoe County, and Balance of State. Figure 2 is the age distribution of the state, in which it is seen, that kids under the age of 18 makes up almost 25% of Nevada's population.

Table 1: Nevada population by county

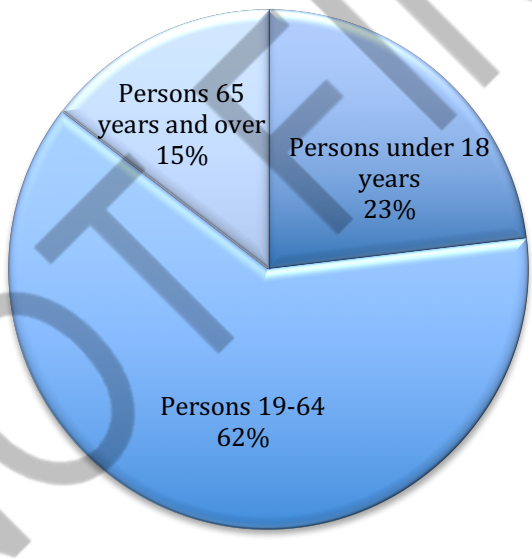
County	Population	Percentage
Carson City	54,521	**1.9%**
Churchill	24,200	**0.8**
Clark	2,114,801	**73.2**
Douglas	47,710	**1.7**
Elko	51,935	**1.8**
Esmeralda	829	**0.03**
Eureka	2,016	**0.07**
Humboldt	17,019	**0.6**
Lander	5,903	**0.2**
Lincoln	5,036	**0.2**
Lyon	52,585	**1.8**
Mineral	4,478	**0.2**
Nye	42,477	**1.5**
Pershing	6,634	**0.2**
Storey	3,987	**0.1**
Washoe	446,903	**15.5**
White Pine	9,811	**0.3**
Total:	**2,890,845**	**100%**

Source: United States Census Bureau, 2015 population estimates www.census.gov

Table 2: Nevada's Youth Under 18

Region	Population
Clark County	500,000
Washoe County	108,975
Balance of State	55,920
Source: United States Census Bureau, 2015 population estimates www.census.gov	

Figure 2: Nevada population, by age



Source: United States Census Bureau, 2015 population estimates www.census.gov

Purpose

The purpose of this project is to specifically focus on the mental health needs of children in Nevada. This report describes the current child population in need of mental health services using area specific data and the problems associated with untreated mental illness.

Unfortunately, Nevada is severely lacking in mental health resources which leads to a lack of data and information for rural counties in the state. Clark and Washoe counties hold the majority of services for those in need of mental health care. For this reason, data provided within this report is divided into three groups: Clark County, Washoe County, and Balance of State.

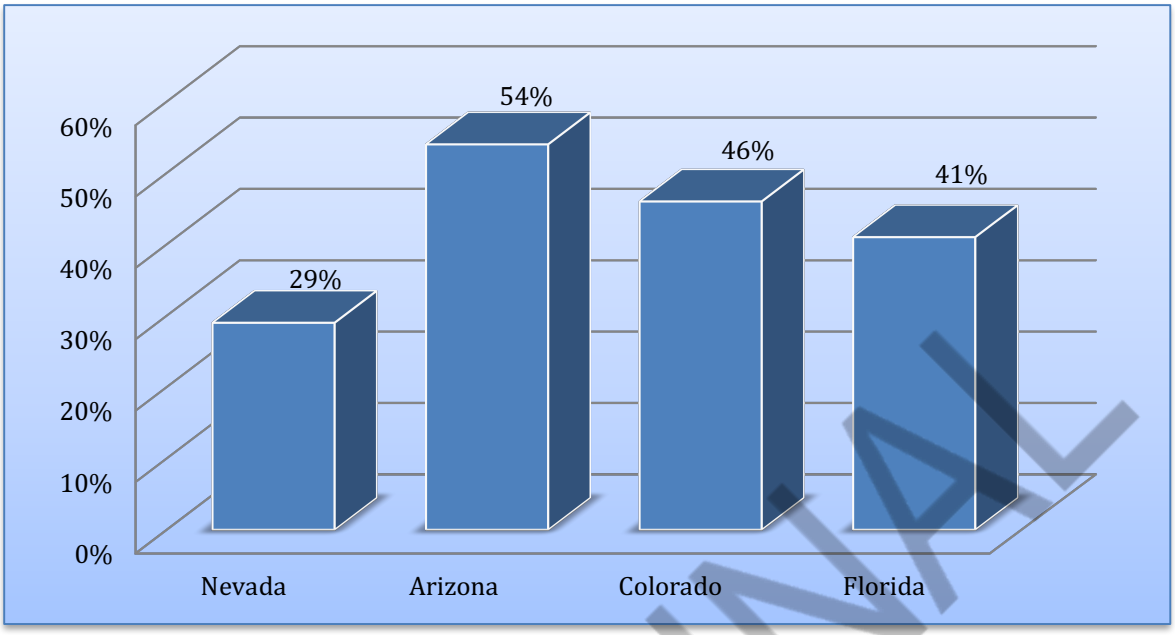
This information is designed to help make policy decisions regarding child mental health concerns in the state of Nevada. National and comparative state best practices are also included with this report.

2. MENTAL HEALTH OF YOUTH IN NEVADA

In Nevada, children with mental health issues are much less likely to receive treatment than children in comparable states (UNLV College of Education, 2014). Nevada has one of the highest rates of major depression and suicide in the nation and ranks 36th in the nation for per capita mental health care state funding (UNLV College of Education 2014). Nevada's mental health budget was also decreased by 23% in 2013 (Denby, Owens & Kern, 2013).

Currently, Nevada is the lowest ranked state (51) for youth with mental illness to lowest levels of access to care (Nguyen, Counts & Mental Health America, 2015). Denby, Owens, and Kern (2013), used Phoenix, Arizona, Denver, Colorado, and Orlando Florida as comparison cities and states to Las Vegas and Nevada. They found that not only does Nevada lack in mental health services but also the rate at which Nevada lags behind is staggering. On average, only about 29% of kids in Nevada will receive the mental health services they need (Denby, Owens, & Kern, 2013). Figure 3 shows the rate at which children with mental health issues receive care compared to Nevada.

Figure 3. Percent of children in need who receive mental health care



(Denby, Owens, Kern, 2013)

Another study found that 7,000 adolescents in Nevada experienced a Major Depressive Episode (MDE) in the last year, however, only 2,200 (31%) received treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

In the last 10 years, Nevada has consistently been in the top five states for the highest suicide rate among residents (UNLV College of Education, 2014). During the 2012-2013 school year, Clark County School District was obligated to implement over 770 suicide intervention protocols due to the rising number of students attempting suicide and showing signs of depression (UNLV College of Education, 2014). Nevada currently ranks 16th in the nation for teens attempting suicide (Children's Advocacy Alliance, 2016).

Clark County

The statistics for youth suffering from mental illness in Clark County generally match the national statistics. Almost 20% of elementary students in Clark County are in need of mental health services (University of Nevada Las Vegas College of Education [UNLV College of Education], 2014). These statistics reflect only those students that were actually identified as exhibiting symptoms; the numbers could be much greater.

Almost 30% of high school students in the Clark County School District (CCSD) reported symptoms of depression.

There are roughly 500,000 youths under the age of 18 in Clark County alone (25% of the population) (U.S. Census Bureau, 2015). It is estimated that in a given year, about 118,900 children in Clark County are in need of mental health services and of those kids about 40,000 suffer from serious mental health and behavioral conditions (Denby, Owen, Kern, 2013).

The Nevada Department of Health and Human Services Division of Child and Family Services found that there are six prevalent issues that children in Clark County experience that either: 1) are caused by mental health disorders or 2) contributes to mental health disorders (2015). These problems are:

1. Child Neglect
2. Depression
3. Suicide Attempt or Threat
4. Parent/Child Problems
5. Physical Aggression
6. Adjustment Problems

Washoe County

"100% of Washoe County residents live in a mental health provider shortage area" (Dinga, Maloy, Aguilar, Spinola & Washoe County Health District, 2015). Washoe County has a population of about 440,00 residents, of those residents 109,000 are under the age of 18.

Statistically, 20% of children under the age of 18 are in need of mental health services, this translates to approximately 22,000 kids in Washoe County that are in need of mental health care. Since Nevada is severely lacking in it's ability to assist youth with mental health issues, only about 6,320 youth in Washoe County are actually receiving services.

Since 2008, Washoe County's suicide rate has been higher than that of both Nevada and the United States. Suicide is the second leading cause of death for 15-44 year olds within Washoe County borders (Dinga, Maloy, Aguilar, Spinola & Washoe County Health District, 2015). In 2013, 34% of adolescents in Washoe County reported feeling hopeless/sad, with nearly 45% of females reporting signs of depression (Washoe County Community Health Needs Assessment, 2015). Approximately 13.7% of adolescents reported that they had attempted suicide in the past year while 22% said they had thoughts of suicide (Gustafson, Kerwin & Gardner, 2015).

When surveyed, Washoe County residents indicated that mental health issues were the biggest issue facing their county. Mental health care has been their top voted need for the past two years. When asked why mental health care is such an important topic, respondents observed that:

* Mental and physical health are intertwined, requiring integrated care;
* There are insufficient mental health providers and inpatient facilities in the state, particularly in the rural counties;
* Affordability of care is an issue; and
* Services like advocacy, case management, and supportive housing are needed to ensure stability (Department of Health and Human Services, Office of Community Partnerships and Grants, 2016).

Balance of State

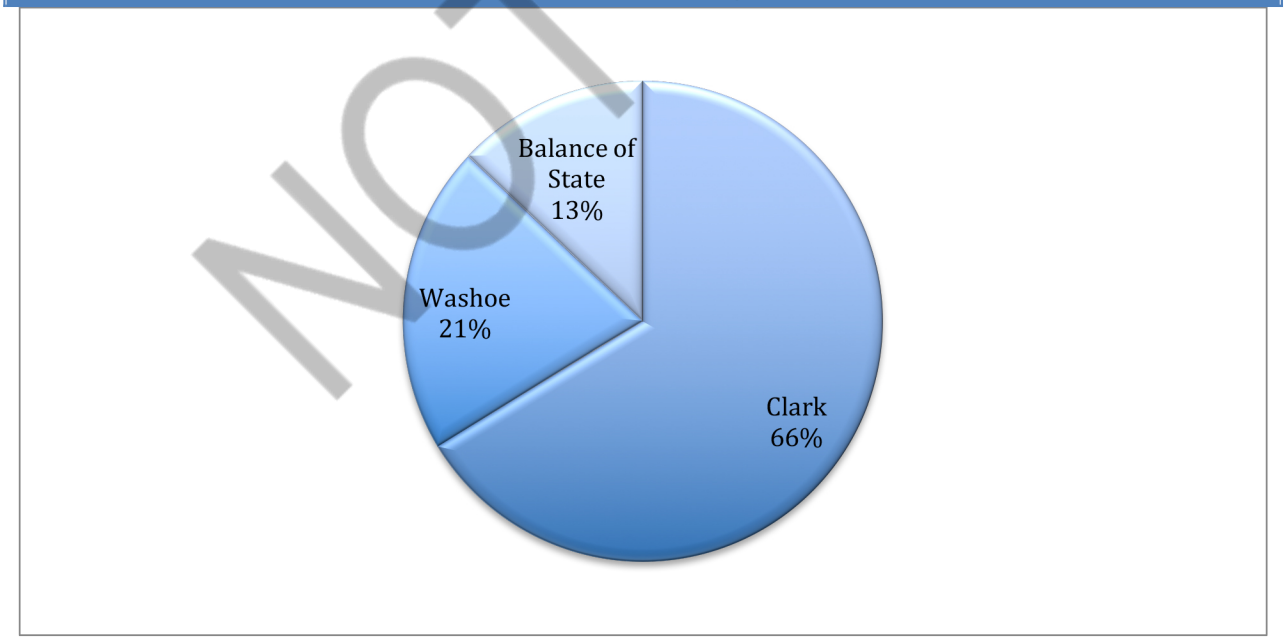
The majority of Nevada's population can be found in Clark and Washoe counties however, there are many rural counties that are often overlooked. There are about 56,000 being youth residing in rural communities in Nevada that are suffering from a lack of mental health care. Using the assumption that about 20% of rural county juveniles are in need of mental health services that equals to about 11,200 kids.

In regards to mental health services, rural communities are struggling even more than the areas that are more densely populated. When looking at the composition of state mental health resources for Nevada, there are only about 50 agencies outside of Clark or Washoe counties. Carson County, where the state capital is found, only has access to XX mental health agencies for youth and juveniles.

3. YOUTH MENTAL HEALTH PROGRAMS IN NEVADA

Both Clark County and Washoe County struggle with access to mental health care for youth but those in the rural areas are almost completely deprived of services. The number of agencies and providers that address juvenile mental health issues is not nearly enough for the number of children that are in need of care. Figure 4 shows the state composition of service agencies in Nevada.

Figure 4. **Youth Mental Health Providers by County**



Appendix D at the end of this report is a list of agencies and providers that specialize in helping juveniles. The list contains not only mental health providers but also agencies that help with social service needs.

Nevada is severely lacking the resources for helping kids with mental health issues. In Clark County there are approximately 302 listed providers that deal with kids and adolescents with mental health issues (www.therapists.psychologytoday.com, 2016). In Washoe County there are about 120 programs and in the rural counties there are about 50 for the entire rest of the state. These agencies include inpatient and outpatient services, addiction and substance abuse specialists, as well as dealing with mental health issues in youth. However, when examined this number of agencies does not even come close to addressing the mental health issues of youth in Clark County. More information can be found in the Gaps Analysis section of this report.

4. MENTAL HEALTH AND HIGH RISK BEHAVIORS

The proper identification of and intervention for mental health issues can directly impact commonly recognized risk factors for delinquency and other high-risk behaviors. These risk factors can occur at the individual (e.g., self-esteem), family (e.g., stressful home situations), school (e.g., peers), and community level (e.g., stability and having stable adults in their life). As the risk factors increase, so does the likelihood of delinquent behavior.

Failing to address mental health concerns in youth when they are young can often increase the likelihood of them engaging in high-risk behaviors during childhood and into adulthood. The juvenile justice system and child protective services are the two agencies that have an overrepresentation of kids with mental health issues for this reason. Figure 5 is a chart to demonstrate how these risk factors are related to behavioral and mental health issues.

Figure 5. Risk Factors for Health and Behavior Problems

Risk Factors for Health and Behavior Problems

Risk Factors	Adolescent Problem Behaviors				
	Substance Abuse	Delinquency	Teenage Pregnancy	School Dropout	Violence
Community					
Availability of Drugs	✓				
Availability of Firearms		✓			✓
Community laws and norms favorable to drug use, firearms, and crime	✓	✓			✓
Media portrayals of violence					✓
Transitions and mobility	✓	✓		✓	
Low neighborhood attachment and community organization	✓	✓			✓
Extreme economic deprivation	✓	✓	✓	✓	✓
Family					
Family history of the problem behavior	✓	✓	✓	✓	
Family management problems	✓	✓	✓	✓	✓
Family conflict	✓	✓	✓	✓	✓
Favorable parental attitudes toward and involvement in the problem behavior	✓	✓			✓
School					
Early and persistent antisocial behavior	✓	✓	✓	✓	✓
Academic failure beginning in elementary school	✓	✓	✓	✓	✓
Lack of commitment to school	✓	✓	✓	✓	
Individual/Peer					
Rebelliousness	✓	✓		✓	
Friends who engage in the problem behavior	✓	✓	✓	✓	✓
Favorable attitudes toward the problem behavior	✓	✓	✓	✓	
Early initiation of the problem behavior	✓	✓	✓	✓	✓
Constitutional factors	✓	✓			✓

Sources: Catalano & Hawkins, Risk Focused Prevention, Using the Social Development Strategy, Seattle, WA: Developmental Research and Programs, Inc. 1995

5. YOUTH MENTAL HEALTH AND SUBSTANCE ABUSE

The connection between mental health issues, substance abuse and addiction should not be ignored. Numerous studies have found that mental health issues lead to substance use disorders (SUDs) (Conway, Swendesen, Husky, He, & Merikangas, 2016; Cotto, Davis, Dowling, Elcano, Staton, & Weiss, 2010; Fryer, Merino, Hirsch, & Porter, 2009; Johnston, O'Malley, Bachman, & Schulenberg, 2008). Conway et al. (2016), found that adolescents with prior histories of anxiety disorders and behavioral disorders were more likely to abuse alcohol and illicit drugs as juveniles than those without history of disorder and more likely to continue use through adulthood. This research concluded that addressing mental health issues is key to preventing drug and alcohol use by adolescents (Conway et al., 2016).

During the Street Outreach Program survey, researchers found that, in the United States, 89% of youth reported having used alcohol at some point in their life, 79% had used marijuana at some point, and 78% had used cigarettes (Whitbeck et al., 2016). Fourteen point five (14.5%) of the participants also reported that they had overdosed at some point in their lives on drugs and had to have medical interventions (Whitbeck et al. 2016).

Substance Abuse in Nevada

Statistically, Nevada ranks among the top states in the nation for youth and adolescent use of substances. In 2009, the United States rate of teens using prescription pain relievers for non-medical uses was dropping, but Nevada's was not. In 2009, it was found that 10% of Nevada's youth were using prescription pain medications on a regular basis and that number is on the rise (Shalin, 2010). The University of Nevada Las Vegas Center for Democratic Culture also found that almost 25% of Nevada's youth had issues with illicit drug dependence or abuse (Shalin, 2010). Table 3 shows the use of drugs by high school students as reported from the 2015 Nevada High School Youth Risk Behavior Survey (YRBS) Comparison report.

Table 3. Nevada High School Student Drug Use

Drug	Percentage of students who have ever tried the drug
Cocaine	6%
Inhalants	7%
Heroin	3%
Methamphetamines	3%
Ecstasy	7%
Synthetic Marijuana	11%
Steroids	4%
Prescriptions Drugs (for non-medical use)	17%
Injectable Drugs	3%

(Nevada High School Youth Risk Behavior Survey (YRBS), 2015)

A 2015 needs assessment identified that Nevada has large groups of people that are in need of substance abuse services including:

* Adolescents with substance abuse and/or mental health problems
* Parents with substance use and/or mental disorders who have dependent children
* Individuals with substance abuse disorders in rural areas
* Women who are pregnant and have substance use and/or mental disorders
* Unaccompanied minor children and youth
* Homeless youth with substance abuse and/or mental health problems
* LGBTQIA youth
* Youth with co-occurring disorders

(Christiansen, 2015)

Although many groups have been identified as needing help with mental health issues with co-occurring substance abuse issues, only about 5% of providers in Nevada treat youth for both mental health and subsequent substance abuse issues (Christiansen, 2015).

Clark County

The 2015 Clark County Community Health Assessment found that 7.8% of Clark County youths are current smokers and 15% admit to binge drinking (Southern Nevada Health District [SNHD], 2015). Shalin found that about 14% of Clark County high school students have used marijuana at least once ever and 2% have tried cocaine (2010). A rising concern for Clark County is the use of prescription drugs for non-medical reasons. Many students are choosing to use their parents' or grandparents' prescriptions for recreational use. According to the YRBS report, prescription drug use is up to about 12% for Clark County (2015).

Washoe County

It seems that Washoe County has a disproportionate amount of youth involved in illicit drugs, alcohol, and tobacco. The amount of alcohol, tobacco, and illegal drug use by adolescents in Washoe County is actually higher than in Clark County. These findings would support the thesis that the lack of mental health care agencies in Washoe County could influence the amount of substance use and abuse in the county.

During the Washoe County Community Health Needs Assessment, about 18% of high school students admitted to either smoking or using tobacco products currently (2015). As for alcohol, high school students reported that about 40% of them currently drink alcohol on a regular basis. Illegal drug use in Washoe County is also fairly high. Table 4 shows the findings from the Washoe Community Health Needs Assessment regarding high school student use of illegal drug use.

Table 4. Washoe County High School Student Drug Use

Drug	Percentage of students who have ever tried the drug
Cocaine	12%
Meth	7%
Inhalants	15%
Prescription Drugs (For non-medical use)	22%
Heroin	5%
Marijuana	45%

(Washoe Community Health Needs Assessment, 2015)

Balance of State

The rural counties do not have the same population density as other counties but the drug use is still a problem. It was found that 16% of high school students have used marijuana and 2% have used cocaine (Shalin, 2010). Additionally, 10% of students have used prescription drugs for non-medical uses, which is about the same rate at Clark County (Shalin, 2010).

6. CHILD PROTECTIVE SERVICES AND MENTAL HEALTH

Children in the child welfare system in Nevada face many challenges and for many mental health issues can be one of those challenges. Negative mental health is often related to histories of involvement with both child protective services and juvenile delinquency. Adverse childhood experiences (ACEs) can have negative impacts on mental, emotional, and behavioral health from childhood through to adulthood (Anda, Butchart, Felitti, & Brown, 2010).

Impacts of adverse childhood experiences can include:

* Social, emotional and cognitive challenges and;
* High-risk behaviors like substance abuse, alcoholism, risky sexual behavior, smoking, obesity and depression.

Traumatic experiences during childhood (such as being removed from a family home) have been found to correlate with: psychiatric problems, unstable relationships, destructive behaviors, and substance abuse and dependence (Maschi, Bradley, & Morgan, 2008). About 70% of children in child protective services are diagnosed with mental health or substance abuse issues (Shufelt & Cocozza, 2006; Kretschmar, Butcher, Flannery & Singer, 2014).

Involvement in child protective services can become its own risk factor for delinquent behavior and the onset of mental health problems. There is a catch 22 in removing children from problematic situations (e.g, dysfunctional households, abusive situations, and access to drugs). In removing children, we are creating the risk factor of instability (Ryan, Herz, Hernandez, & Marshall, 2007). Chapple et al., (2005) found maltreated children were more likely to experience peer rejection and rejection was tied to violence in adolescents. Non-delinquent peers are a protective factor among maltreated children, reducing their tendency toward delinquent behavior (Maschi, Bradley, & Morgen, 2008).

The stress of abuse and maltreatment also affects the physical development of an adolescent brain, making victims susceptible to substance abuse and mental health issues (Teicher et al., 2012; Teicher et al., 2003). This abuse and neglect can be amplified by the overtaxed child welfare system (Abbott & Barnett, 2015). The increased stress of being "in the system" exposes youth to the risk of developing severe mental health issues, such as post-traumatic stress disorder (PTSD), major depression, and psychopathy (Bender, 2010; Keller et al., 2010; Kilpatrick et al., 2003). National studies looking at children involved in child protective services found that a third to half of these youth were also involved in delinquency systems (Herz, Ryan, & Bilchik, 2010; Gillalla, 2015).

Children in child protective services with mental health issues are more likely to be in multiple placements, weakening their bonds with adults even more.

7. YOUTH MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

The juvenile justice system is often the first time children and youth are recognized in having some sort of behavioral or mental health disorder. In Nevada, almost 40% of youth in the Caliente Youth Center need medications for mental health related issues (Valley, 2015). This facility is a correctional institute for youths, and is not designed nor equipped to treat those with mental health disorders. Many of the youth that come in contact with the juvenile justice system are sent to Caliente in lieu of residential treatment centers simply because there are not enough residential treatment spots for youth. The very process of incarcerating youth may exacerbate mental health challenges or interfere with their physical or cognitive development.

Clark County

Research shows that about 70% of youth in the juvenile justice system have a mental illness (NAMI, 2015). Girls in Clark County detention self-report high levels of mental health diagnoses (nearly 50%) and nearly a third reported being hospitalized for their mental health challenges (Kennedy, 2014).

Las Vegas is bears the brunt of this epidemic due to a lack of resources and treatment facilities. In 2015, 9,164 children and teens had contact with the juvenile justice system in

Clark County and almost a third of them were kept in custody (Valley, 2015). The Chief Family Court judge in the Juvenile Division, Judge W. Voy, focuses on youth mental health cases specifically on Monday afternoons. On average, he sees about 25 cases per week dealing with mental health disorders, specifically behavioral disorders.

> "The sooner you diagnose mental health issues, the more likely you're going to get the early intervention you need."
>
> -Judge William Voy (2015).

Washoe County

Washoe County does offer help to individuals with mental illness who are entering the criminal justice system. The county created the Mental Health Court in 2001. The court identifies individuals who may have mental health issues through a combination of their jail staff, pretrial services staff, public defender's office, and municipal and justice court staff. These staff members investigate prior contact with the mental health system.

If an individual is identified as someone who truly suffers from a mental illness, they are placed under a minimum supervision period of one year. During this year individuals participate in treatment programs, must remain compliant with medication recommendations, and stay sober for at least six months. Upon completion of the program, participants are transitioned back into the community. The average defendant is under court supervision for approximately 14 months, though the longest supervision period has been 26 months (Council of State Governments Justice Center, 2012).

Lack of Residential Treatment Facilities

Detention facilities and jails are being used as residential treatment facilities without the treatment component. Sometimes a youth may be lucky enough to be secured a spot in a residential treatment facility (RTC) in another state but most of Nevada's youth are not that

fortunate. There are 12 facilities that are considered residential treatment centers for youth in the state of Nevada. One of these facilities is Caliente Youth Center, which is a correctional facility for youth. The 140 beds at Caliente are considered a part of the RTC centers in Nevada.

Table 5 shows that there are not nearly enough spots for youth that may require residential treatment in Nevada. The 12 facilities equal about 900 beds for youth in need of inpatient mental health care (588 in Clark County, 141 in Washoe). Considering there is a possibility of 100,000 kids in Clark County alone that may require treatment for mental health issues this number is not even close to fulfilling the need for all of Nevada.

Table 5. Residential Treatment Programs in Nevada

Residential Treatment Center	# of Beds	Type of Care	Ages Served	County
Adolescent Treatment Center	16	Residential	13-17	Clark
American Addiction Centers: Desert Hope	148	Residential	12-18	Clark
Caliente Youth Center	140	Correctional	12-18	Lincoln
Center for Hope for the Sierras	10	Residential/ Eating Disorders	14+	Washoe
Depression Treatment Center at Seven Hills	94	Residential	11-17	Clark
Desert Willow	58	Acute/ Residential	6-17	Clark
Monte Vista Hospital	162	Acute	4-18	Clark
New Frontier Treatment Center	28	Residential	12-17	Churchill
Reno/Sparks Adolescent Boys Center	15	Residential/ Religious	12-17	Washoe
Spring Mountain Treatment Center	110	Acute	17 & under	Clark
Vitality Unlimited	30	Residential	All	Elko
Willow Springs	116	Residential	13-17	Washoe
Total Number of Inpatient Beds:	**927**			

8. COSTS OF UNTREATED MENTAL HEALTH ISSUES

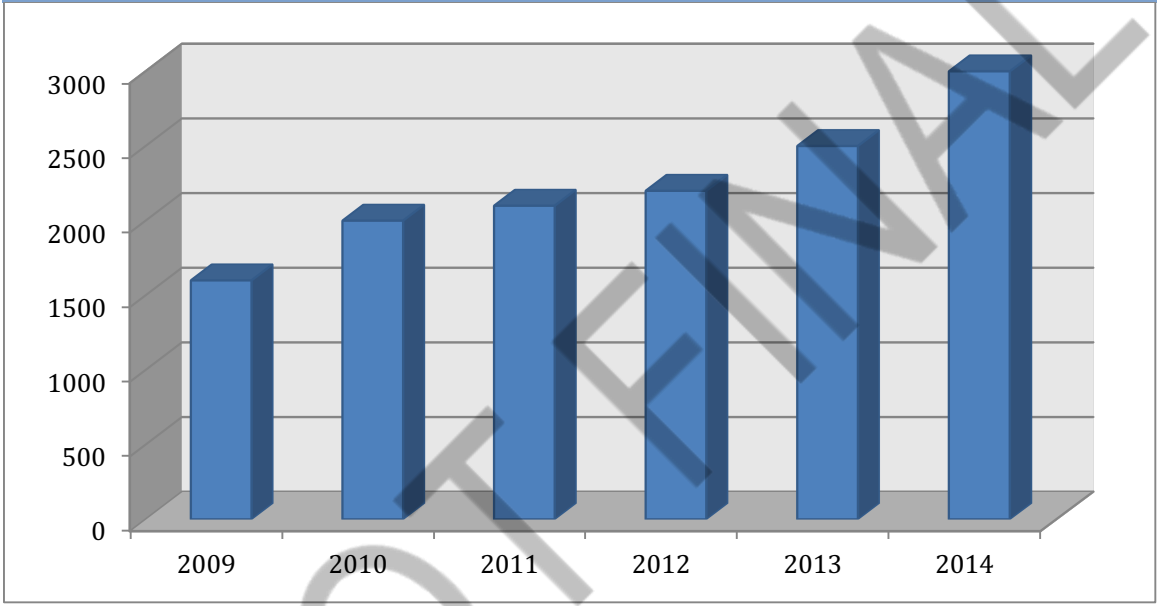
Untreated mental illness has been shown to have a costly effect on society. It has been found that disorders such as autism spectrum disorders, attention deficit hyperactivity disorder (ADHD), conduct disorders, anxiety and depression often go undiagnosed and those with diagnoses have costly medical and non-medical bills (Beecham, 2014). In the case of ADHD, collectively, kids who have been diagnosed with the disorder can accumulate between 38 billion dollars and 72 billion dollars annually (Doshi et al., 2012).

Additionally, there are spillover costs associated with parents missing work and sibling care that can total between 33 billion and 43 billion dollars. However, as expensive as treatment and diagnosis can be, with or without Medicaid or similar insurance, it has been found that children and adolescents that have undiagnosed mental illnesses can be even more expensive. Children who do not receive the appropriate treatment for mental illness can have non-psychiatric *health care costs almost two times higher* than their peers without psychiatric disorders (Wilkes, Guyn, Li, & Cawthorpe, 2012).

Emergency room visits are becoming an increasingly expensive addition to providing mental health services. Many children and youth in Nevada cannot afford mental health services and are forced to use emergency services instead. It was found that most Medicaid

eligible youths are using a more disproportionate amount of emergency services due to the lack of mobile crisis units. Additionally, the lack of mental health services has resulted in about 40% of the children in need of mental health services, are taken to emergency rooms for injuries sustained while attempting suicide (Clark County Children's Mental Health Consortium, 2009). Figure 6 shows the rise in emergency room admissions due to mental health issue. The number has risen steadily since 2009.

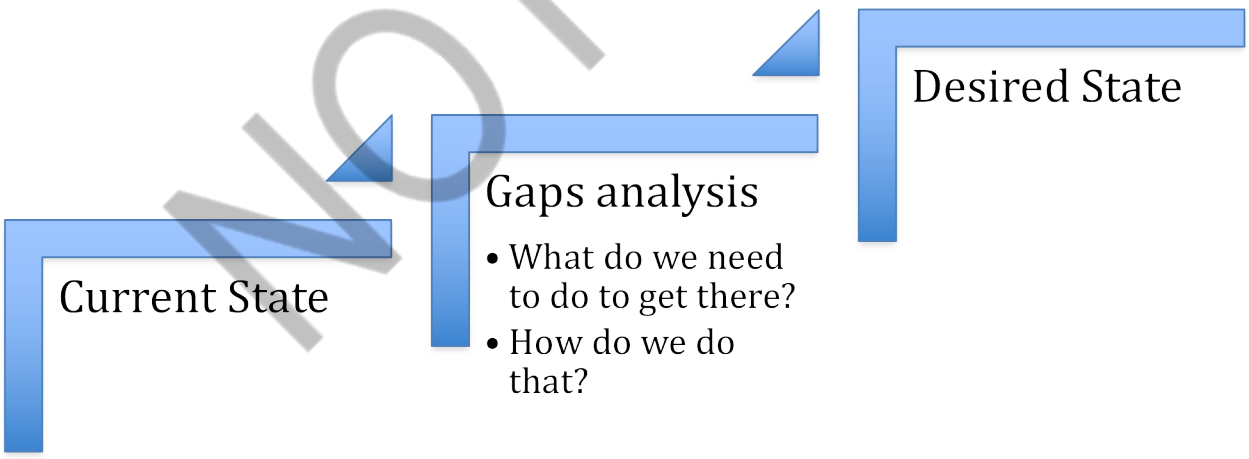
Figure 6. Clark County Youth Mental Health Emergency Room Admissions



(Clark County Children's Mental Health Consortium, 2015)

9. GAPS ANALYSIS

Throughout this report, it has been quite clear that the state of Nevada is failing its youth in providing mental health services. Residential treatment centers have long wait lists or are not providing correct care for patients. Children and youth are falling between the cracks and they face many barriers to receiving proper mental health care. Our current state of mental health care is not promising and there are a lot of steps that need to be taken to get to the desired state but there are barriers that need to be overcome and gaps in the service population that need to be addressed.



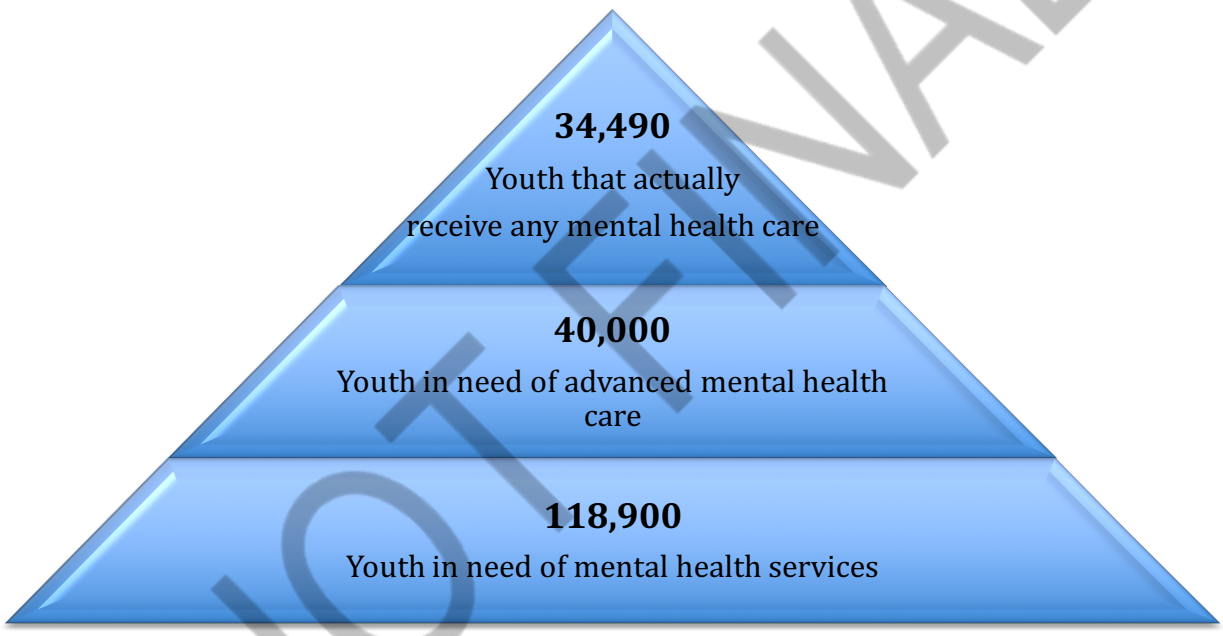
The 2016 Statewide Community Needs Assessment conducted for the Grants Management Advisory Committee, found that mental health was identified as the number one need in the state. Through their interviews, they found that there were three recurring themes pertaining to the need of mental health services. These are the things that were identified as the most urgent needs due to the lack in care:

Mental Health: Accessibility, affordability, integration of care, and supportive services
Health Access: Provider shortages, affordability, and insurance issues
Tobacco Use Prevention and Cessation: Deserves FHN funding

Clark County

It is estimated that there are about 118,900 juveniles in Clark County every year in need of mental health services but in Nevada only 29% of those will actually receive services meaning that only 34,490 children will receive the help they need. Denby, Owens, and Kern found that about 40,000 Clark County kids have severe mental issues that need addressing (2013).

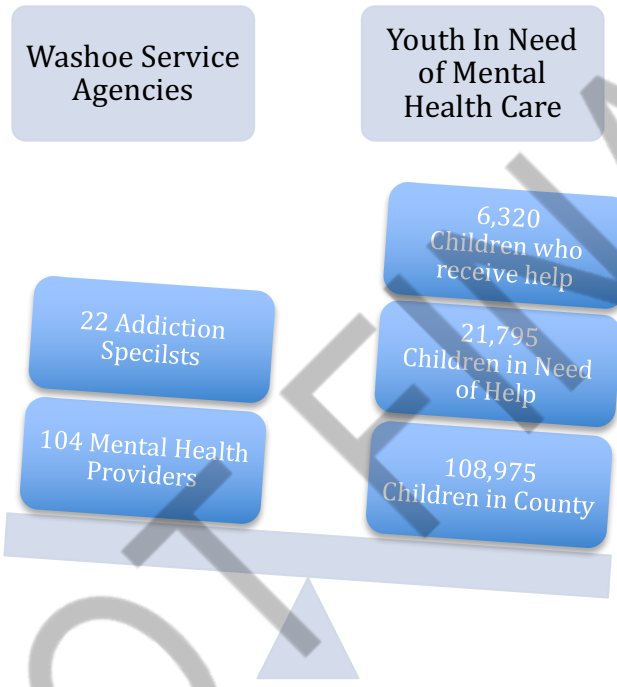
Figure 7. Clark County need for services vs. actual delivery of services



Washoe County

Figure 8 demonstrates the amount the of service agencies for juveniles in the county, the number of juveniles in the area, the number of juveniles in need of mental health services, and those children that are actually receiving services.

Figure 8. Washoe County need for service vs. actual delivery of services



Balance of State

Table 6. Rural juvenile need for service vs. actual delivery of services

	Balance of State
Total youth in area	55,920
Youth in need of mental health services	11,200
Youth who receive mental health services	3,244
Total number of mental health agencies in area	53

Barriers to Providing Mental Health Services

There are a number of barriers to youth getting the mental health services they need besides the lack of providers. In a study conducted by the Nevada Department of Health and Human Services, barriers to mental health services were identified by both providers and patients (Christiansen, 2015). Table 7 shows the barriers that each group perceives and how high that barrier ranks to each group.

Table 7. Top barriers to mental health services

Provider Responses		**Patient Responses**	
Barrier	**Rank**	**Barrier**	**Rank**
Cost	1	Lack of Knowledge	1
Lack of knowledge of resources	2	Lack of insurance coverage	2
Lack of transportation	3	Stigma	3
Lack of insurance coverage	3	Fear	4
Lack of available providers	4	Cost	5
Long wait lists	4	Perception that treatment wouldn't help	6
Fear	5	Took too much time to get services	6

(Christiansen, 2015)

These are not only barriers perceived by clients. In Clark County, it was found that transportation presented a huge barrier for many. Having reliable services within a reasonable distance from home or work presented a challenge for many and prevented them from accessing care (Christiansen, 2015).

These barriers are also creating gaps in the populations being served, and services being offered. The same study identified the top populations and sub-populations that are being missed when treating mental health disorders, with children being the number one population lacking mental health services.

Top Populations in Need of Mental Health Services

* Children with Serious Emotional Disturbance (SED) and their families
* Adults with Serious Mental Illness (SMI)
* Individuals with mental and/or substance use disorders involved in the criminal or juvenile justice systems

(Christiansen, 2015)

It is not surprising that some populations are being missed when serving mental health patients when it has also been identified that numerous services are severely lacking. The services below, were identified by Christiansen when she interviewed service agencies during the 2015 need assessment.

* Children's residential mental health services
* Crisis residential/stabilization
* Lack of inpatient services
* Lack of outpatient services
* Acute Intensive Services: Mobile Crisis
* Intensive home-based services
* Adult residential mental health treatment

(Christiansen, 2015)

As with the at-risk populations, the gaps for suicide prevention are very wide. The biggest failure in preventing suicide is failing to recognize underlying mental health issues. There is a significant lack of training for service providers, educators, and parents in recognizing the signs of suicide and mental health disorders (Christiansen, 2015). The biggest failing is a lack of crisis intervention and prolonged treatment for those contemplating suicide. In the state of Nevada, suicide is the number two cause of death for juveniles (Office of Suicide Prevention, 2014).

Top Populations in Need of Suicide Prevention Services

* Children with Serious Emotional Disturbance (SED) and their families
* Adults with Serious Mental Illness (SMI)
* Individuals with SMI or SED in rural areas
* Individuals with mental and/or substance use disorders involved in the criminal or juvenile justice systems
* Individuals with mental/substance abuse disorders who are LGBT (Christiansen, 2015)

10. CHILDREN'S MENTAL HEALTH NATIONAL BEST PRACTICES

The first step to addressing adolescent mental health care is identifying those in need. Often, screening and assessment are used interchangeably but they are not the same thing. Screening simply identifies if a student or youth needs further evaluation. Assessments are more complete and help determine the best course of action for the youth. In a report by Kennedy and Stout (2015), they outlined the best principles of assessing youth. These principles can apply to youth in need of mental health services, youth in child protective services, and youth in the juvenile justice system.

Principles of best practices for clinical assessments:

1. Use multiple methods of evaluation
    - Observation, mental status examination, family psychiatric and psychosocial history, and interviews with care givers
    - Use reliable and valid instruments for assessments
2. Assessments should include parental input
    - This is particularly valuable for diagnosing attention deficit disorders
3. Focus on recent symptoms to determine current treatment needs
    - Also consider how stress of confinement or involvement in the system may worsen symptoms
4. Strategic reassessment
    - Youth held in custody may have shifts in symptoms and need treatment adjustments

Screening and Assessment

One of the biggest issues with mental health care for many states is that the juvenile justice system is the first time many juveniles are screened for mental health issues. These screenings are most often after the youth has been adjudicated and in a correctional facility.

In Pennsylvania, although youth are still being sent to correctional facilities they have changed the way they screen youth so that they can provide more accurate and timely care for juveniles. They use the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2), this tool has resulted in more effective treatment for youth and a faster response time (Mental Health Needs of Juvenile Offenders [MHNJO], 2015). Pennsylvania has also protected youth from self-incrimination statements made during mental health and substance abuse screenings. Illinois and Texas have also moved toward this type of legislation in protecting youth (MHNJO, 2015).

Under Tennessee law, juveniles who commit crimes that would be felonies for adults are mandated to undergo psychological evaluations (MHNJO, 2015). These evaluations are meant to determine if the juvenile has underlying mental health issues that would cause them to act in a manner that would not be typical of someone their age. The state is also required to pay for the assessments, unless the parents can prove that they can reimburse the state. North Dakota and Oregon also have similar policies. Both of these states require that juveniles who commit crimes dealing with drugs or alcohol must go through substance abuse screenings and education classes (MHNJO, 2015).

Competency

Mental health problems can severely affect the outcome of legal issues, particularly if the youth is unable to understand the ramifications of their actions. Virginia has passed laws stating that a juvenile charged with a misdemeanor but determined "un-restorably incompetent" be dismissed in one year (MHNJO, 2015). Arizona determined that juveniles

with mental issues can be found incompetent to stand trial, but they also take into account maturity levels regardless of mental health screening results.

Diversion

Diversion into community based mental health treatment programs showed significant reductions in recidivism (Colwell, Villarreal, & Espinosa, 2012) Research analyzing over 2,500 youth found that youth diverted to community based mental health and family services also showed significant reductions in trauma symptoms (e.g., anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns), improved psychological functioning and reduced problem severity (Kretschmar et al., 2014).

Ohio has implemented the Integrated Co-Occurring Treatment Model (See Appendix XX), which is an intervention program for kids that exhibit mental health symptoms and show signs of substance abuse. The program reintegrates the youth and involves individual and family therapy sessions (MHNJO, 2015).

Aftercare

Although most youth are identified as having mental issues while incarcerated, they are eventually released. For many youth their release from an institution also means the end of their mental health treatment. Virginia and Texas both have legislation in place to help youth reintegrate into society and help them continue their mental health care (MHNJO, 2015). These laws also help youth get involved with the community so they are less likely to revert to their high-risk behaviors from before.

Collaboration

Wraparound Milwaukee (See Appendix C), is a program that brings together: mental health agencies, juvenile justice department, child protective services, and the schools to help provide complete services to kids (MHNJO, 2015). The agencies develop plans for each child that is tailored for their unique needs. Since the beginning of the program, the need

for residential treatment has decreased by 60% and psychiatric hospitalization decreased by 80% (MHNJO, 2015).

The Dawn Project in Indiana (See Appendix C) brings together Family and Social Services Administration, Mental Health and Addiction, Indiana Department of Corrections, the Marion County Office of Family and Children, the Marion Superior Court Juvenile Division, and the Mental Health Association (MHNJO, 2015). This program is designed to help those youths that have been diagnosed with severe mental health disorders, and create specialized plans for their treatment.

Best Practices for Mental Health Care

Prevention	Early Intervention	Intervention
•Monitoring youth populations for issues •Mental wellness, substance abuse and trauma awareness •Youth •Families •Health care •Schools •Social service providers	•Situational crisis management •Coping (short-term) interventions •anger management •emotional regulation •coping skills •Group counseling •Parent clinics	•Mental Illness services •Substance abuse treatment •Special Educational services •Trauma treatment •Continuum of services •residential •hospitalization •emergency treatment •day treatment •outpatient •evaluations and assessments •home based services •case management •school support •parental education

National recommendations for mental health care need to be incorporated for Nevada to provide the best possible treatment for the mentally ill. Mental health care and physical health care are closely tied together; therefore many of the recommendations will overlap between the two. The National Council for Behavioral Health (NCBH) recommends three major practices to facilitate proper care: making care safer by reducing harm caused in the delivery of care, ensuring that each person and family is engaged as partners in their care, and promoting effective communication and coordination of care (National Council for Behavioral Health [NCBH], 2014).

The NCBH believes that improved communication between family members, the patient, and their health care providers will ensure that a patient is receiving safer treatment. Patients may have multiple providers and improper communication can lead to conflicting

health care recommendations. This may potentially be detrimental to the improvement of the patient's health. Improving communication will also facilitate the patient's engagement in their care, which leads to the NCBH's second recommendation: ensuring that each person and family is engaged as partners in their care.

Ensuring that the friends and family of the patient are up to date on the patient's current treatment is crucial when it comes to treatment outside of the health care provider's office. Proper information gives families the tools they need to support the health care provider's recommendations at home. This information ensures that family is not unintentionally providing some form of treatment that is detrimental to the patient's treatment plan.

This all ties together with the NCBH's final recommendation: promoting effective communication and coordination of care. While this may sound redundant, effective communication allows the patient to be the center of their care. You no longer have multiple providers prescribing different treatment plans, as there is one singular treatment plan for the patient. This method allows the eradication of potentially harmful effects that are caused by conflicting treatment plans.

In addition to the NCBH's recommendations, the 2001 book, *Crossing the Quality Chasm: A New Health System for the 21st Century,* sets forth 10 rules for redesign in the health care system. They are as follows:

1. *Care is based on a continuous healing relationship.*
2. *Care is customized according to patient needs and values.*
3. *The patient is the source of the control.*
4. *Knowledge is shared and information flows freely.*
5. *Decision-making is evidence-based.*
6. *Safety is a system property.*
7. *Transparency is necessary.*
8. *Needs are anticipated.*
9. *Waste is continuously decreased.*
10. *Cooperation among clinicians is a priority* (Corrigan, Donaldson, Kohn, Maguire, & Pike, 2001).

Our nation's health care system is constantly changing and ever-growing and while our methods of treatment may change, these 10 rules for redesign should always be kept in mind. The patient must always come first when it comes to treatment and open communication needs to be kept between providers. Nevada's mental health care system must stay ahead of the curve to properly treat their mentally ill.

Resources for Best Practices, Information and Training Material

Below are few key resources for those seeking to divert youth from the juvenile justice system and provide them with proper mental health care.

National Center for Mental Health and Juvenile Justice

http://www.ncmhjj.com

The overarching philosophy of the National Center for Mental Health and Juvenile Justice (NCMHJJ) appears in their various publications,

> *Whenever safe and appropriate, youth with mental health needs should be prevented from entering the juvenile justice system in the first place*

The NCMHJJ conducts research, trains and publishes on best practices and how to improve programs. One example was their 2012-2013 action network that included technical support and assessments of programs in 8 states. Technical support was provided through webinars such as: Applying proven strategies to reduce racial and ethnic disparities in the juvenile justice center; the role of family in juvenile justice diversion programs for youth with behavior health needs; and trauma-informed juvenile justice and mental health systems: why we need them, how to move toward them. Meetings and reports around screening tools and implementing evidence-based practices were also held.

Models For Change

http://www.modelsforchange.net

This collaborative resources is sponsored by the MacArthur Foundation and publishes work on juvenile justice change models. The Center works in a number of different areas to create juvenile justice reforms. Their major areas of concern are

- Aftercare – post-release services, supervision and supports that help committed youth transition sagely and successfully back into the community.
- Community-based alternatives – local alternatives to formal processing and incarceration.
- Dual status youth – coordinated, multi-system interventions to improve outcomes for youth in the juvenile justice and child welfare systems.
- Evidence-based practices – highlighting programs and services of demonstrated effectiveness in improving behavior.
- Juvenile indigent defense – meaningful access to legal counsel for all youth.
- Racial-ethnic fairness/DMC – data-driven strategies to reduce racial and ethnic disparities and promote a more fair juvenile justice system.
- Status offense reform – strategies to safely and effectively divert non-delinquent youth from the formal juvenile justice system.
- Mental health – collaborative approaches to meet the mental health needs of youth without unnecessary juvenile justice system involvement.

The National Youth Screening & Assessment Project (NYSAP)

http://www.umassmed.edu/sparc/

http://works.bepress.com/gina_vincent/

This resource is a research and technical assistance group based at the University of Massachusetts Medical School and authored both measures and best practice in assessment guidelines.

- Screening and Assessment in Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Reoffending
  http://www.modelsforchange.net/publications/328
- Risk Assessment in Juvenile Justice: A Guidebook for Implementation
  http://modelsforchange.net/publications/346

School-based diversions

Summit County, Ohio produced a manual on how to develop school-based responders programs. It focuses on identification and referrals with training for potential early interveners. Their main goal is to direct children to appropriate mental health services and away from the juvenile justice system. The manual is available at,
http://www.modelsforchange.net/publications/450

11. RECOMMENDATIONS

Collaboration

One of the biggest problems with the current mental health welfare system is that the process of getting help is too complicated for people to navigate. By having social services and mental health agencies collaborate, the process may be less intimidating for someone unfamiliar with the system. This collaborating could create a network of agencies that could help the overall welfare of the youth. The more agencies involved, the more likely a youth is to receive the help they need. The agencies could include: juvenile court judges, law enforcement, probation officers, prosecutors, defense attorneys, child welfare, Clark County School District, adult social services, mental health agencies and community service providers working with these youth. Adult social services should be included to help leverage resources for at risk families. It must be a community wide planning process and could include the media to build community consensus to help at risk youth. Clark County School District has to be engaged in order to do early intervention.

Data Infrastructure

The key to collecting data is sharing information. Without comprehensive monitoring, services can never be improved. Nevada and Clark County specifically has a history of not sharing information between agencies and branches. This obstacle should be overcome to

provide the best services and reduce inefficiencies. A collaboration between agencies should help this problem.

Research Assessment Tools

Private providers and agencies may have screening and assessment tools that they prefer to use but it is recommended that assessment tools be explored. See Appendix XX for a list of potential screening and assessment tools that could be used for both youth at risk for mental illness but high-risk behaviors. Many tools can be combined for multiple purposes and can help with youth in a variety of situations.

Cultural Competency

There is a disproportionate minority contact across multiple service systems in Nevada, particularly in Clark County. Having mandatory cultural competency trainings for staff in social service agencies would help alleviate some of the frustrations between staff and clients. Las Vegas is a very diverse city with many cultures overlapping one another. This type of training and understanding would also help staff understand the barriers that some families may be facing in asking for help.

Create New Diversion Initiatives

Clark County should assess and address the barriers that exist to reducing reliance on confinement. This must include collaborative work with agencies that feed youth into the juvenile justice system such as child protective services and the school district. Clark County and the State of Nevada should conduct a cost-benefit analysis of their juvenile justice policy. It is more beneficial to treat youth with mental health issues than to leave them untreated and continue having to incarcerate them.

Expand Number of Clinicians

Although Appendix D may seem to be an extensive list of mental health agencies and providers, there is still a shortage of clinicians able to help youth. There is a very limited number of agencies that help youth specifically, particularly in the are of substance use

disorders. Youth face many challenges that differ greatly from the challenges that adults face.

Health Care Awareness

Treating mental health issues is more than treating the problem it should include wraparound care. Many youth do not receive the help they need because they don't know how to access help or are afraid to ask. There are many cases where youth may not only need mental health help but also physical health care or their family needs help in other areas. Mental health and social service agencies should be aware of other resources available to youth and their families.

Individualized Care

As with many systems, one size does not fit all. Youth in need of mental health services have unique situations and should not be put into a stagnant system. The mental health provider, social service workers, the child's school, and the family to should come together to create individualized plans that are tailored to the youth.

Incident Reporting and Oversight

As a part of collaboration, there should be a way to report critical incidents to the multi-disciplinary teams working with youth. If a child receives detention for misbehaving at school, there should be a way for the school to relay that information to the appropriate agencies. Nevada currently has inconsistent information sharing between community service providers and government agencies managing youth. Sharing of information between government agencies should also be examined.

Quality Assurance Services

The reason that there is a problem with the way that youth mental health services are provided is because there is no oversight. There is very little in the way that services are reviewed or examined to make sure that proper protocols are followed. There should be a

system in place for a governing body to review the quality of care provided by agencies serving not only youth but mental health patients in general.

Outcome Recommendations for a Juvenile Mental Health

The 3rd recommendation was for data infrastructure. Below are specific suggestions for data priorities.

1. Develop more collaborative case management systems so that multi agency involved youth can have comprehensive files that are accessible to multiple service providers.
2. Track multiple referrals or youth who have multiple engagements with law enforcement or juvenile justice
3. Track match to services. Beyond listing referrals, track participation and success with these referrals
4. Track case processing times. Track time from intake, assessment and accessing services.
5. Track quality of services. Transparency and success of outcomes with community based services need to be tracked to build excellence. The more that agencies know about service providers, the better that they can match the youth to the right programs.
6. Confirm that assessment results are shaping referrals that services provided match the needs identified.
7. Look for patterns like possible widening of net or drawing more youth into the system.
8. Create a quality assurance program

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Appendix A- Clark County Children's Mental Health Consortium

The Clark County Children's Mental Health Consortium (CCCMHC) was created in 2001 by the Nevada Legislature to conduct research and improve mental health care delivery to Clark County. This commission is required to release a 10-year strategic plan for addressing Nevada's mental health issues concerning youth in the state. These goals and priorities were set to be met by the year 2020.

While the CCCMHC has not failed, the 2015 report shows that there is little progress being made to achieve the 6 goals set out in the plan and the four priorities identified within the plan. Below are the provisions of the 10 year plan, the actions steps listed within the plan, and the progress made toward achieving those goals.

Priority 1	Re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcome for Clark County's children and families.	
	Action Steps:	1. Integrated, local system management for publically funded children's behavioral health services 2. Re-structure Medicaid policies and funding to support a single, accountable entity in Clark County that uses a wraparound approach to manage care. 3. Essential health benefits for children should be: family-to-family support, mentoring, mental health consultation, mobile crisis intervention, and respite care. 4. Develop and implement a statewide, universal set of quality standards
	Current Status:	Some Progress

Priority 2	Provide mobile crisis intervention and stabilization services to Clark County youths in crisis.
Action Steps:	1. Expand funding for DCFS to implement an evidence-based mobile crisis intervention program 2. Develop a family-driven approach that ensures all youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior; receive immediate and appropriate inpatient or community-based care.
Current Status:	Significant Progress

Priority 3	Expand access to family-to-family support services for the families of Clark County's children at risk for long-term institutional placement.
Action Steps:	1. Expand funding to provide family-to-family support for Clark County youth with serious emotional disturbance at risk for long-term residential treatment 2. Expand funding to provide family-to-family support for Clark County youth with co-occurring developmental disabilities and behavioral health needs that are at risk for long-term residential treatment
Current Status:	Minimal Progress

Priority 4	Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.
Action Steps:	1. Provide funding to maintain and expand school-based mental health and suicide prevention screening CCSD a. Prioritize funding for parent awareness, and parent support 2. Provide funding from the Office of Suicide Prevention to expand its means reduction program to include a public awareness and family education campaign about the risk of youth suicide caused by availability of firearms and potentially lethal medications
Current Status:	Some Progress

The 10-year plan goals are:

1. Children with serious emotional disturbance and their families will thrive at home, at school, and in the community with intensive supports and services.
2. Children with behavioral health needs and their families will access a comprehensive array of effective services when and where they are needed
3. Families seeking assistance will find an organized pathway to information, referral, assessment and crisis intervention coordinated across agencies and providers.
4. The system will be managed at the local level through a partnership of families, providers and stakeholders committed to community-based family driven, and culturally competent services.
5. County-wide programs will be available to facilitate all children's healthy social and emotional development, identify behavioral health issues as early as possible, and assist all families in caring for their children.
6. Heightened public awareness of children's behavioral health needs will reduce stigma, empower families to seek early assistance and mobilize community support for system enhancements. (CCCMHC, 2015)

Appendix B- Screening and Assessment Tools

Mental Health

Kutcher Adolescent Depression Scale (KADS)

(LeBlanc, Almudevar, Brooks, & Kutcher, 2002)

This 6 item scale is a quick screening that is easy for adolescents to respond to and uses language that teens are familiar with. It quickly determines if teens are at risk for suicide or need immediate mental health care.

This tool is available for free at a number of locations such as:

http://teenmentalhealth.org/toolbox/kutcher-adolescent-depression-scale-kads-english/

Technical Assistance Partnership for Child and Family Mental Health

http://www.tapartnership.org/docs/screenListv3.pdf

This site has a list of mental health and substance abuse screening instruments appropriate for use with youth. The tools are listed by title but also describe the appropriate age group, symptoms screened for and publisher/website information.

Runaway and Homeless Youth Training and Technical Assistance Center

http://www.rhyttac.net/resources/document/assessment-tool-webinar-resource-list

This agency has put together a webinar and list of assessments used by different programs across the county. These tools are not limited to use with runaway and homeless youth but can be used for a variety of youth. The tools they report as currently being used have different purposes including looking at mental health, physical health, life skills and other areas of strengths and challenges for youth.

- Casey Life Skills (CLSA)
- Child & Adolescent Needs & Strengths (CANS)
- Problem Oriented Screening Instrument for Teenagers (POSIT)

- Adolescent Substance Abuse Subtle Screening Inventory (SASSI – A2)
- Massachusetts Youth Screening Instrument Version 2 (MAYSI-2)
    - (Highlighted in Best Practices)
- Developmental Assets Inventory
- Childhood Trauma Questionnaire (CTQ)
- Global Appraisal of Functioning (GAIN- SS)
- Pediatric Symptom Checklist (PSC – 17)
- Trauma Symptom Checklist (TSCC)
- Youth Assessment & Screening Tool (YASI)
- The Child & Adolescent Functional Assessment Scale (CAFAS)
- Beck Depression Inventory (BDI)
- Behavioral Assessment System for Children (BASC – II)
- The Adolescent Resiliency Attitudes Scale (ARAS)
- Child Behavior Checklist (CBCL)

Child Traumatic Stress

National Child Traumatic Stress Network

A searchable database with reviews of measures used in the field of Child Traumatic Stress.

http://www.nctsn.org/resources/online-research/measures-review

Trauma Informed Care

Webinars available through the National Technical Assistance Center for Children's Mental Health

http://gucchdtacenter.georgetown.edu/TraumaInformedCare/

Health Assessments

Duke Health Profile Assessment

It is one page and can be completed by the youth themselves.

http://www.nctsn.org/resources/online-research/measures-review

Substance Abuse Screening

There are multiple tools for assessing substance abuse. A free screening tool is available for youth through the Sassi Institution.

www.sassi.com

ADDITIONAL RESOURCES

Practice Information

Psychological First Aid for Youth Experiencing Homelessness. (2009)
http://www.nctsn.org/sites/default/files/assets/pdfs/pfa_homeless_youth.pdf

Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness. (2006)
http://www.thetaskforce.org/static_html/downloads/reports/reports/HomelessYouth.pdf

Teen Mental Health – screening tools
http://teenmentalhealth.org/

Mental Health America – screening tools
http://www.mentalhealthamerica.net/mental-health-screen/youth

Appendix C- Best Practice Program Examples

The Integrated Co-Occurring Treatment Model (ICT)

* Clemshaw, Shepler, Newman, (2005)
* Intensive home-based treatment to provide vital services to youth with substance use and serious mental illness who have had contact with the juvenile justice system
* Engages both the teen and family to recognize how it affects their relationship with family, peers, school, and community
* http://www.tandfonline.com/doi/pdf/10.1300/J374v01n03_11

Wraparound Milwaukee (1995)

* A unique system of care for children with serious emotional, behavioral, and mental health needs and their families
* Focuses on individualized care with the motto: "One child, one plan"
* Was designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the community and in the child's home.
* The federal government also stressed more family inclusion in treatment programs along with collaboration among social service agencies
* In 2004, Wraparound Milwaukee was named an exemplary program by the President's New Freedom Commission on Mental Health.
* http://wraparoundmke.com

Dawn Project

* A system of care that uses a family-centered, culturally competent approach by blending funding streams from different social service agencies and mental health providers
* Findings suggest that for youth in the project, there is significant clinical improvement during the first year of receiving services, a reduction in the use of more restrictive settings, and a decrease in recidivism among those who successfully complete the program.
* http://www.cmhnetwork.org/alumni/map/indiana/dawn-project

Appendix D- Juvenile Mental Health and Social Service Providers in Nevada

Agency	Phone	Location	County	Types of Services	Website
Aaron Williams Therapy, LLC	702-386-0254	801 South Rancho Dr. Suite D-2 Las Vegas, NV 89106	Clark	Therapy	http://www.aaronwilliamstherapy.com
Addo Recovery	855-229-2336	6268 S. Rainbow Blvd., Suite #110A, Las Vegas, NV 89118	Clark	Therapy	http://addorecovery.com
Advocates to End Domestic Violence	775-884-1886 Crisis Phone: 775-883-7654	885 E. Musser St. Suite #3003 Carson City, NV, 89701	Carson	Crisis, Info, Legal, Therapy	www.aedv.org
Alana Jackson and Assoc LLC	702-675-8967	8685 S Eastern Ave Las Vegas, Nevada 89123	Clark	Therapy	
Alecia L. Towell L.L.C.	775-393-9198 775-225-6968	636 Lander St Reno, NV 89509	Washoe	Therapy	
Alexandria Rees	702-706-4024	9414 W Lake Mead Blvd Suite #210 Las Vegas, Nevada 89134	Clark	Counseling, Therapy	
Alicia Hite	702-625-1451	7331 W. Charleston Blvd, suite #140 Las Vegas, NV 89117	Clark	Therapy	http://www.lasvegastherapist.com/
Allan Berkowitz	702-806-5268	5426 Vegas Drive Las Vegas, Nevada 89108	Clark	Therapy	http://www.nmhslv.com/
Allan Mandell, Ph.D., MFT	775-232-1553	860 Tyler Way Sparks, NV 89431	Washoe	Counseling, Therapy	http://doctormandell.com
Allied Psychological Services, LLC.	702-228-4900	3245 S Rainbow Blvd #100 Las Vegas, NV 89146	Clark	Therapy	
Allison Hilborn-Tatro Therapy, INC	775-830-5901	245 Mt Rose St Reno, NV 89509	Washoe	Therapy	http://txconsultations.wixsite.com/allisonhilborntatro
Alpha Institute, LTD	702-350-3194	500 N Rainbow Blvd Suite #300, Las Vegas NV, 89107	Clark	Therapy	
Alpine Counseling Associates	775-823-9133	4600 Kietzke Ln Reno, NV 89502	Washoe	Therapy	
Alternative to Living in	775-463-5843	400 Main St. Ste. A. Yerington, NV 89447		Crisis	www.facebook.com/alivedo

Violent Environments (A.L.I.V.E.)					mesticviolence/
Amber Elliott LMFT, LLC	702-919-7308	600 Whitney Ranch Dr Suite #A5A Henderson, NV 89014	Clark	Therapy	
American Addiction Centers	702-848-6223 Toll free: 888-983-9954	2465 E Twain Ave Las Vegas, NV 89121	Clark	Counseling, Info, Outreach, Therapy	http://americanaddictioncenters.org/
American Comprehensive Counseling Services	Sparks: 775-365-2896 Reno: 775-337-6644 Carson City: 775-883-4325	860 Tyler Way Sparks, NV 89431 620 E. Plumb Lane Reno, NV 603 E. Robinson St. Carson City NV 89701	Washoe Washoe Carson	Therapy	http://www.accsnv.com
Ana Olivares, Psy.D., LLC	702-803-3115	6284 S Rainbow Blvd Suite #110 Las Vegas, Nevada 89118	Clark	Therapy	
Andrea T. Ornelas, LCSW	702-533-7660	4425 South Jones Blvd. Suite 3 Las Vegas, NV 89103	Clark	Counseling	http://www.ornelastherapy.com/
Andres Counseling Services, LLC	702-318-8260	2441 Tech Center Ct #109 Las Vegas, NV 89128	Clark	Counseling	
Anita T Vaccaro	702-509-6953	3425 Cliff Shadows Pkwy Suite #150 Las Vegas, Nevada 89129	Clark	Therapy	
Anna Goswami L.L.C.	702-904-8845	7371 W Charleston Blvd #110 Las Vegas, Nevada 89117	Clark	Therapy	
Annah-Lizah Vaquilar	702-832-0452	3230 S Buffalo #105 Las Vegas, NV 89117	Clark	Therapy	
Annise Prewitt	702-978-3886	9550 S. Eastern Ave. Suite #220 Las Vegas, NV 89123	Clark	Counseling	http://www.anniseprewitt.com
Ashley Hurley	702-904-8385	2980 S Rainbow Blvd Las Vegas, NV 89146	Clark	Therapy	http://www.aspiremh.com/ashley-hurley-cpci.html
Aspire Mental Health	702-673-7462	2980 S Rainbow Blvd #200A Las Vegas NV 89146	Clark	Crisis, Therapy	http://www.aspiremh.com

Atomic Psychological Associates	702-333-229	4550 West Oake Suite #106 Las Vegas, NV 89102	Clark	Therapy	http://atomicpsych.com
Balance Therapy Center	775-323.1829	556 California Ave Reno, NV 89509	Washoe	Counseling, Info, Therapy	http://www.balancetherapycenterllc.com
Barbara Hudson	775-722-6272	243 Stewart St. Reno, NV 89501	Washoe	Counseling, Therapy	http://barbarahudsonmft.com
Bardos Psychological Services, PLLC	702-487-9169	2501 N. Green Valley Parkway Suite #130 D Henderson, NV 89014	Clark	Counseling, Therapy	http://www.drbardos.com
Battle Mountain Mental Health	775-635-5753	10 E. 6th St. Battle Mountain, NV 89820	Lander	Therapy	
Beach Therapy	702-334-6162	KMG Consulting North Las Vegas, NV	Clark	Counseling, Info	http://beachtherapylv.com
Belume Counseling (LGTBA Friendly Counseling)	702-514-0231	1334 S Maryland Pkwy #3 Las Vegas, NV 89104	Clark	Counseling	http://www.belume.com
A Better Life, LLC	702-800-7311	1070 W Horizon Ridge Parkway Ste #200 Henderson, NV 89012	Clark	Counseling, Therapy	
Beverly J. Paschal, PhD, MFT	775-827-0404	3670 Grant Drive #103-A Reno, NV 89509	Washoe	Counseling, Therapy	http://www.bevpaschaltherapy.com
Blue Lotus Counseling Services	702-236-4181	San Martin Medical Arts Pavilion 8285 W Arby Avenue Suite #225 Las Vegas, NV 89113	Clark	Counseling, Therapy	http://www.bluelotuscounselingservices.com
BrainScape Solutions	702-488-5608	5940 S Rainbow Blvd, Las Vegas, NV 89118	Clark	Therapy	http://www.brainscapesolutions.com
Braun Psychological Services	775-247-5001	10775 Double R Blvd. Reno, NV 89521	Washoe	Counseling, Info, Therapy	https://bpsreno.com
Bree Mullin	702-263-0094	1820 E. Warm Springs Rd Suite# 125 Las Vegas, NV 89119	Clark	Therapy	
Browning Psychological Services	702-410-8400	2110 E Flamingo Rd #317 Las Vegas, NV 89119	Clark	Counseling, Therapy	http://dynamicfamilytherapies.com
Bunker Counseling	702-580-4329	2620 Regatta Dr Las Vegas, NV 89128	Clark	Counseling	https://tbunker.wordpress.com

Cairn Center	702-508-9461	3615 West Charleston Boulevard Las Vegas, NV 89102	Clark	Therapy	http://www.cairncenter.com/
Caliente Youth Center	775-726-3181	500 Youth Center Drive Caliente, NV 89008	Lincoln	Casework, Counseling, Therapy	http://dcfs.nv.gov/Programs/JJS/Caliente/
Care Counseling	702-527-9997	501 S Rancho Dr Las Vegas, NV 89106	Clark	Therapy	http://carecounselingonline.com/
Carol Hemington Turner	702-275-1972	6655 W Sahara Av Las Vegas, NV 89146	Clark	Counseling	
Carson City Community Counseling Center	775-882-3945	205 S. Pratt Ave. Carson City, NV 89701	Carson	Therapy	http://www.ccofcarsoncity.org
Carson Tahoe Health-Outpatient Behavioral Health	775-445-8000	775 Fleischmann Way Carson City, NV 89703	Carson	Therapy	http://www.carsontahoe.com/behavioral-health-services
CASA Court Appointed Special Advocates	Carson City: 775-882-6776	1545 E. 5th Street Carson City, NV 89701	Carson		http://www.casaofcc.org
	Fallon: 775-423-6888 ex 255	73 North Maine, Suite B, Fallon, Nevada 89406	Churchill		http://churchillcounty.org
	Las Vegas: 702-455-4306	601 North Pecos Road Las Vegas, NV 89101	Clark		http://www.casalasvegas.org
	Minden: 775-782-6247	P. O. Box 218 Minden, NV 89423	Douglas		http://www.douglascountynv.gov/sites/casa/contact.cfm
	Yerington: 775-246-1850	PO Box 242 Yerington, NV 89447	Lyon		
	Elko: 775-934-7636	P. O. Box 1543 Elko, NV 89803	Elko		
	Pahrump: 775-513-9514	1321 S. Highway 160, Suite 9A Pahrump, NV 89048	Nye		
	Winnemucca: (775) 623-2328	P.O. Box 1338, Winnemucca, NV 89445-3228	Humboldt		

	Reno: 775-328-3298	75 Court St., Suite 214, Reno, NV 89501	Washoe		http://washoecasafoundation.com
Cathy A. Smith, M.Coun, MFT, CBS	702-938-8887	2441 Tech Center Ct 107 Las Vegas, NV 89128	Clark	Counseling	http://cathysmithcounseling.com
Cathy E Stock	702-367-0393	7495 W. Azure Las Vegas, NV 89130	Clark	Counseling, Therapy	http://www.cathystockmft.com
CBA Healthcare,LLC	775-200-8528	1155 West 4th Street, Suite #101 Reno, NV 89501	Washoe	Counseling, Therapy	http://www.cbahealthcareren o.com
Centennial Psychological Services	702-608-0404	7445 W. Azure Dr. Ste #130 Las Vegas, NV 89130	Clark	Counseling	http://www.centpsych.com
Center for Anxiety & Chronic Worry	775-831-2436	937 Tahoe Blvd Ste. #210 Incline Village, Nevada 89451	Washoe	Counseling, Therapy	http://www.anxietytreatmentinclinevillage.com/anxiety-treatment-incline-village/index.html
Cheri Jacobsen	775-846-8487	180 W. Huffaker Suite #303 Reno, Nevada 89511	Washoe	Counseling	http://www.christiancounselinginreno.com
Children's Cabinet	775-856-6200	1090 South Rock Blvd. Reno, NV 89502	Washoe	Therapy, Casework	www.childrenscabinet.org
Children & Family Counseling, LLC	775-434-8590 775-575-4141 775-575-4141	216 N. Pratt Ave. Carson City 35 N. West St. Fernley 1290 Lahonton St. Silver Springs	Washoe	Counseling	http://cficounseling.com/
Christine Lawler	949-923-0776	1180 North Town Center Drive Suite 100 Las Vegas, NV 89138	Clark	Counseling	http://www.christinelawler.com
Circle Meets Square	702-529-2517	Las Vegas, Nevada 89117	Clark	Counseling, Therapy	http://circlemeetsquare.com
Clark County Family Services	702-455-5444 Hotline: 702-399-0081	121 S. Martin Luther Kind Blvd. Las Vegas, NV 89106	Clark	Crisis, Info, Casework, Legal	http://clarkcountynv.gov/family-services/pages/default.aspx

Clark County Juvenile Justice Services	702-455-5225	601 N. Pecos Road Las Vegas, NV 89101	Clark	Info, Casework, Legal	http://www.clarkcountynv.govjjs/pages/default.aspx
Claudia D'alessio Schwarz	702-372-4072	1820 East Warm Springs Road Suite #125 Las Vegas, NV 89119	Clark	Therapy	http://claudiaschwarz.com
ClinicAD	775-826-6218	10631 Professional Circle Suite A Reno, NV 89521	Washoe	Therapy	http://clinic4ad.com
Collaborative Counseling	775-848-9697	9492 Double R Blvd Suite B Reno, NV 89523	Washoe	Counseling, Therapy	http://www.collaborativecounselingreno.com
Collier Counseling and Life Coaching	702-860-5249	220 E Horizon Dr Henderson, NV 89015	Clark	Counseling	https://www.facebook.com/CollierCounseling/
Committee Against Domestic Violence	Office: 775-738-6524 Toll Free: 1-888-738-9454 Crisis Hotline: 775-738-9454	P.O. Box 2531 Elko, NV 89803	Elko	Crisis, Info, Casework, Legal, Therapy, Outreach	www.elkoharborhouse.com/
Committee to Aid Abused Women	Office: 775-329-4150 Crisis Hotline: 775-329-4150	1735 Vassar St. Reno, NV 89502	Washoe	Crisis, Info, Legal, Therapy	www.caaw.org
Community Chest	Victim Advocate Unit: 775-847-9311 Virginia City: 775-847-0414	Victim Advocate Unit 991 S. C Street Virginia City, NV 89440 175 E. Carson Street Suite A. Virginia City, NV 89440		Therapy, Outreach	https://communitychestnevada.net/
Community Service Agency (CSA)	775-786-6023	1090 E. 8th St. Reno, NV	Washoe	Housing, Counseling	www.csareno.org
Common Ground Therapy and Enhancement	775-549-6497	180 W Huffaker Lane Suite #303 Reno, Nevada 89511	Washoe	Counseling, Therapy	

Compass Behavioral Health	775-461-3622	224 E Winnie Ln #213 Carson City, NV 89706	Carson	Counseling, Therapy	http://www.cbhealthcc.com/
Conservatory of Hope Treatment Services, LLC	702-222-0034	5447 S Durango Dr # 100 Las Vegas, NV 89113	Clark	Counseling, Therapy	https://www.facebook.com/Conservatory-of-Hope-Treatment-Services-1451980378408170/
Constance Sheltren	775-884-3600	623 W Washington St # A Carson City, NV 89703	Carson	Therapy	
Consultation & Counseling Associates Inc.	702-529-2627	5836 S Pecos Road Suite 204 Las Vegas, Nevada 89120	Clark	Counseling	
CorConcepts Counseling & Enrichment Center	775-507-4496	100 N Arlington Ave #330 Reno, NV 89501	Washoe	Therapy	http://corconcepts.us/
Couch Doc	702-635-6171	Scottsdale Plaza 8860 S Maryland Pkwy - Suite 115 Las Vegas, NV 89123	Clark	Counseling, Therapy	http://www.truetherapy.com
Counseling and Educational Services, LLC	775-233-0717	9492 Double R Blvd Building B Reno, NV 89521	Washoe	Counseling, Info	
Counseling Center and Supportive Servs Ely Counseling and Supportive Services	775-289-1671	1675 Avenue F Ely, NV 89301	White Pine	Counseling	http://www.thecarecenters.com/show/Counseling-Center-And-Supportive-Servs-Ely-Counseling-And-Supportive-Services-Ely-NV
Courage to Blossom Counseling	702-789-6471	9414 W Lake Mead Blvd Ste #210 Las Vegas, NV 89129	Clark	Counseling	
Creative Mental Health, LLC Owner	702-472-8516	2770 South Maryland Parkway Suite 316-A Las Vegas, NV 89109	Clark	Counseling	

Crescent Counseling LLC	702-789-6482	2975 S Rainbow Road Suite C Las Vegas, NB 89146	Clark	Counseling	
Cynthia Kozmary	702-567-4810	2851 El Camino Ave., #200 Las Vegas, NV 89102 3595 S. Town Center Drive, #115 Las Vegas, NV 89135	Clark	Counseling, Therapy	http://www.vegascounselingcenter.com
Cynthia Pickett	775-322-6462	401 Court St Reno, NV 89501	Washoe	Counseling, Therapy	http://cynthiapickett.com
D'Arcy Vanderpool	702-242-4222	8440 W. Lake Mead Blvd. Suite #206 Las Vegas, NV 89128-7648	Clark	Counseling, Therapy	http://www.drhappiness.com
Dana Anderson	775-323-4242	333 Flint Street Reno, NV 89501	Washoe	Counseling, Therapy	http://www.danaanderson-mft.com
Danielson Therapy	702-339-5663	9480 S Eastern Avenue Suite #258 Las Vegas, NV 89123	Clark	Therapy	http://danielsontherapy.com
David Gosse	702-385-4673	2620 Regatta Drive Suite #102 Las Vegas, NV 89128	Clark	Counseling	http://www.drgossepsychologist.com
David M Kramer	702-595-8734	2235 E Flamingo Rd #109 Las Vegas, NV 89119	Clark	Counseling, Therapy	
Deborah J Ribnick, PhD, PC	775-786-1234	5595 Kietzke Lane Ste #110 E Reno, NV 89511–5513	Washoe	Counseling, Therapy	http://www.ribnick.net
Deborah Sampson	702-340-5452	8565 S. Eastern Ave. Ste. #186 Las Vegas, NV 89123	Clark	Counseling, Therapy	http://www.deborahsampsonms.com
Deena Shiode	702-384-7661 702-487-9215	501 S Rancho Dr Las Vegas, NV 89106	Clark	Counseling, Therapy	
Delatorre Counseling, LLC	702-930-8453	Henderson, NV 89052	Clark	Counseling, Therapy	
Dena R Johns	702-576-9849	8430 West Lake Mead Suite #112 Las Vegas, NV 89128	Clark	Counseling	https://www.facebook.com/counselingnevada/
Denning Counseling	702-749-4666	Las Vegas, NV 89130	Clark	Counseling	
Department of Child and Family Services	702-715-1182 702-430-0745	4344 W. Cheyenne Ave. Las Vegas, NV 89023-2484	Clark	Crisis, Info, Casework, Legal, Therapy	http://dcfs.nv.gov

Depression Treatment at Seven Hills	Toll free: 866-331-5541	3021 W. Horizon Ridge Parkway Henderson, NV 89052	Clark	Crisis, Casework, Therapy	http://www.sevenhillsbi.com/depression
Derrick Johnson	775-434-1840	Reno, Nevada 89509	Washoe	Counseling	
Desert Psychological	702-650-6508	9183 West Flamingo Road #100 Las Vegas, NV 89147	Clark	Counseling, Therapy	http://www.desertpsychological.com/
Desert Rose Counseling	702-715-1182 702-430-0745	4344 W. Cheyenne Ave. North Las Vegas, NV 89032	Clark	Therapy	https://www.facebook.com/desert-rose-counseling-group-503021176553495/
Desert Willow Residential Treatment Center	702-486-8900 702-486-8900	6171 W Charleston Blvd Las Vegas, NV 89146 1820 E Sahara Ave Las Vegas, NV 89104	Clark	Casework, Crisis, Therapy	http://dcfs.nv.gov/Programs/CMH/Resident-day-treatment-svcs/
Desiree Bowsher	702-430-1342	8879 W Flamingo Rd Ste 101 Las Vegas, NV 89147	Clark	Counseling	http://www.lvmft.com
Destination to Recovery Henderson Outpatient	702-919-6167 Toll free: 877-341-3225	9089 S Pecos Road Suite #3500 Henderson, NV 89074	Clark	Outreach, Therapy, Casework	http://www.destinationstorecovery.com/ourfacilities/henderson/
Diamond Mental Health	702-395-4002	5071 N Rainbow Blvd #170 Las Vegas, NV 89130	Clark	Therapy	
Diana L Kennedy	702-487-9359	4760 S Pecos Road Building 100 Unit 6 Las Vegas, NV 89120	Clark	Counseling, Therapy	
Dignity Counseling Center	702-577-3179	7271 W Charleston Blvd Ste #180 Las Vegas, NV 89117	Clark	Counseling, Therapy	
Dina Noricks	702-430-2682	9418 W Lake Mead Blvd Las Vegas, NV 89134	Clark	Therapy	
Discount Counseling and DUI School	775-250-3149	45 W Cedar St, # 110 Fernley, NV 89408	Lyon	Counseling, Info, Outreach	
Discovery Life Management Services	702-925-8779	2620 Regatta Dr Ste #102 Las Vegas, NV 89128	Clark	Counseling, Therapy	
Domestic Violence	Office: 775-423-1313	485 W. B Street, Ste. 106	Churchill	Crisis, Info, Therapy	https://www.facebook.com

Intervention, Inc.	Crisis Hotline: 775-427-1500	Fallon, NV 89406			/dvi89406/
Donald Posson, Ph.D.	855-799-6897 855-732-7686	222 S Rainbow Ste #222 Las Vegas, NV 89145	Clark	Counseling	
Donna Buddington	775-781-4213 775-591-8960	399 Mottsville Ln Gardnerville, NV 89460	Douglas	Counseling	
Dr. Merle Michelle Askren	619-458-9805	9320 Carmel Mountain Rd. Suite D San Diego, CA 92129 - also practices in Reno	Washoe	Therapy	
Dr. Garen Mirzaian, M.D.	775-858-3303	690 Edison Way Reno, NV 89502	Washoe	Therapy	
Dr. J. Juan Garcia Ph.D.	702-291-8364	3595 S Town Center Las Vegas, NV 89135	Clark	Counseling, Therapy	
Dr. Kathi Zellers	702-800-2357 702-630-8865	9111 W Russell Rd Las Vegas, NV 89148	Clark	Therapy	http://www.mylvtherapist.com
Dr. Rod Jones	702-357-3275	8275 South Eastern Avenue Suite #200 Las Vegas, NV 89123	Clark	Therapist	
Dr. Sylvia Naseath	702-353-7646	6853 W Charleston Blvd Las Vegas, NV 89117	Clark	Counseling, Therapy	
E. Ree Noh, PhD, PLLC	775-473-8807	5595 Kietzke Lane Suite 110-D Reno, NV 89511	Washoe	Therapy	http://www.reenohphd.com
Eagle Quest	702-646-5437	3680 N. Rancho Drive Las Vegas, NV 89130	Clark	Info, Outreach	http://www.eaglequestofnevada.org
Eden Pastor	702-595-6818	107 E Charleston Blvd #215 Las Vegas, NV 89104	Clark	Therapy	http://arttherapylasvegas.com
Eddy House	775-686-6244	423 E. 6th Street Reno, NV 89512	Washoe	Crisis	www.eddyhouse.org
Elaine Zentz	775-773-4413	200 South Virginia St Reno, NV 89501	Washoe	Counseling	
Elements of Motivation	702-331-4874	7040 Laredo Ave Las Vegas, NV 89117	Clark	Counseling, Therapy	http://www.elementsofmotivation.com
Elizabeth 'Betty' Barker	775-741-5800	506 Holcomb Avenue Reno, NV 89502	Washoe	Counseling, Therapy	http://www.bettybarkermft.com/
Elizabeth	702-239-7182	8565 South Eastern	Clark	Counseling,	http://www.e

DeYoung		Ave Suite #140 Las Vegas, NV 89123		Therapy	lizabethdeyounglcsw.com
Elizabeth Schnobrich	702-685-3300	2775 S Jones Blvd Las Vegas, NV 89146	Clark	Therapy	
Elko Counseling and Supportive Services	775-738-8021	1825 Pinion Road, Ste. A Elko, NV 89801	Elko	Counseling	
Equanimity Counseling and Consulting	702-847-7576 702-807-9531	3435 W Craig Rd Suite D Las Vegas, NV 89132	Clark	Counseling, Therapy	https://www.facebook.com/EquanimityCC/
Evelyn D Adelaja	702-570-9263	3430 East Flamingo Road Suite 204 Las Vegas, Nevada 89121	Clark	Therapy	
Evergreen Counseling	702-248-6290	5300 W. Sahara #104 Las Vegas, NV 89146	Clark	Counseling, Therapy	https://2evergreencounseling.com
Evolution Therapy and Counseling	702-978-7988	9480 S Eastern Avenue Suite #258 Las Vegas, NV 89123	Clark	Counseling, Therapy	
Evolving Reflections	702-850-2833	3652 N Rancho Dr #102 Las Vegas, NV 89130	Clark	Counseling, Therapy	http://www.evolvingreflections.com
Faith Ind and Family Counseling	702-553-2396	2620 Regatta Dr, Ste #102 Las Vegas, NV 89128	Clark	Therapy	https://www.facebook.com/FaithFamilyCounseling/ and http://faithindandfamilycounseling.com
Family and Child Treatment (FACT)	702-258-5855	8080 W. Sahara Ave. Suite D Las Vegas, NV 89117	Clark	Therapy, Outreach	http://www.factsnv.org/
Family and Payee Counseling Service of Northern Nevada	775-329-0623	575 E. Plumb Lane Reno, NV 89502	Washoe	Therapy	http://www.fcsnv.org/sexual_abuse_treatment_groups.html
Family Fixer	702-646-6284	3295 North Fort Apache Las Vegas, NV 89129	Clark	Counseling	http://familyfixer.net

Foundations Counseling Center	702-879-5867	2921 N Tenaya Way Suite #235 Las Vegas, NV 89128	Clark	Counseling, Therapy	
Frontline Counseling	775-238-4215	80 Continental Dr Ste #101 Reno, NV 89509	Washoe	Counseling	
The Gay and Lesbian Community Center of Southern Nevada (The Center)	702-733-9800	401 S. Maryland Pkwy Las Vegas, NV 89101	Clark	Info, Therapy, Outreach	http://www.thecenterlv.org/
Gen Wallace	702-286-1984	2298 W Horizon Ridge Pkwy #201 Henderson, NV 89052	Clark	Counseling, Therapy	http://www.pathwaystherapynv.com/bio-geneva-wallace.php
Gender Justice Nevada-Queer Anti-Violence Project	Office: 702-425-7288 Crisis Hotline: 702-425-7287 Toll Free: 1-888-425-7287	7465 W. Lake Mead Blvd #107 Las Vegas, NV 89128	Clark	Info, Crisis	www.genderjusticenv.org
Gentle Minds LLC	702-850-3855	9550 S. Eastern Ave Suite #220 Las Vegas, NV 89123	Clark	Therapy	http://www.gentlemindstherapy.com
Goals 4 Success	702-787-7985	5138 North Juliano Rd. Las Vegas, NV 89149	Clark	Counseling, Therapy, Outreach	http://goals4success.org
Gold Clinical Services	702-875-6618	3885 S. Decatur Suite #2010 Las Vegas, NV	Clark	Therapy	http://goldclinicalservices.com
Gold Mind Hypnotherapy LLC	702-488-7200	410 S. Rampart Blvd., Suite #390 Las Vegas, NV 89145 170 S. Green Valley Pkwy, Suite #300 Henderson, NV 89012	Clark	Therapy	http://www.alexmarichypnosis.com
Grand Desert Psychiatric Services	702-202-0099	2021 South Jones Las Vegas, NV 89146	Clark	Counseling, Info, Therapy	http://www.mentalhealthtreatmentlasvegasnv.com
Great Basin Behavioral	775-453-4143	1325 Airmotive Way, Suite #100	Washoe	Counseling, Info,	http://www.greatbasinwell

Health and Wellness		Reno, NV 89502		Therapy	ness.com
Green Light Counseling	702-907-9443	1180 North Town Center Drive Suite #100 Las Vegas, NV 89144	Clark	Counseling	http://www.greenlightcounseling.org
Griffin Family Therapy	702-534-3788 702-485-0430	6069 S Fort Apache Rd #100 Las Vegas, NV 89148	Clark	Counseling, Therapy	
Guevara Counseling Center,PLLC	702-366-0251 702-728-4869	501 So. Rancho Dr. #C-17 Las Vegas, NV 89106	Clark	Therapy, Info	http://www.guevaracounselingcenter.com
Harmony Healthcare	702-251-8000 Toll free: 800-363-4874	Harmony Healthcare 9140 West Post Road Las Vegas, NV 89148 1701 West Charleston, Suite #300 Las Vegas, NV 89102 (East Side – Horizon Ridge) 3005 W. Horizon Ridge Parkway, Suite 101 Henderson, NV 89052	Clark	Counseling, Info, Therapy	http://www.harmonyhc.com
Head To Heart, LLC	702-460-7236	2821 W. Horizon Ridge Parkway Suite #121 Henderson, NV 89052	Clark	Therapy	http://www.headtoheartnv.com
Heads Up Guidance & Wellness	702-922-7015	2801 S. Valley View Blvd Suite #6 Las Vegas, NV 89102	Clark	Counseling, Info, Outreach, Therapy	http://www.headsupnevada.org
A Healing Center	702-595-7440	3703 Vegas Dr. Suite A Las Vegas, NV 89108	Clark	Therapy	www.a-healing-center.com
Healing Minds, LLC	775-448-9760	6490 S. McCarran Blvd Bldg. A Unit 6 Reno, NV 89509	Washoe	Therapy	www.healingminds.com
Healing Reflections	702-332-5874	6787 W Tropicana Ave Suite 246 Las Vegas, NV 89103	Clark	Therapy	
Healing Solutions Counseling Center	702-799-9660	7371 W Charleston Blvd Suite 110 Las Vegas, NV 89117	Clark	Counseling	
Healing Steps Family Therapy	702-803-3258	3097 E Warm Springs Ave Building 4, Suite 400 Las Vegas, NV 89120	Clark	Therapy	
Health &	702-339-1165	3595 S. Town Center	Clark	Counseling	http://www.h

Harmony Counseling		Dr. Suite 118 Las Vegas, NV 89135			nhlv.com
Healthy Minds	702-455-4629	8845 W. Flamingo Suite 210 Las Vegas, NV 89147 501 S Rancho Dr. Suite B10 Las Vegas, NV 89106 526 S Tonopah Dr. Suite 160 Las Vegas, NV 89106 9065 S. Pecos Rd., Suite 260 Henderson, NV 89074 3551 E Bonanza Road, Suite 101 Las Vegas, NV 89110	Clark	Therapy	http://www.healthymindslv.com
Helaine Hunter-Smith	702- 525- 2050	9402 West Lake Mead Blvd. Las Vegas, NV, 89134	Clark	Therapy	http://therapyinlasvegas.com/contact/
Higher Ground Counseling Services LLC	702-525-8402	7371 W. Charleston Blvd Suite 110 Las Vegas, NV 89117	Clark	Counseling	http://www.highergroundcounselingservicesllc.com
Hilary E Katz	702- 553-1014	2620 Regatta Drive, Suite 102 Las Vegas, NV 89128	Clark	Therapy	http://www.drhilarykatz.com
Hina's Odyssey	702-978-8115	4132 S Rainbow Blvd Suite 149 Las Vegas, NV 89103	Clark	Counseling	https://groups.psychologytoday.com/rms/group/Internship+Meetup_Las+Vegas_Nevada_89103_41979_95106
Honey Bee Behavioral Health/CEH	-702-430-2710	6284 N Rainbow Blvd #110, Las Vegas, NV 89130	Clark	Therapy	http://www.myhoneybeetherapy.com
Human Dimensions Unlimited, Inc.	702-254-0090	9402 W Lake Mead Blvd, Las Vegas, NV 89134	Clark	Counseling	http://www.manta.com/c/mwfpg8w/human-dimensions-unlimited-inc
Ian L. Pritchard,	775-200-0626	6170 Ridgeview Court Suite C	Washoe	Therapy	https://www.drianpritchard

Ph.D.		Reno, NV 89519			.com
ICAN Family Services	702-327-1760	8022 S Rainbow Blvd 318 Las Vegas NV 89139 2340 E. Calvada Blvd Suite E. Pahrump, NV 89048	Clark, Nye	Counseling	http://www.icanfamilyservices.com/contact-us.html
ICLV Wellness Center	702-673 - 4745	3425 Cliff Shadows Pkwy, Las Vegas, NV 89129	Clark	Counseling	http://iclv.com/wellness/
iEvolve Center	702-475-9990	6070 S Eastern Ave #200 Las Vegas, NV 89119	Clark	Therapy	https://www.youtube.com/channel/UChs_lnZcnc7vwaKVOe_cZ_w
Illuminations Counseling	702-431-3626	2320 Paseo Del Prado B-111 Las Vegas, NV 89102	Clark	Counseling	http://www.illuminationscounseling.com
Incrementum Family Development Centers, LLC	702-330-3113	2620 Regatta Drive Suite 102, Office # 212 Las Vegas, NV 89128	Clark	Therapy	
Ingraham Counseling Services, PLLC	702-728-4763	501 S Rancho Dr., C-17 Las Vegas, NV 89106	Clark	Counseling	
Inner Quest Therapeutic Center	702-796-8607	9402 W. Lake Mead Blvd., Suite 106 Las Vegas, NV 89134	Clark	Therapy	http://www.innerquestsite.com/index.htm
Insight Therapy Solutions	702-685-0877	5631 S. Pecos Rd. Las Vegas, NV 89120	Clark	Therapy	http://www.team-iscs.com
Insightful Living Inc.	702-686-2069	5420 W. Sahara #201 Las Vegas, NV 89146	Clark	Therapy	http://www.insightfullivinginc.com
Inspire Counseling Services, LLC	702-824-4878	501 S. Rancho Dr., Ste. E-27 Las Vegas, NV 89106	Clark	Counseling	http://www.inspirecounselingservices.com
Inspired To Shine	702-350-1650	2980 S. Rainbow Blvd. Ste. 210B Las Vegas, NV 89146	Clark	Therapy	http://inspiredtoshine.com
Integrated Behavioral Healthcare	775-657-8499	890 Mill Street Suite 305 Reno, NV 89502	Washoe	Therapy	http://renomemorycare.com
Integrated Psychological, Inc.	702-335-9394	9183 W Flamingo Rd, Las Vegas, NV 89147	Clark	Therapy	https://therapists.psychologytoday.com/rms/zip/89147

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Integrated Sleep & Wellness	775-826-6218	10631 Professional Circle Suite A Reno, NV 89521	Washoe	Therapy	http://www.renosleepwell.com/index.html
James Bowen Counseling	702-728-4972	3243 E Warm Springs Rd Suite 100 Las Vegas, NV 89120	Clark	Counseling	http://www.jamesbowencounseling.com
Jane Heenan	702-475-6474	7465 W Lake Mead Blvd., #107, Las Vegas, NV 89128	Clark	Therapy	http://genderjusticenv.org
Jay Noricks	702-877-4944	9418 W Lake Mead Blvd Las Vegas, NV 89134	Clark	Therapy	http://counselinglasvegas.net
Jeff Andersen	775-453-4105	243 Stewart St Reno, Nevada 89501	Washoe	Therapy	https://therapists.psychologytoday.com/rms/name/Jeff_Andersen_LMFT_Truckee_California_235027
Jennifer Guttman	702-218-0403	2820 W Charleston Blvd, Las Vegas, NV 89102	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Jennifer_Guttman_MA,EdM_Las+Vegas_Nevada_259065
Jennifer K Pietrzak, LCSW	702-219-7597	1770 W. Horizon Ridge Parkway #130 Henderson, NV 89012	Clark	Counseling	http://www.jenniferpietrzak.com
Jennifer Vecchio	702-248-8866	2740 S Jones Blvd, Las Vegas, NV 89146	Clark	Therapy	https://www.healthgrades.com/provider/jennifer-vecchio-3p5ll
Jenny Stepp Professional Counseling	702-336-7620	9418 W. Lake Mead Blvd. Las Vegas, NV 89134	Clark	Counseling	http://www.lvcounselor.com
Jewish Family Service Agency	702-732-0304	4794 S. Eastern Ave. Las Vegas, NV 89119	Clark	Counseling	http://www.jfsalv.org/services/counseling/
JLM Counseling LLC	775-741-2719	118 Selmi Dr. Ste. 201 Reno, NV 89512	Washoe	Therapy	http://www.jlmtherapy.com
JoAnn M. Baird, MFT,	775-629-4701	61 Continental Dr. Reno, NV 89509	Washoe	Therapy	

LLC					
John E Duerr	702-430-6070	2298 W. Horizon Ridge Pkwy, Ste. 213 Henderson, NV 89052	Clark	Counseling	https://www.healthgrades.com/provider/john-duerr-x6x8g#tab=background-check&scrollTo=BackgroundCarePhilosophy_anchor
Joyce D Nash	775-636-8636	243 Stewart St. Reno, NV 89501	Washoe	Therapy	http://drjoycenash.com/contact/
JSM Psychological Services	775-574-4768	502 E. John St. Suite B Carson City, NV	Carson	Therapy	https://therapists.psychologytoday.com/rms/name/JSM+Psychological+Services_Carson+City_Nevada_213083
Judith Mathews	775-233-5977	4747 Caughlin Pkwy Reno, NV 89519	Washoe	Therapy	http://www.judithmathewsmft.com/ServicesProvided.en.html
Julie T. Madgwick, LCSW	702-947-4841	291 N. Tenaya Way Suite 107 Las Vegas, NV 89128-1413	Clark	Counseling	http://www.healthcare4ppl.com/physician/nevada/las-vegas/julie-t-madgwick-1104845130.html#sthash.R7sCNGN0.dpbs
Julius M. Rogina, Ph.D., ABMPP	775-324-2000	427 Ridge St. Reno, NV	Washoe	Therapy	
Justin M. Smith	702-530-8894	3450 E. Russel Road Suite 204 Las Vegas, NV 89120	Clark	Therapy	http://www.justinsmithmft.com/contact-us.html
Kane LCSW, LLC	702-523-8760	7371 E. Charleston Blvd Suite 130 Las Vegas, NV 89117	Clark	Therapy	http://www.kanelcsw.com/contact.html
Kara Lott	702-608-9869	9402 W. Lake Mead Blvd	Clark	Therapy	

		Las Vegas, NV 89134			
Karen E Sims	702-257-0140	6284 S. Rainbow Blvd. Ste. 110 Las Vegas, NV 89118	Clark	Therapy	https://www.healthgrades.com/provider/karen-sims-xf99w
Katherine Wilkinson	800-651-8085 ext. 21933	7371 W. Charleston, Blvd. Suite 110 Las Vegas, NV 89117	Clark	Therapy	http://www.goodtherapy.org/therapists/profile/katie-wilkinson-20140917
Katherine Matthews	702-664-8331	8565 Eastern Ave. Suite 116 Las Vegas, NV 89123	Clark	Therapy	
Kathy Jo Shovlin	702-979-7499	9414 W. Lake Mead Las Vegas, NV 89134	Clark	Therapy	
Katy H Steinkamp MFT, NCPC, LADC	702-723-6912	2298 Horizon Ridge Pkwy Suite 213 Henderson, NV 89052	Clark	Therapy	http://www.disorders.org/therapist/katy-h-steinkamp/
Kay L. Davies, LCSW	775-337-4565	628 Lake St. Reno, NV 89501	Washoe	Counseling	
Kayenta Legacy	702-438-7800	9402, 9414, 9418 W. Lake Mead Las Vegas, NV 89134	Clark	Counseling	https://kayentatherapy.com/contact-us
KC West, LCSW; Clinical Counseling Services, LLC	702-761-3051	8685 S. Eastern Ave Las Vegas, NV 89123	Clark	Therapy	
Keith Lynch	702-209-1095	180 W. Huffaker Lane Suite 303 Reno, NV 89511	Washoe	Counseling	
Kendyll Hollenbeck-Pringle LLC	775-338-1656	1180 Selmi Dr. Reno, NV 89512	Washoe	Therapy	https://kendyllhollenbeck-pringle.com/about/
Keystone Counseling and Consulting, LLC	702-839-3839	295 S. Rainbow Blvd. Suite K Las Vegas, NV 89146	Clark	Therapy, Counseling	http://www.keystonecounselingllc.org
Kiera McGillivray	707-761-6923	7391 W. Charleston Blvd. Las Vegas, NV89117	Clark	Therapy	http://kieramft.wixsite.com/mft-therapist/contact
Kipper	775-621-8727	140 W. Huffaker Lane	Washoe	Therapy	http://www.ki

Horton		Reno, NV 89511			pperhorton.com/index.html
Kiva Counseling, LLC	702-509-0533	9418 W. Lake Mead Blvd Las Vegas, NV 89134	Clark	Therapy	http://www.kivacounseling.com/contact-me/
Kristina Heitzman	800-651-8085 Ext. 25927	2298 W. Horizon Ridge Pkwy Henderson, NV 89052	Clark	Therapy	http://www.goodtherapy.org/therapists/profile/kristina-heitzman-20150618
Lake Mead Wellness Center	702-900-5040	311 S. Water St. Henderson, NV 89015	Clark	Counseling	http://www.lakemeadwellnesscenter.org/contact
Lakeside Psychological Services	847-457-0294	N. Durango Drive Las Vegas, NV 89145	Clark	Therapy	
Las Vegas Counselor LLC	702-892-3900	1980 Festival Plaza Las Vegas, Nevada 89135	Clark	Therapy	http://www.lasvegascounselor.com
Las Vegas Family Therapy LLC	702-485-8470	7391 W Charleston Blvd #120, Las Vegas, NV 89117	Clark	Therapy	http://www.lasvegasfamilytherapy.com
Las Vegas Hypnosis Center	888-783-7880	3430 E Russell Rd #307, Las Vegas, NV 89120	Clark	Therapy	http://lasvegashypnosiscenter.com
Las Vegas Recovery Center	702-515-1373	3321 N Buffalo Dr #150, Las Vegas, NV 89129	Clark	Therapy	http://lasvegasrecovery.com
Las Vegas Therapist & Life Coach Brett Baughman	702-625-1441	10884 Dornoch Castle St Las Vegas, Nevada 89141	Clark	Therapy	http://www.brettbaughman.com
Laura H. Fucci	702-761-3725	9414 W, Lake Mead Las Vegas, Nevada 89134	Clark	Counseling	https://therapists.psychologytoday.com/rms/name/Laura_H_Fucci_MFTSI_Las+Vegas_Nevada_274745
Lauren Greenwood: Anxiety and Stress Solutions	775-360-7134	506 Holcomb Avenue Reno, Nevada 89502	Washoe	Therapy	https://therapists.psychologytoday.com/rms/name/Lauren_Greenwood_MA_Reno_N

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LeBeau Possibilities	702-518-1614	6759 West Charleston BVLD Executive Park East Suite 130 LV NV 89146	Clark	Therapy	http://www.lebeaupossibilities.com
Legacy Health and Wellness	702-942-1774, 775-562-1115	911 N Buffalo Dr #213, Las Vegas, NV 89128 850 Mill Street, Suite 200 Reno, NV 89502	Clark	Counseling	http://legacynv.com
Leigh Church	775-322-6604	325 E Liberty St, Reno, NV 89501	Washoe	Counseling	http://www.renocounseling.net
Leslie Rumph	775-856-0157	1090 S Rock Blvd, Reno, NV 89502	Washoe	Therapy	
Leslie Westfield, PhD PC & Assoc.	702-830-7282	10120 E Eastern Ave Henderson, Nevada 89052	Clark	Therapy	http://drleslie westfield.weebly.com
Leticia A Murphy	702-275-0473	711 Mall Ring Cir #102, Henderson, NV 89014	Clark	Counseling	http://www.leticiamurphytherapy.com
Life Bridge Mental Health	702-765-4965	9402 W Lake Mead Blvd, Las Vegas, NV 89134	Clark	Therapy	http://www.lifebridgekids.com
Life Gateway Behavioral Health	702-823-2313	7548 W Sahara Ave #101, Las Vegas, NV 89117	Clark	Therapy	http://www.lifegatewaybhs.com
Life Relationships Counseling Educational Guidance	702-825-7343	North Las Vegas, Nevada 89031	Clark	Counseling	
Life Steps Counseling & Consulting	702-900-3032	1334 S Maryland Pkwy Las Vegas, NV 89104-3310	Clark	Counseling	http://npiprofile.com/npi/1669748323
LifeQuest Behavioral Health Care	702-830-9740 775-636-7767 775-299-3738	4780 Arville Street Las Vegas, NV 89103 65 Regency Way Suite A Reno, Nevada 89509 405 Idaho Street #216 Elko, Nevada 89801	Clark, Washoe, Elko	Therapy	http://www.lifequestnv.com
Lifespan	775-544-5650	505 So. Arlington Ave.,	Washoe	Counseling	https://www.l

Counseling		Ste 212 Reno, NV 89509-1527			ifespanreno.com
LifeStar	702-513-0508	9418 W Lake Mead Blvd Las Vegas, Nevada 89134	Clark	Therapy	https://kayentatherapy.com
Lynda Harper	775-322-6605	325 E Liberty St, Reno, NV 89501	Washoe	Therapy	http://www.harpercounselingreno.com
Lynne Berardi	702-685-0674	4425 S Jones Blvd, Las Vegas, NV 89103	Clark	Therapy	http://www.aamft.org/cgi-shl/twserver.exe?run:locatmem_1:call:ds_locatmem+where+TCode=898726
Mandie Kelel	702-234-9325	9402 W Lake Mead Blvd, Las Vegas, NV 89134 7331 W Charleston Blvd Suite 140 Las Vegas, Nevada 89117	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Mandie_Kelel_MS,MFT,NCC_Las+Vegas_Nevada_41677
Marcia Lee MS MFT	702-605-0499	5852 S Pecos Road H-2 Las Vegas, Nevada 89120	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Marcia_Lee_MS,MFT_Las+Vegas_Nevada_77161
Margaret Johansen, M.S., MFT	702-492-6773	11145 S Eastern Ave, Henderson, NV 89052	Clark	Therapy	http://margaretjohansen.com
Marjorie Landron	702-888-0036	3085 S Jones Blvd, Las Vegas, NV 89146	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Marjorie_Landron_MSW,LSW,CSW-I_Henderson_Nevada_294268
Mark Anderson	702-363-6429	2620 Regatta Drive, Suite 102 Las Vegas, NV 89128	Clark	Therapy	http://www.nvcbt.com
Mark Brana	702-825-7247	2520 St Rose Parkway Suite 202D	Clark	Therapy	

		Henderson, Nevada 89074			
Mary Howden, MFT	775-237-4595	250 Village Blvd Suite 3 Incline Village, Nevada 89451 691 Sierra Rose Dr Suite B Reno, Nevada 89511	Washoe	Counselor	https://therapists.psychologytoday.com/rms/name/Mary_Howden_MA,MFT,NCC_Incline+Village_Nevada_127718
McAuliffe Therapy	775-722-8316	W Huffaker Ln, Reno, NV 89511	Washoe	Therapy	http://www.mcauliffetherapy.com
Meri L Shadley	775-329-4582	1005 Forest St, Reno, NV 89509	Washoe	Therapy	http://npino.com/marriage-counselor/1962549857-dr.-meri-l.-shadley/
Michelle Dahan MFT, LLC	702-856-6763	7371 W Charleston Blvd #130, Las Vegas, NV 89117	Clark	Therapy	http://www.dahanmft.com
Mick Hall	775-527-1746	4747 Caughlin Pkwy, Reno, NV 89509	Washoe	Counseling, Therapy	https://therapists.psychologytoday.com/rms/name/Mick_Hall_LMFT,LCADC_Reno_Nevada_73991
Mindful Coaching	775-230-1507	2005 Peaceful Valley Dr, Reno, NV 89521	Washoe	Therapy	http://www.mhappe.com
Mindful Mountain Counseling	775-530-8607	626 Humboldt St, Reno, NV 89509	Washoe	Counseling	http://mindfulmountain.com
Mirit Sloves	775-209-1044	180 W Huffaker Lane Suite 303 Reno, Nevada 89511	Washoe	Therapy	https://therapists.psychologytoday.com/rms/name/Mirit_Sloves_PhD,MFT,MCHP_Reno_Nevada_180496
Mojave Mental Health	775-334-3033	745 W. Moana Lane Reno, NV 89509	Washoe	Therapy	http://med.unr.edu/mojave/contact-us
Monica C Joyner	775-636-6453	403 Flint St Reno, Nevada 89501	Washoe	Therapy	https://www.joynercounseling.com
Monique Cox	702-324-1541	3663 E Sunset Rd #102, Las Vegas, NV	Clark	Therapy	http://www.counselingthera

		89120			pistlasvegas.com
MonteVista Hospital	702-364-1111	5900 W Rochelle Ave, Las Vegas, NV 89103	Clark	Therapy	http://www.montevistahospital.com
Namaste Counseling	775-549-6112	505 South Arlington Suite 210 Reno, Nevada 89509	Washoe	Counseling	
Natasha Mosby	702-631-9275	2535 W Cheyenne Ave #102, North Las Vegas, NV 89032	Clark	Therapy	
Neubauer Mental Health Services	702-806-5268	5426 Vegas Dr, Las Vegas, NV 89108 2920 N Green Valley Pkwy Building 8 Suite 812 Henderson 89014	Clark	Therapy	http://www.nmhslv.com
Neurofeedback & Counseling Associates	720-466-2924	5852 South Pecos Rd Bldg H, Suite 9 Las Vegas, Nevada 89119	Clark	Counseling	http://www.counseling-eeg.com
Nevada Behavioral Solutions	702-802-4900	6889 S Eastern Ave #102, Las Vegas, NV 89119	Clark	Therapy	http://www.nevadabehavioralsolutions.com/contact-us/our-office-location/
Nevada Family Psychiatry	702-714-1904	2780 S Jones Suite 205 Las Vegas, Nevada 89146	Clark	Therapy	
Nevada Psych Eval Inc	775-235-4356	2450 Vassar Street Reno, Nevada 89502	Washoe	Counseling	
Never Give Up Behavioral Health Services	702-951-9751	2675 S Jones .., 102 Las Vegas NV 89146 3111 S. Valley View Blvd., G101 Las Vegas NV 89102	Clark	Therapy, Counseling	http://nevergiveupbehaviorhealthservices.com
Nevada Indians, Inc., HealthCare & Community Services	775-788-7600	1475 Terminal Way Suite B Reno, NV	Washoe	Info, Legal, Therapy	www.nevadaurbanindians.org
Nevada Partnership for Homeless Youth	702-383-1332	481 Shirley St. Las Vegas, NV 89119	Clark	Crisis, Info	http://wwwnphy.org/

Nevada Suicide Prevention	None	N/A	--	Outreach	http://nvsuicideprevention.org
New Horizons Counseling Center	702-545-0229	7371 W Charleston Blvd #130, Las Vegas, NV 89117	Clark	Counseling /Therapy	http://nhcclv.com
New Leaf Counseling	702-830-4576	3017 W Charleston Blvd Suite 70 Las Vegas, Nevada 89102	Clark	Counseling	
New Leaf Therapy	775-600-9660	180 W. Huffaker Lane Suite 303 Reno, NV 89511	Washoe	Therapy	http://www.newleaftherapynv.com
New U Therapy	702-728-4118	2298 West Horizon Ridge Parkway Suite 201 Henderson, Nevada 89052	Clark	Therapy	http://newutherapy.wixsite.com/newutherapy
Niles E Strohl	702-623-4915	3097 E Warm Springs Rd Las Vegas, Nevada 89120	Clark	Therapy, Counseling	http://www.nilesstrohl.com
Niswonger Psychological Health	702-825-2515	7495 W Azure Dr #204, Las Vegas, NV 89130	Clark	Therapy	http://www.nphlv.com
Norma Yadira Platt	702-904-8456	4560 S Eastern Ave Suite 15 Las Vegas, Nevada 89119	Clark	Therapy	
Oasis Counseling	702.294.0433	2360 W Horizon Ridge Pkwy, #120, Henderson NV 89052 7361 Prairie Falcon Rd, Las Vegas NV 89128 4985 S Rainbow Blvd, Las Vegas NV 89118	Clark	Counseling	http://oasiscounselingtoday.com
Odelia Duhel	702-803-3170	220 E Horizon Dr Suite G Henderson, Nevada 89015	Clark	Therapy	http://odeliatherapy.wixsite.com/odeliatherapy
Olive Branch Therapeutic Services	775-644-3434	495 Apple St, Suite 225 Reno, Nevada 89502	Washoe	Therapy	http://www.olivebranchtherapeuticservices.com
Open Arms Counseling	702-823-4300, 775-751-0444	203 S. Water Street, Henderson, NV 89015	Clark, Nye	Counseling	http://www.openarmscounseling.com

		1017 E. Basin Ave Suite 3, Pahrump, Nevada 89060			
Owens Psychological Services	702-714-0806	2510 W Horizon Ridge Pkwy #200, Henderson, NV 89052	Clark	Therapy	http://owensps.com
Pacific Behavioral Health	775-287-8270	860 Tyler Way Sparks, NV 89431	Washoe	Therapy	http://pbehavioralhealth.com/about/
Pamela Smith	702-623-0460	7 Water Street Suite A Henderson, Nevada 89015 730 N Eastern Ave Las Vegas, Nevada 89101	Clark	Counseling	https://therapists.psychologytoday.com/rms/name/Pamela_Smith_MS,CADC-I,LPC-I_Henderson_Nevada_294417
Pathways Therapy and Wellness Center	702-363-7284	2298 W Horizon Ridge Pkwy #201, Henderson, NV 89052	Clark	Therapy	http://www.pathwaystherapynv.com
Patricia Hanisee	702-825-7119	2620 Regatta Dr Building 102 Suite 219 Las Vegas, Nevada 89128	Clark	Therapy	
Penny Fife	702-228-3306	9402 W Lake Mead Blvd, Las Vegas, NV 89134	Clark	Therapy	http://www.pennyfife.com
Person-Holistic Innovations	702-518-4532	3150 West Sahara Avenue, Ste B21, Las Vegas, NV 89102	Clark	Therapy	https://www.personholisticinnovations.com
Presence Therapy	775-384-8340	527 Plumas St Reno, Nevada 89509	Washoe	Therapy	http://www.presencetherapyreno.com
Proffit Therapy Services	657-666-0460	7495 W Azure Dr #260, Las Vegas, NV 89130	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Jessica_S_Proffit_LCSW_Las+Vegas_Nevada_160412
Proteus Therapeutic Solutions, Inc.	702-966-3121	4000 S Eastern Ave #140, Las Vegas, NV 89119	Clark	Therapy	http://www.proteus-inc.org
A Psychiatrist Who Does Talk Therapy	510-495-4826	3663 E Sunset Rd Ste 104 Las Vegas, NV, 89120	Clark	Therapy	

Purple Wings	Email: pwgirls@purplewings.org	N/A	Clark	Casework, Legal, Outreach	http://purplewings.org/
Rape Crisis Center of Southern Nevada	702-385-2153	801 S. Rancho Dr. Ste. B-2 Las Vegas, NV 89106	Clark	Crisis, Info, Casework, Legal, Therapy, Outreach	http://rcclv.org/
Rational Therapy and Recovery, Inc.	775-786-8801	501 W 1st St, Reno, NV 89503	Washoe	Therapy	http://rationaltherapyandrecovery.com
Rebecca Love	702-685-0674	4425 S Jones Blvd, Las Vegas, NV 89103	Clark	Therapy	https://therapists.psychologytoday.com/rms/name/Rebecca_Love_MS,LMFT,LADC_Las+Vegas_Nevada_121746
Reflections Therapy- Dr. Soseh Esmaeili, PsyD	702-978-7791	2620 Regatta Drive Suite 102 (room 220) Las Vegas, Nevada 89128	Clark	Therapy	
Relational Wellness Institute	702-533-8411	3425 Cliff Shadows Pkwy #150 Las Vegas, NV 89129 8879 W Flamingo Rd Ste 101 Las Vegas, NV 89147 220 E Horizon Drive Henderson, NV 89015	Clark	Therapy	http://relationalwellnessinstitute.com
Renee Walker, MFT	775-671-0581	370 Wheeler Avenue Reno, NV 89502	Washoe	Therapy	http://reneewalkertherapies.com
Renegade Counseling	775-348-4900	527 Humboldt St, Reno, NV 89509	Washoe	Counseling	http://www.renegadecounseling.com
Reno / Sparks Adolescent Boys' Center	775- 424-6777	7555 Pyramid Way Sparks, NV 89436	Washoe	Counseling	http://teenchallenge.net/centers/reno
Reno Sparks Gospel Mission	Office: 775-323-0386 24 Hour Line: 775-329-0485	2115 Timber Way Reno, NV 89512	Washoe	Crisis, Therapy	www.rsgm.org
Reno Psy Services	775-784-6828	1664 N. Virginia Street Reno, NV 89557	Washoe	Therapy	http://www.unr.edu/psycho

					logy/psychological-services
Reno Therapy	775-827-7500	177 Cadillac Place Reno, NV 89509	Washoe	Therapy	http://www.reno-therapy.com
Renovation Mental Health	775-525-0270	255 W Moana Ln, Reno, NV 89509	Washoe	Therapy	http://www.rmhsllc.org
Rich McGuffin, Ph.D., MFT	775-391-4049	61 Continental Dr. Reno, NV 89509	Washoe	Therapy	http://www.drrichmcguffin.com
Richer Life Counseling	888-443-4903	9414 W Lake Mead Blvd, Las Vegas, NV 89134	Clark	Counseling	http://richerlifecounseling.com
RISE Center For Recovery	918-876-5001	4575 W. Torino Ave., Suite 300, Las Vegas, NV	Clark	Therapy	http://www.nevadacouncil.org/treatment/rise-center-recovery/
Robert L. Vazzo, LMFT	800-249-3501	3460 EAST SUNSET ROAD, Suite K-108 LAS VEGAS, Nevada, US 89120	Clark	Therapy	http://www.christiancounselordirectory.com/Therapist/Robert-L-Vazzo-LMFT_32259
ROI Counseling LLC	702- 816-2595	5017 Alta Dr, Las Vegas, NV 89107	Clark	Counseling	http://www.roicounseling.com
Ron Zedek	702-434-1200	6889 S Eastern Ave, Las Vegas, NV 89119	Clark	Therapy	http://www.nevadabehavioralsolutions.com
Rosa Bellota MD	702-987-6174	4958 S Rainbow Blvd Suite 100, Las Vegas, NV 89118	Clark	Therapy	http://www.oasisbehavioralhealthlv.com
Ruth Ann Wright	775-322-1957	327 Thoma St, Reno, NV 89502	Washoe	Therapy	http://www.drrawright.com
Safe Embrace	Office: 775-322-3466 Crisis Hotline: 775-322-3466 Toll Free Crisis 1-877-781-0565	780 E. Lincoln Way Sparks, NV 89434 PO Box 3745 Reno, 89505	Washoe	Crisis Therapy	www.safeembrace.org
S.A.F.E. House Nevada Hotline	702-564-3227	921 American Pacific Dr. Suite 300	Clark	Crisis, Info, Casework, Therapy	http://www.safehousnv.org/

		Henderson, NV 89014			
Safe Nest	Counseling: 702-877-0133 Crisis Hotline: 702-646-4981 or 800-486-7282	2915 W. Charleston Blvd. Suite 12 Las Vegas, NV 89102	Clark	Crisis, Info, Casework, Legal, Therapy, Outreach	http://www.safenest.org
SAFY of Nevada Specialized Alternatives for Families	702-385-5331	4285 N. Rancho Drive, Suite 130 Las Vegas, NV 89130	Clark	Therapy	http://www.safy.org/nevada/
Sage Health Services, LLC	702-319-1555 775-200-0935	3130 South Durango Dr. Ste 400 Las Vegas, NV 89117 4600 Kietzke Ln., Ste M-246 Reno, NV 89502 3595 Hwy 50 W. Suite 2 Silver Springs, NV 89429 1255 Waterloo Ln Gardnerville, NV 89410 40 East Center Street Unit #6 Fallon, NV 89406	Clark, Washoe, Lyon, Douglas, Churchill	Therapy	http://www.sagehealthservices.com
Salvation Army Shelter	702-870-4430	2900 Palomino Lane Las Vegas, NV 89107	Clark	Info, Casework, Therapy	http://www.salvationarmysouthernnevada.org
Sandal Kelly PhD LMFT	702-490-6500	5836 S PECOS ROAD, SUITE 102 Las Vegas NV, 89120	Clark	Therapy	http://www.skellyphd.com
Sandra Abdullah	702-979-3695	3885 S Decatur Blvd Suite 2100 Las Vegas, Nevada 89103	Clark	Therapy	
Sandy Lowery	775-825-3428	327 Thoma Street Reno, Nevada 89502	Washoe	Therapy	
Sarah Haggerty	702-675-8351	1334 S. Maryland Pkwy. Suite 3 Las Vegas, Nevada	Clark	Therapy	http://www.belume.com

		89104			
Sarah Longson	702-449-9001	801 S Rancho Dr E-8, Las Vegas, NV 89106	Clark	Therapy	http://www.longsontherapy.com
The Shade Tree	702-385-0072	6675 S. Tenya Way #130 Las Vegas, NV 89113	Clark	Crisis, Info, Casework, Legal, Therapy, Outreach	http://www.theshadetree.org/
Shainker Behavioral Therapy, LLC	702-625-0060	7473 W. Lake Mead Blvd. Suite 100 Las Vegas, NV 89128	Clark	Therapy	www.shainkertherapy.com
Shannon L Becker	702-761-3783	8430 W. Lake Mead Blvd, Suite100 Las Vegas, NV 89128	Clark	Therapy	
Sherita Childress	702-728-4435	3652 N. Rancho Drive Suite 102 Las Vegas, NV 89130	Clark	Counseling	
Shining Star Community Services	702-882-7827	5420 W. Sahara Ave. Las Vegas, NV 89146	Clark	Skills training, Therapy	www.shiningstarlv.com
Siena Family Therapy	702-380-3290	2649 W. Horizon Ridge Henderson, NV 89052	Clark	Therapy	
Sierra Counseling & Neurotherapy	775-885-7717	Eagle Medical Center 2874 N. Carson St. Suite 215 Carson City, NV 89706	Carson	Counseling	www.scncounseling.com
Sierra Ridge Counseling	775-232-6835	150 Country Estates Suite 107 Reno, NV 89511	Washoe	Counseling, Addictions	www.sierraridgecounseling.com
Sierra Sunrise Wellness Group	775-240-0814	888 W. Second Street Reno, NV 89503	Washoe	Counseling, Life Coach	www.sagespiritcoaching.com
Silver State Counseling and Therapy	775-323-1829	556 California Ave. Reno, NV 89509	Washoe	Counseling & Therapy	
Simmons LMFT, LLC	702-260-6203	9053 S. Pecos Rd Henderson, NV 89074	Clark	Counseling	
Southern Nevada Child and Adolescent Mental Health Services	702-486-6120	6171 W. Charleston Blvd. Bldg. 8 Las Vegas, NV 89146	Clark	Info, Caseworkd	www.dcfs.nv.gov/programs/cmh/contact_cmhs/
Southern Nevada Children's Assessment	702-455-5371	701 N. Pecos Blvd. Building K1 Las Vegas, NV 89101	Clark	Info, Casework, Legal	http://www.clarkcountynv.gov/sncac/

Center (SNAC)					
Sparks Christian Fellowship	775-331-2303 ext. 119	510 Greenbrae Dr. Sparks, NV 89431	Washoe	Therapy	http://www.scf.net/ministries/supportrecovery-groups/
Spring Mountain Treatment Center	702-873-2400	7000 W. Spring Mountain Rd. Las Vegas, NV 89117	Clark	Inpatient/ Outpatient	www.springmountaintreatmentcenter.com
Spring Valley Therapy	702-830-9315	6069 S. Fort Apache Rd. Suite 100 Las Vegas, NV 89148	Clark	Therapy	
Step 2	775-787-9411	3700 Safe Harbor Way, Reno, NV	Washoe	Crisis, Therapy	www.step2.org
Stephanie Dillon	775-329-4345	1065 Haskell St. Reno, NV 89509	Washoe	Therapy	
Stephanie Robinson	702-937-3493	3150 W. Sahara Ave. Suite B21 Las Vegas, NV 89102	Clark	Counseling	
Stephanie Stowman PhD	702-690-5983	2470 St. Rose Parkway Henderson, NV 89074	Clark	Therapy	www.drstowman.com
Stephen Nicholas	775-825-2503	691 Sierra Rose Dr. Suite B. Reno, NV 89511	Carson	Therapy	
Strength in Life BHS	702-998-0551	3650 N. Rancho Drive Suite 104 Las Vegas, NV 89130	Clark	Therapy	
Summerlin Counseling associates	702-360-8050	8440 W. Lake Mead Blvd. Las Vegas NV 89128	Clark	Therapy	
Summit Mental Health	702-823-3910	3017 W. Charleston Blvd. Suite 70 Las Vegas, NV 89102	Clark	Therapy	
Susan Deakyne	775-741-0973	305 Stewart St. Reno, NV 89502	Washoe	Counseling	www.Susandeakyn.com
Susan Dow	702-370-8912	1980 Festival Plaza Dr. Suite300 Las Vegas, NV 89135	Clark	Counseling / Addictions	www.susandow.com
Suzanne Faust, Ph.D.	702-551-1234	6787 W. Tropicana Ave. Suite 272 Las Vegas, NV 89103	Clark	Counseling	
T & Z Psychotherapy Practice, LLC	702-978-7059	5135 Camino Al Norte Suite 279 N. Las Vegas, NV 89031	Clark	Therapy	

Tahoe SAFE Alliance	Office: 775-298-0010 Truckee: 530-582-9117 Tahoe City: 530-583-3440 ext. 15 24-hour Line: 800-736-1060	948 Incline Way Incline Village, NV 89457	Washoe	Crisis, Legal, Therapy, Outreach	www.tahoesafealliance.org
Tahoe Treatment Center	775-636-8289	5421 Kietzke Lane Suite 202 Reno, NV 89511	Washoe	Therapy	www.tahoetreatmentcenter.com
Tami Nurkin Gruner	702-459-8264	720 W. Cheyenne Ave. Suite 200 N. Las Vegas, NV 89030	Clark	Counseling	
Tammi Johnson	702-518-8061	6787 W. Tropicana Ave. Suite 262 Las Vegas, NV 89103	Clark	Counseling / Addictions	www.tammijohnsoncounselinglv.com
Terianne Harrison	775-391-0099	571 California Ave. Reno, NV 89509	Washoe	Therapy	www.tntharrison.com
The Brain Train Center	702-228-8236	5600 Spring Mountain Rd. Bldg B, Suite 207 Las Vegas, NV 89146	Clark	Counseling	www.thebraintraincenter.com
The Center for Emotional Health	702-776-9287 ext. 203	6284 S. Rainbow Blvd. Suite 110 Las Vegas, NV 89118	Clark	Therapy	
The Healthy Foundations Center	702-789-7834	6871 W. Charleston Blvd. Las Vegas, NV 89117	Clark	Counseling	
Therapeutic Wellness Services, INC	702-930-8087	5020 Alta Dr. Suite B Las Vegas, NV 89107	Clark	Counseling	
Therapy Treatment Centers	702-423-2625	2055 W. Charleston Blvd. Suite C Las Vegas, NV 89102	Clark	Therapy	www.therapytreatmentcenters.com
Three Leaf Therapy	775-200-9509	Reno, NV 89512	Washoe	Therapy	
Through Life's Challenges	702-756-5234	6787 W. Tropicana Ave Suite 262 Las Vegas, NV 89103	Clark	Counseling	www.tlc-lv.com
Tina M Groves	775-772-1884	243 Stewart Street Reno, NV 89501	Washoe	Counseling	www.tinagrovescounseling.com

TLC Coaching, Counseling & Hypnotherapy	702-321-5062	2920 S. Jones Suite 110-B Las Vegas, NV 89146	Clark	Counseling / Hypnosis	www.drlisalamb.com
Tommie K. Forage, LCSW	702-726-0709	Las Vegas, NV	Clark	Therapy	www.coreselftherapy.com
Trailways Mental Health	702-560-5973	5120 S. Pecos Rd Las Vegas, NV 89120	Clark	Therapy	www.trailwaysmg.com
Transitional Wellness Center	702-339-0346	5820 S. Pecos Rd. Suite 100 Las Vegas, NV 89120	Clark	Therapy	www.transitionalwellnesscenter.com
Treatment Consultation Services	775-557-4024	245 Mt. Rose Street Reno, NV 89509	Washoe	Intervention Services	
Triston Neeson	702-758-3582	9414 W. Lake Mead Blvd. Las Vegas, NV 89134	Clark	Therapy	www.tristonneeson.wixsite.com
True North Treatment Center	775-870-5027	3740 Lakeside Dr. Suite 202 Reno, NV 89509	Washoe	Counseling	www.tntcreno.com
Turning Tides Therapy & Wellness LLC	775-842-5669	140 W. Huffaker Lane Suite 505 Reno, LV 89511	Washoe	Therapy	www.turningtidestherapy.com
UNLV The Center for Individual, Couple, and Family Counseling	702-895-3627	4505 S. Maryland Pkwy Las Vegas, NV 89154	Clark	Therapy	https://www.unlv.edu/cicfc
UNLV The Practice	702-895-3627	4505 S. Maryland Pkwy Las Vegas, NV 89154	Clark	Therapy	https://www.unlv.edu/thepractice/about
UNLV Counseling and Psychological Services	702-895-3627	4505 S. Maryland Pkwy	Clark	Therapy	http://www.unlv.edu/srwc/caps
(UNR) Psychological Services Center	775-682-8684	Dept. of Psychology 1664 N. Virginia Street Reno, NV 89557	Washoe	Therapy	http://www.unr.edu/psychology/psychologicalservices/services
UNR- Victims of Crime Treatment Center	775-682-8684	Edmund J. Cain Hall Room 206 Reno, NV 89512	Washoe	Therapy	http://www.unr.edu/psychology/psychological-services
Valerie E Leclercq	702-336-3855	1481 West Warm Springs #132, Henderson, NV 89014	Clark	Therapy	http://www.drvalerieleclercq.com/index.html

Valley Counseling Center, LLC.	702-830-9418	3230 S Buffalo Drive Suite 107 Las Vegas, Nevada 89117	Clark	Counseling	http://www.samradayani.com
Valley View Family Counseling	702-320-3180	7530 W Sahara Ave, Las Vegas, NV 89117	Clark	Counseling	http://www.valleyviewfamilycounseling.com
Vegas Therapy	702-333-4391	801 South Rancho Drive Suite E8 Las Vegas, NV 89106	Clark	Therapy	http://vegastherapy.net
Vencer Youth Services	702-267-6277	4955 S Durango Dr Las Vegas, NV 89113	Clark	Counseling	http://www.venceryouth.com
Victorious Beginnings Behavioral Center	702-278-3622	9414 W Lake Mead Blvd, Las Vegas, NV 89134	Clark	Counseling	http://www.victoriousbeginnings.org
Volunteer Attorneys for Rural Nevadans (VARN)	775-883-8278 or 866-448-8276	904 N. Nevada Street Carson City, NV 89703	Carson	Crisis, info, casework, legal	www.varn.org
Washoe County Children's Advocacy Center	775-284-2761	2097 Longley Lane Reno, NV 89502	Washoe	Legal	
Washoe County Department of Juvenile Services	775-325-7800	650 Ferrari-McLeod Blvd. Reno, NV 89512	Washoe	Info	https://www.washoecounty.us/juveniles/index.php
Washoe County Department of Social Services	775-328-2700	1001 E. Ninth Street Building C, Room 135-C Reno, NV 89512	Washoe	Casework	https://www.washoecounty.us/socsrv/
William Jenkins	775-885-7717	2874 N Carson St Carson City, NV 89703	Carson	Therapy	http://www.sncounseling.com/home.html
Yountina Tona Ambis	702-241-2472	4560 S Eastern Ave #13, Las Vegas, NV 89119	Clark	Counseling	http://www.tonaambis.com
Yunique Counseling	775-432-2742	2435 Pyramid Way b, Sparks, NV 89431	Washoe	Counseling	http://www.yuniquecounseling.com
Zephyr Wellness	775-525-1616	418 Cheney St, Reno, NV 89502	Washoe	Therapy	http://www.zephyrwellness.org

Appendix E- Nevada Addiction Specialists for Juveniles

Agency	City	County	Inpatient/ Outpatient	Website
A.T.W. HOUSE	Las Vegas	Clark	Inpatient/ Outpatient	
American Addiction Centers	Las Vegas	Clark	Inpatient	http://americanaddictioncenters.com
Associated Bilingual Counselors	Henderson	Clark	Outpatient	
B.S.I. HOUSE	Las Vegas	Clark	Outpatient	
Behavioral Health Services	Carson City	Carson	Outpatient	
Bridge Counseling Associates	Las Vegas	Clark	Outpatient	http://www.bcalv.com/Home.html
Carson City Community Counseling Center	Carson City	Carson	Outpatient	http://www.cccofcarsoncity.org/us/contact-us/
Center for Addiction Medicine	Las Vegas	Clark	Outpatient	http://addictionhelp.com
Center for Behavioral Health of	Las Vegas	Clark	Outpatient	http://centerforbehavioralhealth.com
Center for Independent Living	Las Vegas	Clark	Inpatient/ Outpatient	http://www.sncil.org
Choices Group Inc.	Las Vegas	Clark	Outpatient	
Community Counseling Center of Southern Nevada	Las Vegas	Clark	Outpatient	http://www.cccofsn.org
Counseling Center and Supportive Services- Ely Counseling and Supportive Services	Ely	White Pine	Outpatient	
Dana Anderson	Reno	Washoe	Outpatient	http://www.danaanderson-mft.com
Dawn Spillman	Las Vegas	Clark	Outpatient	
Depression Treatment at Seven Hills	Henderson	Clark	Inpatient/ Outpatient	http://www.sevenhillsbi.com/depression
Destination to Recovery Henderson Outpatient	Henderson	Clark	Outpatient	http://www.destinationstorecovery.com
Discount Counseling and DUI School	Fernley	Lyon	Outpatient	
Donna Buddington	Gardnerville	Douglas	Outpatient	
Double R Counseling	Reno	Washoe	Outpatient	
Ely Health Station	Ely	White Pine	Outpatient	
Family and Child Treatment of Southern Nevada	Las Vegas	Clark	Outpatient	http://www.factsnv.org/FACT/HOME.html
Fresh Start Family Services	North Las Vegas	Clark	Outpatient	

Harmony Healthcare	Las Vegas	Clark	Outpatient	http://www.harmonyhc.com/about/location
JSM Psychological Services	Reno	Washoe	Outpatient	
Kendyll Hollenbeck-Pringle LLC	Reno	Washoe	Outpatient	https://kendyllhollenbeck-pringle.com
Las Vegas Drug Alcohol Treatment	Las Vegas	Clark	Inpatient/ Outpatient	
Las Vegas Indian Center	Las Vegas	Clark	Outpatient	
Las Vegas Recovery Center	Las Vegas	Clark	Outpatient	http://lasvegasrecovery.com/?cpao=118
LifeStar	Las Vegas	Clark	Outpatient	https://kayentatherapy.com
Love All, Serve All, LLC.	Las Vegas	Clark	Inpatient/ Outpatient	
Lynda Harper	Reno	Washoe	Outpatient	
Lyon Council on Alcohol - Dayton	Dayton	Lyon	Outpatient	
Lyon Council on Alcohol - Fernley	Fernley	Lyon	Outpatient	
Lyon Council on Alcohol – Silver Springs	Silver Springs	Lyon	Outpatient	
Lyon Council on Alcohol – Virginia City	Virginia City	Lyon	Outpatient	
Mary Howden, MFT	Incline Village	Washoe	Outpatient	
McAuliffe Therapy	Reno	Washoe	Outpatient	http://www.mcauliffetherapy.com
Mirit Sloves	Reno	Washoe	Outpatient	
Namaste Counseling	Reno	Washoe	Outpatient	
Nevada Behavioral Solutions	Las Vegas	Clark	Outpatient	http://www.nevadabehavioralsolutions.com
New Frontier	Fallon	Churchill	Inpatient/ Outpatient	
Nicole Altamirano	Reno	Washoe	Outpatient	
Oasis Counseling	Henderson	Clark	Outpatient	http://oasiscounselingtoday.com
Oasis Counseling	Las Vegas	Clark	Outpatient	http://oasiscounselingtoday.com
Professional Bi-lingual Counseling	Reno	Washoe	Outpatient	
Rational Therapy and Recovery, Inc.	Reno	Washoe	Outpatient	http://www.rationaltherapyandrecovery.com
Renegade Counseling	Reno	Washoe	Outpatient	
Ruby View Counseling Service	Elko	Elko	Outpatient	
Sierra Counseling & Neurotherapy	Carson City	Carson	Outpatient	http://www.scncounseling.com/home.html
Summit Mental Health	Las Vegas	Clark	Outpatient	http://www.summitmentalhealth.org
Transitional Wellness Center	Las Vegas	Clark	Outpatient	

Treatment Consultation Services	Reno	Washoe	Outpatient	
Vencer Youth Services	Las Vegas	Clark	Outpatient	http://www.venceryouth.com
Vitality Center - Cottonwood Counseling Services	Battle Mountain	Lander	Outpatient	http://vitalityunlimited.org/home.shtml
Vitality Unlimited - Actions of Elko County	Elko	Elko	Inpatient/ Outpatient	http://vitalityunlimited.org/home.shtml
Vitality Unlimited - Restoration Counseling Services	Las Vegas	Clark	Outpatient	http://vitalityunlimited.org/Home.shtml
Westcare, Henderson	Henderson	Clark	Outpatient	https://www.westcare.com
Westcare, Nevada	Las Vegas	Clark	Inpatient	https://www.westcare.com
William Jenkins	Carson City	Carson	Outpatient	http://www.scncounseling.com/home.html
Willow Springs Center	Reno	Washoe	Outpatient	http://willowspringscenter.com
Yunique Counseling	Sparks	Washoe	Outpatient	http://www.yuniquecounseling.com

Appendix F- Nevada Psychiatrists

Practitioner	Phone	City	Zip	County
Dr. Robert Fliegler, M.D.	(775) 841-7644	Carson City	89703	Carson City
Dr. Gail Marie Krivan, M.D.	(775) 461-3132	Carson City	89703	Carson City
Dr. Dwarakanath Vuppalapati, M.D.	(775) 885-4521	Carson City	89703	Carson City
Dr. Gary Charles Ridenour, M.D.	(775) 423-6400	Fallon	89406	Churchill County
Dr. Kim Alan Adamson, M.D.	(775) 530-7614	Fallon	89406	Churchill County
Dr. John R. Ares, M.D.	(702) 386-4700	Las Vegas	89128	Clark County
Raymond Allen Mondora, D.O.	(702) 322-1051	Las Vegas	89101	Clark County
Dr. Chinyere L. Okeke, M.D.	(702) 202-0099	Las Vegas	89146	Clark County
Dr. Sanghamitra Basu, M.D.	(702) 362-7246	Las Vegas	89149	Clark County
Willis Y. Wu, M.D.	(702) 362-7246	Las Vegas	89149	Clark County
Dr. Sanghamitra Basu, M.D.	(702) 362-7246	Las Vegas	89149	Clark County
Dr. Ronald Jay Kohn, M.D.	(702) 487-6500	Las Vegas	89130	Clark County
Dr. Rick Ray Horton, M.D.	(702) 791-9000 x15296	North Las Vegas	89086	Clark County
Dr. Leon Schwartz Perel,	(702) 476-9999	Las Vegas	89129	Clark County
Dr. James Robert Eells, M.D.	(702) 796-3847	Las Vegas	89128	Clark County
Dr. Kevin Templar, M.D.	(702) 835-9760	North Las Vegas	89032	Clark County
Elena Belen Garcia, M.D.	(702) 363-5575	Las Vegas	89128	Clark County
Dr. Sanghamitra Basu, M.D.	(702) 362-7246	Las Vegas	89128	Clark County
Zachariah W. Chambers, M.D.	(702) 463-1088	Las Vegas	89130	Clark County
Dr. Brian Thomas Le, D.O.	(702) 676-2000	Las vegas	89128	Clark County
Leo Capobianco, D.O.	(702) 233-1715	Las Vegas	89128	Clark County
Dr. quan Haduong, M.D.	(702) 386-3700	Las Vegas	89128	Clark County
Dr. William H. Baumgartl, M.D.	(702) 320-8111	Las Vegas	89128	Clark County
Dr. Elliot Eungyong Shin, M.D.	(702) 796-3847	Las Vegas	89128	Clark County
Dr. James Robert Eells, M.D.	(702) 796-3847	Las Vegas	89128	Clark County
Dr. Praveen Saran, M.D.	(702) 355-9111	Las Vegas	89128	Clark County
Dr. Floyd Thomas Meachum, D.O.	(702) 636-0085	North Las Vegas	89032	Clark County
Dr. Thomas Chih-Han Yee, M.D.	(702) 813-3888	Las Vegas	89144	Clark County

Dr. Steven Johnson, M.D.	(702) 804-0166	Las Vegas	89145	Clark County
Dr. David D. Moon, D.O.	(702) 876-2225	Las Vegas	89145	Clark County
Dr. David Henry Rosenstein,	(702) 242-2737	Las Vegas	89145	Clark County
Dr. Paterno S. Jurani, M.D.	(702) 258-4900	Las Vegas	89107	Clark County
Rosalita C. Jurani, M.D.	(702) 258-4900	Las Vegas	89107	Clark County
Bernard Addo-Quaye, M.D.	(702) 657-6365	North Las Vegas	89030	Clark County
Dr. Paul Nguyen, M.D.	(702) 405-9080	N. Las Vegas	89030	Clark County
Dr. Michael Raoul Coy, D.O.	(702) 255-4200	Las Vegas	89145	Clark County
Dr. Seth Kabutey Adjovu, M.D.	(702) 798-1233	North Las Vegas	89030	Clark County
James G. Marx, M.D.	(702) 878-4568	Las Vegas	89107	Clark County
Dr. Brandon Lawrence Snead, M.D.	(702) 518-5774	Las Vegas	89146	Clark County
Dr. Westbrook Lawrence Kaplan,	(702) 544-2289	Las Vegas	89135	Clark County
Dr. Leo Lee Gallofin, M.D.	(702) 518-7562	Las Vegas	89146	Clark County
Jacob Manjooran, M.D.	(702) 486-4400	Las Vegas	89146	Clark County
Dr. Stephen Howard Frye, M.D.	(702) 341-6411	Las Vegas	89117	Clark County
Matthew Obim Okeke, M.D.	(702) 202-0099	Las Vegas	89146	Clark County
Dr. Mustafa Rawaf, D.O.	(702) 527-7401	Las Vegas	89102	Clark County
Dr. Jelena Kunovac, M.D.	(702) 527-7401	Las Vegas	89102	Clark County
Dr. Steven A. Holper, M.D.	(702) 878-3510	Las Vegas	89102	Clark County
Dr. Alain Coppel,	(702) 476-9999	Las Vegas	89102	Clark County
Dr. Victor Klausner, D.O.	(702) 474-4454	Las Vegas	89106	Clark County
Dr. Joel Mark Grisham, M.D.	(725) 777-3168	Las Vegas	89102	Clark County
Maurice D. Gregory, Jr., M.D.	(702) 822-1356	Las Vegas	89106	Clark County
Dr. Robert Lynn Horne, M.D.	(702) 822-1188	Las Vegas	89102	Clark County
Dr. Kunal R. Parikh, M.D.	(702) 476-9999	Las Vegas	89102	Clark County
Dr. Jaemi Keith, M.D.	(702) 476-9999	Las Vegas	89102	Clark County
Dr. Harry Leo Duran, M.D.	(702) 671-5637	Las Vegas	89101	Clark County
Dr. David Michael Mathis, D.O.	(702) 671-5685	Las Vegas	89101	Clark County
Alafuro Oruene, M.D.	(702) 310-9110	Las Vegas	89106	Clark County
Chinenye Ezeanolue, M.D.	(702) 310-9110	Las Vegas	89106	Clark County
Dolue David Ezeanolue, M.D.	(702) 310-9110	Las Vegas	89106	Clark County
Dr. George B. Kaiser, M.D.	(702) 385-3330	Las Vegas	89101	Clark County

Dr. David E Linden,	(702) 384-2238	Las Vegas	89146	Clark County
Dr. Robert J Mendenhall, D.O.	(702) 454-0201	Las Vegas	89102	Clark County
Dr. James Joseph Vilt, M.D.	(702) 251-8000	Las Vegas	89102	Clark County
Dr. Anurag Gupta, M.D.	(702) 228-4900	Las Vegas	89146	Clark County
Lesley R. Dickson, M.D.	(702) 382-6262	Las Vegas	89104	Clark County
Dr. Steven V. Kozmary, M.D.	(702) 380-3210	Las Vegas	89102	Clark County
Dr. Karen L. Cruey, M.D.	(702) 247-1703	Las Vegas	89102	Clark County
Constance Gayle Brown, M.D.	(702) 485-5212	Las Vegas	89147	Clark County
Dr. Danial Olen Laird, M.D.	(702) 595-8378	Las Vegas	89147	Clark County
Dr. Collin Davis Johnston, D.O.	(702) 759-2443	Las Vegas	89147	Clark County
Dr. Joseph David Lee, M.D.	(702) 630-1100	Las Vegas	89102	Clark County
Dr. Kahmien A. LaRusch, M.D.	(702) 257-3099	Las Vegas	89146	Clark County
Agapito B. Racoma, M.D.	(702) 382-7878	Las Vegas	89146	Clark County
Dr. Sudhir S. Khemka, M.D,	(702) 880-4193	Las Vegas	89103	Clark County
Dr. Kathleen Crosby Cansler, M.D.	(702) 932-3176	Las Vegas	89103	Clark County
Dr. Peter A. Mansky, M.D.	(702) 405-7285	Las Vegas	89147	Clark County
Dr. Faisal Ahmed Suba, M.D.	(845) 659-6317	Las Vegas	89103	Clark County
Dr. Christopher Cruz, M.D.	(702) 220-9667	Las Vegas	89103	Clark County
Ivan L. Goldsmith, M.D.	(702) 367-0808	Las Vegas	89148	Clark County
Traci Grossman, M.D.	(702) 399-9000	Las Vegas	89113	Clark County
Dr. Daniel Park, D.O.	(702) 364-1111	Las Vegas	89103	Clark County
Dr. Melvin I. Pohl, M.D.	(702) 364-1484	Las Vegas	89103	Clark County
Dr. Michael S. Levy, D.O., F.A.S.A.M.	(702) 873-7800	Las Vegas	89103	Clark County
Dr. Brian M Pierson, M.D.	(702) 485-2100	Las Vegas	89103	Clark County
Dr. Mario F. Tarquino,	(702) 968-6259	Las Vegas	89109	Clark County
Dr. Marjorie Elaine Belsky, M.D.	(702) 968-6259	Las Vegas	89109	Clark County
Dr. Eric Wolfson, M.D.	(702) 452-2525	Las Vegas	89103	Clark County
Dr. Warren James Seeds, M.D.	(702) 948-8660	Las Vegas	89148	Clark County
Dr. Stacie Lynnette Oliver, M.D.	(702) 948-8660	Las Vegas	89148	Clark County
Dr. Heath R. Wills,	(702) 948-8660	Las Vegas	89148	Clark County
Dr. Jeremy Marc Lipshutz, M.D.	(702) 948-8660	Las Vegas	89148	Clark County
Lesley R. Dickson, M.D.	(702) 796-0660	Las Vegas	89121	Clark County
Dr. Caroline M. DeLucia, M.D.	(702) 533-2193	Las Vegas	89118	Clark County

Dr. Armen Edward Nikogosian, M.D.	(702) 362-9930	Las Vegas	89118	Clark County
Dr. Jonathan George Still, M.D.	(702) 251-8000	Las Vegas	89148	Clark County
Dr. Farrukh Imtiaz, M.D.	(702) 933-6767	Las Vegas	89169	Clark County
Dr. Muhammad Ali Hyder, M.D.	(800) 447-9150	Las Vegas	89121	Clark County
Dr. Robert P. Kaplan, M.D.	(702) 462-9350	Las Vegas	89119	Clark County
Dr. Charles Henry McSwain, D.O.	(702) 419-7529	Las Vegas	89119	Clark County
Dr. José Maria Partida Corona, M.D.	(702) 565-6004	Las Vegas	89121	Clark County
Dr. Brian Eric Lee,	(702) 434-6336	Las Vegas	89121	Clark County
Dr. Edward K. Tsai, D.O.	(702) 896-4433	Las Vegas	89139	Clark County
Dr. Charles Henry Tadlock, M.D.	(702) 474-0200	Las Vegas	89119	Clark County
Dr. Renee Lim Ngo, M.D.	(702) 855-0748	Las Vegas	89120	Clark County
Dr. Thomas Andrew Gonda, Jr., M.D.	(510) 495-4826	Las Vegas	89120	Clark County
Dr. Maxine B. Ingham, M.D.	(702) 367-8204	Henderson	89014	Clark County
Phil Y. Chen, D.O.	(702) 260-7818	Henderson	89074	Clark County
Dr. Rob Toledo, D.O.	(702) 933-5544	Henderson	89014	Clark County
Dr. Evan Curt Allen, M.D.	(702) 541-8240	Henderson	89074	Clark County
Dr. Carolyn Anne Matzinger, M.D.	(702) 380-1974	Las Vegas	89141	Clark County
Saleha Baig, M.D.	(702) 365-9006	Las Vegas	89123	Clark County
Dr. Alexander Imas,	(702) 982-7100	Henderson	89012	Clark County
Mostafa Sheta, M.D.	(702) 567-9002	Henderson	89015	Clark County
Dr. Colin Matthew Rock, M.D.	(702) 476-9999	Henderson	89012	Clark County
Linda Jean Fuller-Brown,		N Las Vegas	89086	Clark County
Dr. Zahid Hamid,	(702) 655-1400	Las Vegas	89146	Clark County
Dr. James Henry Sullivan, M.D.	(775) 445-7225	Carson City	89705	Douglas County
Kirin Leslie Madden,	(775) 738-2252	Elko	89801	Elko County
Richard W. Katschke, Jr., M.D.	(775) 726-3121	Caliente	89008	Lincoln County
Dr. Stephen Andracki, M.D.	(775) 727-5509	Pahrump	89048	Nye County
Dr. Kim Alan Adamson, M.D.	(775) 530-7614	Lovelock	89419	Pershing County
Dr. Howard Junior Wing, M.D.	(435) 634-5600	Saint George	84770	Washington County
Dr. Abdollah Assad, M.D.	(775) 322-8900	Reno	89512	Washoe County
Dr. Dwarakanath Vuppalapati, M.D.	(775) 356-4595	Sparks	89434	Washoe County

Dr. Jeffrey W. Lovett, M.D.	(775) 331-6400	Sparks	89434	Washoe County
Karen Sue McDermott, M.D.	(775) 825-5008	Sparks	89434	Washoe County
Dr. Dan G. Snow, M.D.	(775) 853-7669	Reno	89511	Washoe County
Dr. Michael M Salas, M.D.	(775) 982-5000	Reno	89521	Washoe County
Dr. Mark William Viner, M.D.	(775) 772-6015	Sparks	89441	Washoe County
Jacob L. Blake, M.D.	(775) 323-2080	Reno	89511	Washoe County
Dr. Michael P. O'Brien,	(775) 851-1505	Reno	89511	Washoe County
Dr. Andrew Lawrence Geisler, M.D.	(775) 828-2873	Reno	89509	Washoe County
Thomas A. Naegele, D.O.	(775) 424-0785	Sparks	89436	Washoe County
Dr. Kenneth W. Pitman, M.D.	(775) 689-5410	Reno	89511	Washoe County
Dr. Andrew C. Wesely, M.D.	(775) 689-5410	Reno	89511	Washoe County
Dr. Steven E. Berman,	(775) 689-5410	Reno	89511	Washoe County
Dr. Jan Meyer Thompson, M.D.	(775) 832-9332	Reno	89502	Washoe County
Dr. Robert Gene Rand, M.D.	(775) 826-7263	Reno	89509	Washoe County
Dr. Garen Mirzaian, M.D.	(775) 326-2920	Reno	89502	Washoe County
Sarah Zinati, D.O.	(775) 785-7104	Reno	89502	Washoe County
Dr. Kenneth Todd Thunder, M.D.	(775) 328-1414	Reno	89502	Washoe County
Dr. Ryan P. Zeller, D.O.	(775) 786-3330	Reno	89502	Washoe County
Dr. Mark Eric Hahn, M.D.	(775) 328-3066	Reno	89512	Washoe County
Dr. Ryan M. Ley, M.D.	(775) 323-0478	Reno	89507	Washoe County
Jose Mathew Thekkekara, M.D.	(775) 982-5318	Reno	89506	Washoe County
Dr. Quinton Keith Thomas, M.D.	(775) 624-6000	Reno	89523	Washoe County
Dr. Inder Bhanver, M.D.	(775) 787-6463	Reno	89523	Washoe County
Dr. Rob Ruddell Ashby, M.D.	(928) 778-5097	Las Vegas	89129	Yavapai County

About the Author

This report has been prepared by Strategic Progress, LLC., Strategic Progress, led by Cyndy Ortiz Gustafson, MA, specializes in the design and implementation of large scale public policy initiatives, research, data analytics, strategic financing of public programs and projects, and evaluation.

The lead authors on the report are Kelly Stout and Dr. M. Alexis Kennedy, Director of the University of Nevada Las Vegas.

Partners on the 2016 Children's Mental Health systems change project include Reset Management Consultants, Innovative Research and Analysis and the Department of Political Science at the University of Nevada, Reno.

www.strategicprogress.com

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ( ) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

   Nevada's rate of suicide is high and demands continued attention. Yet, it is also notable the gap between the rate in Nevada and for the United States (U.S) overall has narrowed. Rates in Nevada have remained relatively steady since 1999, while the rate for the nation has increased. Nevada has also reduced suicide as a leading cause of death, from being the sixth leading cause to the eighth leading cause of death. Suicide remains the tenth leading cause of death for the nation. Across all states (excluding the District of Columbia), Nevada was the only state with a lower rate in 2014 and 2015 compared to 2005 (WISQARS, 2017). The factors contributing to this difference are not clear and warrant further study. Nevada recognizes the barriers that currently exist to appropriate follow-up care with ever-increasing admissions to emergency departments and mental health hospitals. Exploring effective programs where hospitals follow up with patients after release, ensure the patient is still taking the medication and is connected to outpatient services will help the person stay well. Partners will explore current programs to facilitate patient connection to services within the community which would encourage follow through with discharge plans, reduce return visits to the emergency department, and provide caring outreach post-discharge when risk can be highest. Community programs exist that collaborate with psychiatric hospitals for follow-up such as the Mobile Outreach Safety Team (MOST) team, Crisis Call Center and Division of Child and Family Services (DCFS) Mobile Crisis Response Team. These are all programs that can introduce patients and their families to alternatives which might help avoid visiting an emergency department if services are needed in the future. This proposal will meet individuals recovering from ideation and behaviors through development of a continuity of care pathway that must coordinate within and between systems including health care, public health, law enforcement, and community/family supports. Nevada's proposed goals and objectives will leverage and coordinate existing resources, address unmet needs in our continuity of care and follow-up for treatment and prevention, and establish a sustainable infrastructure to address suicide in our state now and in the future.

3. Have you incorporated any strategies supportive of Zero Suicide? ( ) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ( ) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ( ) Yes ( ) No

   If so, please describe the population targeted.

   Nevada passed legislation to mandate training in suicide prevention for ALL healthcare providers. This initiative was the #1 priority for Nevada Veterans but will also improve outcomes for older adults as well. Priority Populations
   Veterans: Nevada's veterans die by suicide 2 to 2.5 times more frequently than their civilian counterparts. Nevada's suicide rate among veterans also appears to be considerably higher than the national rate. For 2015-2016, preliminary data shows the rate for Nevada veterans was 50.3 per 100,000 compared to an estimated 35.3 per 100,000 Nationwide. Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans (Nevada Office of Public Health Informatics and Epidemiology, 2017). The percentage of veterans with a disability is considerably higher than for non-veterans, and, among disabled veterans, 68% are disabled by a service-connected condition (State of Nevada, 2015).

   Across the United States, the proportion of suicide deaths resulting from firearms among veterans is higher than the non-veteran or civilian population (U.S. Department of Veterans Affairs, 2016). From 2010-2014 the majority (70%) of Nevada's veteran suicide deaths were caused by firearms or explosives.

   Seniors: Since 2001, seniors in Nevada have died from suicide at substantially high rate, nearly twice the rate seen nationwide.

From 1999-2015, the average rate for Nevada was 31.5, compared to 15.3 for the US. In general, the rate of suicide increases throughout the lifespan, with the oldest adults among those most at risk. As with younger adults, those 65 years and older are more likely to have suicidal thoughts if they have depression, other mood disorders, or problems with substance abuse. However, compared to younger cohorts, older adults are more likely to face additional issues which can produce suicidal thoughts, such as ongoing medical conditions, chronic pain, a lack of mobility, or lack of autonomy. Older adults may also be at higher risk of social isolation, undiagnosed depression, or feelings they are a burden (SAMHSA, 2016). These issues point to the need for different strategies and partners to prevent suicide among older adults. As with Nevada's veterans, firearms were used in the majority of deaths among older adults, with firearms/explosives the method of seven out of ten senior suicides from 2010-2015. Poisoning was second most common method among older adults, making up 17% of suicides.

Middle Age Adults: The rate of suicide both nationally and in Nevada is high in middle age. In 2015, the estimated age-adjusted rate for people 55-64 was 29.1, second only to the oldest adults (31.6 for the population 85 and older). In Nevada, people middle age (45-64) are considerably more at risk than younger people including youth. The suicide rate among middle age adults has been increasing nationwide – and a recent study showed while "all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases" (Case & Deaton, 2015). Physical pain, addiction, and declines in mental health, have been hypothesized to contribute to the national increase in suicide observed among this group. A broad number of circumstances may contribute to this rise; however, on the whole, it is reasonable to consider risk factors have increased, while some protective factors have decreased (Keating & Bernstein, 2016). Syndromic surveillance data shows young adult and middle age showing up in EDs with suicide ideation and attempts at higher rates than other ages.

Nevada proposes to use some resources available through this funding opportunity to build capacity and infrastructure related to data collection, specifically concerning suicide. Improvements in data collection related to suicide and suicide attempts would enable DPBH to better determine populations most at risk evaluate the effectiveness of interventions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

File name: Suicide Prevention Narrative 4-17-17 Final Misty Vaughan Allen

Table of Contents

A Population of Focus and Statement of Need

A-1 Comprehensive Demographic Profile (25 years and older)

Geographically, Nevada is the seventh largest state in the United States, covering 110,567 square miles. However, Nevada is only the 35th most populous state. Nevada has fewer people residing in a much larger geographical area than the majority of other states. There are 16 counties and one independent city (Carson City) in the state. According to the U.S. Census Bureau, Nevada has four urbanized areas: Las Vegas, Henderson, Reno and Carson City. These urban areas account for 88% of the state's population. The remaining 12% of the state's population reside in three rural and 11 frontier areas. The U.S. Census Bureau defines an urbanized area as an area which consists of densely developed territory that contains 50,000 people or more. A rural area encompasses all population, housing, and territory not included in an urban area. Frontier areas are sparsely populated rural areas that are isolated from population centers and services. According to the U.S. Census Bureau, the population estimate for Nevada in 2014 was 2,839,099, which represents a 5.1 percent increase from 2010. Nevada saw an increase in population growth of 35% from 2000 to 2010 and has one of the strongest annual growth rates in the country of 1.08%, placing it 16th in the nation. Nevada's growth is expected to continue, reaching a population of 3.36 million residents by 2030. The largest metropolitan areas include Las Vegas, Henderson and North Las Vegas in Clark County, and Reno in Washoe County. Henderson and North Las Vegas are among the 20 fastest growing cities in the United States.

Availability of primary health care and behavioral health care remain a critical issue throughout Nevada. An annual report by the Office of Rural Health, at the University of Nevada, Reno, released in 2016 reported Nevada is ranked 48th among U.S. states for physician per capita. Rankings for behavioral health and health care providers per capita for Nevada are sobering; primary care physicians ranked 50th, family medicine/general practice ranked 46th, registered nurses ranked 51st, psychiatrists ranked 47th, and psychologists ranked 41st. Equally troubling, in the same report, the following statistics related to health professional and mental health professional shortage areas.

- 911,684 Nevadans or 33.7% of the state's population reside in a federally designated primary medical care health professional shortage area (HPSA); nine of 17 of Nevada's counties qualify as single-county primary medical shortage areas.
- Approximately 50.6% of Nevada's population (142,476 residents) of rural and frontier Nevada reside in a primary medical care health professional shortage area (HPSA); nine of 14 rural and frontier counties are single-county primary medical care HPSAs.
- Approximately 53.3% of Nevadans (1.5 million) reside in a federally designated mental health professional shortage area (HPSA); 16 of 17 counties are single-county mental HPSA.
- 100% of the population (286,251 residents) of rural and frontier Nevada live in a mental health professional shortage area (HPSA); 14 of 14 rural and frontier counties are single-county mental HPSAs.

Needs Assessment, Gaps, and Barriers

The Nevada Division of Public and Behavioral Health (DPBH) completed the Certified Community Behavioral Health Clinic (CCBHC) needs assessments to identify behavioral health needs and resources in the service areas using an approach that combined both quantitative and qualitative information. DPBH conducted a systematic review of available data across the Nevada Department

of Health and Human Services (DHHS) that could be used to better understand the unique needs of the populations within the communities the CCBHCs would be located. This data included:

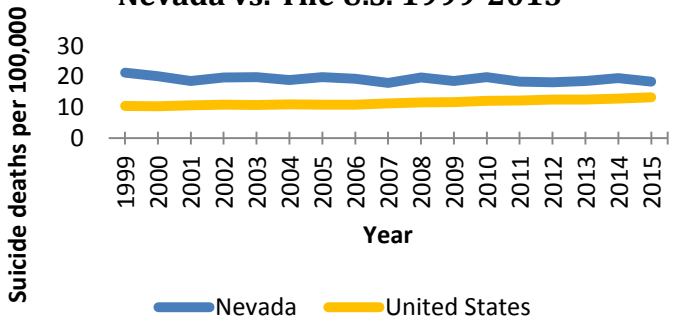
- Number of veterans residing in geographic catchment areas and the distance they would have to travel to obtain services through the Veterans Administration (VA) and other veterans organizations;
- Behavioral health and health risk indicators including crisis call center utilization, wait times for behavioral health services; suicides; behavioral health emergency room (ER) visits and inpatient admissions; data from the Youth Behavior Risk Surveillance Survey (YRBSS); and the Behavioral Risk Factor Surveillance System (BRFSS);
- Social determinants of health including rates of poverty, housing/homelessness, access to transportation, supportive services, and community integration opportunities;
- Access to health services, prevalence of chronic diseases, and preventive health care;
- Demographic information including income levels, ethnicity/race, languages spoken, and demographics of sub-populations including veterans; lesbian, bisexual, gay, and transgender (LBGT) individuals; and transitioning youth (ages 18-25).

Suicide impacts individuals, families, friends, and entire communities. Additionally, being a suicide survivor immediately puts a person at-risk for suicide (Centers for Disease Control and Prevention, 2015). From this standpoint, suicide is a critical public health issue, and communities can benefit from a broad range of actions, including reducing factors that put people at risk for suicide, and increasing factors that help to protect people from suicidal behavior (Centers for Disease Control and Prevention, 2015).

A-2 Nevada Suicide Rates

Nevada's rate of suicide is high and demands continued attention. Yet, it is also notable the gap between the rate in Nevada and for the United States (U.S) overall has narrowed. Rates in Nevada have remained relatively steady since 1999, while the rate for the nation has increased. Nevada has also reduced suicide as a leading cause of death, from being the sixth leading cause to the eighth leading cause of death. Suicide remains the tenth leading cause of death for the nation. Across all states (excluding the District of Columbia), Nevada was the *only* state

Figure 2: Age-adjusted Rate of Suicide Nevada vs. The U.S. 1999-2015



with a lower rate in 2014 and 2015 compared to 2005 (WISQARS, 2017). The factors contributing to this difference are not clear and warrant further study. For the grant focus of ages 25 and higher, Nevada has the 9th highest rate in the nation at 25.04 versus the U.S. rate of 17.7. Suicide crosses all social, economic, and demographic lines. However, our data has identified subgroups that show increased risk in Nevada. Rates are higher across all of the subgroups compared the national rates for those same groups.

Gender

In the US, rates of suicide for women have been, and continue to be, lower than the rates for men. However, a recent report showed for females, the age-adjusted suicide rates increased between 1999 and 2014 for all racial and ethnic groups except non-Hispanic Asian or Pacific Islanders (Curtin, Warner, & Hedegaard, 2016). In Nevada, roughly three out of four deaths by suicide are males (Nevada Office of Public Health Informatics and Epidemiology, 2016). Looking at recent syndromic surveillance data on suicide ideation and attempts collected from Nevada hospitals, males present at double the rate of females, a trend which should be explored. Nationally, female attempt rates are considerably higher than male attempt rates (Office of Public Health Informatics and Epidemiology, 2016).

Figure 3

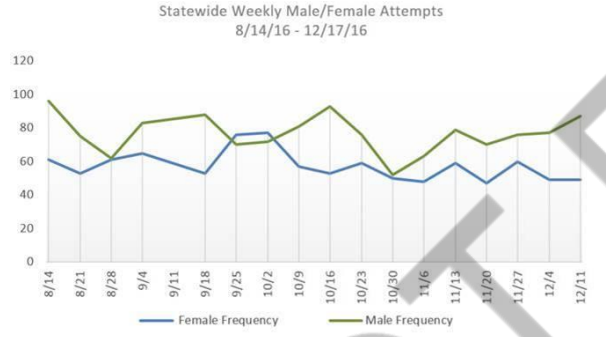
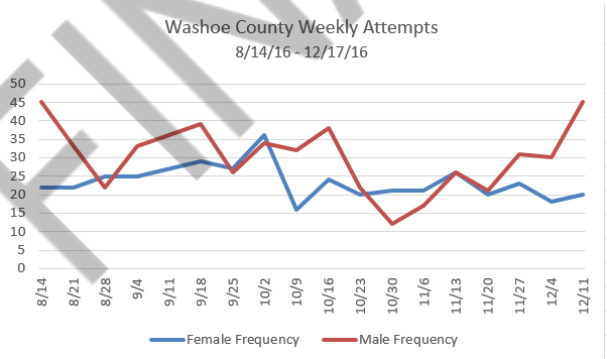


Figure 4



Race and Ethnicity

In Nevada, the crude rates for suicide were highest among people who were white (non-Hispanic) at 28.5 vs. the U.S. rate of 20.2. Hispanic rates were 10.3 vs. the U.S. rate of 7.7. Suicides rates were higher in Nevada within every racial and ethnic group compared with U.S. rates; the issue crosses all racial and ethnic boundaries (Nevada Office of Public Health Informatics and Epidemiology, 2016). Opportunities exist to improve prevention using attempt data by race and ethnicity. Native American Indian/Alaska Native (AI/AN) represented 1.1% of Nevada's population in 2015. Preliminary data from 2015 shows numbers that are too low to report for confidentiality although suicide ideation and attempts are high in our Native American communities. In 2015, African Americans represented 8.2% of Nevada's statewide population with the majority residing in Clark County, the largest urban setting in the state. The African American suicide rate was 11.4 vs. the U.S. rate of 6.8. Preliminary data from 2015 indicates that African Americans are over-represented in terms of Inpatient hospitalization, (IP), Emergency Department encounters (ED), and deaths related to opioid use. Asian American rates are also higher at 12 vs. the U.S. rate of 2.3.

People in Criminal Justice Systems

Adults who are incarcerated as well as those recently released are also at high risk (Noonan, Rohloff, & Grinder, 2015). The Washoe County jail's suicide rate is nearly 10 times higher than

the rate in the general community. It is also five times the national rate of suicides in local jails. Surveillance systems within and across justice systems offer a key opportunity for prevention. Expanding and supporting behavioral health and reentry services has been a top priority for Nevada for several years. The DPBH Substance Abuse Prevention and Treatment Agency (SAPTA) currently funds pilot programs for jail diversion and forensic assessment and triage across Northern Nevada. Nevada proposes to expand services to ensure a treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.

Other Groups with Higher Risk

In addition to the priority populations identified in this report, many other groups may be at higher risk for suicide compared to the general population. They include people who have witnessed or are bereaved by suicide, people involved with child welfare settings, people who have attempted suicide, people with medical conditions, people with mental or substance use disorders, people who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ), members of the armed forces and their families, and people who have engaged in non-suicidal self-injury (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012).

Priority Populations

Veterans: Nevada's veterans die by suicide 2 to 2.5 times more frequently than their civilian counterparts. Nevada's suicide rate among veterans also appears to be considerably higher than the national rate. For 2015-2016, preliminary data shows the rate for Nevada veterans was 50.3 per 100,000 compared to an estimated 35.3 per 100,000 Nationwide. Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans (Nevada Office of Public Health Informatics and Epidemiology, 2017). The percentage of veterans with a disability is considerably higher than for non-veterans, and, among disabled veterans, 68% are disabled by a service-connected condition (State of Nevada, 2015).

Across the United States, the proportion of suicide deaths resulting from firearms among veterans is higher than the non-veteran or civilian population (U.S. Department of Veterans Affairs, 2016). From 2010-2014 the majority (70%) of Nevada's veteran suicide deaths were caused by firearms or explosives.

Seniors: Since 2001, seniors in Nevada have died from suicide at substantially high rate, nearly twice the rate seen nationwide. From 1999-2015, the average rate for Nevada was 31.5, compared to 15.3 for the US. In general, the rate of suicide increases throughout the lifespan, with the oldest adults among those most at risk. As with younger adults, those 65 years and older are more likely to have suicidal thoughts if they have depression, other mood disorders, or problems with substance abuse. However, compared to younger cohorts, older adults are more likely to face additional issues which can produce suicidal thoughts, such as ongoing medical conditions, chronic pain, a lack of mobility, or lack of autonomy. Older adults may also be at higher risk of social isolation, undiagnosed depression, or feelings they are a burden (SAMHSA, 2016). These issues point to the need for different strategies and partners to prevent suicide among older adults. As with Nevada's veterans, firearms were used in the majority of deaths among older adults, with firearms/explosives the method of seven out of ten senior suicides from

2010-2015. Poisoning was second most common method among older adults, making up 17% of suicides.

Middle Age Adults: The rate of suicide both nationally and in Nevada is high in middle age. In 2015, the estimated age-adjusted rate for people 55-64 was 29.1, second only to the oldest adults (31.6 for the population 85 and older). In Nevada, people middle age (45-64) are considerably more at risk than younger people including youth. The suicide rate among middle age adults has been increasing nationwide – and a recent study showed while "all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases" (Case & Deaton, 2015). Physical pain, addiction, and declines in mental health, have been hypothesized to contribute to the national increase in suicide observed among this group. A broad number of circumstances may contribute to this rise; however, on the whole, it is reasonable to consider risk factors have increased, while some protective factors have decreased (Keating & Bernstein, 2016). Syndromic surveillance data shows young adult and middle age showing up in EDs with suicide ideation and attempts at higher rates than other ages.

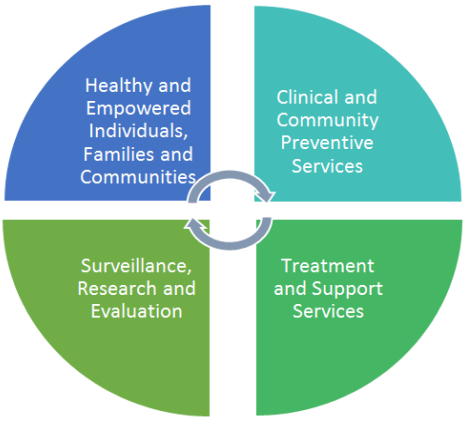
Nevada proposes to use some resources available through this funding opportunity to build capacity and infrastructure related to data collection, specifically concerning suicide. Improvements in data collection related to suicide and suicide attempts would enable DPBH to better determine populations most at risk evaluate the effectiveness of interventions.

A-3 Service Gaps and Need

Nevada's Weaknesses:

- Electronic health records (EHR) are not widely utilized or linked, creating a barrier to federal funding streams. This also impacts continuity of services between providers.
- Office of Suicide Prevention (OSP) is not as closely linked to some of the other state initiatives working on mental health and behavioral health interventions (e.g. block grant initiatives).
- Many people experiencing problems cannot access services, including public systems like criminal justice, until or unless they are in crisis. Upstream preventions are not adequate and are not currently aligned to the national strategy of providing care in the least restrictive setting.

Figure 5

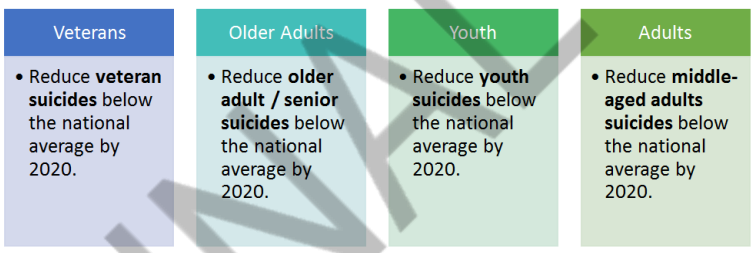


Nevada's Opportunities

- Suicide awareness and screening can take place using the existing healthcare workforce.
- Research can help to inform practice in Nevada. Programs and initiatives showing successes can provide strategic direction. For example, the Suicide Prevention Resource Center (SPRC) has compiled programs which are promising as well evidence-based (http://www.sprc.org/resources-programs).
- Collaborative groups working on issues related to mental health, safety, and other community health issues offer an opportunity to further advance suicide prevention.

- The OSP can work strategically and with leaders to reach more people throughout the state. There is broad interest in suicide prevention, and leaders are likely to be interested in learning how they can support it, regardless of sector or role. By working to educate, influence, and collaborate with leaders from health care, business, nonprofit organizations, and coalitions, the reach of effective strategies is multiplied considerably.
- The national focus on the Zero Suicide Initiative (National Action Alliance) is proven to be effective in reducing rates within a closed system (e.g. U.S. Air Force) when implemented with fidelity.
- OSP can strengthen the alignment between suicide prevention strategies and state mental and behavioral health initiatives (e.g. block grant initiatives).
- OSP can work to strengthen screening and supports for people of all ages to ensure people get the help they need prior to crisis or emergency.

Figure 6



Nevada's leaders are working to address suicide. Governor Sandoval's Strategic Planning Framework presented in 2016 identified objectives to reduce suicide among Nevada's veterans, senior citizens, and youth to rates lower than the national average by 2020.

Nevada's Plan is based on research focusing on the unique state and local needs and circumstances. These findings and recommendations were integrated with the U.S. Department of Health and Human Services' National Strategy for Suicide Prevention. In alignment with the National Strategy for Suicide Prevention, Nevada is working in four related strategic directions.

Over the past several years, leaders in Nevada have worked to address these issues in their communities and statewide efforts have been mobilizing. This funding opportunity will take into account all of the unique needs of Nevada's communities, while aligning and building on the continued work of leadership. It will leverage the work being done throughout the state to develop, coordinate and increase follow-up and supportive services for those with thoughts of suicide as well as those with lived experience after suicide attempts.

B Proposed Implementation

B-1 Proposed Project, Goals and Objectives

Research shows after hospitalization the risk for suicide increases over the next thirty days. This project will establish protocols that provide continuity of care and appropriate outpatient follow-up for persons at risk for suicide. Referring emergency department patients to follow-up services is a critical piece of developing a thorough discharge plan. Nevada recognizes the barriers that currently exist to appropriate follow-up care with ever-increasing admissions to emergency departments and mental health hospitals. Exploring effective programs where hospitals follow up with patients after release, ensure the patient is still taking the medication and is connected to outpatient services will help the person stay well. Partners will explore current programs to facilitate patient connection to services within the community which would encourage follow through with discharge plans, reduce return visits to the emergency department, and provide

caring outreach post-discharge when risk can be highest. Community programs exist that collaborate with psychiatric hospitals for follow-up such as the Mobile Outreach Safety Team (MOST) team, Crisis Call Center and Division of Child and Family Services (DCFS) Mobile Crisis Response Team. These are all programs that can introduce patients and their families to alternatives which might help avoid visiting an emergency department if services are needed in the future. Funding to support these important programs and the collaboration with hospitals is crucial to solidify the safety net of this recommendation. According to the recently released Joint Commission Sentinel Event Alert, "…identifying, developing and integrating comprehensive behavioral health, primary care and community resources so these people don't fall through the cracks. For hospitals and EDs, critical is discharge follow-up and care transitions. Closing this post-discharge engagement gap between settings is vital for immediate and ongoing safety. "Owning" responsibility for a high-risk individual in the community, once they leave the hospital yet before they've walked into the outpatient clinic for their first post-discharge appointment, may not come naturally to providers, yet is key to keep people safe from suicide." The proposed project aims to address the suicide crisis in Nevada by increasing access to treatment, reducing unmet treatment need, and reducing deaths and suicide attempts through the provision of prevention, treatment and recovery activities. The complexity of the issue of suicide and its prevention, both nationally and in Nevada, requires a multipronged approach that brings together prevention, early intervention, treatment, law enforcement, public policy, public health models, and recovery oriented systems of care. The intricacy of the issues demonstrates the needs for many solutions to be leveraged towards the whole. The crisis has highlighted some of the opportunities within our current state and local infrastructures that need to be brought together to develop a comprehensive, coordinated system of care and follow-up after emergency department visits and inpatient hospitalization discharge.

This proposal will meet individuals recovering from ideation and behaviors through development of a continuity of care pathway that must coordinate within and between systems including health care, public health, law enforcement, and community/family supports. Nevada is proposing the following goals and objectives to leverage and coordinate existing resources, address unmet needs in our continuity of care and follow-up for treatment and prevention, and to establish a sustainable infrastructure to address suicide in our state now and in the future.

Table 1: Project Goals	**Measurable Objectives**
Implementing Suicide Prevention into Core Components of Health Care Services in Nevada	• Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings. • Ensured Alignment with NSSP Strategies • Developed and Implemented Plan for Rapid-follow up • Implemented Transition Protocols • Third-party Revenue Plan for Sustained Provision of Services
Implementing Effective Professional Development for those Assessing and Treating At-risk Suicide Behaviors	• Effective Suicide Prevention Training to Community and Clinical Services • Reduced Access to Lethal Means • Coordinated Cross-agency Implementation of Comprehensive Suicide Prevention • Enhanced Veteran Affairs Suicide Prevention

	Coordination • Integrated Mental Health and Substance Abuse Delivery Settings • Inclusive Survivor Insight for Suicide Prevention Activity Planning and Implementation

Table 2: Required Activities

Comprehensive Statewide Plan	The Office of Suicide Prevention Plan 2017-2019 aligns with the NSSP. This will continue to be a comprehensive, lifespan plan. (Attachment 5)
Rapid Follow Up Plan for Adults	Renown Healthcare System has recently held a rapid response summit to develop improved triage and continuity of care in the ED for patients with behavioral health concerns; and Development of multi-partner projects for sustainability.
Establish Follow Up and Care Transition protocols	Partnership with Crisis Call Center, our National Suicide Prevention Lifeline responder to expand telephone follow up services and case management; Currently has MOU with West Hills hospital to provide follow up; and Workforce development, quality management, and planning to increase evidence-based services.
Provide community and clinical service provider training	Over 15,000 Nevadans have been trained since 2006 in suicide awareness, prevention, intervention and post-vention courses; Legislation to establish policy mandating ALL healthcare providers receive 2 hours of EB continuing education upon licensure and recertification; currently all behavioral health providers are mandated; and Nevada Nursing Association currently partnering to have 30 nurses trained as safeTALK trainers, reaching the majority of counties across Nevada. Renown Health commits to training ALL doctors and other relevant staff; Desert Rose Counseling partnering to reach health care providers.
Reducing Access to Lethal Means	Partnership with NV gun shop owners to bring staff training, including owners trained as safeTALK trainers; Attend gun shows to share reducing access to lethal means information, gun locks and gun safes; over 9,000 community members educated on reducing access; NV firearm use has decreased from 57% to 52%, impacting overall male and state rates.
Working Across state departments and systems	Office of Suicide Prevention, the Office of Public Health Informatics (OPHIE), and the Office of Supportive Services (Welfare/Medicaid) Nevada will be able to increase awareness of and commitment to suicide prevention and treatment. These systems will work to expand the collaboration and efforts statewide to target all service agencies across the state.
Work with VHA and Dept. of Veterans' Services	VHA has suicide prevention specialist appointed the statewide Committee to Review Suicide Fatalities;

	Partnering with Dept. of Veteran Services to provide training to VSOs; and Workforce development, quality management, and planning to increase evidence-based services.
Collaborate across sectors, including mental health and substance use	Annual state and local assessments of need, gaps, and access barriers and plans to address Partnership with Nevada's Higher Education System (UNR, TMCC) and community colleges that serve our rural communities; National evaluation and research; Participation in Nevada System of Care; Training for gatekeepers and crisis response teams; and Identify culturally appropriate intervention strategies Workforce development.
Ensure Crisis Call Center Suicide Prevention Lifeline 70%	Crisis Call Center is a regional center for the National Suicide Prevention Lifeline. As of February 2017, our Nevada answer rate was at 70.16%.
Incorporate input of suicide attempt and loss survivors	Partnering with the Nevada Coalition for Suicide Prevention, a public private partnership with survivors of suicide attempts and loss as board members; Network of 9 Survivor Bereavement support groups across NV; and Identify culturally appropriate intervention strategies.
Demonstrate through timely surveillance data	Nevada is part of the National Violent Death Reporting System and Syndromic Surveillance data; and The Committee to Review Suicide Fatalities works to establish more timely communication of data and trends.

B-2 Meaningful and Relevant Results

The project is expected to reduce the rate of non-fatal suicidal attempts and deaths in adults ages 25 and older. Meaningful and relevant results will be achieved by utilizing the syndromic surveillance (attempt data) and partnerships throughout Continuity of Care for Suicidality Workgroup to recognize and monitor trends in real time and develop a system of follow-up care and minimize repeated attempts. This will align with the National Suicide Strategic Priorities to improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. (NS-11.3)

Action Steps

1. Continue development and use of syndromic surveillance data.
2. Complete study to understand feasibility of attempt data. Include issues of privacy; permission to collect and identify opportunities to systematically collect and analyze; data sharing.
3. Explore amending legislation to include attempts data collection.

Additionally, enhanced data collection will capture information about specific characteristics of the population including veterans, active duty military and families, LGBTQ, and race/ethnicity.

Action Steps

1. Use National Violent Death Reporting and Committee to Review Suicide Fatalities to recognize trends and opportunities.
2. Establish workgroup to advise on reporting military / veteran deaths.
3. Work with coroners' offices to develop protocols for reporting on veteran suicide deaths.
4. Work with coroners' offices and medical examiners across the state to share protocols.
5. Assess challenges and make changes as needed to protocols once established.
6. Continue development of a memorandum of understanding (MOU) being developed with the key partners on the expansion of data use.

B-3 System-level Change and Impact

Understanding, and ability to use, timely surveillance data within our key sectors will ensure system-level change and impact through the adoption of standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings. Baseline syndromic surveillance data has been utilized in section A-1. Working with MPH interns, EDs and our county medical examiners, we will continue to build upon capture of this real-time data to recognize immediate impact, trends or opportunities to modify our pathway of care and follow up. This will align with three (3) National Priorities: 1) Promote suicide prevention as a core component of health care services. (NS-G8); 2) Integrate and coordinate suicide prevention activities across multiple sectors and settings. (NS-G1); and 3) Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. (NS-G8.2)

Action Steps

1. Work to understand existing practices within Nevada hospitals using a survey and additional outreach.
2. Use data from survey (step 1) to assess what is in place and identify system gaps.
3. Share suicide prevention plan and use to engage partners in strong prevention efforts.
4. Support suicide prevention training for health care providers by working to build capacity for training and education.
5. Participate in dialogue regarding suicide prevention among all primary care providers.
6. Hold informational interviews with key leaders to understand barriers to patient follow up.
7. Identify any areas of policy or practice where the state and Office of Suicide Prevention can support improvement.
8. Engage partners to understand HIPAA as an opportunity, not a barrier, to providing follow up care.
9. Foster and support collaborations between emergency departments and other health care providers to deliver services for individuals with suicide risk collaboratively, responsively, and in the least restrictive settings.

System level change and impact must address sustainability of efforts, and infrastructure. Nevada has aligned three (3) additional National Strategies to ensure this is successful: 1) Promote effective programs and practices to increase protection from suicide risk. NS-3.1); 2) Develop and sustain public-private partnerships to advance suicide prevention. NS-1.4); and 3) Integrate suicide prevention into all relevant health care reform efforts. NS-1.5)

Action Steps

1. Support expansion of Mobile Crisis Response Teams
2. Identify barriers to using electronic health records.
3. Provide support for expansion of electronic health records.
4. Share data, plans, and awareness about suicide in Nevada.
5. Commit additional state funds to support suicide prevention in Nevada.
6. Seek out additional grant funds to support suicide prevention

B-4 Cross-Agency Coordination

Through the collaboration of the Office of Suicide Prevention, the Office of Public Health Informatics (OPHIE), and the Office of Supportive Services (Welfare/Medicaid) Nevada will be able to increase awareness of and commitment to suicide prevention and treatment. These systems will work to expand the collaboration and efforts statewide to target all service agencies across the state. The State will facilitate this exposure to prevention and treatment collaborations through training opportunities for workforce development; participating with agency and community partners on workgroups; providing technical assistance, and public outreach methods to share the importance of their involvement. *Nevada will engage in community outreach and education program targeted to emergency department staff, first responders, nurses and social workers; family and pediatric physicians; and psychiatric practitioners, clinics, hospitals and Medicaid; health, mental health, and substance abuse; justice; corrections; labor; veterans affairs; and the National Guard.* The objectives are to: (a) increase knowledge of early warning signs, (b) increase appropriate referrals, (c) create and educate a system of professional and community member early identifiers, and (d) decrease barriers to early identification, including stigma. These collaborations include a broad public and private partnership which Nevada recognizes is essential for developing and implementing a successful system of care at the state and local level.

B-5 Table 3: Key Activity Timeline

Goal 1: Promote suicide prevention as a core component of health care services (NS-G8)			
Objective 1.1 Staff in Place			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
1.10. Establish job descriptions and advertise 1.11. Interview candidates	Hire project coordinator, account specialist, Healthcare Liaison	OSP Coordinator and	January 31, 2018 (4 months after award)
Objective 1.2 Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings.			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
1.20. Organizational policies provide guidance for successful care transitions 1.21. Track and manage using an electronic health record (Health Information Exchange)	Increase knowledge of early warning signs, increase appropriate referrals, create and educate a system of professional and community member early identifiers, and decrease barriers to early identification, including stigma.	OSP staff and Evaluation Team	Develop December 15, 2017.
Objective 2.2 Hold informational interviews with key leaders to understand barriers to patient follow			

up.			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
2.20 Public Awareness to educate, inform and engage the public, prescribers, physicians and community-based organizations about suicide prevention. 2.21 Engage partners to understand HIPPAA as an opportunity, not a barrier, to providing follow up care. 2.22 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up	Increased knowledge around suicide and its prevention that will lead to attitudinal and behavioral change.	Project Lead Partnering hospitals and organizations Suicide Prevention SAPTA Prevention Coalitions Statewide Mobile Crisis Continuity of Care for Suicidality Work Group	Implementation by December 30, 2017 Ongoing as needed
Objective 1.3 Support expansion of Mobile Crisis/Outreach/Recovery Response Teams			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
1.30 Provide a continuing education courses around continuity of care pathway and referral partners;	Nevada's medical community will receive information.	Project Coord. OSP Medical Boards Discharge supervisors Statewide Mobile Recovery Unit	September 2018.
1.31 Review current recovery models and evidence-based programs to adapt for Nevada 1.32 Establish multiple pathways to recovery support groups that can travel to community and behavioral health providers. 1.33 Train a network of peer support specialists and coaches that can provide services to clients within a hospital or community setting to connect the recoveree with support services. 1.34 Review statewide strategic plan and	Mobile follow up team will assist with continued client engagement to engaging in safety plan and treatment if needed Partner with Mobile outreach recovery team will offer services such as Peer Recovery Planning referral for recovery capital and recovery coaching services. Establish gaps in continuity of care and follow up in order to develop a comprehensive care pathway appropriate	Project Coord., Nevada Coalition for Suicide Prevention and Workgroup for Continuity of Care for Suicidality	Planning by January, 2018 Implementation by June, 2018 Implementation by January, 2019

implement a continuity of care/follow up needs assessment for remaining gaps	to the climate of the State of Nevada with QI		
Goal 2. Implementing Effective Professional Development for those Assessing and Treating At-risk Suicide Behaviors			
Objective 2.1 Support suicide prevention training for health care providers by working to build capacity for training and education.			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
2.10 Survey partners to assess existing knowledge, skills, attitudes and practices within ER departments, clinics, and hospital settings. 2.11Use data from survey to establish what is in place and system gaps. 2.12 Train responders and family members, behavioral health clinicians and primary care physicians on the signs and symptoms suicide risk 2.13 Provide trainings to first responders and law enforcement to build continuity of processes	From data collected in Zero Suicide survey address any gaps identified and additional training required to bring physicians and other staff appropriate training opportunities. A more responsive Workforce will change attitudes, improving experiences for those with thoughts and behaviors toward a more caring and safe pathway to healing	Project Coordinator, OSP And Evaluation Team	Implementation by February 2018.
Objective 2.2 Onboarding and Community Training			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
2.20 Onboard additional four hospitals, health centers and/or community based organizations 2.21 Ensure that EMS, hospital and community organizations receive training and educational materials for distribution. 2.22 Face to face trainings EMS, medical personnel and community organizations.	Reduction in suicide attempts and mortality Increase continuity of care due to awareness of processes	Project Staff and statewide community partners;	September 2017
Goal 3. Increase Access to Clinically Appropriate Treatment for suicide.			
Objective 3.1 Ensure Physicians have sufficient training and support to provide suicide prevention screening, intervention and management.			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
3.10 Training for Physicians throughout the state	Increase knowledge base for best-practices related to suicide screening, intervention and management	Project Coordinator	Ongoing
3.11 Expand and promote Screening (C-SSRS),	Develop tiered system or screening in community,	Columbia Training	Currently working to bring train-the trainer

Intervention, and Referral to Treatment services for medical providers. To ensure patients are being screened and referred to the correct level of care.	first responders and EDs	Coordination team with Continuity of Care for Suicidality work group	courses to LV Ongoing
Objective 3.2 Identify barriers to using electronic health records.			
3.20 Review existing partners utilizing HIE 3.21 Train providers in use of EHR and the HIE	Determine how to expand usage Patients will be referred to the correct level of care and service through the hub and spoke model. Referrals can be bi-directional as part of an adaptive stepped care model	Project Coord Program Staff Health care partners, OPHIE	March, 2018
Goal 4. Data Collection and Program Evaluation			
Objective 4.1 Enhance current data System to integrate attempt, syndromic surveillance NVDRS, data collection and reporting			
Specific Tasks	**Expected Outcomes**	**Key Individuals**	**Timeline**
5.10 Fully implement data collection and reporting 5.11 Support for Clinics	Fully operational data system for identifying suicide prevention needs	Project Team OPHIE, Evaluator	Approximately 6 months Mar 2017.
Objective 4.2 Evaluate overall program impact			
5.20 Effectiveness of the Suicide Prevention Pathway 5.21 Evaluate Effectiveness of Mobile Follow Up 5.22 Evaluate Knowledge gained	Reduction of suicide attempts and deaths Reduction of ED visits Increase in program referrals Increase in screening by physicians	Project Team Project staff Evaluator	Initial Process and Outcome evaluations to be completed by September 30, 2020

B-6 Ensuring Relevant Insight for Assessing, Planning and Implementing

The voice of those with "lived experience" continues to offer relevant insight in creating a true system of care and respect. Our outreach and education will perpetuate survivors' voices and experiences to move away from a system that can seem stigmatizing and punishing and move to a more healing and holistic system of care. We know families and other supports must have a voice that is listened to, respected, and utilized within planning, implementation and evaluation. Representatives of National Alliance on Mental Illness, NV (NAMI-NV) and other consumer-serving entities at the local and statewide level will help oversee community-based planning and implementation.

B-7 Partner Organizations

Crisis Call Center Crisis Centers is uniquely positioned to partner with the activities proposed due to their:

- 24-hr access to staff trained in suicide assessment (RA, support, referrals, safety plan, and emergency rescue);
- Connect directly to local crisis teams;
- Facilitate linkage/maintain linkage;
- Provide telephonic support in rural areas, including follow up support;

- Avert unnecessary ED visits/Reduce ED burden

Additionally, the following Centers are committed to providing care from emergency room referral of suicidal patients and will follow up with individual discharged within 48 hours: 1) Family Resource Center Humboldt County; 2) Desert Rose Counseling Center; and 3) Nevada Coalition for Suicide Prevention. The Washoe County Department of Social Services is a public agency that provides regional social services throughout Washoe County, including children's services, adult services, and senior services. Through staff and contractual relationships, the Department provides crisis intervention and linkages to services for all of these populations. The Department is currently working with the State of Nevada to transition the Mobile Outreach Safety Team (MOST), a police-mental health co-response model, from a state-operated program to local control at the County level through a regional partnership with the three local law enforcement agencies. This transition will offer new opportunities and potential expansion of the MOST Team to include the possibility of post-discharge home visits to vulnerable people.

West Hills Hospital is a 95-bed acute care inpatient behavioral health hospital serving children, adolescents and adults of all ages. This hospital maintains a full-time medical staff to provide patients with the best possible care and ensures professional medical providers. Their inpatient hospitalization treatment is designed to quickly stabilize the most serious symptoms to allow a quick transition to less intensive levels of care. The majority of patients admitting to our in-patient level of care are experiencing Suicidal thoughts with intent and plan.

B-8 Aligning and Coordinating Community Strategies

The Nevada Action Plan synthesizes information about Nevada's four priority areas and target populations, our alignment to National Strategies, and shows key action steps. These action steps were developed based on recommendations from the Committee to Review Suicide Fatalities and aligned with the National Strategy. They are only the first steps on the longer journey to continue the downward trajectory of Nevada's suicide rate.

B-9 Expected Unduplicated to be Served

For 2016, West Hills performed 5,411 assessments, admitting 3,320 to inpatient care. Renown had 4,571visits to the Emergency Department for primary behavioral health emergency, including suicidal ideation and suicide attempt-related hospitalizations. The Northern Nevada Mobile Outreach Support Team (MOST) had 1,608 citizen contacts with 1,069 (66%) not receiving mental health care at the time of the crisis. Nevada is proposing to use this as a baseline estimate for numbers served.

B-10 Table 4: Plan for Follow-up and Care Transition Protocols

Nevada's proposal for follow-up and care transition (SPRC, 2015):

Appointment is made within 7 days of discharge	• Patient is safe/supported by informal caregivers and/or crisis center at home • Within 24-48 hours, patient receives follow-up phone (CCC) or in-person visit between ED discharge and outpatient appointment • PHI is transmitted to referral provider with consent

	• Patient attends appointment; Access barriers addressed • Patient receives caring contact if missed appointment • Rapid referral, open scheduling models
Discharge planning	• Warm handoff • Discharge planning checklist to include Reducing Access to Lethal Means (CALM) discussion with family/friend supports
Follow-up	• Caring contacts (postcards) • Follow-up phone calls or in-person visits within 24 hours
Case management, care coordination	• Facilitators for Care Coordination through Crisis Call Center after warm handoff from ED or other care facility
MOUs for Development	• Transmit patient health information • Electronic health records / HIEs (training needed) • Patient consent protocols • Continuity of care flowsheets • Community resource listing • Informal caregiver involvement in discharge planning

A lack of coordinated crisis services in the state contributes to high rates of utilization of EDs by individuals in need of crisis intervention and stabilization. Availability of urgent behavioral health care is one key indicator of access to timely treatment. Currently, outpatient crisis evaluation and stabilization is limited in Nevada. OSP will work closely with the newly forming Certified Community Behavioral Health Clinics (CCBHC) to expand availability for crisis evaluation, ambulatory detoxification services and outpatient stabilization for individuals who are appropriate for such services. For individuals with needs that exceed outpatient treatment, CCBHCs are required to provide coordinated referrals to higher levels of care in the community. Such availability has the potential to reduce preventable ED and inpatient stays for individuals in psychiatric crisis who can safely be managed in an outpatient setting. Availability of such services within the community also allows individuals in frontier regions to remain in their communities instead of having to travel great distances for care.

This project will coordinate with the Nevada's CCBHCs whom are working to build capacity within 2017 to establish a presence in their communities through outreach and community engagement to notify their community of the ability to access crisis services and mobile crisis services 24/7. By the second year of the demonstration program, communities will be aware and readily utilizing the 24/7 crisis services through their local CCBHC. CCBHCs are required to develop formal agreements with hospitals to ensure care coordination following discharge.

B-11 Ensuring Professional Development

The Office of Suicide Prevention, through the Division of Public and Behavioral Health, is the state office for training and technical assistance on a variety of topics dealing with identification, prevention, intervention, and survivor support of suicide. Nevada is currently pursuing legislation (AB105) to mandate suicide awareness, prevention and management education for all health care providers. OSP partners with the Nevada Coalition for Suicide Prevention, the Nevada National Guard, the Nevada Nursing Association and various other groups, to sustain our training corps and maintain fidelity to the evidence-based models. OSP has worked across

the state since 2006, to provide ASIST training (Applied Suicide Intervention Skills Training), safeTALK and YMHFA. Target audiences for professional development training will include primary and behavioral health-care providers, first responders, community-based criminal justice system professionals, including community corrections officers (probation, parole, and pre-trial services), court personnel, law enforcement officers (including local CIT trainers), and human service providers who work with adult populations. Competence/confidence of those trained will be measured utilizing a Nevada-adapted version of the Zero-Suicide survey (piloted in 2016) to determine baseline knowledge and readiness. This will be followed up at the half-way point and at the project's conclusion.

B-12 Addressing State Calls on National Suicide Prevention Lifeline

Crisis Call Center, based in Reno, NV, serves as a regional call center for the National Suicide Prevention Lifeline and Nevada's statewide hotline for crisis intervention/suicide prevention as well as abuse/bullying reporting. Crisis Call currently receives **70.16%** of our in-state calls, in addition to calls that are routed to the call center from other States.

C Proposed Evidence-Based Practices/Services (EBP)

C-1 EBP to Implement the National Strategy for Suicide Prevention

To reduce suicide, the state has focused on several areas: extra caution at points of transition such as discharge from inpatient and ED units, safe storage of guns and medication, and crisis hotlines and existing mobile crisis outreach aimed at reaching adults who may not seek help. Crisis Behavioral Health Services will include 24-hour crisis services, including access to crisis evaluation and outpatient stabilization. Comprehensive suicide assessments and interventions using the ***Collaborative Management and Assessment of Suicidality (CAMS)*** to identify and address immediate safety needs of the client will be used. Individuals in crisis will receive rapid response to address immediate needs, including Mobile Crisis Response to provide triage services and stabilization services or appropriate transfer to a higher level of care. Screening, Assessment and Diagnostic Services will include a range of evidence based practices. These standardized screening tools include developmentally appropriate measures to determine the existence of behavioral and symptom indicators that may signify the existence of a behavioral health need. ***The Patient Health Questionnaire-9 (PHQ-9)*** and the ***Columbia Suicide Severity Rating Scale (C-SSRS).*** The C-SSRS was the first scale to address the full range of suicidal thoughts and behaviors that point to heightened risk. The C-SSRS screens for this wide range of risk factors without becoming unwieldy or overwhelming, because it includes the most essential, evidence-supported questions required for a thorough assessment. The standard of practice for many at this point is to screen everyone at every time of service delivery. We also know that 25% of all people who die from suicide are seen in an ER for non-psychiatric reasons sometime in the 12 months before their death. OSP will embed C-SSRS questions and training in a tiered system, with tailored messaging for various audiences such as first responders versus ED staff and community members.

Table 5: Evidence-Based/ Promising Practice	SAMHSA EBP	NREPP	Population Addressed

Counseling Access to Lethal Means (CALM)	◆	◆	**Clinical providers/Discharge nurses**
Applied Suicide Intervention Skills Training (ASIST)	◆	◆	**Lifespan, Tribal, rural, clinical and non**
Suicide Alertness for Everyone (safeTALK)	◆		**Non-clinical providers**
Patient Health Questionnaire-9 (PHQ-9)	◆	◆	**Clinical care providers, EDs**
CAMS	◆	◆	**Framework for clinical providers**
Columbia Suicide Severity Rating Scale: C-SSRS	◆		**3 tiers: Community, First Responders, ED/health-care providers**

ASIST is a two-day intensive, interactive and practice-dominated course designed to help caregivers recognize and review risk, and intervene to prevent the immediate risk of suicide. It is by far the most widely used, acclaimed and researched suicide intervention training workshop in the world. ASIST adheres to promising practices in the NREPP Registry. ASIST has been used with AI/AN populations with success (Hymer, IHS Primary Care Provider; 2009). There are local Native American ASIST trainers in Nevada, as well as other ASIST trainers in northern Nevada who have experience implementing ASIST in Indian Country.

safeTALK adheres to standards in the Best Practices Registry which reviews programs, practices, policies, protocols, and informational materials according to current program development standards and recommendations. safeTALK has been well received by Nevada Tribes, and there is a local Native American trainer. The goal of safeTALK is to train community members and providers to identify youth at risk of suicide and link them to resources in the community. Suicide Prevention Material provided to hospital and agencies will include:

- ODMHSAS Care Pathway For Emergency Departments poster
- SAMHSA 'Is Your Patient Suicidal?' packets
- National Suicide Prevention Lifeline wallet cards
- SAMHSA 'After the Attempt' brochures

The Collaborative Assessment and Management of Suicidality (CAMS) is listed with promising outcomes. CAMS was first developed in 1998, as a therapeutic framework that is designed to assess a patient's suicidal risk, and plan and manage suicide-specific "driver-oriented" treatment. The clinical intervention can be used for a wide range of suicidal patients across outpatient and inpatient treatment settings and different treatment modalities. CAMS was brought to state agencies and partners in 2016 with excellent feedback. It shows effectiveness with all genders, all ages, most races/ethnicities and in various clinical settings, including outpatient facilities and Mental Health Treatment Centers.

C-2 Table 6: Follow-up After Discharge from Emergency Department (ED)

Building off of the current project to address Nevada's opioid crisis, OSP will work to engage with the current mobile outreach and workforce development opportunities to maximize efficiency of these systems.

Crisis Call Center hotline/Mobile Outreach Team	
Hospital staff:	• Screen patients to determine level of follow up • Ask patients if they would like to be referred for follow up • Refer patients to follow up (phone or mobile) if patients give written permission
Phone/Mobile Case Manager:	• Meets with patients at their bedside • Screens and assesses patients to determine type of treatment needed • Discusses treatment options with patients and completes referral to treatment • Coordinates with treatment agency to determine pickup time for patients • Connects patients to community resources • Educates hospital staff on suicide, MH, substance use disorders and the recovery process
The Peer Recovery Specialist (CRS)/Peer Coach:	• Has lived experience of MH/substance use disorder/suicide attempts and the recovery process • Can meet first with patients on request • Educates patients' families on the recovery process • Connects patients to natural community supports • Attends support group meetings with recoverees, as needed
Discharge Planning Checklist	• Involve the patient as a partner • Make follow-up appointments • Review and discuss the Patient Care Plan (discharge plan) • Discuss barriers • Provide crisis center phone number • Discuss limiting access to lethal means • Provide written instructions and education materials • Confirm that the patient understands the Patient Care Plan • Share patient health information with referral providers • Communicate your concern

C-3 Supporting, Promoting Effective Professional Development

Nevada is currently pursuing legislation (AB105) to mandate suicide awareness, prevention and management education for all health care providers. OSP partners with the Nevada Coalition for Suicide Prevention, the Nevada National Guard, the Nevada Nursing Association and various other groups, to sustain our training corps and maintain fidelity to the evidence-based models. OSP has worked across the state since 2006, to provide ASIST training (Applied Suicide Intervention Skills Training), safeTALK and YMHFA. Target audiences for professional development training will include primary and behavioral health-care providers, first responders, community-based criminal justice system professionals, including community corrections officers (probation, parole, and pre-trial services), court personnel, law enforcement officers (including local CIT trainers), and human service providers who work with adult populations. Competence/confidence of those trained will be measured utilizing a Nevada-adapted version of

the Zero-Suicide survey (piloted in 2016) to determine baseline knowledge and readiness. This will be followed up at the half-way point and at the project's conclusion.

C-4 EBP to Address Disparities for Access, Use and Outcomes

Nevada will improve disparities in access, service use and outcomes by developing a comprehensive, coordinated system of care that allows diverse perspectives and feedback to shape quality improvement. The proposed project will address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy and gender in the target population at three levels. The first level is through having a diverse representative group of stakeholders govern the proposed project (i.e., consortia and workgroups) in all of the assessment, planning, implementation and planning activities. The second is by adapting the materials for the project (e.g., public engagement, training, screening materials, and referral formats and sources) to the needs of patients and families from different cultures and languages, including the communication technology that youth are comfortable using (texting) will be to individualize services for each person and family based on their strengths, needs and culture.

C-5 Modifications to Proposed EBP

Nevada is not proposing any modification to be made to the evidence-based practices to be implemented as part of Nevada's program.

C-6 Efforts to Reduce Access to Lethal Means for those At-risk

The Nevada Reducing Access to Lethal Means Program: The goals of this public awareness program will include expanding education to parents, public, gun shops, gun ranges, gun distributors, gun retailers, attendees of gun shows and all individuals who are gun-owners. Awareness and education efforts will include: (a) understanding the risk of accidents and suicide associated with gun ownership and medications; (b) Accessibility to guns and medications by those faced with a crisis can be deadly; (c) The importance of making medications/guns inoperable and inaccessible to people at risk, struggling with mental illness and/or going through a crisis; (d) Increasing knowledge on what to look for and how to help someone at risk for suicide. The program includes four key components: (1) Building community partnerships with relevant agencies and businesses at public events; along with healthcare providers, law enforcement agencies, policy makers, school administrators, legislators, heads of state agencies, and those people responsible for creating statutes, rules, and regulations ensuring the health and safety of our community members. These individuals and organizations they represent should consult with one another on key decisions throughout the project and to partner in "message delivery"; and (2) directly educating community members on lethal means restriction and other suicide prevention techniques through community-based suicide prevention training sessions. The movement has been increasing since June 2012 and will continue because of strong training partnerships. Over 9,000 community members have been directly educated through firearm events such as gun shows as part of the program. NV firearm use has decreased from 57% to 52%, impacting overall male and state rates.

D Staff and Organizational Experience

D-1 Organizational Capability and Experience

Office of Suicide Prevention - The Office of Suicide Prevention, through the Division of Public and Behavioral Health, is the state office for training and technical assistance on a variety of topics dealing with identification, prevention, intervention, and survivor support of suicide. The Office of Suicide Prevention collaborated with partners statewide to draft the Nevada suicide prevention plan. This plan is modeled after the National Strategy for Suicide Prevention, which is maintained by the national Substance Abuse and Mental Health Services Administration of the federal Department of Health and Human Services.

This proposal includes a number of experienced planners with well over 30 years of knowledge in implementation and evaluation of programs throughout the state of Nevada. DPBH works to reduce the impact of health disparities in Nevada. This Division is responsible for developing, implementing, and evaluating state, regional and local projects, programs and plans for a variety of prevention and treatment, coordination of state and federal resources to include:

1. Statewide formulation, coordination, and implementation of a state plan for prevention, intervention, treatment, and recovery of substance abuse;
2. Statewide data collection, reporting and analysis of medical treatment, disease and infection; and,
3. Statewide development and publication of standards for certification and the authority to certify treatment levels of suicide prevention and treatment programs

The mission of the Nevada Office of Suicide Prevention is to reduce the rates of suicide and suicidal acts in Nevada through statewide collaborative efforts to develop, implement and evaluate a state strategy which advances the goals and objectives of the National Strategy for Suicide Prevention. The vision for Nevada's Suicide Prevention Plan is to catalyze collaborative action, improve understanding, and increase wellness in communities across Nevada. This plan is based on the strong belief everyone has a role to play in suicide prevention, and those individuals and groups addressing the physical, emotional, psychological, and spiritual needs of individuals and communities must work together if they are to be effective. Many organizations and agencies working at the state and local level are working to address and prevent suicide. This plan is intended to help connect these efforts, enhance collaboration, and illuminate best practices available for prevention as identified by state and national sources.

D-2 Partner Organization Capability and Experience

The following partners are committed to providing care from emergency room referral of suicidal patients and will follow up with individual discharged within 48 hours: 1) Family Resource Center Humboldt County; 2) Desert Rose Counseling Center; and 3) Nevada Coalition for Suicide Prevention. The Washoe County Department of Social Services is a public agency that provides regional social services throughout Washoe County, including children's services, adult services, and senior services. Through staff and contractual relationships, the Department provides crisis intervention and linkages to services for all of these populations. The Department is currently working with the State of Nevada to transition the Mobile Outreach Safety Team (MOST), a police-mental health co-response model, from a state-operated program to local control at the County level through a regional partnership with the three local law enforcement agencies. This transition will offer new opportunities and potential expansion of the MOST Team to include the possibility of post-discharge home visits to vulnerable people.

D-3 Coordinating with Prevention Coalitions and Survivors

In 2005, DHHS received one of the first Garrett Lee Smith (GLS) Memorial Act Grants. OSP was responsible for implementing this grant, which included school-based screening programs, stigma reduction and gatekeeper training, and a public education campaign. Since that time, strategic partnerships have been formed to advance public policy around youth suicide prevention. For example, the OSP partnered with the Office of Veterans Services and the Health Division to submit legislation for a Suicide Fatality Review Committee to be established in Nevada. AB 29 was signed into law in June, 2013. OSP also partnered with the Crisis Call Center to establish the first 24/7 texting intervention program in the nation. It now receives 1/3 as many texts as phone calls for help. OSP partnered with the Clark County School District, behavioral health providers, and the parent advocacy organization (Nevada Parents Encouraging Parents) to implement and model school-based screening program which has expanded to eleven other counties.

To promote and sustain survivors of suicide participation, the State of Nevada will focus on building partnerships with individuals, families, community organizations (NAMI-WNV) and key stakeholders to promote prevention, recovery, treatment collaboration and wellness. The activities that will be conducted with the community partners include: advocating for the development of environments that are supportive and welcoming to individuals and families; working with individuals and families to identify concerns and remove barriers to inclusion and resolving issues impacting service delivery; establish structure and mechanisms to increase adult and family input and leadership; develop training, technical assistance and related materials to individuals served through Nevada's health system and their families in areas of advocacy, program development, resource identification and coordination; ensuring survivors of suicide and peer support are available to all.

D-4 Key Personnel

Julia Peek, Deputy Administrator, Community Services, oversees the Community Service branch of DPBH. She has extensive background on data and data systems within DPBH, and was formerly the OPHIE Manager for five years. She has a Master of Health Administration from the University of Washington with a focus on Rural Health.

Misty Vaughan Allen, Suicide Prevention Coordinator, plans organizes, and directs suicide prevention activities within the State of Nevada; functions as the principle to advise program management for day-to-day decision making. She started her work in suicide prevention at the Crisis Call Center, running the hotline and training volunteers for five years. Ms. Allen has been with OSP since 2005 and has directed multiple youth suicide prevention grants through SAMHSA.

Andrea Rivers, Office of Public Health Informatics and Epidemiology Manager, oversees day to day operations of the OPHIE. Ms. Rivers also provides budget oversight and has extensive program management knowledge as well as epidemiology and data.

D-5 Key Staff to Focus Population

Table 8: Key Staff

Principal Investigator	Julia Peek	Serves as Deputy Administrator for Community Services	As the Deputy Administrator over the Community Services Section for DPBH, I provide	5% and Leveraged Funding

			administrative direction to 3 bureaus within DPBH. The Community Services Section functions almost solely on federal grant funds with $118,008,991 in state fiscal year 2018. This includes grants from HRSA, CDC, SAMSHA and other similar agencies.	
Project Director	Misty Vaughan Allen, Suicide Prevention Coordinator	Serve as the Project Director for the grant project, as well as technical assistance and training.	She started her work in suicide prevention at the Crisis Call Center, running the hotline and training volunteers for five years. Ms. Allen has been with OSP since 2005 and has directed multiple youth suicide prevention grants through SAMHSA.	10% and Leveraged Funding
Project Coordinator	TBD/ Office of Suicide Prevention, contracted position	Lead, oversee, and manage all grant activities and be the liaison between the partner organizations.		1 @ 100%
Healthcare Liaison	TBD/ Office of Suicide Prevention, contracted position	Assist Coordinator, provide outreach and education to partners and hospitals		1 @ 50%
Accounting Specialist	TBD/ Office of Suicide Prevention, contracted position	Assists the Project Coordinator in the processes of implementing the grant project, including record keeping, scheduling, communication, travel preparation, etc.	Reporting skills; Microsoft Office skills; managing processes, organization; analyzing information; financial management skills	0.5 SPE
Data	Existing Analyst	Data collection and	Work collaboratively	Leveraged

Specialist	within Office of Public Health Informatics (OPHIE)	analysis for reporting	with the many offices of the Division of Public and Behavioral Health to deliver data using the 50+ data sets being reported on.	Funding

D-6 Effective Organization

Promoting System-level Change and Intensive Community Outreach

Nevada began suicide prevention efforts in 2005, with OSP being responsible for implementing a GLS grant, which included school-based screening programs, stigma reduction and gatekeeper training, and a public education campaign. Through strategic partnerships that were formed to advance public policy around youth suicide prevention, with Nevada's youth rate dropping to the national average from initially being in the top ten highest. The State Office of Suicide Prevention has the experience and expertise necessary to engage with diverse community partners and systems that will be brought together through this project and have led to sustained partnerships with eight rural community coalitions that work toward substance abuse prevention, eleven county school districts, our system of higher education, the Nevada National Guard, law enforcement agencies, corrections and the Office of Veterans Services. Through these efforts the survivor-focused prevention and treatment system matured and has begun to produce positive outcomes. OSP has trained over 15,000 Nevadans, leading to an increased mental health literacy to help the public identify, understand, and respond to the signs of mental illness, alcohol abuse, and substance abuse. This has improved connections to treatment and recovery support. Knowing how to prevent a mental health disorder, alcohol or substance abuse, mental health crisis leading to increased risk for suicide is the key to prevention and mental health and wellness promotion

D-7 Experience working across state departments and systems:

DPBH has provided leadership and technical assistance statewide, providing evidence-based training and to stakeholders and providers. Additionally, evidence-based training has been made available to providers, to include wraparound, motivational interviewing, trauma informed care, and positive behavioral supports. DPBH and local consortia continue to collaborate with various agencies in communities throughout the state to promote the mission of the Department of Health and Human Services as well as those of the collaborating agencies. DPBH will work closely to collaborate with community partners to act as the Suicide Prevention Authority and provide the resources, technical assistance, and tools necessary to create the successful system of care necessary for survivors of suicide. Through these relationships and partners, this program will support the wide scale operation, expansion and integration of the system of care approach by creating sustainable infrastructure and services.

Incorporating Substance Abuse Prevention and Treatment

If awarded funding, the Division of Public and Behavioral Health (DPBH) will leverage the Substance Abuse Prevention program staff to integrate relevant policy and activities to ensure coordination of existing programs, referrals and treatment for substance abuse prevention and treatment. OSP will build upon current activities addressing the opioid crisis and other substance

abuse prevention initiatives, and continue to work with eight community coalitions that work toward substance abuse prevention across the state. At the state level, *the Multi-Disciplinary Prevention Advisory Council (MPAC)* is focusing on the opioid situation in Nevada through statewide messaging. The group has worked closely with the National Governors Association Policy Academy on Prescription Drug Abuse, aligning many of our approaches with that group's priorities to avoid duplication of effort and continue the momentum created in Nevada on this issue. This group's membership has recently been revamped to include a Justice of the Nevada Supreme Court, additional coalition representation, a person in recovery, Maternal and Child Health, the Office of the Governor and a member of the National Council on Problem Gambling. The Evidence-based Practices Workgroup is creating a Program Guide to aid communities in selecting strategies and practices that have been found to be effective. This group is also forming a team to vet new and emerging programs and practices to broaden relevant program choices.

Providing Rapid Follow-up

The Office of Suicide Prevention has developed effective partnerships across state departments and systems. These partnerships ensure meaningful communications between providers and care centers and works to ensure the continuity-of-care after discharge. Additionally, OSP resides within the DPBH which houses community and behavioral health programs for the state. Renown Health has recently developed rapid response triage in their three EDs and are working to build upon these protocols for improved workforce training around suicide-safer discharge, continuity of care and follow-up with other project partners.

D-7 Experienced Cross-agency Coordination

DPBH will be the lead agency for the implementation of this statewide suicide prevention and treatment program. Because of its integral position as the proposed Suicide Prevention authority and through coordination with the consortia and other system partners, DPBH has the capacity and infrastructure to ensure the appropriate operations, staffing, outreach, and implementation. In addition, DPBH is part of a system that works to implement the provisions of care for mental health and related recovery support services to adults with serious emotional disturbances, and those with early signs and symptoms of serious emotional disturbance as well as their families.

State Management Team

Our State Management Team will be comprised of members from the State of Nevada Division of Public and Behavioral Health, hospital administration, Crisis Call Center, county representatives, justice-serving agencies, first responders/law enforcement, veteran/military partners, including the VHA and Department of Veterans Services.

E Data Collection and Performance Measurement

E-1 Ability to Collect and Report Performance Measurement

The Division of Public and Behavioral Health (DPBH) works to ensure effective performance measurement and use data collected for ongoing monitoring of projects to evaluate its effectiveness and for continuous program improvement. DPBH works to reduce the impact of health disparities in Nevada. This Division is responsible for developing, implementing, and evaluating state, regional and local projects, programs and plans for a variety of prevention and

treatment, coordination of state and federal resources to include: 1. Statewide formulation, coordination, and implementation of a state plan for prevention, intervention, treatment, and recovery of suicide; 2. Statewide data collection, reporting and analysis of medical treatment; and 3. Statewide development and publication of standards for certification and the authority to certify treatment levels of care, professional development, and prevention programs.

Data will be gathered using the uniform data collection tool provided by SAMHSA (see https://www.cmhs-gpra.samhsa.gov) and submitted via SAMHSA's data entry and reporting system. The following performance measures will be tracked and reported during the project.

Table 9: Data-to-be-Reported	**Assigned**	**Frequency**
# of Policy Changes	Evaluator	Quarterly
# of Organizations that Improved Readiness	Evaluator	Quarterly
# of Organizations Entering into Formal MOU/MOA	Evaluator	Quarterly
# of Communities Establishing Technology Links to Shared Data	Evaluator	Quarterly
# and % of Work Group who are Survivors	Evaluator	Quarterly
# of Individuals Contacted through Program Outreach	Evaluator	Quarterly
# of Contacts made through Program Outreach	Evaluator	Quarterly
# of Programs Implemented specific Mental Health Practices Consistent with Goals of Project/Grant	Evaluator	Quarterly
# of Programs that Implement specific Mental Health Practices as a result of Project/Grant	Evaluator	Quarterly
# of Individuals Screened for Mental Health Interventions	Evaluator	Quarterly
# of Individuals Referred to Mental Health Services	Evaluator	Quarterly
# and % of Individuals Receiving Mental Health Services After Referral	Evaluator	Quarterly

In addition to the required performance measures, a workforce survey will be used to assess staff knowledge, beliefs, practices, and confidence in working with individuals at risk of suicide. The instrument was previously adapted and used by the State (see Attachment 2). Data collected from this measure will be used to inform and improve project trainings, materials, and staff support.

Data collection for this project will be in accordance with the Protection of Human Subjects Regulations (42 CFR 46) as outlined below.

Table 10: Confidentiality and Protection/Human Subjects Guidelines
1. Protect Clients and Staff from Potential Risk: The target audiences for professional development training will include previously trained to deal with crisis situations. Although the data collection process itself should not represent any risks to participants, there may be unforeseeable adverse/stressful effect related to reporting on situations related to intervening in or responding to a suicide. Every effort will be made to minimize risks and protect participants. Project staff will underscore the voluntary nature of participation in all events and in completion of all evaluation forms. All participants will be advised to inform staff if they become uncomfortable with the content or processes associated with the event, and that they may discontinue participation in all or any part of the event without adverse consequences. Counseling services will be made available for any participants requesting them
2. Fair Selection of Participants: Target audiences for professional development training will

include primary and behavioral health-care providers, first responders, community-based criminal justice system professionals, including community corrections officers (probation, parole, and pre-trial services), court personnel, law enforcement officers (including local CIT trainers), and human service providers who work with adult populations. These groups have been identified as they work with individuals at-risk for suicide.
3. Absence of Coercion: Participants will be informed that their participation in any data collection efforts beyond reporting on the performance measures required by SAMHSA is voluntary. No compensation or incentives will be used encourage participation. Participants will be able to take advantage of any and all trainings and support services even if they do not agree to complete additional data collection measures.
4. Data Collection: Data will be collected from the target audience identified in Item 2 above using surveys that do not collect personally identifiable information. The Zero Suicide Survey is provided in Attachment 2.
5. Privacy and Confidentiality: Data from the required performance measures will be collected and uploaded into the limited access SAMHSA data collection site by the external evaluator. Other survey data will be collected (either using paper and pencil or web-based surveys) and entered into a limited access, secure data file by the external evaluator. All data will be de-identified so as not to be able to link responses back to participants. Paper and pencil surveys will be stored in a locked cabinet and destroyed after 5 years as per the external evaluator's protocol. Consent forms (described below) will be collected and stored separately from the surveys.
6. Adequate Consent Procedures: Participants will be provided information on the purpose of the data being collected, how it will be used and stored, and who will have access to the data. Consent forms will inform participants that their participation is voluntary, they can leave the project and/or not complete the survey at any time without any problems, possible risks to participation, and plans to protect them against those risks. Participants for this project are all adult professionals and English speaking, thereby eliminating the need to consider obtaining consent from youth, elderly, or individuals with limited reading skills. A sample consent form is included in Attachment 3.
7. Risk/Benefit Discussion: The target audience for this project is trained professionals who routinely respond to/intervene with critical and stressful situations. Although there is a risk to individuals' ability to cope with these situations, the information and support provided through this project has the potential to greatly reduce the prevalence of suicide in Nevada. Thus, the benefits of participation outweigh the risks.

E-3 Plan for Local Performance Assessment

Nevada's plan for conducting the local performance assessment will be completed through an outside evaluator through Nevada's current Master Service Agreement (MSA). The external evaluator will work with the State Suicide Prevention Task Force to identify appropriate data sources to assess the project's impact on impact on suicide deaths and non-fatal suicide attempts for individuals 25 and older. The external evaluator will oversee data collection, management, analysis, and reporting for the purpose of tracking progress towards meeting project objectives. Specific data for the measures reported through the SAMHSA system, program and grant measures, and data integrity will be considered for baseline; consistency in reporting and evaluating of meeting program measures. Nevada's efforts to implement statewide prevention

will be reviewed by the State Suicide Prevention Task Force through progress reports generated quarterly by the external evaluator to examine progress towards meeting goals and objectives.

E-4 Quality Improvement Process

The State of Nevada will review the performance data reported to SAMHSA to assess progress towards meeting goals and objectives and improve project management and determine if the project is having the intended impact within the grant catchment area. The following questions will guide the quality improvement process and be reported to SAMHSA quarterly.

- How did the activities impact suicide deaths and non-fatal suicide attempts, including suicide deaths and attempts within key sectors such as health and behavioral health?
- How has the competence/confidence of health and behavioral health clinical staff changed over the course of the grant? In particular, how have the activities impacted clinical skills in the areas of:
    - assessment of suicide risk and protective factors;
    - formulation of a risk summary to inform the choice of intervention;
    - use of best practice interventions to ensure safety including lethal means safety, treatment of suicide risk, and follow-up to ensure continuity of care?
- How have the grant activities impacted the Nevada's success in achieving the objectives of the NSSP?

In addition, outcome and process measures will be used to ensure appropriate populations are being served and disparities in services and outcomes are minimized.

Table 11: Outcome and Process Measures

Outcome Questions

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/sexual orientation/gender identity?
- How durable were the effects?
- Was the intervention effective in maintaining the project outcomes at six-month follow-up?

Process Questions

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

Section G. Confidentiality and SAMHSA Participant Protection/Human Subjects

Data collection for this project will be in accordance with the Protection of Human Subjects Regulations (42 CFR 46) as outlined below.

Table 11: Confidentiality and Protection/Human Subjects Guidelines
1. Protect Clients and Staff from Potential Risk: The target audiences for professional development training will include previously trained to deal with crisis situations. Although the data collection process itself should not represent any risks to participants, there may be unforeseeable adverse/stressful effect related to reporting on situations related to intervening in or responding to a suicide. Every effort will be made to minimize risks and protect participants. Project staff will underscore the voluntary nature of participation in all events and in completion of all evaluation forms. All participants will be advised to inform staff if they become uncomfortable with the content or processes associated with the event, and that they may discontinue participation in all or any part of the event without adverse consequences. Counseling services will be made available for any participants requesting them
2. Fair Selection of Participants: Target audiences for professional development training will include primary and behavioral health-care providers, first responders, community-based criminal justice system professionals, including community corrections officers (probation, parole, and pre-trial services), court personnel, law enforcement officers (including local CIT trainers), and human service providers who work with adult populations. These groups have been identified as they work with individuals at-risk for suicide.
3. Absence of Coercion: Participants will be informed that their participation in any data collection efforts beyond reporting on the performance measures required by SAMHSA is voluntary. No compensation or incentives will be used encourage participation. Participants will be able to take advantage of any and all trainings and support services even if they do not agree to complete additional data collection measures.
4. Data Collection: Data will be collected from the target audience identified in Item 2 above using surveys that do not collect personally identifiable information. The Zero Suicide Survey is provided in Attachment 2.
5. Privacy and Confidentiality: Data from the required performance measures will be collected and uploaded into the limited access SAMHSA data collection site by the external evaluator. Other survey data will be collected (either using paper and pencil or web-based surveys) and entered into a limited access, secure data file by the external evaluator. All data will be de-identified so as not to be able to link responses back to participants. Paper and pencil surveys will be stored in a locked cabinet and destroyed after 5 years as per the external evaluator's protocol. Consent forms (described below) will be collected and stored separately from the surveys.
6. Adequate Consent Procedures: Participants will be provided information on the purpose of the data being collected, how it will be used and stored, and who will have access to the data. Consent forms will inform participants that their participation is voluntary, they can leave the project and/or not complete the survey at any time without any problems, possible risks to participation, and plans to protect them against those risks. Participants for this project are all adult professionals and English speaking, thereby eliminating the need to consider obtaining consent from youth, elderly, or individuals with limited reading skills. A sample consent form is included in Attachment 3.

7. Risk/Benefit Discussion: The target audience for this project is trained professionals who routinely respond to/intervene with critical and stressful situations. Although there is a risk to individuals' ability to cope with these situations, the information and support provided through this project has the potential to greatly reduce the prevalence of suicide in Nevada. Thus, the benefits of participation outweigh the risks.

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

   N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   Nevada has recently hired regional coordinators to work with their assigned counties and develop plans, engage new partners, and work towards creating a healthier Nevada. One regional coordinator has been in place for over a year and has worked steadily to bring 5 counties together and much of that collaborative work is highlighted in the attachments. The hiring of new coordinators will cover the rest of the state and enhance the partnerships exponentially. The regional coordinators serve as the voice of the people for each of their perspective counties. their service to the counties helps build a lead from the middle model partnership in Nevada where the voice of all willing participants from multiple sectors of the local community are heard. The collaborative efforts are used to identify service needs and gaps, create funding streams, and bring messages back to the State partners to build a solid system of care, and create change as needed.

   Does the state have any activities related to this section that you would like to highlight?

   The State has created a few bodies of management as required by various grants. As the same people often serve on multiple councils recent efforts have been made to combine efforts and work together and have one meeting rather than 5 or 6. We have learned that maintaining a neutral party to convene the meetings helps avoid focusing on one group such as education or child and family services more than the other participants. The members of the teams involve many of the decision makers and leaders

of various state agencies and community leaders. These bodies share multiple perspectives, and current initiatives with one another, and take action on important issues. The groups include the System of Care subcommittee's (SOC), The State Management Team (SMT), and the Inter agency Counsel (IAC). Representation from these groups include everyone from family members, students, mental health providers, various government agencies, universities, community coalitions, courts, advocacy groups, substance use treatment providers, non profit entities, and private citizens. Combining efforts is challenging because different grants require different bodies to manage and guide the projects. As the various groups explore options for working together and still maintaining the necessary elements of each grant they grow stronger and increase their ability to have the clout to create the necessary lasting change.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Brian Sandoval
Governor

Florence Jameson, MD
Chairwoman

Heather Korbulic
Executive Director

Silver State Health Insurance Exchange
2310 South Carson Street, Suite 2 Carson City, NV 89701 T: 775-687-9939 F: 775-687-9932
www.nevadahealthlink.com/sshix

August 11, 2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As the Executive Director of the Silver State Health Insurance Exchange, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Silver State Health Insurance Exchange will be available to contribute to this process by consultation on expanded Medicaid and other Affordable Care Act (ACA) issues, collaborating on how behavioral health care needs are addressed in light of the ACA, and any other issues we may offer as guidance on.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Heather Korbulic

INTER-TRIBAL COUNCIL OF NEVADA, INC.

680 GREENBRAE DR., SUITE 265 • SPARKS, NV 89431
P.O. BOX 7440 • RENO, NV 89510
PHONE (775) 355-0600 • FAX (775) 355-0648

August 10, 2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As Inter-Tribal Council of Nevada, Inc. and Nevada Tribal Health Directors we are writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Inter-Tribal Council of Nevada, Inc. will be available to contribute to this process by sharing the State of Nevada Strategic Prevention Framework Steps with the Nevada Tribal Health Directors as resource information for the Rural Nevada Tribal Health Centers and Clinical staff.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Daryl Crawford, Executive Director

Inter-Tribal Council of Nevada, Inc.

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

AMY ROUKIE, MBA
Administrator, DPBH

JOHN DIMURO, D.O., MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
4150 Technology Way, Suite 300
Carson City, Nevada 89706
Telephone: (775) 684-4200 · Fax: (775) 687-7570

August 14, 2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As the Suicide Prevention Coordinator, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and SAPTA will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Nevada Office of Suicide Prevention will be available to contribute to this process by continuing to develop, implement and evaluate Nevada's suicide prevention strategy, utilizing the guidance of the four steps outlined. I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Misty Vaughan Allen
Suicide Prevention Coordinator

Ken Furlong
Sheriff

911 E. Musser St.
Carson City, NV
89701

775-887-2500
Fax: 775-887-2026

August 9, 2017

To:
Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As Sheriff, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

- Assess the behavioral health needs of the Nevada based on epidemiological data;
- Build the capacity to address those needs;
- Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Carson City Sheriff's Office will be available to contribute to this process by working collaboratively through regional mental health cooperatives and data derived from jail diversion programs, as well as mobile outreach programs. I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Ken Furlong
Sheriff

August 7,2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As the Chair of the Clark County Children's Mental Health Consortium, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Consortium will be available to contribute to this process by working with DHHS to ensure that the strategic goals of our 10 year plan is always considered as the department works to implement this grant.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Daniel C. Musgrove, Chair
Clark County Children's Mental Health Consortium

Nevada Statewide
Coalition Partnership

P.O. Box 20732
Carson City, NV 89721
Cell: 775.450.7333
lindalang1628@gmail.com

August 2, 2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As the Director of the Nevada Statewide Coalition Partnership (NSCP), I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS) combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the SAPT Block Grant and the CMHS Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework (SPF) process as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Nevada will also plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The NSCP will contribute to this process by collaborating with state partners to ensure prevention services are coordinated, strategic, and in line with the goals of this funding. Additionally, the NSCP coordinate evaluation strategies between community level partners and the state, ensuring consistent collection of data outcomes. I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Linda Lang, Director

NEVADA PEP

Strengthening Families *with*
Education • Empowerment • Encouragement

August 7, 2017

Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

On behalf of Nevada PEP, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:
1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

Nevada PEP, as Nevada's Statewide Family Network, will be available to contribute to this process by providing the family and youth voice to planning groups and advisory committees. I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Karen Taycher
Executive Director

Statewide
Toll-Free 800-216-5188
www.nvpep.org
pepinfo@nvpep.org

Central Office
7211 W. Charleston Blvd.
Las Vegas, Nevada 89117
Phone: 702-388-8899
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Satellite Office
4600 Kietzke Lane, Suite I-202
Reno, Nevada 89502
Phone: 775-448-9950
Fax: 775-448-9603

Development of Regional Behavioral Health Coalition mission, priorities and next steps

Regional Priorities	
1. Address behavioral health concerns across spectrum focusing on: -*Youth and families* - Increase school involvement in community collaboration - Identify opportunities for prevention and early intervention - Develop supports for specific populations such as LGBT youth. **-***Seniors* - Identify gaps and strategies to assist seniors in need and in crisis **2. Develop regional and county strategic plans for behavioral health based on priorities** **3. Identify legislative action needed and develop action plans** - Identify and organize data needed to advocacy - Identify initiative for advocacy that are beneficial to regional behavioral health efforts **4. Formalize relationships, programs, and initiatives** - Develop MOU's, policies, and procedures for FASTT, MOST, CIT, and MDT's and Behavioral Health Task Forces - Standardize initiatives while allowing for flexibility to address each community's specific needs - Develop community triage flowsheets for providers	**5. Strengthen continuity of care and care coordination through:** - Identifying information sharing strategies - Development of care coordination inter local agreements and MOUS - Improve discharge/ reentry planning processes from hospitals, jails, and out-of-state treatment - Identify uses of technology to overcome barriers to integration **6. Increase community engagement:** - Reduce stigma of mental illness through: a) Increasing public awareness b) Engage decision makers c) Provide behavioral health training and trauma informed care training to community members and first responders **7. Address basic needs of individuals with behavioral health issues** - Increase affordable housing - Identify transitional housing **8. Increase diversity of services** - Develop peer and family support network

Mission statements- ideas

1. Working together to improve behavioral health so that individuals, youth, and families in our communities can experience healthy and satisfying lives

2. Working together to improve behavioral health with the vision of building healthy communities

3. Collaborating to develop healthy, safe and supportive communities through improving behavioral health

Stakeholder input on the purpose of the Regional Behavioral Health Coalition

Proactive regional organizing:

- Identify top priorities in community
- Allows for collective identification of needs and the resources available for those needs. Can then take this information back to other communities
- Helps inform what new programs and initiatives need to provide in order to be responsive to the community.
- Developing local, regional, and state infrastructure to be responsive to community needs
- Regional coalition is a group that initiates, and motivates action
- Bringing the right people to the table to effect change
- Formalize community initiatives through role definition, formalized relationships, policies and procedures, and what future opportunities exist

Information sharing:

- Hear about regional experiences and lessons learned to bring back information to other communities
- Discussion leads to program change and improvement to better respond to community needs
- Identify and discuss needs of region and possible solutions

Collaboration:

- Diverse groups working together to influence legislature
- Increased communication decreases risk
- Increase local and regional collaboration and sharing supports sustainable momentum on behavioral health initiatives such as CIT, MOST, FASTT

- Similar community integration with unique community vision
- Regional coordination has brought focus, collaboration, discussion of national perspectives, and coordination through technology.
- Identify gaps, work with agencies to support community and stabilize super-utilizers through change of process
- Collaborative with agencies to support special groups such as older people and individuals with disabilities
- Regionalization provides mutual support of the problem
- Communities can work on behavioral health issues through learning how to address existing behavioral health issues
- Collaboration helps communities feels like they are not addressing behavioral health issues alone.
- Mentoring and learning through other community's experiences
- Enhancing continuity of care through strengthening discharge plans
- Developing frontier model of behavioral health network through identifying hidden resources, rather than assuming lack of resources
- Willingness to address needs and problems openness and willingness
- Coordination of between communities
- Cohesiveness of group
- Develop ideas for solutions to solve problems
- Sharing relationship, building relationships
- Keep up with local, regional, and national change
- Focusing on goals such as one stop shop, no wrong door by getting agencies to work together to provide more effective and appropriate services

Reducing Silos:

- Collaboration assists in:
  - Stabilizing individuals who are experiencing complex and chronic challenges.
  - Allows for agencies to understand what each are doing, the services they provide, and where gaps are.
  - Assists in no duplicating efforts
  - Allows communities and counties to taking ownership to collectively respond to and support our shared clients
  - Move from siloed system to true system

Community improvement:

- -improving communities for our children
- -develop initiatives and programs to stabilize children and prevent future crises
- -develop infrastructure to meet local needs

Increasing Access to Care

Identification and support for crisis prevention

Prevention

Community Solutions: **Behavioral Health Task Forces** focusing on collaboration and policy, community behavioral health training, Multi-disciplinary Teams, Mental Health First Aid Training

Partners: Community coalitions, Fire/ EMS, School social workers, National Alliance on Mental Illness, County Human Service (CHS) Providers, community providers.

Early Response

Crisis Stabilization

Community Solutions: **Crisis Intervention Training** (40 hr behavioral health training), behavioral health awareness training, community stabilization database (CMIS) for data collection and case coordination

Partners: Fire/ EMS, Law Enforcement, DPBH Rural Clinics , CHS Providers

Diversion from unnecessary arrests and ER

Diversion

Community Solutions: Expanding **Mobile Outreach Safety Team** (partnership between law enforcement and clinician, and EMS/ Fire in some counties), **Crisis Intervention Training** in all four counties to increase officer awareness of mental illness. **Carson Tahoe Mallory Crisis Center, Silver Springs West Care Triage Center** (coming soon)

Community support and follow up

Treatment

Community Solutions: Identifying **coordinated community follow up** for release from jail, hospital, and contact with MOST, and collaborating with Community outreach welfare workers to connect individuals with Medicaid and other resources, strengthening our workforce

Partners: DPBH Rural Clinics, DWSS, community treatment providers, County Human Service (CHS) providers

Community Reentry and Integration

Recovery

Community Solutions: **Forensic Assessment Services Triage Team** (FASTT jail reentry case management to prevent further arrests)

Partners: County Human Service Providers, National Alliance on Mental Illness,

Douglas, Lyon, Carson & Churchill County Behavioral Health Solutions

Rural Community Priorities

1. Stabilize funding to sustain regional and community based behavioral health
-Programs such as Forensic Assessment Services Triage Team (FASTT jail reentry) and Mobile Outreach Safety Team, Crisis Triage Centers

2. Support workforce development for health care professionals- Develop incentives to bring providers into rural counties

3. Increase community capacity for access to care- Identify solutions and opportunities to support providers in rural communities

4. Develop Interim committee- Study issue of public and behavioral health in rural counties

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Incorporating Cultural and Linguistic Appropriate Service (CLAS) Standards in Nevada

-A Group Dialogue in a World Café Style-

August 28, 2017

10:30 – 5:00

Nevada Department of Education

700 E. Fifth St. Carson City

Since 2011, the Substance Abuse Mental Health Services Administration (SAMHSA) has required that all states that receive federal grants develop a Plan to Reduce Racial and Ethnic Health Disparities. Using the National Standards for Culturally and Linguistically Appropriate Services, we can work together to improve how we serve our diverse populations.

The National CLAS Standards in Health and Healthcare is the foundation for quality improvement efforts to reduce disparities by improving services and access to care. They focus strategically on individuals from ethnic, racial, and other underserved populations that typically have less access to healthcare, poor utilization of available services, and worse outcomes than individuals from historically advantaged populations.

Please join us for a day long facilitated conversation with various state partner groups and participate in this conversation.

LUNCH WILL BE PROVIDED

BRIAN SANDOVAL
Governor
STEVE CANAVERO, Ph.D.
Superintendent of Public Instruction

STATE OF NEVADA

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August, 15th 2017

To:
Amy Roukie, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way Suite 200
Carson City, NV 89706

Dear Ms. Roukie:

As the Department of Education, Office of Safe and Respectful Learning, I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY18/19 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with the recently revised Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under the revised Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is my understanding that DHHS will undertake the Strategic Prevention Framework Steps (SPF) as part of its Behavioral Health Assessment and Plan, and will continue to use the SPF process during the current biennium with a goal of completing the following four steps:

1. Assess the behavioral health needs of the Nevada based on epidemiological data;
2. Build the capacity to address those needs;
3. Develop a comprehensive strategic plan with goals, objectives and strategies aimed at meeting the behavioral health needs of the State; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services. Also, plan for the implementation of new services on a statewide basis that will include integrative work with primary care providers. It will also focus on newly defined areas of mental health such as prevention/treatment of depression in early adolescents and early intervention in schizophrenia in late adolescents and early adulthood, as well as suicide prevention.

The Office of Safe and Respectful Learning will be available to contribute to this process by training and connecting school social workers to Community Mental Health Services and Support. We are also very interested in partnering to give students school comprehensive support in implementing prevention, intervention, and treatment in the school and community settings.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Christy McGill
Director, Office of Safe and Respectful Learning.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

      The Behavioral Health Planning and Advisory Council is involved on a quarterly basis in advising and guiding the work and making ongoing recommendations when new plans are presented. The counsel is invited at any time to give their insights and suggestions on plans that are developed through an open meeting structure. The State uses multiple sources to plan and implement SUD treatment and recovery services. They utilize data from providers, hold strategic planning sessions, town halls, conduct needs assessments, analyze data provided by medicaid, birth records, treatment episodes, billing and claims data, and utilize a vast array of partners from all sectors affected by substance use to help guide future plans. The partners include but are not limited to treatment and prevention providers, universities, family members, advocacy groups, professionals, coalitions Epidemiologist, medical professionals, and state staff from different divisions and departments.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ( ) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes ( ) No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   Duties, Responsibilities, and Gathering Meaningful Input: The BHPAC for the State of Nevada performs the following functions:
   • Holds regular quarterly Council meetings.
   • Gather input from the public during an open meeting for feedback.
   • Recruits a diverse and culturally competent Council membership.
   • Assists consumers and family members in attending Council meetings.
   • Develops education and training opportunities for Council members, including consumers and family members.
   • Reviewed the Community Mental Health Services (CMHS) Joint Block Grant application and makes recommendations to BPBH, SAPTA, and the Division of Child and Family Services (DCFS), as well as Nevada's State Plan. DPBH manages the committee and ensure they are updated on programs, grants, activities and engages the committee for comments and recommendations.
   • Monitors, reviews, and evaluates the allocation and adequacy of mental health, substance abuse and co-occurring services within the State.
   • Addresses issues such as the transition of clients between child and adult systems of care, and the integration of mental health services within criminal justice systems.

• Collaborates with various public and private mental health regulatory and advocacy organizations on mental health, substance use and co-occurring issues.
• Serves as an advocate for all persons having mental illness, substance use and co-occurring disorders.

Duties and responsibilities of the Council include:
• The Council shall advise DPBH, DCFS, and SAPTA in the development of the state mental health and substance abuse plans in accordance with federal and state regulations. Any recommendations regarding the state plan received by the State must be submitted to the federal government along with the application, whether or not they were incorporated in the plan.
• Serve as an advocate for adults, children and adolescents with serious mental illness, substance use or abuse, and co-occurring disorders.

• The Council shall monitor, review, and evaluate, no less than once each year, the allocation and adequacy of mental health services within the state.
• Utilize health statistics, research, and proven theories in both the decision-making and the planning process.
• Support and advocate for quality, cost effective and individualized consumer/family based services through evidence-based best practices and other effective models of care. Encourage research and use of promising practices with a goal for excellence.
• Improve quality of life for consumers through the lifespan by removing barriers to services. The Council's focus is to support and maintain children at home and in their community; meaningful daily activities, including supported employment for adults; and meaningful daily activities for older adults. Services will focus on recovery and resiliency.
• Promote educational opportunities about mental illness and substance abuse in an effort to reduce stigma.

Council Active Involvement and Successful Integration:

On July 20, 2017, the Behavioral Health Planning and Advisory Council met to review Nevada's first drafts of planning steps 1 and 2 of the Block Grant application including priorities and recommendations This meeting was directed under open meeting laws and materials for the meeting were provided to BHPAC members 7 days prior to the meeting for review. The materials provided prior to the meeting included a slide show with the priorities for the joint block grant application with information regarding the sources of information used to create the priorities and the completed SAPTA strategic plan.
During the open meeting (agenda attached) there were opportunities for public comment to occur and for BHPAC to provide comments and request clarification and feedback. members discussed extensively the need for coordination of peer support specialist training, but had minimal feedback regarding the application. Following the presentations members were encouraged to ask questions and provide additional feedback. A follow up meeting was planned for late August to discuss the final application and get additional feedback to potentially implement prior to final submission of the application.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

BRIAN SANDOVAL
Governor

STATE OF NEVADA
BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL
4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

RENE NORRIS
Chair

ALI JAI FAISON
Vice Chair

Behavioral Health Planning & Advisory Council
Quarterly Meeting Minutes
January 21, 2016

Division of Public & Behavioral Health
4150 Technology Way, Room 301
Carson City, Nevada 89706

S. NV Adult Mental Health Services
6161 Charleston Boulevard, West Hall
Las Vegas, Nevada 89146

1. **Call to Order, Roll Call, and Introductions.**
The chair called the meeting to order at 9:10am

MEMBERS PRESENT

Ali Jai Faison, Vice Chair	Denise Everett	Rene Norris, Chair
Alyce Thomas	Elizabeth Burcio	Robert Volk
Anis Abi-Karam	Heather Kuhn	Sharon Wilson
Barbara Jackson	Hillary Jones	Susan Maunder
Cynthia Matteson	Katherine Mayhew	Susan Orton
Debra Parra	Mechelle Merrill	William Kirby

MEMBERS ABSENT

Dawn Walker	LaJune Primous	Marion Scott

STAFF & GUESTS

Anabel Ballard, Administrative Support
Barry Lovgren, Private Citizen
Dennis Humphrey
Jeanette Belz, Lobbyist
Jeanyne Ward, Nevada Peer Leadership Advisory Council
Kevin Quint, Bureau Chief, Substance Abuse Prevention and Treatment Agency
Meg Matta, Administrative Support
Michael McMahon, Division of Public and Behavioral Health
Ruben Harper, Expressions Behavioral Health Services, Inc.
Stephanie Woodard, State Project Officer, CCBHC Grant
Susanne Sliwa, Senior Deputy Attorney General
Tracey Green, Medical Officer, Public and Behavioral Health

2. **Public Comment**
Ms. Burcio relayed concerns about availability of substance abuse treatment to pregnant women in Lyon County. Mr. Quint offered to review any complaints.

3. **Review, Discuss and Receive Public Comment on the Substance Abuse Prevention and Treatment Agency (SAPTA)/Mental Health Block Grant Application**
Mr. Lovgren commented that he was happy to see Block Grant Application revisions regarding treatment for pregnant women and expansion of opioid maintenance therapy on the agenda for this meeting. He encouraged Council members to approve both agenda items.

4. **Review and Approve Minutes from Council's By-Laws Meeting of September 10, 2015, and Quarterly Meeting of November 19, 2015**
Ms. Jones moved to approve minutes of September 10, 2015, and from November 19, 2015. Mr. Kirby seconded and the motion carried.

5. **Presentation on the Certified Community Behavioral Health Clinics (CCBHC) Grant**
Dr. Woodard presented an overview of Nevada Certified Community Behavioral Health Clinics Planning Grant. In March 2014, the Protecting Access to Medicare Act (PAMA) was enacted which funded a two-phase (CCBHC) demonstration program. The first phase is the Planning Grant Phase in which CMS and SAMHSA awarded a total of $22.9 million in CCBHC planning grants to 24 states. Nevada received a CCBHC planning grant in the amount of $933,067 to engage stakeholders, certify CCBHCs, identify primary care and behavioral health services that will be available, implement evidence-based practices, support existing behavioral health and primary care providers, and establish a Performance Based Standards (PBS) methodology for payment.

The second phase will be the Demonstration Phase, where up to eight states will be selected to participate in the CCBHC demonstration. The goals of the CCBHC grant are to improve overall health by providing improved community-based mental health and substance use disorder treatment. Emphasis will be placed on care for individuals with serious mental illness, serious emotional disturbance, and chronic substance use disorders. Effective coordination of care through integration of behavioral health care will be developed, with physical health care to serve the whole person using consistent evidence-based practices.

CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs. States must certify that each CCBHC offers the required services either directly or through a formal contract with a designated collaborating organization (DCO). Through the demonstration, the required services must be offered and paid for even if they are not included in a states' Medicaid plans.

CCBHCs will support BHPAC's top five behavioral health priorities to be addressed in 2016 through 2018. These priorities are to increase the number and quality of behavioral health professions in Nevada, improve screening, assessment, and referral services for at-risk populations, support earlier access to prevention and early intervention services, increase community-based services across the system of care, and provide community-based intervention and support to address trauma and prevent incarceration. The BHPAC, in turn, will have a role in providing on-going feedback and input on planning stages, and representation on the CCBHC Steering Committee.

6. **New Member Orientation Planning.**
Ms. Kuhn informed the members that the technical assistance application, which is currently under review by SAMHSA, will provide access to new member orientation materials, webinars, and definition of member roles and expectations. There are also previously used materials which will need to be updated for use.

Ms. Norris said that in the past, trainings occurred in October. The format was one day for the meeting, and one day for training. Members were provided with an orientation binder containing information on the Block Grant and the duties of the Council. Mr. Faison suggested a sooner training would be more beneficial. Ms. Norris will coordinate with Mr. McMahon to decide possible dates.

7. **Block Grant Application Revision to Increase Number of Pregnant Women Receiving Substance Abuse Treatment**
Mr. Quint said there is a weekly block grant meeting working on changes. He said whatever this group decides, he will take back to the block grant committee for inclusion. Mr. Quint added that there was some inconsistency with the reported numbers on treatment for pregnant women. He offered the opportunity for the Council to set a target for the Block Grant committee to consider. Or, he will arrive at a target with the committee and bring it back to the Council for consideration.

Ms. Wilson moved to increase the number of pregnant women to receive substance use treatment in the Block Grant. Ms. Thomas seconded, and the motion carried.

8. **Block Grant Application Revision to Expand Funded Opioid Maintenance Therapy to Washoe County**
Currently, funded opioid maintenance therapy (OMT) is available only in Las Vegas. SAPTA certifies a number of facilities for OMT, but funds only one.

Ms. Wilson moved to expand funding for OMT to Washoe County and other areas in Nevada. Ms. Thomas seconded, and the motion carried.

9. **Update on the Nevada Commission on Behavioral Health**
Ms. Kuhn provided an update from Ms. Kinnikin. With regard to Children's services, they are working with the grant received by the State to help implement a statewide system of care-driven services for families. For adult services, they are continuing to address issues with seclusion and restraints, timely evaluation for forensic purposes, co-occurring treatment, and aftercare post-hospitalization. They are also working on an annual letter to the Governor that will reflect the successes and concerns of behavioral health in Nevada.

10. **Update and Discuss the Statewide Peer Leadership Advisory Council**
The last quarterly meeting was Nov 12, 2015 via conference call. The Council discussed the Individual Peer Certification Subcommittee work. What other states are doing and how our council wants to move forward with individual peer certification. The council assigned tasks.

The Subcommittee met Jan 13, 2016 via conference call. There wasn't a quorum so a new date was set for a meeting via conference call. The council is still moving forward with how to get an individual peer certification in Nevada as well as starting to plan how to help organizations implement SB489 that was passed in 2015. A new subcommittee call was set for Jan 28 from 10-11, the subcommittee will be discussing SB489.

The next NPLAC quarterly meeting is set for Feb 17, 2016 from 10-1130 via conference call. The council will discuss the assigned tasks from November's meeting and update the council on the subcommittee's work. All meeting announcements and notes are located on the website NV.PPS.com. Please direct any questions to Jeanyne Ward or Michelle Berry at CASAT

11. **Overview of the Governor's Interagency Council on Homelessness.**
Ms. Kuhn provided a short update provided by Mr. McMahon. The Council has come up with a Strategic Plan, and developed five workgroups to work on sections of the Plan. The next meeting is on February 28. If anyone has further questions, please contact Ms. Matta.

12. **Update on Technical Assistance for Planning Councils**
Ms. Kuhn said SAMHSA is currently reviewing their application for technical assistance. She expects to receive their recommendations in the next couple of weeks. An initial proposal was to begin with webinars and trainings before building up to an onsite orientation. Last summer, a survey based on SAMHSA's Behavioral Health Assessment IQ was sent to the members, and the survey responses together with additional comments were included in the application. If new concerns have arisen since that time, they will be incorporated. Ms. Norris asked Ms. Kuhn for a copy of the application.

13. **Committee Reviews**
    - **Executive Committee – Vacancies and Pending Members on Adult and Child Planner Committee**
      Ms. Wilson suggested the Chair send a letter to people who have excessive absences to notify them their membership may be rescinded.
    - **Behavioral Health Promotion Committee – Vacancies and Pending Members**
      Ms. Norris asked for volunteers to join the committee. Ms. Mayhew and Ms. Everett volunteered.
    - **Nominating Committee – Vacancies and Pending Members**
      Ms. Matta reported that Sharon Wilson was in the process of submitting paperwork to renew her appointment; and Charlene Frost was sent an application but has not yet submitted it. The Council currently has one vacancy for someone in education and one vacancy for a co-occurring consumer. The member representing a family member for a child has not attended the meetings.
    - **Rural Monitoring Subcommittee – New/Returning Members**
      Ms. Burcio volunteered to participate in the subcommittee.
    - **Bylaws Ad Hoc Committee**
      Bylaw changes will be voted upon at the next meeting.

Ms. Norris will email a description of the various committee responsibilities for distribution to the members.

14. **Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).**
Mr. Lovgren, a private citizen, said the bylaws state that the Council should monitor, review and evaluate the adequacy of mental health services in the State no less than once each year. The Governor's Order for this Council in 2013 called for a monitor, review and evaluation of mental health and behavioral health services. Behavioral health services include services for substance abuse and co-occurring disorders. Neither the Bylaws nor the proposed changes to the Bylaws address this expanded duty. If the Governor has ordered the Council to monitor these services, the Council should be provided resources sufficient to carry out the order. The BHPAC is not provided regular reports from the Commission on Behavioral Health for State agencies that address things like how many people are provided services and how many are on waiting lists. It is difficult to make decisions without information. The technical assistance the Council is requesting may help address the expanded duties; but until that time it is premature for the Division to state in the Block Grant application that the Council monitors, reviews and evaluates the adequacy of services for mental health, substance abuse and co-occurring disorders within the State.

Ms. Wilson responded that this issue had been brought up at the Bylaws Subcommittee meeting and it was decided that as the rural monitoring activities had been suspended for two years due to time requirements, an amount would not be requested at this time. Rather than request more funds than the Council had capacity to use, it would be easier to revisit it at a later time. If the Council wants to include a budget amount at this time, the recommendation can be made at the next meeting during approval of the proposed bylaw changes.

Mr. Lovgren agreed that it may not be possible for this Council to undertake that large responsibility, but the Governor should be asked to amend the order. He added that there are other ways to monitor services that do not require a site visit, which is expensive. Some states review applications to receive funding for services.

15. **Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting on April 21, 2016**
    - Orientation for New Members
    - Technical Assistance
    - Review and Approve Bylaws
    - Review Block Grant Budget and Review and Approve Council Budget
    - Promotion Committee Budget

Ms. Wilson moved to accept the date and agenda items for the next meeting, and additional subcommittee members. Ms. Jones seconded and the motion carried.

16. **Adjournment**
There being no further business to come before the meeting, Mr. Faison moved to adjourn the meeting and Ms. Wilson seconded. Motion carried and the meeting adjourned at 11:10 a.m.

Brian Sandoval
Governor

STATE OF NEVADA

BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
Thursday, April 21, 2016

9:00 a.m. to Adjournment

Video Conference Locations

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

SNAMHS
6161 W. Charleston Blvd. Bldg. 1
West Hall Conference Room

Teleconference Access
Phone Number: 1 (775) 887-5619 Access Code: 2000#

REVISED AGENDA

Item		Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions	Rene Norris
2.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit)	
3.	Review and Approve Minutes of January 21, 2016 *For Possible Action*	Rene Norris
4.	Report, Discuss and Approve BHPAC Recommendations from Previous Meeting to Increase the Number in the Mental Health Block Grant of Pregnant Women to Receive Substance Use Treatment *For Possible Action*	Kevin Quint
5.	Report, Discuss and Approve BHPAC Recommendations from Previous Meeting to Expand Opioid Maintenance Therapy Funding for Washoe Counties and Other Areas In Nevada *For Possible Action*	Kevin Quint
6.	Update on Status of Certified Community Behavioral Health Clinics (CCBHC) Project	Stephanie Woodard
7.	Update on Orientation and Technical Assistance Planning for Councils	Mike McMahon
8.	Update on the Nevada Commission on Behavioral Health	Viki Kinnikin
9.	Update and Discuss the Statewide Peer Leadership Advisory Council	Michelle Berry
10.	Overview of the Governor's Interagency Council on Homelessness	Mike McMahon
11.	Committee Reviews *For Possible Action* ➢ Executive Committee – Vacancies and Pending Members ➢ Behavioral Health Promotion Committee – Update on Behavioral Health Month Activities ➢ Nominating Committee – Vacancies and Pending Members ➢ Rural Monitoring Subcommittee – New/Returning Members ➢ Bylaws Ad Hoc Committee – Approval of Changes to Bylaws of September 10, 2015	Rene Norris Mechelle Merrill Sharon Wilson
12.	Propose and Approve Agenda Items for the Council's Next Quarterly Meeting on July 21, 2016. *For Possible Action*	Rene Norris
13.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).	
14.	Adjournment *For Possible Action*	Rene Norris

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Agenda Notification:

- The meeting may commence on or after the designated start time;
- Items on the agenda may be taken out of order;
- The public body may combine two or more agenda items for consideration;
- The public body may remove an item from the agenda or delay discussion relating to an item on the agenda at any time;
- Members of the public in attendance should identify themselves when requested under Agenda Item 1;
- Public Comment will be taken during this agenda item. No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken. The Chair or presiding member of the Council will place a five (5) minute limit on the time individuals may address the Council. The Chair may elect to allow public comment on a specific agenda item when that item is being considered;
- Action items typically include review, approval, denial, and/or postponement of specific items. Certain items may be referred to a subcommittee for additional review and action;
- The Council is pleased to provide reasonable accommodations for members of the public who are disabled and require special arrangements or assistance at the meeting. If assistance is required, please notify Council staff by phone or e-mail no later than three (3) working days prior to the meeting. Please contact: Mike McMahon (775) 687-7519; e-mail mjmcmahon@health.nv.gov or Heather Kuhn (775) 684-4068; e-mail hkuhn@health.nv.gov.

Public notices for this meeting have been posted in compliance with NRS 241.020 at the following locations:

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- **State of Nevada – Desert Regional Center** 1391 South Jones, Las Vegas, NV 89146
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- **State of Nevada – Sierra Regional Center** 605 South 21st Street, Sparks, NV 89431
- **State of Nevada – Southern Nevada Adult Mental Health Services** 6161 W Charleston Blvd, Las Vegas, NV 89146
- **State of Nevada – Grant Sawyer Building** 555 E. Washington Ave. Las Vegas, NV 89101
- **Washoe County Department of Social Services** 350 South Center Street, Reno, NV 89501
- **DPBH Website: http://dpbh.nv.gov/Programs/ClinicalBHSP/Meetings/BHPACAgendasMinutes/**
- **Nevada Public Notices: https://notice.nv.gov**

BRIAN SANDOVAL
Governor

STATE OF NEVADA
BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL
4126 Technology Way, Suite 201
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RENE NORRIS
Chair

ALI JAI FAISON
Vice Chair

Behavioral Health Planning & Advisory Council
Quarterly Meeting Minutes
April 21, 2016

Division of Public & Behavioral Health
4150 Technology Way, Room 301
Carson City, Nevada 89706

S. NV Adult Mental Health Services
6161 Charleston Boulevard, West Hall
Las Vegas, Nevada 89146

1. **Call to Order, Roll Call, and Introductions**
The chair called the meeting to order at 9:10 a.m.

MEMBERS PRESENT

Ali Jai Faison, Vice Chair	Denise Everett	Mechelle Merrill
Alyce Thomas	Elizabeth Burcio	Rene Norris, Chair
Anis Abi-Karam	Heather Kuhn	Sharon Wilson
Barbara Jackson	Hilary Jones	William Kirby
Debra Parra	Katherine Mayhew	

MEMBERS ABSENT

Dawn Walker	LaJune Primous	Robert Volk
Cynthia Matteson	Marion Scott	Susan Maunder
		Susan Orton

STAFF & GUESTS

Alexis Tucey, Health Care Financing and Policy
Barry Lovgren, Private Citizen
Charlene Frost, Private Citizen
Dennis Humphrey, Project Manager CCBHC
John Rhodes, Diversified Community Services
Julie Slabaugh, Senior Deputy Attorney General
Kevin Quint, Bureau Chief, Behavioral Health Prevention and Treatment Agency (BHPT)
Lea Cartwright, JK Belz & Associates
Meg Matta, Administrative Support , BHPT
Michael McMahon, Clinical Program Planner, BHPT
Michelle Berry, Nevada Peer Leadership Advisory Council
R.J. Ramirez, Grants Manager BHPT
Stephanie Woodard, State Project Officer, CCBHC Grant
Susanne Sliwa, Senior Deputy Attorney General
Tami Chartraw, Quality Assurance Specialist III, BHPT

2. **Public Comment**

Mr. Lovgren asked permission to defer public comment to the points in the meeting where the agenda items of interest are being discussed. Permission was granted by the Chair.

3. **Review and Approve Minutes of January 21, 2016**

Ms. Jones moved to approve the minutes. Ms. Everett seconded, and the motion carried.

4. **Report, Discuss and Approve BHPAC Recommendations from Previous Meeting to Increase the Number in the Mental Health Block Grant of Pregnant Women to Receive Substance Use Treatment**

Mr. Quint provided information on revisions to Priority #5 in the Block Grant as recommended in the last BHPAC meeting. Additions were as follows:

- Item 6: *Strategies to attain the goal*: the addition was to "Monitor the number of pregnant women receiving substance use disorder treatment and adjust outreach efforts accordingly."
- Item 7a: *Baseline measurement*: "Per NHIPPS, from July 1, 2014 to June 30, 2015, 190 women received substance use disorder treatment funded by SAPTA." Mr. Quint commented that this figure does not include Medicaid or any other form of insurance.
- Item 7b: *First-year target/outcome measurement:* "Increase the number of pregnant women receiving substance use disorder treatment by September 2016." Mr. Quint commented that there should be a measurement; he would appreciate the Council's input on what the number should be, and would provide information during the next meeting date of the Block Grant Committee. The Committee is working closely with epidemiology to get better data on pregnant women on which to base their decisions.
- Item 7c: *Second-year outcome measurement:* "Increase the number of pregnant women receiving substance use disorder treatment by September 2017." Mr. Quint would also like to add a measurement to this item.
- Item 7e: *Description of Data:* "SAPTA will monitor data from Medicaid to capture the number of pregnant women receiving services funded by that source to measure service access beyond SAPTA-funded services." Mr. Quint has reached out to Medicaid to obtain data to inform the measurement of this item.
- Item 7f: *Data issues/caveats that affect outcome measures:* "With the implementation of the Affordable Care Act in early 2014, substance use and mental health disorder treatment is now covered by private insurance. Further, Nevada is a Medicaid expansion state. These two factors, most notable Medicaid, have led to a reduction in the number of client treatment services being covered by SAPTA funding." Mr. Quint commented that more information needs to be obtained to inform SAPTA on this item.

Ms. Everett said it was unclear if the provided treatment referenced in items 7b and 7c were only referring to SAPTA-funded treatment. Mr. Quint said that while the point has been made that SAPTA needs to increase the number of treatments to pregnant women, that number has been decreased by the cases paid for by Medicaid and private insurance. He would like to be able to count other sources, and he agreed it needs to be specified. Ms. Wilson said she favored keeping the focus on the global effort to increase treatment. She would like to see more services available for pregnant women regardless of how it is being funded. Mr. Lovgren pointed out that, regardless if the focus is on global efforts or SAPTA-funded efforts only, the numbers need to be consistent with regard to baseline vs. outcome. He added that in item 7c, the time frame needs to be explicitly stated from

2016. In items 7a, 7b, and 7c, using NHIPPS data as a baseline relates only to SAPTA-funded clients. Baseline figures for the general population should come from the Behavioral Risk Factor Surveillance System (BRFSS).

Mr. Faison moved to adjust the baseline figures and outcome measures so that they are from consistent sources; and that previously included data, using baseline figures and outcome measures from NHIPPS, be deleted. Ms. Mayhew seconded, and the motion carried.

5. **Report, Discuss and Approve BHPAC Recommendations from Previous Meeting to Expand Opioid Maintenance Therapy Funding for Washoe Counties and Other Areas In Nevada**
Mr. Quint provided information on revisions to Priority #1 in the Block Grant. The original document handed out to members used the terminology "Medication Assisted Therapy (MAT)," which encompasses a broad range of medications including Buprenorphine, Suboxone, much of which can be prescribed by a physician, and medications for alcohol abuse as well. It was consistently changed to opioid maintenance therapy, which administers methadone and must be approved by the Drug Enforcement Agency (DEA). The DEA has more stringent licensing requirements. The changes and additions were recommended in the last BHPAC meeting as follows:
    - Item 6: *Strategies to attain the goal:* "expand funded opioid maintenance therapy (OMT) services to Washoe County and statewide."
    - Item 7: *Annual Performance Indicators to measure goal success:* Indicator #3 – Number of OMT programs that are funded by SAPTA.
    - Item 7a: *Baseline measurement:* #3 – SAPTA currently funds one OMT program and that is in Clark County.
    - Item 7b: *First-year target/outcome measurement:* #3 – the number of funded OMT programs in Washoe County will increase by at least one.
    - Item 7c: *Second-year outcome measurement:* #3 – the number of funded OMT programs in the state will increase by at least two.
    - Item 7d: *Data Source:* #3 – List of SAPTA-funded OMT programs.
    - Item 7e: *Description of Data:* #3 – List of SAPTA-funded OMT programs.

Mr. Quint said the numbers are modest because there are few providers applying to SAPTA for certification and funding. There are no providers in rural Nevada as it is an expensive form of treatment. They are currently considering a provider in Washoe County and hope for one more in Clark County.

Ms. Wilson moved to accept the additions proposed with MAT changed to OMT. Ms. Thomas seconded, and the motion carried.

6. **Update on Status of Certified Community Behavioral Health Clinics (CCBHC) Project**
Dr. Woodard provided an update on the CCBHC which may be viewed at:
http://dpbh.nv.gov/Programs/ClinicalBHSP/Meetings/BHPACAgendasMinutes/
She asked the BHPAC to become a formalized arm of the governance of the CCBHC in Nevada. The CCBHC Planning Grant, through Substance Abuse and Mental Health Services Administration (SAMHSA), is a one year grant that began in October, 2015. Of the 24 states that were awarded planning grants, 8 will be selected to receive a Demonstration Grant. The State of Nevada has been building the infrastructure necessary to support the Demonstration Grant if awarded, or to equip the

CCBHCs to continue on their own if the grant is not awarded. Dr. Woodard fielded questions from the Council members and guests to clarify the process and role of the CCBHCs.

7. **Update on Orientation and Technical Assistance Planning for Councils**
Mr. McMahon said the application for technical assistance (TA) was successful. The TA will provide training and guidance to the Council leadership and orientation to the members. It will also help facilitate the integration of the various tasks and responsibilities before the Council and assist to expand the Council's scope to include new focuses such as the CCBHC. This type of grant is not a financial allocation; instead, it provides access to experts who are currently working with other states on similar types of situations.

The BHPAC Executive Committee was able to meet with the TA provider to discuss the best way to provide information to a geographically disbursed membership. It was suggested the initial orientation be a webinar; then use web-based training materials for the council members, culminating in a face-to-face meeting. The provider will be coming back in a week or two with recommendations. The TA training sessions will not occur during regular meetings, but after the initial webinar, members can access the web-based materials at their convenience.

8. **Update on the Nevada Commission on Behavioral Health**
Tabled.
9. **Update and Discuss the Statewide Peer Leadership Advisory Council**
Ms. Berry was prepared to provide a report but the telephone connection was inaudible.
10. **Overview of the Governor's Interagency Council on Homelessness (ICH)**
Mr. McMahon reported on the ICH. The goals and strategies of the ICH have been broken out under five workgroups which are working aggressively to meet timelines. The workgroups are meeting with representatives from Clark and Washoe Counties, the VA, the Housing Authority, Medicaid and others to coordinate services and leverage programs. A report on the efforts underway is currently being finalized, which Mr. McMahon will make available to the BHPAC. There will be an upcoming meeting in Washington DC to address questions nationwide.

11. **Committee Reviews**
    - Executive Committee – Ms. Norris said the Committee will review one application previously forwarded, and expects one more application in the near future.
    - Behavioral Health Promotion Committee – Ms. Merrill reported the Committee has moved forward with gusto. Activities for a successful Mental Health Month promotion will include public service announcements on radio and television, as well as social media. Hopefully, the campaign will extend beyond the month of May.
    - Nominating Committee – Ms. Norris said once prospective members are approved, the Committee will conduct interviews.
    - Rural Monitoring Subcommittee – Current members are Ms. Thomas, Ms. Wilson and Ms. Norris. Elizabeth Burcio volunteered to join the Committee. McMahon said there is a review underway on the federal regulations and legal requirements for quality assurance. There is a possibility the reports may come back to the Council as a whole. The monitoring may be less costly and more expansive if the Council elevated the review process to reviewing monitors produced by fiscal and program staff of the Division rather than make duplicate on-site visits. Once a mechanism has been developed it will be put to the Council

for further discussion and approval. There was discussion on the way monitors were conducted in the past.

- Bylaws Ad Hoc Committee – Ms. Wilson provided an overview of the proposed changes on a handout showing track changes, which may be viewed at: http://dpbh.nv.gov/Programs/ClinicalBHSP/Meetings/BHPACAgendasMinutes/.
  - The Council asked for additional language on the requirement of annual orientation "if made available."
  - A revision to the language regarding the program monitoring process was suggested to ensure consistency with the Governor's Order. The Council can develop a "report card" and use the reports to inform their recommendations to the Division. Mr. Quint added that the language is vague on whether the Council should be monitoring planning processes, programs or data. Ms. Wilson suggested that perhaps there is a need for a Data Committee. Mr. Lovgren affirmed that other states have successfully adopted the practice of reviewing reports. He expressed a concern that substance abuse does not become obscured in the process.
  - The Council recommended the terminology, "Behavioral Health Services."
  - Ensuring language clearly requires members' regular attendance to meetings and active participation in a committee.
  - Ensuring language provides a mechanism for removing or replacing a member.

Ms. Jones moved to adopt the proposed changes to the By-Laws. Ms. Thomas seconded, and the motion carried.

Propose and Approve Agenda Items for the Council's Next Quarterly Meeting on July 21, 2016.

- Approve BHPAC to become a formalized arm of the governance of the CCBHC in Nevada
- Update on the Nevada Commission on Behavioral Health

Ms. Jones moved to include the two items on the next agenda. Ms. Wilson seconded, and the motion carried.

12. **Public Comment**
There was no further public comment.

13. **Adjournment**
There being no further business to come before the members, Ms. Mayhew moved to adjourn the meeting. Ms. Thomas seconded, and the motion carried.

Brian Sandoval
Governor

STATE OF NEVADA

BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
Thursday, July 21, 2016

9:00 a.m. to Adjournment

Video Conference Locations

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

SNAMHS
6161 W. Charleston Blvd. Bldg. 1
West Hall Conference Room

Teleconference Access

Phone Number: (775) 887-5619 Conference number 2000 Conference PIN 0721#

Item	AGENDA	Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions.	Rene Norris
2.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).	
3.	Review and Approve Minutes of April 21, 2016. *For Possible Action*	Rene Norris
4.	Review, Discuss and Approve BHPAC to Become a Formalized Arm of the Governance of the Certified Community Behavioral Health Clinics (CCBHC) *For Possible Action*	Rene Norris
5.	Review, Discuss and Approve BHPAC to Serve as a Decision Making Body to Review and Approve Proposed Alternate Approaches by the CCBHC. *The guiding criteria for the establishment of Certified Community Behavioral Health Clinics (CCBHC) requires an external decision making entity that is comprised of at least 51% consumers. BHPAC meets the criteria and action is needed for approval for BHPAC to accept the responsibility as a decision making body for CCBHC. Further information on CCBHCs may be found on their website:* http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main/ *For Possible Action*	Stephanie Woodard
6.	Update on New Member Orientation Planning and Technical Assistance for Planning Councils *For Possible Action*	Mike McMahon
7.	Update on the Nevada Commission on Behavioral Health. *For Possible Action*	Viki Kinnikin
8.	Update and Discuss the Statewide Peer Leadership Advisory Council. *For Possible Action*	Michelle Berry
9.	Committee Reviews *For Possible Action* ➢ Executive Committee ➢ Nominating Committee – BHPAC Vacancies, Committee Vacancies and Proposed Members ➢ Behavioral Health Promotion Committee – Ongoing and Plans for 2017 Promotion ➢ Bylaws Ad Hoc Committee ➢ Rural Monitoring Committee	Rene Norris
10.	Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting on October 20, 2016. *For Possible Action*	Rene Norris
11.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).	
12.	Adjournment *For Possible Action*	Rene Norris

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Agenda Notification:

- The meeting may commence on or after the designated start time;
- Items on the agenda may be taken out of order;
- The public body may combine two or more agenda items for consideration;
- The public body may remove an item from the agenda or delay discussion relating to an item on the agenda at any time;
- Members of the public in attendance should identify themselves when requested under Agenda Item 1;
- Public Comment will be taken during this agenda item. No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken. The Chair or presiding member of the Council will place a five (5) minute limit on the time individuals may address the Council. The Chair may elect to allow public comment on a specific agenda item when that item is being considered;
- Action items typically include review, approval, denial, and/or postponement of specific items. Certain items may be referred to a subcommittee for additional review and action;
- The Council is pleased to provide reasonable accommodations for members of the public who are disabled and require special arrangements or assistance at the meeting. If assistance is required, please notify Council staff by phone or e-mail no later than three (3) working days prior to the meeting. Please contact: Mike McMahon (775) 687-7519; e-mail mjmcmahon@health.nv.gov or Heather Kuhn (775) 684-4068; e-mail hkuhn@health.nv.gov.

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BRIAN SANDOVAL
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RENE NORRIS
Chair

ALI JAI FAISON
Vice Chair

Behavioral Health Planning & Advisory Council
Quarterly Meeting Minutes
September 9, 2016

Division of Public & Behavioral Health
4126 Technology Way
Second Floor Conference Room
Carson City, Nevada 89706

Desert Regional Center
1391 S. Jones Blvd
Las Vegas, Nevada 89146

1. **Call to Order, Roll Call, and Introductions**
Ms. Norris, as chair, called the meeting to order at 9:12 a.m.

MEMBERS PRESENT

Ali Jai Faison, Vice Chair	Dawn Walker	Mechelle Merrill
Alyce Thomas	Denise Everett	Rene Norris, Chair
Anis Abi-Karam	Elizabeth Burcio	Sharon Wilson
Christi Hines-Coates	Katherine Mayhew	William Kirby

MEMBERS ABSENT

Barbara Jackson	LaJune Primous	Susan Maunder
Cynthia Matteson	Marion Scott	Susan Orton
Debra Parra	Robert Volk	

STAFF & GUESTS

Barry Lovgren, Private Citizen
Dale Hansen, Nevada Housing
Jessica Hoff, SAPTA
Kendra Furlong, SAPTA
Ramona Derby-Brinson, UNLV
Susanne Sliwa, Senior Deputy Attorney General
Vanessa Pickles, SAPTA

2. **Public Comment**
Mr. Lovgren provided a handout containing his public comment submitted on the Block Grant mini application which is attached to these minutes as exhibit "A." Mr. Lovgren said the application for the 2017 Mental Health/Substance Abuse Prevention and Treatment Block Grant was submitted on August 30 without the Council having an opportunity to review and submit recommendations to the State. Mr. Lovgren suggested the Council place a review and discussion on recommendations to present to the State for the Block Grant.

Ms. Norris said the attempted BHPAC Orientation scheduled for September 8, 2016, was cancelled due to lack of quorum and reminded the Council it is extremely important everyone attends scheduled meetings.

3. **Review and Approve Minutes of April 21, 2016**

Ms. Thomas moved to approve the minutes. Ms. Wilson seconded, and the motion carried.

4. **Review of Block Grant planning**

Ms. Furlong began her presentation with the fiscal year 2016 planned expenditure dollar amounts for the Substance Abuse and Mental Health Block Grant. She said the mini application was submitted on August 30, 2016, with no substantial changes made to the State Plan, so per the Mental Health State Project Officer, the mini application did not meet the criteria needed to be opened for public comment. Ms. Furlong also said a request is pending with the Treatment State Project Officer for the application to be opened to add meeting minutes from a previous BHPAC meeting with intended updates to Table 1 which can be updated on an annual basis. Next, Ms. Furlong mentioned in 2015 the BHPAC identified five top behavioral health priorities to be addressed in 2016-2018. These priorities include:

- Increase the number and quality of behavioral health professionals in Nevada
- Improve screening, assessment, and referral services for at-risk populations
- Support earlier access to prevention and early intervention services
- Increase community-based services across the system of care
- Provide community-based intervention and support services to address trauma and prevent incarceration

Ms. Furlong highlighted which programs were funded by the Block Grant in the previous year which included behavioral health coordinators, jail diversion, children's behavioral health, NAMI [National Alliance on Mental Illness] and workforce development. Next, Ms. Furlong addressed the projects and funding for the upcoming year. She said the State will be changing the way the treatment programs are funded to offer more flexibility to support program innovation and growth within communities. She added most special projects will be paid through State General Fund dollars, and the Substance Abuse Block Grant will fund Fee-For-Service, which supports all the direct treatment services. The projects to be funded by the Mental Health Block Grant are: building community capacity to provide psychiatric crisis services and suicide prevention for veterans as well as Washoe County senior services. Prevention funding will support prevention activities on prescription drug abuse, marijuana, marijuana dispensaries, reduce binge drinking, underage drinking, and use of e-cigarettes. It will also support Community Health Worker models, target substance abuse in Native American Communities, at risk youth, women of childbearing years and women who are currently pregnant. Ms. Furlong added these activities are just some of the highlights for the upcoming year, not an exclusive list on the activities that will be funded. Next, Ms. Furlong led the Workgroup through the 2017 Block Grant application timeline as follows:

- January 2016 – November 2016
  - Collect SABG [Substance Abuse Block Grant] and MH [Mental Health] Data
  - Support Epi Profile Draft
- December 2016
  - Annual Report Due December 1, 2016
- January 2017
  - Final Epi Profile Due

- March 2017
  - Needs Assessment Complete
- March 2017 – April 2017
  - Public Workshops in Northern, Southern and Rural Areas for State Plan Input
- May 2017
  - Draft State Plan released 5/15/17 for 30 days public comment
- July 2017 – August 2017
  - Final Plan and proposed expenditures to BHPAC for Public Hearing and Approval
- August 2017
  - Final Plan/Application for Administrative Approval
- September 2017
  - Submission to SAMHSA [Substance Abuse and Mental Health Services Administration] NO LATER THAN September 1, 2017

Ms. Furlong said the State would like to have the Block Grant presentation added as a re-occurring agenda item for BHPAC meetings and emphasized the importance of meeting quorum so frequent updates can be communicated and advised on a routine basis. Ms. Furlong also asked the Council what information would be helpful for the State to report on an ongoing basis and stated the end goal is sufficient planning, input and communication on the 2017 integrated Substance Abuse and Mental Health Block Grant Application.

Ms. Furlong's Block Grant presentation is attached to these minutes under exhibit "B."

Ms. Mayhew asked Ms. Furlong who the Mental Health State Project Officer and the Treatment State Project Officer are for Nevada. Ms. Furlong said the Treatment State Project Officer is Theresa Hampton-Mitchell, and stated she would follow-up with the Council with the name of the Mental Health State Project Officer.

Mr. Faison asked Ms. Furlong how the public would be notified of the workshops mentioned in the timeline and also what population is to be targeted to participate. Ms. Furlong stated she would follow-up with Stephanie Woodard to find out what the State's plans are regarding the workshops and bring the information back to the Council.

Ms. Wilson asked Ms. Furlong to define "Epi Profile." Ms. Furlong said the Epi Profile is the data collection and review by the Statewide Epidemiologist which communicates data trends and analysis.

Ms. Norris asked Ms. Furlong if the State would present certain parts of the grant at each meeting on which the Council can give input. Ms. Furlong stated the intention is to place it on the agenda as an action item so recommendations and feedback can be given by the Council and taken into consideration for modification, change or addition to the Block Grant application.

Ms. Furlong asked the Council what information would be helpful to present at future meetings regarding the Block Grant.

Ms. Everett said it would be helpful to hear a comparison of this year to last year including who is seeking and receiving treatment, if there are any waiting lists, who is benefiting from the Block Grant funding, etc.

Ms. Norris said it would also be helpful to list the BHPAC goals and objectives on the needs assessment for the Block Grant.

Ms. Mayhew said she would like to know how many people are being served by First Episode Psychosis and what the outcomes are.

Ms. Norris said the Council would like to see a budget with a breakdown of where the funding will be allocated.

5. **Update on New Member Orientation Planning and Technical Assistance for Planning Councils**

Ms. Sliwa said although the meeting scheduled on September 8, 2016, was an orientation and training, pursuant to Nevada's Open Meeting Law (OML), when a public body such as the BHPAC meets and discusses council business that is considered a meeting. All OML requirements must be followed including agendizing the meeting, posting for the public notice as well meeting quorum. The Governor's Executive Order for the BHPAC mandates 23 positions on the Council, so to meet quorum (half plus one) there needs to be 12 BHPAC members present in order to proceed with the meeting. There were 10 Council members in attendance so Ms. Sliwa advised the group not to proceed due to the OML. Ms. Sliwa said she would work with the State when drafting future agendas to ensure the type of action that may be taken is more specific in hopes of preventing future issues. Ms. Sliwa said although she is here to advise the Council on the OML for every meeting, her office also does investigate and enforce the OML. Ms. Sliwa said she is always available to answer questions concerning the OML and Council members should direct them to the Division to relay to her office.

Ms. Sliwa said it is important these meetings be made a priority so quorum is met and the Council is able to conduct business and fulfill its mission.

Ms. Norris said if anyone does not have the time or does not want to be on the Council they should turn in their resignation so the spots can be filled with those that do have the time to participate. Ms. Norris said the Council needs to discuss rescheduling the orientation as it is required per the bylaws.

Mr. Faison said John Hudgens, the facilitator of the orientation, wants to meet with the Executive Subcommittee to determine the Council's next steps. He said the matter should be discussed among the entire Council so any questions or concerns may be addressed at that time. Mr. Faison also asked the Council to respond to email communications and calendar invites to help ensure there will be a quorum.

Mr. Faison motioned for the BHPAC Executive Subcommittee to meet with Mr. Hudgens to discuss rescheduling the member orientation, Ms. Everett seconded and the motion carried.

6. **Update on the Nevada Commission on Behavioral Health**
Tabled.

7. **Update and Discuss the Statewide Peer Leadership Advisory Council**
Ms. Berry said at the Council's last meeting they discussed bylaws, application for reappointment, Senate Bill 489, certification updates as well as the Reno Peer Training, which was held on August 22 through August 25, 2016. Ms. Berry also discussed the Council's application to IC&RC [International Certification & Reciprocity Consortium] in order to move forward with the voluntary certification for peers.

Mr. Faison asked Ms. Berry what the certification process was for and what the peers are participating in (i.e., substance abuse, mental health, behavioral health.) Ms. Berry said the voluntary certification will include mental health and addiction peers.

Mr. Faison asked Ms. Berry if there is equal participation throughout the state on the Council. Ms. Berry said there are members in Las Vegas, in the rural areas as well as in northern Nevada.

8. **Committee Reviews**
   - **Executive Committee**
     Ms. Norris said the Committee will meet and continue to pursue the orientation training with technical support from John Hudgens.

   - **Nominating Committee – BHPAC Vacancies, Committee Vacancies and Proposed Members**
     Ms. Norris said the committee has identified vacancies and they are currently still looking for additional applicants. She asked the committee to encourage people to apply especially those who are family members of persons with mental illness and persons with substance abuse and co-occurring disorders who are receiving (or have received) behavioral health services.

   - **Behavioral Health Promotion Committee – Ongoing Plans for 2017 Promotion**
     Ms. Merrill said the committee has also experienced issues meeting due to quorum, but at their previous meetings the main focus has been on Mental Health Awareness Month. The committee was able to release a PSA [Public Service Announcement] on radio stations which ran for three months.

   - **Bylaws Ad Hoc Committee**
     Ms. Wilson said the latest copy of the bylaws sent to the Council did not include one addition under Article II, Section 4, number 3. The first sentence should read "New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years thereafter, ***if made available.***" The verbiage should also be added to Article III, Section 3, number 7, which contains the same sentence. The latest copy of the bylaws sent before this meeting did not include that amendment, but all other changes were listed.
     Ms. Wilson moved to update the bylaws with the previously approved verbiage of "if made available" at the two sections mentioned above, Ms. Thomas seconded and the motion carried.

- **Rural Monitoring Committee**
  Ms. Norris noted the committee does not have anything to report at this time.

9. **Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting on January 19, 2017**
   Agenda items will include:
   - DBT [Dialectical Behavior Therapy]
   - Rescheduling the orientation with facilitator John Hudgens
   - Update from the Commission on Behavioral Health
   - Update from the Statewide Peer Leadership Advisory Council
   - Standing committee reviews
   - Review of block grant planning
   - Update on CCBHC [Certified Community Behavioral Health Clinics]
   - Postpone Bylaws Subcommittee until further notice

   Ms. Wilson moved to accept all proposed agenda items, Ms. Everett seconded and the motion carried.

10. **Public Comment**
    Mr. Lovgren referenced Ms. Furlong's Block Grant presentation which states "Per the Mental Health State Project Officer, there were no substantial changes made to the state plan so the mini application did not meet the criteria needed to be opened for public comment." He said the application is, in fact, open for public and Council comment and has been since it was posted on August 30.

    Mr. Faison said the Council is working to fill gaps and improve efficiency and does plan to move forward with the Orientation as there are Council members who have not attended one since being appointed.

11. **Adjournment**
    Ms. Mayhew motioned to adjourn the meeting, Ms. Thomas seconded and the meeting was adjourned at 10:41 a.m.

Brian Sandoval
Governor

STATE OF NEVADA

BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
Thursday, January 19, 2017

9:00 a.m. to Adjournment

Video Conference Locations

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

Desert Regional Center
1391 S. Jones Blvd
Las Vegas, NV 89146

Teleconference Access

Phone Number: (775) 887-5619 Conference No: 2004# Conference PIN: 0119#

Item	AGENDA		Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions		Rene Norris
2.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).		
3.	Review and Approve Minutes of September 9, 2016	*For Possible Action*	Rene Norris
4.	Update on Block Grant Planning		Tami Chartraw
5.	Update on Certified Community Behavioral Health Clinics (CCBHC)		Dennis Humphrey
6.	Review, Discuss and Make Decision on New Member Orientation Planning and Technical Assistance for Planning Councils	*For Possible Action*	Rene Norris
7.	Update on the Nevada Commission on Behavioral Health		Valarie Kinnikin
8.	Update on the Statewide Peer Leadership Advisory Council		Michelle Berry
9.	Committee Reviews ➢ Executive Committee ➢ Nominating Committee ➢ Behavioral Health Promotion Committee ➢ Bylaws Ad Hoc Committee – Postpone Committee Until Further Notice ➢ Rural Monitoring Committee		Rene Norris
10.	Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting on April 20, 2017	*For Possible Action*	Rene Norris
11.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit)		
12.	Adjournment	*For Possible Action*	Rene Norris

Agenda Notification:

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- **State of Nevada – Department of Health and Human Services** 4126 Technology Way Ste 100, Carson City, NV 89706
- **State of Nevada – Desert Regional Center** 1391 South Jones, Las Vegas, NV 89146
- **State of Nevada – Rural Services** 1665 Old Hot Springs Ste 164 & 157, Carson City, NV 89706
- **State of Nevada – Sierra Regional Center** 605 South 21st Street, Sparks, NV 89431
- **State of Nevada – Southern Nevada Adult Mental Health Services** 6161 W Charleston Blvd, Las Vegas, NV 89146
- **State of Nevada – Grant Sawyer Building** 555 E. Washington Ave. Las Vegas, NV 89101
- **Washoe County Department of Social Services** 350 South Center Street, Reno, NV 89501

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Brian Sandoval
Governor

STATE OF NEVADA

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4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
Thursday, April 20, 2017

9:00 a.m. to Adjournment

Video Conference Locations

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

Rawson-Neal Psychiatric Hospital
1650 Community College Dr.
Las Vegas, NV 89146

Teleconference Access

Phone Number: (775) 887-5619; Conference Number: 2000#; Conference PIN: 0420#

Item	AGENDA		Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions		Rene Norris
2.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).		
3.	Review and Approve Minutes of September 9, 2016	*For Possible Action*	Rene Norris
4.	Update on Block Grant Planning		Kendra Furlong
5.	Discuss BHPAC Membership		Rene Norris
6.	Removal of Members	*For Possible Action*	Rene Norris
7.	Update on Certified Community Behavioral Health Clinics (CCBHC)		Dennis Humphrey
8.	Review, Discuss and Make Decision on New Member Orientation Planning and Technical Assistance for Planning Councils	*For Possible Action*	Rene Norris
9.	Update on the Nevada Commission on Behavioral Health		Viki Kinnikin
10.	Update on the Statewide Peer Leadership Advisory Council		Michelle Berry
11.	Committee Reviews ➢ Executive Committee ➢ Nominating Committee ➢ Behavioral Health Promotion Committee ➢ Bylaws Ad Hoc Committee – Postpone Committee Until Further Notice ➢ Rural Monitoring Committee		Rene Norris
12.	Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting	*For Possible Action*	Rene Norris
13.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit)		
14.	Adjournment	*For Possible Action*	Rene Norris

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- **State of Nevada – Sierra Regional Center** 605 South 21st Street, Sparks, NV 89431
- **State of Nevada – Southern Nevada Adult Mental Health Services** 6161 W Charleston Blvd, Las Vegas, NV 89146
- **State of Nevada – Grant Sawyer Building** 555 E. Washington Ave. Las Vegas, NV 89101
- **Washoe County Department of Social Services** 350 South Center Street, Reno, NV 89501

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Brian Sandoval
Governor

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Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
Monday, June 5, 2017

9:00 a.m. to Adjournment

Video Conference Locations

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

Rawson-Neal Psychiatric Hospital
1650 Community College Dr.
Las Vegas, NV 89146

Teleconference Access

Phone Number: (775) 887-5619; Conference Number: 2015#; Conference PIN: 0605#

***AMENDED* AGENDA**

Item			Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions		Rene Norris
2.	Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit).		
3.	Review and Approve Minutes of September 9, 2016	*For Possible Action*	Rene Norris
4.	Update on Block Grant Planning		Kendra Furlong
5.	Discuss BHPAC Membership		Rene Norris
6.	Removal of Members	*For Possible Action*	Rene Norris
7.	Update on Certified Community Behavioral Health Clinics (CCBHC)		Dennis Humphrey
8.	Review, Discuss and Make Decision on New Member Orientation Planning and Technical Assistance for Planning Councils	*For Possible Action*	Rene Norris
9.	Update on the Nevada Commission on Behavioral Health		Viki Kinnikin
10.	Update on the Statewide Peer Leadership Advisory Council		Michelle Berry
11.	Clark County Children's Mental Health Consortium's 10 year Strategic Plan 2017 Status Report		Katherine Mayhew
12.	Nevada Rural Children's Mental Health Consortium Annual Progress Report for Ten-Year Strategic Plan		Katherine Mayhew
13.	Washoe County Children's Mental Health Consortium Summary of the Annual Plan 2017-18		Katherine Mayhew
14.	Committee Reviews ➢ Executive Committee ➢ Nominating Committee ➢ Behavioral Health Promotion Committee ➢ Bylaws Ad Hoc Committee – Postpone Committee Until Further Notice ➢ Rural Monitoring Committee		Rene Norris

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15. Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting — *For Possible Action* — Rene Norris

16. Public Comment (No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit)

17. Adjournment — *For Possible Action* — Rene Norris

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- **State of NV – Grant Sawyer Building** 555 E. Washington Ave. Las Vegas, NV 89101
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- **State of NV – Southern Nevada Adult Mental Health Services** 6161 W. Charleston Blvd., Las Vegas, NV 89146
- **State of NV – Substance Abuse Prevention & Treatment Agency** 4126 Technology Way, 2nd Floor, Carson City, NV 89706
- **Washoe County Department of Social Services** 350 South Center Street, Reno, NV 89501

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BRIAN SANDOVAL
Governor

STATE OF NEVADA
BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL
4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

RENE NORRIS
Chair

ALI JAI FAISON
Vice Chair

Behavioral Health Planning & Advisory Council
Quarterly Meeting Minutes
June 5, 2017

Division of Public & Behavioral Health
4126 Technology Way
Second Floor Conference Room
Carson City, Nevada 89706

Rawson-Neal Psychiatric Hospital
1650 Community College Dr.
Training Room
Las Vegas, Nevada 8914

Teleconference Access
Phone Number: (775) 887-5619; Conference Number: 2015#; Conference PIN: 0605#

1. **Call to Order, Roll Call, and Introductions**
Ms. Norris, as Chair, called the meeting to order at 9:05 a.m.

MEMBERS PRESENT

Ali Jai Faison, Vice Chair	Denise Everett	Sharon Wilson
Barbara Jackson	Elizabeth Burcio	Susan Maunder
Christi Hines-Coates	Katherine Mayhew	Susan Orton
Dawn Walker	Rene Norris, Chair	William Kirby

MEMBERS ABSENT

Alyce Thomas	Mechelle Merrill
Anis Abi-Karam	Robert Volk
Debra Parra	
LaJune Primous	

STAFF & GUESTS

Barry Lovgren, Private Citizen
Dennis Humphrey, SAPTA
Julie Slabaugh, Senior Deputy Attorney General
Kendra Furlong, SAPTA
Kyle Devine, BHWP
Michelle Berry, CASAT
Ramona Derby-Brinson, UNLV
Susanne Sliwa, Senior Deputy Attorney General
Trey Delap, Group Six Partners

2. **Public Comment**
Sharon Wilson announced that she would be retiring and that her supervisor Dr. Sexton would like to take Sharon's place on the council. Katherine Mayhew announced that she will be retiring in September.

3. **Review and Approve Minutes of September 9, 2016**
Ms. Wilson moved to approve the minutes and Denise Everett seconded and the motion carried.

4. **Update on Block Grant planning**
Marco Erickson spoke on behalf of Kendra Furlong about the planning document showing a time, and in the next couple of weeks there should be a solid plan for the block grant planning. Mr. Erickson explained the planning document and the resources used to create it and asked for feedback from BHPAC membership. Kyle Devine reiterated that it was just preliminary information that was looked at and that feedback was important to have so there would be a good draft before the next meeting. The due date for the block grant application is September 1st, however; Mr. Erickson would like to have it complete by August 15th to allow for some leeway in submission of the grant. Ms. Norris suggested to meet before August 15th for review. Date and time of that meet is TBA.

5. **Discuss BHPAC Membership**
There are issues with meeting Quorum. The council discussed the vacant position and the members who have not attended any meeting. A letter will be drafted and sent to the department heads of the vacant state position requesting them to put a name forward to the Governors. Ms. Norris asked Ms. Wilson if there is a replacement to take her place. Ms. Wilson replied by stating that her supervisor, Dr. Jennifer Sexton, is willing to take her place. The Nominating Committee meet will help fill the non-state positions. Meeting date and time TBA.

6. **Removal of Members**
A motion to remove and replace LaJune Primous was made by Ms. Wilson and seconded by Elizabeth Burcio and the motion carried. A letter will be drafted and sent to Ms. Norris and Vice Chair Ali Jai Faison for approval. Upon approval, the letter will be sent to Ms. Primous and the Governor's Office.
Barbara Jackson asked for clarification regarding the chronically mentally ill individuals. Ms. Burcio stated that she thinks that refers to people that are diagnosed and are clients of behavioral health who are receiving treatment and medication. Ms. Jackson stated that it would more appropriate to specify consumers and mentally ill separately. Ms. Burcio believes that anyone who is being provided behavioral health services falls under chronically mentally ill. She went on to explain her reasoning by stating that if you are a consumer then you are either seeing a therapist, involved in classes or receiving medications through a behavioral health clinic. Julie Slabaugh added that the Executive Order identifies the chronically mentally ill as someone who is receiving services or has received services. Ms. Norris asked if that clarified it for Ms. Jackson. Ms. Jackson answered by stating that in her opinion "consumer" should replace "chronically" or they should just refer to it as mentally ill.

7. **Update on Certified Community Behavioral Health Clinics (CCBHC)**
Dennis Humphrey began by stating that since the last meeting Nevada was one of twenty-four states that was participating in the planning stage of the Certified Community Behavioral Health Clinics grant, and last December Nevada was one of the fortunate eight states that was selected to move on to the demonstration grant program. Those eight states that are moving on are Nevada, Oregon,

Minnesota, Missouri, Oklahoma, Pennsylvania, New York, and New Jersey. There will be four perspective CCBHC's in Nevada; Bridge Counseling in Las Vegas, West Care in Las Vegas and a satellite office in Reno, New Frontier in Fallon, and Vitality in Elko. Substance Abuse and Mental Health Services Administration's (SAMHSA) requirements for a CCBHC is that we must have one rural location and one urban location certified to perform the functions of a CCBHC. Nine other requirements that SAMHSA requires is that of the nine these four must be provided by the clinic; licenses services, diagnosis and risk assessment, outpatient mental health substance use services, and treatment planning. The next five can either be performed by the clinic or they can designate a contract which they refer to as a DCO, Designated Collaborative Organization, and these services are; psychiatric rehab services, peer family support, target case management, community based mental health care for veterans, and outpatient primary care screening and monitoring. Mr. Humphrey went on to explain that what they have done is developed a team comprised of Health Care Quality and Compliance (HCQC) staff, Center for the Application of Substance Abuse Technologies (CASAT) staff, and Division of Public and Behavioral (DPBH) certification team. They initially went out to the clinics in February and March to aid in their certification process. Basically, they went through all the requirements and discussed any risks they might be up against. The site visits were performed with all four of the perspective CCBHC's. They certified New Frontier as their rural in Fallon, and Bridge Counseling in Las Vegas. They're currently working with West Care and Vitality through their certification process. The demonstration grant will be effective July 1st. Mr. Humphrey concluded his update and was open to questions.
Ms. Burcio talked about the rural Nevada mental health clinic in Yerington, and wanted to know what is going there because she feels that it is under staffed. She mentioned that she knows the Director retired and that she thinks they only have about two therapists. She went on to ask if that clinic was looked at and reviewed.
Mr. Humphrey responded by stating that they could only select four clinics and from the CCBHC perspective he can find out what the status of that clinic is.

8. **Review, Discuss and Make Decision on New Member Orientation Planning and Technical Assistance for Planning Councils**
Mr. Devine said that he has been in contact with the individual who is working on the technical assistance and they are waiting for further direction as to what is needed. Mr. Devine also mentioned that some time has passed since the application had been filed and that there have been some changes during that period of time. Mr. Devine also mentioned that they are trying to narrow the scope of the technical assistance and that IT is still available to help in that effort.
Ms. Norris asked if they were still going to be updating the new member orientation to include SAPTA information.
Mr. Devine confirmed that that was part of the process that was taking place, and said that he would follow up on the progress of the project.
Ms. Norris said that this was important because there are members still waiting for orientation because of the need for the update.
Ms. Burcio asked who would be receiving the training once it was available.
Ms. Norris said that it is something that everyone attends every two years.

9. **Update on the Nevada Commission on Behavioral Health**
Ms. Norris asked if anyone was present who could offer an update.
Ms. Jackson said that there was no update for her to give at this time.

10. **Update on the Statewide Peer Leadership Advisory Council**
Michelle Berry said that a lot the focus of the Peer Leadership Council has been monitoring AB194. Since the bill did not pass, the Council is looking at its strategic planning. The have had planning meetings in both the north and the south and they will be meeting again on June 15th to combine the priorities from the two meetings. Ms. Berry said that the Council is looking at expanding their education efforts for peers, workforce development for peers, and the certification process. The Behavioral Health Association houses the credentialing board for the certification process for peers. The send out a survey that askes two questions: 1.) Are interested in learning more about the peer certification process? 2.) Would you actually move forward in the peer certification process? Ms. Berry also said that since AB194 did not pass, the Council has decided to put a hold on the grandfathering period for certification. It will begin on July 1st, when peers can start submitting applications for the certification process.
Ali Jai Faison asked if there was a provision to look at the behavioral health and mental illness component because a lot of the peers were primarily involved in the substance abuse area.
Ms. Berry said that there was equal representation on the Council between those who work in the mental health field and those who work in the addiction field. They are always looking for new members and they have been reviewing the curriculum that is used to train peers throughout the state.
Katherine Mayhew wanted to inform everyone that, with the system of care grant, a Nevada chapter of Youth Move, a national organization, was developed. The organization is very involved in mental health issues and making sure that youth have a voice in the planning process.

11. **Clark County Children Mental Health Consortium 10-year Strategic Plan 2017 Status Report**
Hereto attached as attachment A.

12. **Nevada Rural Children's Mental Health Consortium Annual Progress Report for Ten-Year Strategic**
Hereto attached as attachment B.

13. **Washoe County Children's Mental Health Consortium Summary of the Annual Plan 2017-18**
Hereto attached as attachment C.

14. **Committee Reviews**
    - **Executive Committee**
      Ms. Norris said that the Executive Committee met to discuss vacancies and attendance which was brought before this council. She also said that the Executive Committee would need to meet before the next meeting of the Behavioral Health Planning and Advisory Council meeting, which has to happen before August 15th.

    - **Nominating Committee – BHPAC Vacancies, Committee Vacancies and Proposed Members**
      Ms. Norris said that the Nominating Committee did not meet because they were unsure about how many vacancies there would be. Ms. Norris said that the Nominating Committee would need to meet soon and ask Raul Martinez to ask the members about a date for the next meeting.

    - **Behavioral Health Promotion Committee – Ongoing Plans for 2017 Promotion**

Commented [SRW1]: Is this correct?

Ms. Norris asked Mr. Martinez if the Behavioral Health Promotion Committee had met. Mr. Martinez said that, to the best of his knowledge, they had not.

- **Bylaws Ad Hoc Committee**
  Ms. Norris said that the Bylaws Ad Hoc Committee would not meet again until they needed to.

- **Rural Monitoring Committee**
  No report was given.

15. **Discuss Date and Propose Agenda Items for the Council's Next Quarterly Meeting**
Ms. Norris said that a meeting needs to take place in July 2017. She also mentioned that they will need to discuss the block grants at the July meeting.

16. **Public Comment**
Barry Lovgren referenced the timeline document and asked questions regarding the due dates of specific document and which documents where specified where on the time line. Mr. Lovgren asked if the Epidemiological Profile and the other epidemiology documents listed on the timeline were the same.
Mr. Devine answered that they were different documents.
Mr. Lovgren then asked if the Epidemiological Profile had been completed.
Mr. Devine said that the Epidemiological Profile was going under revision based on the discussion from the last Statewide Epidemiology Workgroup meeting and should be finalized soon.
Mr. Lovgren said that he would encourage that the profile, upon completion, be presented to the council.
Mr. Lovgren then asked when the needs assessment would be completed.
Mr. Devine said that, to the best of his knowledge, the needs assessment had not yet been completed.
Mr. Lovgren asked that the needs assessment also be provided to the council upon its completion.

17. **Adjournment – 10:12 a.m.**

Brian Sandoval
Governor

STATE OF NEVADA

BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

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Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5966

Rene Norris
Chair

Ali Jai Faison
Vice Chair

BHPAC
Quarterly Meeting
AMENDED AGENDA
Thursday, July 20, 2017

9:00 a.m. to Adjournment

Meeting Locations with Video Conference

Division of Public & Behavioral Health
4126 Technology Way, Second Floor Conference Room
Carson City, NV 89706

Rawson-Neal Psychiatric Hospital
1650 Community College Dr.
Las Vegas, NV 89146

Teleconference Access

Phone Number: (775) 887-5619; Conference Number: 2003#; Conference PIN: 0720#

Item	AGENDA		Primary Speaker(s)
1.	Call to Order, Roll Call, and Introductions		Rene Norris
2.	Public Comment (*No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken; five (5) minute limit*).		
3.	Review and Approve Minutes of June 5, 2017	*For Possible Action*	Rene Norris
4.	Presentation of Strategic Plan		Kyle Devine
5.	Review of Block Grant Application and Recommendations on Priorities		Marco Erickson
6.	Update on New Member Orientation Planning and Technical Assistance for Planning Councils *For Possible Action*		Rene Norris
7.	Discuss BHPAC Membership Reappointment and Vacant Positions		Raul Martinez
8.	Update on Certified Community Behavioral Health Clinics (CCBHC)		Dennis Humphrey
9.	Update on the Nevada Commission on Behavioral Health		Viki Kinnikin
10.	Update on the Statewide Peer Leadership Advisory Council		Michelle Berry
11.	Committee Reviews ➢ Executive Committee ➢ Nominating Committee ➢ Behavioral Health Promotion Committee ➢ Bylaws Ad Hoc Committee – Postpone Committee Until Further Notice ➢ Rural Monitoring Committee		Rene Norris
12.	Discuss Date and Proposed Agenda Items for the Council's Next Quarterly Meeting		Rene Norris
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14. Adjournment — Rene Norris

BHPAC QUARTERLY MEETING
AGENDA – Page 2
2017

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- Public Comment will be taken during this agenda item. No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken. The Chair or presiding member of the Council will place a five (5) minute limit on the time individuals may address the Council. The Chair may elect to allow public comment on a specific agenda item when that item is being considered;
- Action items typically include review, approval, denial, and/or postponement of specific items. Certain items may be referred to a subcommittee for additional review and action;
- The Council is pleased to provide reasonable accommodations for members of the public who are disabled and require special arrangements or assistance at the meeting. If assistance is required, please notify Council staff by phone or e-mail no later than three (3) working days prior to the meeting. Please contact: Sara Weaver (775) 684-5987; e-mail srweaver@health.nv.gov.

Public notices for this meeting have been posted in compliance with NRS 241.020 at the following locations:

- **State of NV – Department of Health and Human Services** 4126 Technology Way, 1st Floor, Carson City, NV 89706
- **State of NV – Desert Regional Center** 1391 South Jones, Las Vegas, NV 89146
- **State of NV – Grant Sawyer Building** 555 E. Washington Ave. Las Vegas, NV 89101
- **State of NV – Rural Community Health Services** 727 Fairview Dr., Carson City, NV 89701
- **State of NV – Sierra Regional Center** 605 South 21st Street, Sparks, NV 89431
- **State of NV – Southern Nevada Adult Mental Health Services** 6161 W. Charleston Blvd., Las Vegas, NV 89146
- **State of NV – Substance Abuse Prevention & Treatment Agency** 4126 Technology Way, 2nd Floor, Carson City, NV 89706
- **Washoe County Department of Social Services** 350 South Center Street, Reno, NV 89501

DPBH Website: http://dpbh.nv.gov/Programs/ClinicalBHSP/Meetings/BHPACAgendasMinutes/

Nevada Public Notices: https://notice.nv.gov

You may register on the Behavioral Health Listserv to receive agenda notices to your email at:
http://listserv.state.nv.us/cgi-bin/wa?HOME

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Anis Abi-Karam	Providers		2740 So. Jones Blvd. Las Vegas NV, 89146 PH: 702-271-1395	
Elizabeth Burcio	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		15 Shirley Avenue Yerington NV, 89447 PH: 775-463-2608	burcioe@gmail.com
Ali Jai Faison	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1504 Couples Street Las Vegas NV, 89128 PH: 702-619-6237	ebhsi@icloud.com
Barbara Jackson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Northern Nevada Adult Mental Health Services Sparks NV, 89431 PH: 775-688-0401 FX: 775-688-2040	bjackson@nnamhs.nv.gov
Bill Kirby	State Employees	Substance Abuse Prevention & Treatment Agency	4126 Technology Way, Ste. 200 Carson City NV, 89706 PH: 775-684-4054 FX: 775-684-4185	bkirby@sapta.nv.gov
Susan Maunder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2900 El Camino Avenue, No 220 Las Vegas NV, 89102 PH: 702-752-1878	greyhoundwon@yahoo.com
Katherine Mayhew	State Employees	DCFS - Children's Mental Health	NV,	
Rene Norris	Parents of children with SED		8301 W. Charleston Blvd, No1002 Las Vegas NV, 89117 PH: 702-485-6031 FX: 702-388-2966	renenorris@ymail.com
Susan Orton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Dept. of Veterans Affairs, So. Nevada Healthcare System	1820 LaVerne Circle Las Vegas NV, 89108 PH: 702-791-9000	suezq14437@yahoo.com
Alyce Thomas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Bob Volk	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1225 Searchlight Ct. Reno NV, 89523 PH: 775-747-5773	rmv123@sbcglobal.net
Dawn Walker	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1827 Haren Drive Las Vegas NV, 89011 PH: 702-487-5815	Sinsay.u2@gmail.com

Footnotes:

We currently have 4 applications in process that have been nominated and are waiting for an official letter from the Governor appointing

the applicant. We have 1 application that is waiting for a nomination from the SSA.
1. Nevada Department of Education
2. Medicaid
3. Housing
4. Vocational Rehabiliation
5. Criminal Justice

We have had some members resign with no official record, and others whose terms have ended but attempts are being made to replace those members.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	17	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	11	64.71%
State Employees	2	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	3	
Total State Employees & Providers	6	35.29%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The BHPAC was presented the beginning stages of the block grant application on July 20th 2017 with no action item on the official agenda to make recommendations, but discussion was held related to the application. On August 24th 2017 there is a meeting with BHPAC dedicated to reviewing the application and making recommendations for any changes. As noted in some of the council minutes the block grant is a continual topic of discussion ongoing as things are being implemented and recommendations or advising related to implementation is often given.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	[ ] Yes [ ] No
b)	Posting of the plan on the web for public comment?	[ ] Yes [ ] No
c)	Other (e.g. public service announcements, print media)	[ ] Yes [ ] No

If yes, provide URL:

http://dpbh.nv.gov/Programs/ClinicalSAPTA/dta/Grants/SAPTAGrants/

Footnotes:

Barry W. Lovgren
PO Box 6744
Gardnerville, NV 89460
(775)265-2659
barry.lovgren@gmail.com
(775)265-2659

Nevada Division of Public and Behavioral Health
Attn: Amy Roukie, Administrator
4150 Technology Way, Third Floor
Carson City, NV 89706 July 31, 2017

Dear Ms. Roukie:

Please don't give the Substance Abuse and Mental Health Services Administration (SAMHSA) false assurance that Nevada will comply with eligibility requirements for receiving Substance Abuse and Mental Health (SAMH) Block Grant funding. It's a sad commentary that I have to make this request. It's an even sadder commentary that this is a repeated request. Since you're new as Division Administrator you may be unaware of this issue.

A year ago I made this request of Richard Whitley, then Division Administrator and now Department of Health and Human Services Director. Mr. Whitley was the most recent in a long line of Nevada public officials who for years had been giving such false assurance. That request was copied to Cody Phinney. When the application for FY 2017 funding was submitted last September Ms. Phinney had become Division Administrator and it became her turn to sign false assurance of compliance – which she then did.

I assume that the Governor will now delegate his signatory authority to you as the new Division Administrator. You'll then have to decide before the September 1 deadline for submitting the application for FY 2018-19 SAMH Block Grant funding whether you will impugn the integrity of Nevada State government and place millions of dollars of SAMH Block Grant funding at risk by signing false assurance of compliance. Please don't. Please sign assurance that SAMH Block Grant requirements will be met only if that assurance will be kept.

I became aware of SAMHSA being given false assurance of compliance with SAMH Block Grant requirements in 2009 when the number of pregnant women receiving substance abuse treatment in Nevada had fallen by half: For many years signed assurance had been given to SAMHSA that Nevada complies with the requirement of 42 USC 300x-27 that the State publicize the availability of treatment and admission priority for pregnant women at funded programs. Instead of doing this the Division's Substance Abuse Prevention and Treatment Agency (SAPTA) simply delegated the responsibility to the treatment programs as an unenforced subgrant requirement. Delegating a responsibility isn't necessarily meeting it.

The result of reliance upon an unenforced subgrant requirement was that the availability of treatment and admission priority for pregnant women at funded treatment programs was not being publicized, making Nevada ineligible for Block Grant funding. But so far SAMHSA doesn't enforce Block Grant requirements any more than SAPTA enforced this subgrant requirement.

This noncompliance was largely resolved in 2015 when the Bureau of Child, Family, and Community Wellness began a public education campaign publicizing the substance treatment available to pregnant women by running public service announcements and by establishing the sobermomshealthybabies.org website. In addition, Nevada's Learning Collaborative Action Plan for Improving Birth Outcomes in Nevada, a National Governors' Association project, calls for greatly enhancing public awareness through signs posted in the women's restrooms of food establishments in Nevada which serve alcohol by the drink (which includes bars).

However, Nevada remains out of compliance with other requirements of 42 USC 300x-27 (substance abuse treatment for pregnant women), along with those of 42 USC 300x-23 (substance abuse treatment for persons who inject drugs), and of 42 USC 300x-3 (mental health planning and advisory council). Nevada hasn't complied with these eligibility requirements for SAMH Block Grant funding for years, yet State officials have shown no compunction about signing false assurance of compliance. Nevada's SAMH Block Grant funding continues to rely upon SAMHSA turning a blind eye to Nevada's failure to meet eligibility requirements.

This is much more than legalistic nit-picking: For example, one consequence of noncompliance is that while Nevada is suffers from a heroin epidemic it doesn't have the requisite outreach to encourage persons who inject drugs to get into treatment. This doesn't just violate Block Grant law. This violates common sense and simple human decency. In addition, the very act of signing false assurance as a designee of the Governor has violated the trust placed in State officials by the Governor, impugned the integrity of State government, and demonstrated a cynical disregard for the rule of law.

- -

Please don't sign false assurance of compliance with 42 USC 300x-27, which addresses substance abuse services for pregnant women which must be provided if Nevada is to be eligible for receiving Substance Abuse Block Grant funds.

45 CFR 96.131 is the regulation implementing this statute. Nevada complies with some, but not all, of its requirements. The State doesn't comply with the requirement to "maintain a continually updated system to identify treatment capacity" and "establish a mechanism for matching the women in need of such services with a treatment facility that has the capacity to treat the woman". It fails to comply with the requirement that a program that's full must contact the State if a pregnant woman seeks treatment from it so the State can refer her to a program which can admit her, fails to meet the requirement to ensure that a pregnant woman is provided interim services if timely admission can't be obtained, and fails to meet the requirement that Nevada's Block Grant application

includes a report on the strategies adopted to monitor for compliance and to identify corrective action required.

These requirements were established by federal law well over 20 years ago. The Bureau of Behavioral Health Prevention and Treatment (BHPT) has finally begun the process of developing policy to address them. It isn't known whether the Bureau is meeting the requirement to do so in consultation with the State Medical Director, nor is it known when appropriate policy will be adopted, established by the Behavioral Health Commission as required by NRS 433.314, and then implemented.

Nevada hasn't kept its promise to comply with the requirements of 42 USC 300x-27 during the current Block Grant funding cycle.

Please don't sign false assurance of compliance with 42 USC 300x.23, which addresses requirements for services for persons who inject drugs if Nevada is be eligible for receiving Substance Abuse Block Grant funds.

45 CFR 96.126 is the regulation implementing this statute. Nevada doesn't comply with the requirement to have a capacity and waiting list management system which ensures that the State is notified when a program reaches 90% of its capacity, doesn't comply with the requirement to provide for identifying a program which can admit a person who injects drugs if the program to which the person had applied for treatment is full, doesn't comply with the requirement that the State ensure that a person who injects drugs is admitted to treatment wtihin120 days of applying for treatment and is provided interim services if not admitted within 14 days, doesn't comply with the requirement that funded treatment programs conduct outreach which meets very specific federal standards to persons who inject drugs, and it fails to meet the requirement that Nevada's Block Grant application includes a report "on the specific strategies to be used to identify compliance problems and corrective actions to be taken" with regard to these requirements.

Like the requirements for services for pregnant women who suffer from substance abuse, these requirements were established by federal law over 20 years ago, and BHPT finally has begun the process of developing policy to address them. Outreach to persons who inject drugs isn't currently required by SAPTA as a condition of subgrant funding, so the current subgrant funding structure doesn't consider the costs of providing it. Hopefully the requirement that funded treatment programs provide outreach to persons who inject drugs which meets specific federal standards won't be addressed by a protocol which gives only the illusion of compliance through an unenforced and unfunded mandate upon the programs, as had been the case with the requirement that the availability of treatment and admission priority for pregnant women be publicized.

It isn't known when appropriate policy will be adopted, established by the Behavioral Health Commission as required by NRS 433.314, and actually implemented, nor is it known when the State will develop the requisite compliance monitoring. Hopefully the application for FY 2018-19 funding will contain the requisite report "on the specific strategies to be used to identify compliance problems and corrective actions to be taken".

Nevada hasn't kept its promise to comply with these requirements during the current Block Grant funding cycle.

Please don't sign false assurance of compliance with 42 USC 300x-3, which requires that the State's mental health planning and advisory council "monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State" if the State is to eligible for receiving Mental Health Block Grant funds.

Prior to 2013 the Mental Health Planning and Advisory Council's monitoring, reviewing, and evaluation of Nevada's mental health services was limited to rural mental health services. In 2013 the Governor re-named it the Behavioral Health Planning and Advisory Council and ordered it to expand these functions beyond mental health services to include services for substance abuse and co-occurring disorders – i.e. services for behavioral health. Minutes of the January, 2014, meeting of the Council show that the Division announced to the Council that it "would not continue with Rural Monitoring and will instead focus their efforts on the entire system."

Ironically, at the same meeting the Division presented to the Council its Gaps Analysis of difficulties to be overcome by the newly-formed Division of Public and Behavioral Health; one of the gaps identified is lack of public supervision of mental health services. Yet since 2013 the Division hasn't had the Council monitor, review, and evaluate even rural mental health services, let alone other mental health services and the rest of Nevada's behavioral health services as ordered by the Governor.

Nevada hasn't kept its promise to comply with the statutory requirement for its planning and advisory council's monitoring, reviewing, and evaluation activities during the current Block Grant funding cycle.

- -

Both the Division and BHPT have come to be under new leadership since the last application for SAMH Block Grant funding was written. The Division has developed a Strategic Plan for SAPTA, now a subsidiary of BHPT, which addresses problems specific to the substance abuse component of the SAMH Block Grant.

The Situational Analysis which is the foundation of the Plan notes that, "Compliance with federal block grant requirements and federal and state regulations is lacking." Accordingly, the Strategic Plan calls for the State to "Ensure Nevada is fully compliant with all federal mandates designated in the Code of Federal Regulations as well as substance abuse federal block grants (SABG)", to "Comply with federal law for content of SAPT Block Grant application by August 2017", and to "Comply with federal law for eligibility for SAPT Block Grant funding by August 2018". This is most commendable. Acknowledging that a problem exists is the first step in resolving it.

SAMHSA has also revised the application format to provide for greater accountability, for example no longer allowing the State to remain silent on whether it's in compliance

with the requirements of 42 USC 300x-23 for persons who inject drugs. Required elements of the application for which the application format does not explicitly provide can be addressed in an attachment to the application, as was done, albeit incompletely, in the application for FY 2014-15 funding.

Please note that SAMHSA's instructions for the SAMH Block Grant application specify that, "For the Secretary of HHS, acting through the Assistant Secretary of Mental Health and Substance Use, to make an award under the programs involved, states must submit an application(s) sufficient to meet the requirements described in the authorizing legislation and implementing regulations."

The legislation and regulations require that the application to be submitted by September 1 includes a plan for meeting the requirements of 42 USC 300x-23 for services for persons who inject drugs and for meeting the requirements of 42 USC 300x-27 for services for pregnant women. The legislation and regulations also require that the application includes signed assurance of compliance during the funding period with the requirements of those statutes along the requirements of 42 USC 300x-3 for the planning and advisory council.

I'm looking forward to the Division submitting under your leadership an application for SAMH Block Grant funding which complies with statutory and regulatory requirements, and looking forward to the assurances you will be signing in the application representing promises which the Division at long last will keep. Only then will Nevada's SAMH Block Grant funding no longer be contingent upon SAMHSA failing to meet its duty to enforce Block Grant eligibility requirements.

Sincerely,

Barry W. Lovgren

cc: Kana Enomoto, Acting Deputy Assistant Secretary for Mental Health and Substance Use
John Campbell, Chief, Center for Substance Abuse Treatment Performance Partnership Branch
Theresa Mitchell, Center for Substance Abuse Treatment Project Officer
Clark Hagen, Center for Substance Abuse Prevention Project Officer
Cathleen Crowley, Community Mental Health Services Project Officer
Governor Brian Sandoval
Mike Willden, Chief Staff for Governor Sandoval
Richard Whitley, Director, Nevada Department of Health and Human Service
Julia Peek, Deputy Administrator, Division of Public and Behavioral Health
Kyle Devine, Chief, Bureau of Behavioral Health Prevention and Treatment
Nevada Behavioral Health Planning and Advisory Council
Nevada State Legislature

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

AMY ROUKIE, MBA
Administrator, DPBH

JOHN DiMURO, DO MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

August 8, 2017

Barry Lovgren
PO Box 6744
Gardnerville, NV 89460

Dear Mr. Lovgren:

I hope that you are recovering from your recent surgery, and that this correspondence finds you recuperating well and feeling good.

Thank you for your letter dated July 31, 2017, which discusses your concerns about Nevada's compliance with the Federal requirements for the Mental Health and Substance Use Block Grant. I understand that the Division staff have been working on improving processes that address your concerns. I will be considering them while I review and prior to signing, the assurances for the FY 2018-2019 Mental Health and Substance Abuse Block Grant application, so thank you for bringing them to my attention.

I also understand that you had regular monthly meetings with the previous Administrator and the Chief of the Bureau of Behavioral Health Wellness and Prevention. I would like to continue this practice if you are interested and find them to be helpful. Please feel free to contact me or Pat Wendell, my Executive Assistant to set up the monthly meetings.

Sincerely,

Amy Roukie, MBA
Administrator

cc: Governor Brian Sandoval
Mike Wilden, Chief of Staff for Governor Sandoval
Richard Whitley, Director, Nevada Department of Health and Human Services
Julia Peek, Deputy Administrator, Division of Public and Behavioral Health
Kyle Devine, Chief, bureau of Behavioral Health Wellness and Prevention
Nevada Behavioral Health Planning and Advisory Council

STATE OF NEVADA

BRIAN SANDOVAL
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RICHARD WHITLEY, MS
Director, DHHS

CODY L. PHINNEY, MPH
Administrator, DPBH

JOHN DIMURO, D.O., MBA
Chief Medical Officer

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June 6, 2017
Barry Lovgren
PO Box 6744
Gardnerville, NV 89460

Dear Mr. Lovgren,

Thank you so much for spending time with Kyle Devine and I this afternoon. I hope that you found the discussion as productive as we did. We share the goal of ensuring that Nevada meets the federal requirements for the block grant, but more importantly we share the goal of ensuring that substance abuse services are available and accessible to Nevadans. These are very broad goals and there is a myriad of steps that the Bureau must take to achieve them.

To that end, we spent our time today identifying the action steps that we agree are working toward for which you advocate. I believe we agreed that the steps outlined below are building blocks that move us farther down the road to the very large goals above.

Action Step	Due Date	Contact Person
Strategic Plan	6/16/17	Kyle Devine
Revised Sub Grant Template Draft	6/12/17	Kyle Devine
Implemented Subgrant Template	6/30/17	Kyle Devine
Quarterly Report Template Finalized	6/30/17	Kyle Devine
Wait List Protocol Finalized	6/30/17	Kyle Devine
Capacity Management Protocol Finalized	6/30/17	Kyle Devine
Update on print advertising in restrooms of bars and restaurants	6/16/17	Cody Phinney

I also appreciate your sharing with us your suggestions on improving the management of the Bureau and your dissatisfaction with our view of our current compliance. I am certainly willing to agree that we disagree on the compliance issue.

Finally, we discussed the issue of the paradigm shift from SAPTA client to SAPTA services. This is a very large issue, and one that we continue to work through across the Department. I have not added action steps on this item for now. I agree with you that this must be addressed. I hope that you will sit

down with Kyle and I again when we are able to provide a progress update on the steps above and the concrete steps on this last issue. I will see you on June 14th, per your request.

Sincerely,

Cody L. Phinney, MPH
Administrator

Cc: Richard Whitley, Director
Kyle Devine, Chief
Marco Ericson, Health Program Manager
Julia Peek, Deputy Administrator

STATE OF NEVADA

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June 20, 2017

Mr. Barry Lovgren
PO Box 6744
Gardnerville, Nevada 89460

Dear Mr. Lovgren,

Thank you for meeting with Julia Peek and me on June 14, 2017. We continue to share a vision of improving the bureau and ensuring we meet the federal requirements of the block grant. We always appreciate your going over the history back to 2009, and hearing our vision on current activity.

I wanted to highlight several of the topics we discussed at the meeting. Several were a continuation of our meeting on June 6, 2017, but there were new items, which are also noted.

Strategic Plan for the Bureau of Behavioral Health Wellness and Prevention (BBHWP)

Thank you for participating on the Steering Committee for the Strategic Plan for the BBHWP. Your feedback was very helpful. The final document was provided to the Committee on Friday, June 9th for final edits. The plan is now finalized. It represents a great deal of work, and it provides specific direction to the bureau through 2020.

Revised Subgrant Template Draft

The subgrant template for the BBHWP has been completed and is with the central fiscal office for review and finalization. Please find that draft attached. The BBHWP still plans to meet the deadline of June 30, 2017 to have it implemented. As we discussed, this is one of many steps we are taking to improve our processes and demonstrate full compliance with block grant rules.

Access to Care Issues

You expressed you concern about access to substance abuse treatment, specifically, we discussed services for low income residents. This aligns with our discussion on wait lists and sliding fee scale services. For the Certified Behavioral Health Clinics (CCBHCs), we discussed that the proposed CCBHCs are aware of the requirement to have a sliding fee scale in place and to share that information within their clinic and on their website.

The issue of low-income seniors accessing treatment and concerns about inability to pay was discussed. You understood that if someone was on Medicare they were ineligible for Medicaid. We offered to provide additional information on the Centers for Medicare & Medicaid Services related to "dual eligible" clients. CMS already has some helpful documents prepared, so the hyperlinks are noted below:

- Dual Eligible Changes through the Affordable Care Act: https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html
- Dual Eligible Beneficiaries Guide: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf. Starting on page 3 of this document is a good summary of what is provided, including coverage of premiums, deductibles, coinsurance, and copayments.

If you have any questions on dual eligibility, we can get you in communication with the Division of Healthcare Financing and Policy.

Statewide Epidemiological Profile

You noted that you were very satisfied with the final Statewide Epidemiological Profile. Specifically, you noted the great efforts of James Kuzhippala. We too are very happy with the effort of James and his staff. The document will be very helpful in identifying trends and priority populations. In fact, this document was used by the MPAC to make recommendation last week.

Policies and Protocols

The policies for wait list and capacity management were reviewed by the SAPTA Advisory Board on June 14th (see links to the policies below). You noted you still had issues with the policies and offered to send us a mark-up with those edits for our review. I will provide final review of these documents, then they will be implemented.

- Wait List Policy - http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/061417%20Waitlist%20Policy%20Revised.pdf
- Capacity Management Policy - http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/061417%20Capacity%20Policy%20Revised.pdf

Perinatal Substance Use

You noted concern with BBHWP meeting the requirements of 45 CFR subpart L, 96.131, subpart B:

The State will, in carrying out this provision publicize the availability to such women of services from the facilities and the fact that pregnant women receive such preference. This may be done by means of street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social service agencies.

In order to comply with this CFR, Nevada has done several innovative projects of which you are aware that DPBH feels meet this requirement:

- Text4Baby (see attached for the actual messages sent to the participants)

- Sober Moms, Healthy Babies - https://sobermomshealthybabies.org/

The messaging includes the language – "If you are pregnant and using, you will be considered top priority at any treatment center in Nevada."

On this same topic, we discussed the print advertisement in restrooms or menus of bars and restaurants that serve alcohol. We discussed that there may be opportunity to work through the state environmental health programs to distribute signs with "211" noted as a referral tool during their inspections. We certainly appreciate this suggestion, and will take it under advisement. However, we are focused on the communication mediums that are most relevant to people of child bearing age, like text and internet.

We look forward to meeting with you again in July to review the progress on these activities.

Sincerely,

Cody L. Phinney, MPH
Administrator

Cc: Richard Whitely, Director, Department of Health and Human Services
Kyle Devine, Chief, Bureau of Behavioral Health Wellness and Prevention
Marco Ericson, Manager, Substance Abuse Prevention and Treatment Agency
Julia Peek, Deputy Administrator, Community Services

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RICHARD WHITLEY, MS
Director, DHHS

CODY L. PHINNEY, MPH
Administrator, DPBH

JOHN DIMURO, D.O., MBA
Chief Medical Officer

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Behavioral Health Wellness and Prevention
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May 9, 2017

Barry Lovgren
P.O. Box 6744
Gardnerville, NV 89460

Dear Mr. Lovgren:

Thank you, once again, for your diligence in assuring Nevada is in compliance with federal substance abuse block grant requirements.

Your letter dated May 6, 2017, points out an error in our subgrant assurances. The federal requirement in the subgrant that was provided to you referenced "42 CFR 300." The correct reference is "42 U.S.C. 300" instead. Specifically, 42 U.S.C. 300x-21 addresses the requirements for intravenous substance abuse. This reference was added to all of our treatment subgrants as there was previously no reference to this requirement; rather, there was a general requirement to "comply with all applicable rules, regulations, requirements, guidelines and policies and procedures to include, but not limited to: . . . c. All applicable funding source requirements . . ."

Note that 42 U.S.C. 300x-21 requires outreach to persons who inject drugs and specifically states:

> (b) Outreach to persons who inject drugs
> A funding agreement for a grant under section 300x-21 of this title is that the State involved, in providing amounts from the grant to any entity for treatment services for persons who inject drugs, will require the entity to carry out activities to encourage individuals in need of such treatment to undergo treatment.

This section clearly requires the state and its subrecipients or funded entities to carry out activities to encourage individuals using intravenous drugs to get treatment. This reference was added to address the lack of acknowledging this requirement in previous year's subgrants. The requirement is met; however, we can do better by being more explicit about the requirements. Therefore, I am directing staff to provide more explicit language by not only providing federal references but also following the reference with an explicit explanation of the requirement in plain language.

As you are aware, from your participation in our April SAPTA Advisory Board meeting, we have been working diligently to improve our policies concerning the requirements listed in 45 CFR 96.122 through 96.131. These include our Wait List and Capacity Monitoring Policies. The drafts currently being finalized did benefit from your input and recommendations. Once the policies are finalized, and the changed procedures are rolled out to the providers, we will be in even stronger compliance with the CFRs.

In addition, the requirement stated in 45 CFR 96.133, which requires the state to submit an assessment of needs, is accomplished through the Substance Abuse Block Grant application. The application developed by SAMHSA requires the state to submit the most current incidence and prevalence data for substance and alcohol use as well as the detailed description on current prevention and treatment activities. This mandatory information submitted with the Substance Abuse Block Grant application fulfills the requirement for an assessment of needs as referenced in 45 CFR 96.133 as evidenced by our federal project officer approving the application for funding. We can do better with a more comprehensive assessment. Our commitment to this is demonstrated by the fact that a more comprehensive assessment is included in the Strategic Plan, a plan of which your input has been included. This improved plan will be implemented in the coming year.

As always, I do appreciate your assistance in pointing out potential issues. Working together, as we have been, I am confident that we will improve our policies in complying with federal requirements.

Sincerely,

Kyle Devine, MSW
Chief
Bureau of Behavioral Health Wellness and Prevention

cc: Michael Willden
Richard Whitley
Cody Phinney
Marco Erickson
Karen Taycher
Michelle Berry
Ali Jai Faison
Amy Roukie
Elyse Monroy
James Kuzhippala
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May 6, 2017

Nevada Bureau of Behavioral Health, Wellness, and Prevention
Attn: Kyle Devine, Bureau Chief
4126 Technology Way, Suite 200
Carson City, NV 89706

Dear Mr. Devine:

At the April 7, 2017, meeting of the SAPTA Strategic Plan Steering Committee you reported that the difficulty with the Bureau not complying with federal law mandating that the Bureau require funded treatment programs to conduct outreach to injection drug users had been resolved by revising the subgrant agreement with the funded programs.

In response to my subsequent public record request, the Bureau has provided me a copy of a treatment program's subgrant agreement which was signed on April 14th, a week after you reported that the revision had been made.

There is no such revision.

The subgrant agreement continues to address the federal requirement for outreach to injection drug users with:
"The sub-grantee must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines and policies and procedures to include, but not limited to the following…
"42 CFR 300, including outreach to injection drug users…"

There is no 42 CFR 300.

However, there is 45 CFR 96.126(e). Like nearly all Block Grant regulations, it imposes requirements upon the State, not upon the programs: A subgrant requirement that the program comply with its requirements is meaningless; its requirements are incumbent upon the State, not the programs. And, as with many such Block Grant regulations*, the Bureau has yet to comply with it.

45 CFR 96.126(e) mandates that, "The State shall require that any entity that receives funding for treatment services for intravenous drug abuse carry out activities to encourage individuals in need of such treatment to undergo such treatment. The States shall require such entities to use outreach models that are scientifically sound, or if no such models are available which are applicable to the local situation, to use an approach

which reasonably can be expected to be an effective outreach method. The model shall require that outreach efforts include the following:

"(1) Selecting, training and supervising outreach workers;

"(2) Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentially requirements, including 42 CFR part 2;

"(3) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;

"(4) Recommend steps that can be taken to ensure that HIV transmission does not occur; and

"(5) Encouraging entry into treatment."

The Bureau doesn't require funded treatment programs to do any of this. The only ones who suffer are those who continue to be injection drug addicts because nobody is providing outreach to them in the middle of a heroin epidemic.

This is tediously familiar. In 2009 it was brought to the Bureau's attention that the State was failing to meet its duty under the Block Grant regulations to publicize the availability of substance abuse treatment and admission priority for pregnant women. It would be another six years before the State began to meet this duty, when Maternal and Child Health began a public education campaign which does this. In the meantime, the only ones who suffered were babies born with substance-related birth defects which could have been avoided if only mom had known she could have gotten treatment.

It took six years for the State to begin meeting its duty to publicize the availability of treatment and admission priority for pregnant women. Hopefully it won't take another six years for the State to begin meeting its duty to have funded treatment programs conduct outreach to injection drug abusers.

This is getting very old.

Sincerely,

Barry W. Lovgren

* Examples:

- The requirement of 96.122(g)(4) that the Block Grant application include "A detailed description of the State procedures to monitor programs that reach 90% capacity pursuant to 96.126(a)"

- The requirement of 96.122(g)(5) that the Block Grant application include "A detailed description of the State procedures to implement the 14/120 day requirement provided by

96.126(b) as well as the interim services to be provided and a description of the strategies to be used in monitoring program compliance in accordance with 96.126(f)"

- The requirement of 96.122(g)(6) that the Block Grant application include "A full description of the outreach efforts States will require entities which receive funds to provide pursuant to 96.126(e)"

- The requirement of 96.122(g)(13) that the Block Grant application include "Statewide assessment of needs as provided in 96.133"

- The requirement of 96.126(a) that the State maintain a capacity management system which ensures a continually updated record of reports it requires of programs providing treatment to intravenous drug abusers when 90% capacity is reached and which makes excess capacity information available to the programs

- The requirement of 96.126(b) that the State ensure that persons seeking treatment for intravenous drug abuse are admitted within 14 days of requesting admission or within 120 days if the program is full and interim services are provided to the person within 48 hours of the request

- The requirement of 96.126(f) that the State identify problems with compliance with the requirements of 96.126 for treatment of, interim services for, and outreach to injection drug abusers and report in the Block Grant application on the specific strategies used to identify compliance problems and the action to be taken to correct them

- The requirement of 96.131(c) that the State maintain a "continually updated system to identify treatment capacity" for pregnant substance abusers and to "establish a mechanism for matching the women in need of such services with a treatment facility that has the capacity to treat the woman"

- The requirement of 96.133 that the State conduct a substance abuse needs assessment which meets the requirements specified in that that regulation

Substance Abuse Prevention and Treatment Agency

Bureau of Behavioral Health, Wellness and Prevention

Strategic Plan

2017-2020

Nevada Division of Public and Behavioral Health

Acknowledgements

The Bureau would like to recognize the following individuals who contributed to the strategic plan, listed alphabetically.

Name	Position	Organization
Michelle Berry	Project Manager	Center for the Application of Substance Abuse Technology
Steve Burt	Chair, Executive Director	SAPTA Advisory Board, Ridge House
Lyell Collins	HIV Prevention Program Manager	Nevada HIV/AIDS Prevention Program
Kyle Devine	Bureau Chief	Nevada Bureau of Public and Behavioral Health, Behavioral Health, Wellness and Prevention
Mark Disselkoen	Project Manager	Center for the Application of Substance Abuse Technology
Ali Jai Faison	Vice Chair	Behavioral Health Planning and Advisory Council (BHPAC)
Kendra Furlong	Health Program Specialist II	Nevada Bureau of Public and Behavioral Health, Behavioral Health, Wellness and Prevention
James Kuzhippala	Health Program Specialist	Office of Public Health Informatics and Epidemiology
Linda Lang	Director	Nevada Statewide Coalition Partnership
Barry Lovgren	Public	Private Citizen
Kathy Mayhew	Clinical Program Planner	Division of Child and Family Services
Julia Peek	Deputy Administrator	Division of Public and Behavioral Health
Karen Taycher	Executive Director	Nevada PEP
Stephanie Woodard	Senior Advisor on Behavioral Health State of Nevada	Department of Health and Human Services

Social Entrepreneurs, Inc., a company dedicated to improving the lives of people by helping organizations realize their potential, provided facilitation for the strategic planning process.

Table of Contents

Executive Summary

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates statewide substance abuse service delivery.[1] SAPTA's key roles include distributing funding (tax dollars, general fund, and grants), creating and implementing statewide plans for substance abuse services, and developing standards for certification of programs and services.

In January 2017, a Steering Committee was convened to develop a strategic plan to both guide SAPTA's efforts and to fully align with state and federal regulations. This Strategic Plan documents a path to administer funding and coordinate substance use disorder services between 2017 and 2020. The plan was informed by a situational analysis based on community input, epidemiological data, key informant interviews, and other sources. Both critical issues identified by stakeholders and strategic initiatives identified in the Substance Abuse Block Grant (SABG) were used in the identification of plan goals and strategies.

The mission, or core purpose for this plan, is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's residents and communities. The vision is that Nevadans are healthy and resilient and able to fully participate in their communities.

The Steering Committee drafted six values to guide both the planning process and its implementation, and, developed five goals and 12 objectives to guide its work between June 2017 and June 2020. Strategies were also identified to help launch implementation. Note that while goals and objectives are intended to stay fixed during the plan term, strategies may need to be adjusted to reflect the most current situations at the federal, state, and local levels.

Regular use, review, and updates to the public are critical to the success of this plan.

[1] Many of the statutes and regulations refer to substance abuse; however, goals and strategies reflect the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) language. The DSM no longer uses the terms substance abuse and substance dependence.

Goal 1 **Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.**	
Objectives	Objective 1.1: By August 30, 2018, attain compliance with federal and state regulations.
	Objective 1.2: By June 30, 2018, structure the Bureau for effective planning and administration.
	Objective 1.3: By December 31, 2018, establish practices to increase accountability and transparency in alignment with the values described in this plan.
	Objective 1.4: By March 31, 2018, develop protocols that provide for consistent affordable billing by the funded treatment programs for the uninsured and the underinsured.
Goal 2 **Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.**	
Objectives	Objective 2.1: By December 2018, reduce service gaps.
	Objective 2.2: By December 2019, increase the capacity of local communities.
Goal 3 **Sustain and strengthen evidence-based practices and promote a competent workforce.**	
Objectives	Objective 3.1: By December 2018, increase the use of evidence-based practices.
	Objective 3.2: By December 2020, increase the competency of the workforce.
Goal 4 **Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.**	
Objectives	Objective 4.1: By December 2018, improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information.
	Objective 4.2: By December 2019, improve intercommunication between the Bureau, the public, and its partners.
Goal 5 **Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.**	
Objectives	Objective 5.1: By December 2018, improve access to timely and appropriate treatment and care.
	Objective 5.2: By December 2018, increase collaboration among funded providers.

The plan will be reviewed at least annually by the Behavioral Health Planning and Advisory Council (BHPAC) or its successor and the Bureau to evaluate progress towards completion of goals, as well as the feasibility of strategies.

Introduction and Purpose

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of Nevada's Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates statewide substance abuse service delivery.[2] While SAPTA is not responsible for direct service delivery, it distributes state and federal grant funding, creates and implements statewide plans for substance abuse services, and develops standards for certification of programs and services.

Because the last SAPTA Strategic Plan was completed in 2007, the Bureau recognized the need for a new plan to guide its efforts and to fully align with state and federal regulations.

State Regulations

According to Nevada Revised Statutes (NRS 458.025), the Division of Public and Behavioral Health (DPBH):

(*a) Shall formulate and operate a comprehensive state plan for alcohol and drug abuse programs which must include:*

> *(1) A survey of the need for prevention and treatment of alcohol and drug abuse, including a survey of the treatment providers needed to provide services and a plan for the development and distribution of services and programs throughout this State.*
>
> *(2) A plan for programs to educate the public in the problems of the abuse of alcohol and other drugs.*
>
> *(3) A survey of the need for persons who have professional training in fields of health and other persons involved in the prevention of alcohol and drug abuse and in the treatment and recovery of alcohol and drug abusers, and a plan to provide the necessary treatment*.[3]

NRS 458. 025 goes on to require that, "In developing and revising the state plan, the Division shall consider, without limitation, the amount of money available from the Federal Government for alcohol and drug abuse programs and the conditions attached to the acceptance of that money, and the limitations of legislative appropriations for alcohol and drug abuse programs."

[2] Many of the statutes and regulations refer to substance abuse; however, goals and strategies reflect the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) language. The DSM no longer uses the terms substance abuse and substance dependence.

[3] Retrieved on October 17, 2016 from: https://www.leg.state.nv.us/nrs/NRS-458.html

Any specifics within the state plan will also be compliant with the Nevada Administrative Code, specifically those provisions in Chapter 458 regarding the Abuse of Alcohol and Drugs.

Federal Block Grants

The Nevada Division of Public and Behavioral Health (DPBH) is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of the DPBH, SAPTA administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant - referred to as SABG by SAMHSA and SAPT by DPBH (Nevada Division of Public and Behavioral Health (DPBH), n.d.). Note that "prevention and treatment" is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery.

The SABG program, mandated by Congress, provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services. (Substance Abuse and Mental Health Administration, 2016).

SABG has identified target populations and service areas to include:

SABG Targeted Populations and Services				
Pregnant women and women with dependent children	Persons who inject drugs	People with tuberculosis	Early intervention services for people with HIV/AIDS	Primary prevention services (at 20% or more)

Primary prevention strategies are used for those who are not in need of treatment. The requirement for the SABG allotment towards prevention strategies is “no less than 20%” (Substance Abuse and Mental Health Services Administration, 2015).

Plan Creation

A Steering Committee consisting of diverse stakeholders from the community, professional organizations, and advisory boards and councils was convened to guide the development of this plan. A situational analysis was conducted to develop critical issues and goals. Additional input from public town hall meetings helped to prioritize needs and provide feedback on draft goals.

This Strategic Plan creates a comprehensive path forward from 2017-2020 for SAPTA to best administer funding and coordinate substance use disorder services. It facilitates compliance with state and federal requirements while bolstering its own organizational cohesion, strengthening collaboration with other state entities, and directing services to those populations most at risk.

Organization of this Document

This strategic plan contains the following sections:

Methods and Approach

This section outlines the methods and approach to the strategic planning process.

Situational Analysis Summary

This section summarizes the Situational Analysis, describing the regulatory framework for the plan. It also identifies needs, strengths, and potential areas for focus both within SAPTA as an organization and within Nevada’s communities.

Plan Framework

This section describes the mission, vision, and values that articulate SAPTA’s philosophy.

Critical Issues and Goals

This section outlines the priorities established in light of the situational analysis.

Strategic Plan Goals and Strategies

This section details the goals and strategies as well as an implementation timeline. It also identifies potential parties responsible for accomplishing these goals.

Management and Evaluation of the Plan

This section explains how SAPTA plans to measure and monitor accomplishments.

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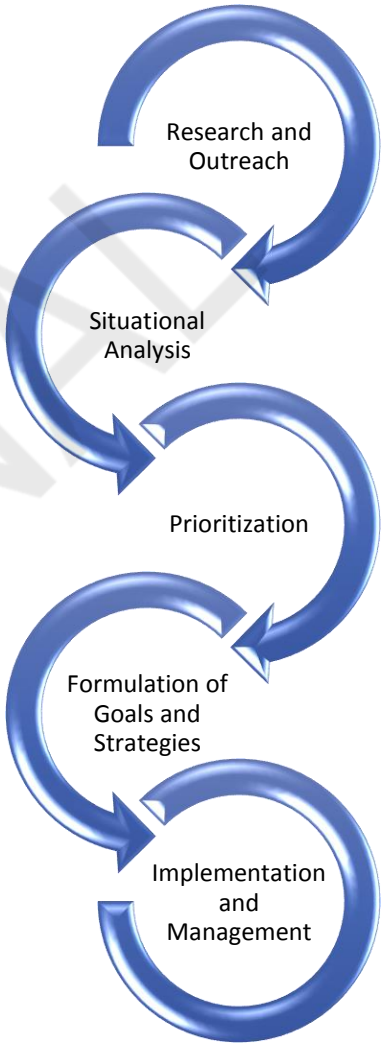
Methods and Approach

To arrive at the Strategic Plan, Focused Strategic Thinking (FST) was employed. FST is a process for thinking about and planning for the future of an organization that is simple, structured, participative, efficient, and effective. The process involves developing and implementing a strategy and requires three activities – strategic thinking, strategic planning, and strategic management. In practice, the model calls for understanding the situation and then planning the strategy, its implementation, and control. The strategy links leadership's understanding of the organization today with where it wants, can, and should be at some point in the future (Ginter, Duncan, & Swayne, 2013).



Additionally, SAMHSA's Strategic Prevention Framework (SPF), designed to answer the following questions, was also incorporated in the approach (Substance Abuse and Mental Health Services Administration, 2016).

1. What is the problem and how can I learn more? (Situational Analysis)
2. What do I have to work with? (Situational Analysis)
3. What should I do and how should I do it? (Strategic Plan)
4. How can I put my plan into action? (Strategic Plan)
5. Is my plan succeeding? (Strategic Plan)

The Steering Committee agreed to use consensus based decision-making in developing the strategic plan, but reserved the option of taking decisions to a vote if the group became deadlocked on an issue. Consensus based decision-making is an inclusive, participatory, and collaborative approach to making decisions that seeks the entire group's agreement before moving forward with a proposal (Seeds for Change, 2010).

In the first phase, the Steering Committee established a mission, vision, and values for SAPTA's Strategic Plan. Additionally, a consulting firm under contract with SAPTA conducted research

and outreach to explore and confirm the most pressing needs facing SAPTA using the regulatory framework provided by the Code of Federal Regulations (CFR), the SABG, Nevada Administrative Code (NAC), and Nevada Revised Statutes (NRS). The results of this research produced the situational analysis. The Steering Committee used the situational analysis and its expertise to develop a S.W.O.T. and identify critical issues. It is important to note that not all data for a complete needs assessment was available, and these limitations were detailed in the Situational Analysis.

Next, with additional input from the general public via Town Hall Meetings, the Steering Committee determined priorities based on the situational analysis. These priorities were used to formulate goals and strategies to guide SAPTA over the next three years. Again, public input on drafted goals and strategies was solicited. Finally, the Steering Committee decided how the plan would be implemented and managed in the coming years.

Situational Analysis (Summary)

Overview

Both quantitative and qualitative data were used to develop the situational analysis. Data from multiple sources, including data systems, reports, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps. It is important to note that the Situational Analysis was created without a comprehensive needs assessment as defined by CFR 96.133. However, to help identify and clarify the most important assets and issues related to substance use disorder outreach, intervention, prevention, treatment, and recovery, the consulting firm that facilitated the planning process interviewed stakeholders across the state, completed a S.W.O.T. analysis with Steering Committee Members, and conducted Town Hall Meetings in Las Vegas, Carson City, and Elko. This section provides a high-level overview of the situational analysis. The complete version can be accessed in the Appendix of this plan.

Summary

Nevada's population is growing and much of the data available indicates that more resources and better outcomes are needed to address prevention and treatment of substance misuse. The current system of care appears overly reliant on emergency rooms and criminal justice settings to identify and engage individuals with substance use and mental health needs. Wait lists for services are long. Additionally, uncertainty about the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives.

In 2017, Nevada's top needs align well with SAMHSA's strategic initiatives. Several highlights are provided below.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

- **Focus on high risk populations.** Key informants identified subpopulations that may have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with

dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

- **Integrate behavioral health with health promotion and health care delivery.** Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the situational analysis suggests that stronger support for people with co-occurring disorders should remain a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

- **Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.** Data from the situational analysis indicates considerable gains are possible through attention to trauma. The state is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. Work through local corrections (jails) and hospitals is an important short-term strategy to address the current situation. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, 'upstream' prevention efforts, for example focusing on reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

- **Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience.** Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services—such as residential treatment—were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

- **Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT).** Nevada has made many

advancements in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between state and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

- **Support active strategies to strengthen and expand the behavioral health workforce.** Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the state to address issues of reimbursement and payment for providers.

Additionally, a summary of what is working, needs and issues, emerging issues, and opportunities identified through the situational analysis is provided in the following tables.

What's Working Well	*Examples and Support for Finding*
Improvements to Nevada's Behavioral Health System	Nevada has successfully applied for many grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) and the State Targeted Response (STR) to the Opioid Crisis grant will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard to reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities. Behavioral health data has been prepared and presented at the coalition-level to direct prevention and treatment sources and identify areas of unmet need.
Substance Misuse Decreasing for Many	Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol

What's Working Well	Examples and Support for Finding
Substances and Populations	before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	➡ Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. ➡ SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for claims that are denied by Medicaid.
State-level Improvements	➡ Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges	Examples and Support for Finding
System Challenges	➡ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps. ➡ Services are not well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer. ➡ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area. ➡ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state.

Issues and Challenges	*Examples and Support for Finding*
	➢ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration. ➢ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others. ➢ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.
Substance Misuse Is Elevated for Many Substances and Populations	➢ Rates of substance misuse including dependency are higher among many populations within Nevada compared to the nation. ➢ Survey data shows that many people needing treatment do not get the care they need. ➢ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➢ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
Workforce Shortages	➢ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➢ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➢ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➢ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➢ More outreach and services are needed in languages other than English and that are culturally competent.

Issues and Challenges	*Examples and Support for Finding*
	➢ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➢ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.
Service Gaps	➢ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery. ➢ Insurance requirements can create problems with continuity of care and individualization of care. ➢ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	➢ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation. ➢ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc. ➢ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations. ➢ For both prevention and treatment, enhanced two-way communication with the state to discuss the data available would support evaluation, reporting, and funding.

Threats and Emerging Issues	*Examples and Support for Finding*
Policy Changes	➢ The ACA has contributed many improvements to Nevada's system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➢ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	➢ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➢ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➢ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	➢ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➢ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities	*Examples and Support for Finding*
Engage in Effective Planning	➢ Many states are innovating, including Nevada. Nevada can learn from other states' efforts to improve policies, systems, and practices toward improved behavioral health outcomes. Nevada also needs to share best practices and highlight innovative programs implemented in the state. ➢ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada's planning efforts. ➢ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.
Build Sustainability	➢ Outreach indicated a willingness by providers to work with limited resources and collaborate to better serve communities. The state can help to increase this capacity by creating greater transparency related to funding that would allow for

Opportunities	*Examples and Support for Finding*
	a clearer picture of the funding available and the identification of effective collaborations. ➡ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➡ The work of other planning processes, for example Olmstead Planning and *Nevada's No Wrong Door,* can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
Enhance Communication, Relationships, and Collaboration	➡ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➡ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➡ There are many opportunities for the state to work more closely and collaboratively within communities. ➡ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
Regional and Local Control	➡ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.
Develop the Workforce	➡ Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.

Opportunities	*Examples and Support for Finding*
Expand Knowledge and Practice of Effective Services	Key informants identified many practices that hold promise for improved outcomes, including: ▪ Targeted outreach and messaging for prevention ▪ Assistance with navigation and coordination for services ▪ Interventions that utilize family members and peer support ▪ Medication-assisted treatment (MAT), including walk-in clinics ▪ Trauma–informed approaches to care ▪ Cognitive behavioral therapy and related practices ▪ Best practices for working with people recovering from opioid addiction ▪ Supportive transitions through a continuum of treatment services Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Plan Framework

This section describes the components that serve as the basis for SAPTA's Strategic Plan. The vision statement gives a compelling view of the type of future that the plan seeks to create for the clients and communities being served. The mission statement clearly and succinctly describes the fundamental purpose for the plan's existence, while the concepts and values are used for all decision-making related to the plan.

Together, the mission, vision, concepts, and values guide SAPTA's philosophy for implementing its strategic plan.

Mission	The mission of this plan is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's people and communities.
Vision	Nevadans are healthy and resilient and able to fully participate in their communities.
SAMHSA's Core Concepts	Behavioral health is essential to health. Prevention works. Treatment is effective. People recover from mental and substance use disorders.

Values

Data driven decision-making. We strive to develop and use data as a primary foundation for all planning and decision-making.

Comprehensive, coordinated, and integrated services. We believe that outcomes are strengthened through community-based mental health and substance use disorder outreach, prevention, intervention, treatment, and recovery services, creating a recovery-oriented system of care that addresses people's comprehensive needs and uses evidence-based and trauma-informed care consistently.

Affordable and timely care that meets state quality assurance standards. We believe that people have a right to access care that meets state quality assurance standards and receive respectful substance abuse services in a timely manner, regardless of ability to pay.

Culturally and linguistically appropriate services. We believe that substance abuse outreach, prevention, intervention, treatment, and recovery services should be respectful of and responsive to cultural and linguistic needs, as established by the culturally and linguistically appropriate service (CLAS) standards developed by the U.S. Department of Health and Human Services. We embrace principles of equal access and non-discriminatory practices in service delivery. We strive to incorporate cultural and linguistic competence into policy making, infrastructure, and practice.

Well-trained and incentivized workforce sufficient to meet community needs. We believe that an educated, trained, and appropriately compensated workforce can provide the best care for the people of Nevada. Additionally, we recognize that there must be enough providers to meet community needs.

Accountable to the people who are served, local communities, and the public. We include opportunities for public engagement in planning and decision-making and promote access to information through transparency in all processes.

Critical Issues and Goals

This section outlines the critical issues and the corresponding goals established by the Steering Committee and the public.

Based on the evidence presented in the situational analysis, the Steering Committee, webinar participants, and Town Hall participants established five critical issues and developed goals to address each one.

Critical Issue #1: *State Capacity*

A critical issue is the state's capacity to assess need, manage available resources, report on utilization and outcomes, and comply with federal regulations and federal grant requirements. This issue contributes to lack of integration as specified in statute and has the potential to impact much-needed funding. The capacity gap includes the need for state-level subject matter expertise, knowledge capture, and the transfer of institutional knowledge.

Goal #1:

Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.

Critical Issue #2: *Service Gaps*

A critical issue is the gap in services needed for prevention, outreach, intervention, treatment, and recovery in Nevada, including (but not limited to):

a. Lack of wraparound services

b. Lack of person-centered planning and recovery supports

c. Services for adolescents

d. Services to address needs in justice systems

Goal #2:

Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.

Critical Issue #3: *Strong, Sustainable Resources for Evidence-Based and Integrated Approaches*

A critical issue is the need to sustain and strengthen evidence-based practices and promote a competent workforce to implement evidence-based practices. Promote cross-system, integrated approaches, and cross-agency initiatives.

Goal #3:

Sustain and strengthen evidence-based practices and promote a competent workforce.

Critical Issue #4: *Public Education and Information*

A critical issue is insufficient public education and information that addresses stigma and promotes the availability of resources to allow for better navigation of the system.

Goal #4:

Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.

Critical Issue #5: *Fragmented Systems*

A critical issue is the lack of consistent eligibility assessment and referral within the state and community-based service delivery system that creates silos and obstacles for an effective system of referral and care for people needing treatment and recovery.

Goal #5:

Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.

Goals, Objectives, and Strategies

This section presents each goal and its subsequent objectives and strategies for completion that were articulated as a result of the priorities set by the Steering Committee and the public. Note that strategies may need to be modified during the life of the plan to best address current situations.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 1.1: By August 30, 2018, attain compliance with federal and state regulations.	1.1.1 Ensure Nevada is fully compliant with all federal mandates designated in the Code of Federal Regulations as well as substance abuse federal block grants (SABG). • Comply with federal law for content of SAPT Block Grant application by August 2017 • Comply with federal law for eligibility for SAPT Block Grant funding by August 2018	Ongoing	Bureau staff with technical assistance.
	1.1.2 Complete a statewide needs assessment that meets all state and federal standards.	Every other year	Bureau staff to lead; suggest building on Situational Analysis document with additional data (See the Situational Analysis for documentation of needs as well a list of other information needed).
	1.1.3 Develop and implement a quality assurance system to ensure compliance with federal and state regulations.	Ongoing	Bureau staff, with guidance from SAMHSA technical assistance providers.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 1.2: By June 30, 2018, structure the Bureau for effective planning and administration.	1.2.1 Define the focus and purpose of the Bureau.	One time; review when there are changes to regulations	Bureau staff; consider both existing mandates as well as the emerging changes at the federal level.
	1.2.2 Clearly identify the Bureau's capabilities and essential functions via an internal assessment.	Every other year and on an "as needed" basis	Bureau staff; consider use of a TA provider to map functions, capabilities, and, recommendations.
	1.2.3 Develop and implement a plan for the recruitment and retention of qualified staff.	As determined by plan	Bureau staff, working with state HR to develop and document the plan.
	1.2.4 Review policies and statutes to strengthen prevention, outreach, intervention, treatment, and recovery systems, including a review rules of practice.	Every other year or as needed	A workgroup facilitated by Bureau staff, engaging knowledgeable experts in these areas.
	1.2.5 Develop a system to capture and transfer institutional knowledge.	Ongoing	Bureau staff. Review, update, and compile policies and practices with necessary updates. Allocate hours for keeping this information up to date, organized, and accessible.
	1.2.6 Identify any outstanding funding needs and identify plans to address them (e.g. through fiscal leveraging, new grant applications, etc.)	After completion of 1.1-1.5	Bureau staff.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 1.3: By December 31, 2018, establish practices to increase accountability and transparency in alignment with the values described in this plan.	1.3.1 Implement an integrated and streamlined approach for the collection, analysis, interpretation, and use of data. • Identify redundancies and issues within existing systems and make plans to address. • Review existing questions to ensure that high quality and useful information is being collected.	Ongoing	Bureau staff with guidance and coordination from Office of Public Health Informatics and Epidemiology (OPHIE). Any additions of 'new data' from providers should be considered with the context that multiple data-systems are already required and are cumbersome. Improving efficiency should be part of this work.
	1.3.2 Increase opportunities for public involvement and public oversight.	Ongoing; track activities each month	Use workgroups or subcommittees to address specific aspects and have these groups shape future plans.
	1.3.3 Increase transparency and improve communication by sharing accurate epidemiological information with the public and the Bureau's partners.	Ongoing; track activities each month	Continue to work with OPHIE to analyze and share data.
	1.3.4 Assure collaboration with other state agencies.	Ongoing; track activities each month	Bureau staff with technical assistance.
Objective 1.4: By March 31, 2018, develop protocols that provide for consistent affordable billing by the	1.4.1 Review billing and collection protocols for funded treatment programs.	One time and as needed	Bureau staff with technical assistance.
	1.4.2 Clarify billing and collection protocols for funded treatment programs.	Every five years or as needed	Bureau staff with technical assistance.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
funded treatment programs for the uninsured and the underinsured.	1.4.3 Publicize billing and collection protocols for funded treatment programs.	Ongoing; track activities each month	Bureau staff with technical assistance. Work with coalitions and funded treatment providers to publicize.
	1.4.4. Develop systems to enforce the requirement that funded partners meet grant assurances.	One time and as needed	Bureau staff working with other state agencies as well as with funded partners.

Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 2.1: By December 2018, reduce service gaps.	2.1.1 Leverage the coalition assessment process to identify and document local and regional service needs and gaps and potential resources to best address those gaps.	Every other year	In alignment with timing for coalition assessments.
	2.1.2 Evaluate existing strategic frameworks for planning, including the Strategic Prevention Framework and the Integrated Block Grant Planning Framework, to identify applicable aspects of these frameworks and leverage coalition knowledge and processes for specific communities.	Every five years	Bureau staff with input from coalition leadership.

Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 2.2: By December 2019, increase the capacity of local communities.	2.2.1 Determine which aspects of local infrastructure can be enhanced in order to address service gaps.	Every other year	Bureau staff to support local leadership.
	2.2.2 Distribute data to community stakeholders to inform local and regional planning.	Quarterly	Bureau staff in partnership with OPHIE and the Statewide Epidemiological Workgroup (SEW).
	2.2.3 Facilitate public and private partnerships to increase the impact of services.	Ongoing	Bureau staff working to support public and private partnerships.
	2.2.4 Establish a continuum of resources that includes Medicaid, block grant funding, and other resources to best serve the needs of each community.	One time; update only as needed	Bureau staff working together with other state partners.
	2.2.5 Use data to inform and drive policy and practice changes. For example: • Assess number of providers to treat the number of patients/clients. • Assess the number of patients with diagnosis that needs treatment. • Recommend funding and policy changes to address data issues. • Review national and regional research that can help address behavioral health needs and issues. • Identify and recommend policies to improve the state's system of care. • See Situational Analysis for additional data gaps.	Ongoing	Bureau staff working with OPHIE, SEW, and in communication with local leaders.
	2.2.6 Encourage and support Medicaid to provide sufficient technical assistance to providers.	Ongoing	Bureau staff working together with other state partners.

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Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
	2.2.7 Create a training and technical assistance system that is community-driven. Identify the training and technical assistance needs of providers to address the specific needs of their service populations. (Related to 2.3.3)	Ongoing	Bureau staff working together with other state partners and local leaders to design, implement and maintain a strategic and responsive system for TA.

Goal #3: Sustain and strengthen evidence-based practices and promote a competent workforce.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 3.1: By December 2018, increase the use of evidence-based practices.	3.1.1 Utilize the agency certification process to embed evidence-based practices in service provision.	One-time to set up; review annually	Bureau staff.
	3.1.2 Strengthen the linkage between the agency certification process and funding allocation.	One-time to set up; review annually	Bureau staff.
	3.1.3 Utilize public-private partnerships to increase resources at the federal, state, and local levels to encourage use of evidence-based practices.	Ongoing	Bureau staff working with other state partners, as well as local leaders, to strengthen EBP.
Objective 3.2: By December 2020, increase the competency of the workforce.	3.2.1 Promote training and technical assistance opportunities, in partnership with other state and community entities.	Ongoing	Bureau staff working with other state and community entities.

Goal #3: Sustain and strengthen evidence-based practices and promote a competent workforce.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
	3.2.2 Utilize public-private partnerships to increase workforce development resources at the federal, state, and local levels. Include Nevada's system of higher education as a partner in this work. (See 2.3.5)	Ongoing	Bureau staff working with other partners, including other state and local partners. Note that placements are also needed and other partners may need to be engaged to accomplish this task.
	3.2.3 Identify common concerns and recommendations for improving credentialing, certification, and other factors related to workforce. Provide information and recommendations for consideration to credentialing and advisory boards.	Work to begin as soon as possible with preparation for 2019 legislative session	Bureau staff to support workgroup meetings and communications centered on consensus of concerns and recommendations for improvement.
	3.2.4 Engage with educational partners including higher education (Nevada System of Higher Education) and secondary education partners to create a pipeline of qualified workforce that addresses community needs.	Ongoing	Bureau staff working to engage education partners in workgroups. Note that other partners may also be needed to support placements of qualified personnel into the workforce.

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Goal #4: Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 4.1: By December 2018, improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information.	4.1.1 Provide adequate public information and education about the admission priorities and availability of treatment for all federal and state priority populations at Bureau-funded treatment programs.	Ongoing	Bureau staff working with funded partners.
	4.1.2 Require Bureau-funded providers to provide up-to-date information to 2-1-1 about access and availability of services.	Ongoing	Bureau staff working with funded partners and Nevada 2-1-1.
	4.1.3 Create linkages between state systems to ensure seamless access to information (e.g. provide 2-1-1 with HavBed to improve referral services).	Ongoing (and after completion of 4.1.2)	Bureau staff working with 2-1-1.
	4.1.4 Increase publicity and visibility for the Bureau itself, including promoting its role in funding local education efforts.	Ongoing	Bureau staff working with funded partners and other state agencies.
	4.1.5 Share up-to-date state-funded prevention, outreach, intervention, treatment, and recovery resources with other public and private entities that offer information and referral services that meet Culturally and Linguistically Appropriate Service (CLAS) Standards.	Quarterly	Bureau staff working with funded partners and other state agencies.
	4.1.6 Develop a communications plan and engage partners in sharing up-to-date messaging and information.	One time, with updates as needed	Bureau staff with technical assistance.
	4.1.7 Assure educational and informational materials meet Culturally and Linguistically Appropriate Service (CLAS) Standards.	Every five years or as needed	Bureau staff with technical assistance.

Goal #4: Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 4.2: By December 2019, improve intercommunication between the Bureau, the public, and its partners.	4.2.1 Improve public feedback mechanisms to allow the public to communicate with Bureau about service quality and service needs.	Ongoing	Bureau staff.
	4.2.2 Provide support for coalitions and other funded providers to maintain up-to-date information resources on their websites.	Ongoing	Bureau staff working with funded partners.
	4.2.3 Support local and regional communities to conduct outreach to and engage individuals and their families in recovery in accordance with the values of the plan.	Ongoing	Bureau staff working with funded partners and other state agencies.
	4.2.4 Support targeted trainings to build the public's knowledge-base in relationship to effective prevention, outreach, intervention, treatment, and recovery.	Ongoing	Bureau staff working with funded partners and other community leaders.

Goal #5: Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
Objective 5.1: By December 2018, improve access to timely and appropriate treatment and care.	5.1.1 Implement and track a quality assurance system, including capacity management and waitlist.	One-time to establish system; ongoing	Bureau staff with technical assistance.

Goal #5: Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.			
Objective	**Strategy**	**Timeline or Frequency**	**Responsible Parties and Potential Partners**
	5.1.2 Report annually on quality assurance system, including capacity management and waitlist, specifically addressing priority populations.	Annually and as needed	Bureau staff.
	5.1.3 Incorporate consumer and community voices into planning, implementation, and evaluation of services.	Ongoing	Bureau staff with technical assistance.
	5.1.4 Support and facilitate screening and referral for substance use and co-occurring disorders within the Bureau's network and develop partnerships outside of the network for referrals.	Ongoing	Bureau staff working with funded partners as well as non-funded providers.
Objective 5.2: By December 2018, increase collaboration among funded providers.	5.2.1 Require funded programs to demonstrate participation and engagement in local collaborative partnerships.	Ongoing	Bureau staff working with funded partners.
	5.2.2 Encourage certified programs to participate and engage in local collaborative partnerships.	Ongoing	Bureau staff working with non-funded partners through the certification process.

Management and Evaluation of the Plan

This Strategic Plan was developed to drive change within the Bureau while simultaneously offering flexible strategies to create adaptability and ensure goal fulfillment. The plan may also be used to inform SAPTA's annual budget.

The plan will be reviewed annually by the Behavioral Health Planning and Advisory Council (BHPAC) or its successor and the Bureau to evaluate progress towards completion of goals, as well as the feasibility of strategies. Additionally, this annual review will be used to scan the internal and external environment for potential changes. In the case that there are considerable changes, the plan will be updated to reflect changes and adapt accordingly.

Additionally, it is important to review data as part of updating the plan. Trends in the situational analysis can be updated annually, and new data elements are likely to be available through system improvements. Monitoring community needs and resources is critical for ensuring the plan remains relevant and for meeting federal requirements for a comprehensive needs assessment.

Updates on progress and changes to the plan resulting from these annual reviews will be communicated to the public via the Bureau of Behavioral Health, Wellness and Prevention page on the DPBH website.

If you have any feedback on this plan or would like to offer suggestions or improvements, please email: Julia Peek, Deputy Administrator at jpeek@health.nv.gov or Kyle Devine, Bureau Chief at kdevine@health.nv.gov.

Glossary of Terms

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

CFR: Code of Federal Regulations.

Charitable Choice: Provisions of the SAMHSA Charitable Choice regulations are designed to strengthen the capacity of faith-based and other neighborhood organizations to deliver services effectively to those in need and provide people with a choice of SAMHSA-supported substance use prevention and treatment programs. Provisions also ensure that funding administered by SAMHSA is accomplished without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries.

Co-Occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. Substance use disorder. A substance use disorder includes. Alcohol or drug abuse (Behavioral Health Evolution, n.d.).

DPBH: Division of Public and Behavioral Health

Evidence-Based Practice: A working definition for evidence-based practices has been included from SAMHSA and meets the following criteria:

- The intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP) OR
- The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal OR
- The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed. These guidelines require interventions to be:
    - ✓ Based on a theory of change that is documented in a clear logic or conceptual mode AND
    - ✓ Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals AND
    - ✓ Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects AND
    - ✓ Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

FST: Focused Strategic Thinking. Method of strategic planning employed to create this plan.

NRS: Nevada Revised Statutes

NAC: Nevada Administrative Code

OPHIE: Office of Public Health Informatics and Epidemiology

Person-and Family-centered Planning: According to SAMHSA, "Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible."

Recovery: SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-

based clinical treatment and recovery support services for all populations. SAMHSA has delineated four major dimensions that support a life in recovery:

> Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
>
> Home—having a stable and safe place to live
>
> Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
>
> Community—having relationships and social networks that provide support, friendship, love, and hope

Recovery-Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada's Substance Abuse and Treatment Agency.

Serious Mental Illness (SMI): Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment. In 2014, there were an estimated 9.8 million adults (4.1%) ages 18 and up with a serious mental illness in the past year. People with serious mental illness are more likely to be unemployed, arrested, and/or face inadequate housing compared to those without mental illness (Substance Abuse and Mental Health Services Administration., 2015).

Serious Emotional Disturbance (SED): Serious emotional disturbance. The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional

impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A Centers for Disease Control and Prevention (CDC) review of population-level information found that estimates of the number of children with a mental disorder range from 13 to 20%, but current national surveys do not have an indicator of SED (Substance Abuse and Mental Health Services Administration., 2015).

Substance Use Disorder (SUD): The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. (Substance Abuse and Mental Health Services Administration., 2015).

SPF: "SAMHSA's Strategic Prevention Framework (SPF) is a planning process for preventing substance use and misuse. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and involves community members in all stages of the planning process" (Substance Abuse and Mental Health Services Administration, 2016).

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015).

Trauma-Informed Approach: According to SAMHSA, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015).

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2017 Situational Analysis

Substance Abuse and Prevention Treatment Agency, Bureau of Behavioral Health, Wellness and Prevention

Nevada Division of Public and Behavioral Health

April 2017

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Report compiled by Social Entrepreneurs Inc. for the Division of Public and Behavioral Health

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Acknowledgements

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Introduction and Purpose

In January 2017, the Division of Public and Behavioral Health Behavioral (DPBH) embarked upon a strategic planning process for the Substance Abuse Prevention and Treatment Agency (SAPTA), now contained within the Bureau of Behavioral Health, Wellness and Prevention. This process is guided by a Steering Committee consisting of key community and state government stakeholders.

SAPTA's mission has been to reduce the negative impact of substance abuse in Nevada. DPBH is currently revising its mission, vision, and will develop goals to guide its work over the next three years, which will also guide SAPTA as part of the Bureau of Behavioral Health, Wellness and Prevention. While SAPTA does not provide direct substance abuse service delivery, it does serve in an administrative role, planning, funding, and coordinating statewide efforts and providing technical assistance when necessary.

The Nevada Division of Public and Behavioral Health is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of DPBH, the Bureau administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant (referred to as SABG by SAMHSA and SAPT by DPBH) (Nevada Division of Public and Behavioral Health (DPBH), n.d.). Note that "prevention and treatment" is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery.

The Bureau must comply with certain federal requirements in order to qualify for funding. The 2018-2019 Substance Abuse Prevention and Treatment Block Grant (SABG) application draft states that "states should identify and analyze the strengths, needs, and priorities of the state's behavioral health system." This analysis "should take into account specific populations that are the current focus of the block grants, the changing health care environment, and SAMHSA's Strategic Initiatives" (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration). Furthermore, Nevada Revised Statutes (NRS 458.025) require an assessment of the state's needs related to prevention and treatment, an assessment of professional needs for those involved in the field, and a "plan for the development and distribution of services throughout [Nevada]." Thus, in undertaking the required strategic planning process, the Bureau must first assess its internal and external environment to ensure planning is informed and relevant to the current situation.

In order to create this multifaceted understanding of the Bureau's current situation, based on these state and federal guidelines, complementary research and outreach was completed. The approach included analysis of existing state data regarding abuse incidence, prevalence, and outcomes; key informant interviews; and a review of state services systems and capacity to identify needs and gaps.

The following situational analysis summarizes the key findings of that outreach and research. Additionally, it details the methods of research; provides a description of services, systems, and capacity; identifies needs and gaps in the system; and finally, establishes potential priorities for consideration during strategic planning.

Summary of Findings

Overview

Nevada's population is growing and much of the data available indicates that more resources and better outcomes are needed for prevention and treatment of substance misuse. The current system of care appears overly reliant on emergency rooms and criminal justice settings to identify and engage individuals with substance and mental health needs. According to many key informant interviews, wait lists for services are long. Additionally, uncertainty about the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives.

Nevada's identified issues align well with SAMHSA's strategic initiatives. Several highlights are provided below, followed by a summary of what is working, needs and issues, emerging issues, and opportunities identified through the situational analysis.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

- **Focus on high risk populations.** Key informants identified subpopulations that may have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

- **Integrate behavioral health with health promotion and health care delivery.** Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the situational analysis suggests that stronger support for people with co-occurring disorders should be a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

- **Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.** Data from the situational analysis suggests considerable gains are possible through attention to trauma. The state is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. Work through local corrections (jails) and hospitals is an important short-term strategy to address the current situation. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, 'upstream' prevention efforts, for example focusing on

reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

- **Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience.** Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services—such as residential treatment—were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

- **Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT).** Nevada has made many advancements in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between state and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

- **Support active strategies to strengthen and expand the behavioral health workforce.** Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the state to address issues of reimbursement and payment for providers.

What's Working Well	
	Examples and Support for Finding
Improvements to Nevada's Behavioral Health System	Nevada has successfully applied for a number of grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard-to-reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities.
Substance Misuse Decreasing for Many Substances and Populations	Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for claims that are denied by Medicaid.
State-level Improvements	Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges	
	Examples and Support for Finding
System Challenges	➢ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps. ➢ Services aren't well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer. ➢ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area. ➢ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state. ➢ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration. ➢ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others. ➢ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.
Substance Misuse Is	➢ Rates of substance misuse including dependency are higher among many

Issues and Challenges	
	Examples and Support for Finding
Elevated for Many Substances and Populations	populations within Nevada compared to the nation. ➡ Survey data shows that many people needing treatment do not get the care they need. ➡ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➡ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
Workforce Shortages	➡ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➡ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➡ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➡ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➡ More outreach and services are needed in languages other than English and that are culturally competent. ➡ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➡ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.
Service Gaps	➡ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery.

Issues and Challenges	
	Examples and Support for Finding
	➢ Insurance requirements can create problems with continuity of care and individualization of care. ➢ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	➢ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation. ➢ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc. ➢ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations. ➢ For funded providers throughout the state, enhanced two-way communication with the state would support data, evaluation, reporting, and funding.

Threats and Emerging Issues	
	Examples and Support for Finding
Policy Changes	➢ The ACA has contributed many improvements to Nevada's system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➢ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	➢ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➢ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➢ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	➢ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➢ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities	
	Examples and Support for Finding
Engage in Effective Planning	➢ Many states are innovating, including Nevada. Nevada can learn from other states' efforts to improve policies, systems, and practices toward improved behavioral health outcomes. ➢ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada's planning efforts. ➢ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.
Build Sustainability	➢ Outreach indicated a willingness by providers to work with limited

Opportunities	
	Examples and Support for Finding
	resources and collaborate to better serve communities. The state can help to increase this capacity by enhancing transparency related to funding that would allow for a clearer picture of the funding available and the identification of effective collaborations. ➡ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➡ The work of other planning processes, for example Olmstead Planning and *Nevada's No Wrong Door,* can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
Enhance Communication, Relationships, and Collaboration	➡ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➡ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➡ There are many opportunities for the state to work more closely and collaboratively within communities. ➡ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
Regional and Local Control	➡ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.
Develop the Workforce	➡ Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better

Opportunities	
	Examples and Support for Finding
	programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.
Expand Knowledge and Practice of Effective Services	➢ Key informants identified many practices that hold promise for improved outcomes, including: ▪ Targeted outreach and messaging for prevention ▪ Assistance with navigation and coordination for services ▪ Interventions that utilize family members and peer support ▪ Medication-assisted treatment (MAT), including walk-in clinics ▪ Trauma–informed approaches to care ▪ Cognitive behavioral therapy and related practices ▪ Best practices for working with people recovering from opioid addiction ▪ Supportive transitions through a continuum of treatment services ➢ Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Methods and Limitations

Methods

Both quantitative and qualitative data were used to develop the situational analysis. Data from multiple sources, including data systems, reports, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps. These sources are cited throughout the document can be found in the Appendix. In addition, SEI interviewed stakeholders across the state to help identify and clarify the most important assets and issues related substance abuse prevention, outreach, intervention, treatment, and recovery.

The following table, Table 1, summarizes research and outreach components. These elements were based on Substance Abuse Prevention Block Grant (SABG) 2018-2019 Draft Application Requirements, the Ryan White HIV/AIDS Part B regulations, Nevada Revised Statutes and Nevada Administrative Code, as well as the Bureau's expressed desire to align with the Mental Health and Substance Abuse and Prevention Objectives from the National Healthy People 2020 initiative.

Table 1: Elements for Inquiry

Element for Inquiry	*Data Request*	*Key Informant*
Nevada's Services and Systems		
State Partners		
Provider collaboration and partnerships regarding health information systems, electronic health records and effective and efficient service systems	X	X
Provider collaboration between primary, specialty, emergency and rehabilitative care, and behavioral health providers	X	X
Participation in and state support of provider networks	X	X
Types of providers and their certifications	X	X
Primary Prevention Strategies		
Evidence-based and cost-effective prevention programs, policies and practices: a. Tobacco use prevention and tobacco-free facilities b. Alcohol and under-age drinking c. Drug Use	X	X
Prevention efforts that target: a. Youth and adolescents b. Harder to reach minority communities, including racial/ethnic minorities and people that are LGBTQ c. Other populations	X	X
Prevention efforts that engage schools, workplaces and communities	X	X
Changes in perceptions of risk related to substance use and abuse	X	
Prevention program outcomes or assessment activities	X	X
Treatment and Recovery Activities		
Treatment activities for the general population including adults, adolescents and children	X	
Treatment activities for populations designated by the SABG, including: a. Pregnant women and women with dependent children b. Persons who inject drugs c. People with tuberculosis and HIV/AIDS	X	X
Treatment activities for targeted services to other specific populations:	X	X

Element for Inquiry	*Data Request*	*Key Informant*
a. People that are homeless b. Older adults c. People that are LGBTQ d. Adults with co-occurring mental illness and substance use disorders		
The use of wait lists and, if available, duration of wait, especially for priority populations	X	X
The use of person-centered planning, self-direction, and participant directed care	X	X
Recovery services	X	X
Nevada's Behavioral Health System		
Other potential components of Nevada's Behavioral Health System that overlap with substance abuse and prevention	X	X
Statewide Needs and Gaps		
Trends in alcohol and drug use and alcohol and drug-related deaths amongst general and priority populations	X	
Services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for the general population including adults, adolescents, and children	X	X
Services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for populations identified by the SABG, including: a. Pregnant women and women with dependent children b. Persons who inject drugs c. People with tuberculosis and HIV/AIDS	X	X
If available, services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for targeted services to other specific populations: a. People that are homeless b. Older adults c. People that are LGBTQ d. Adults with co-occurring serious mental illness and substance use disorders	X	X
Service Systems and Capacity		
State and provider capacity to provide evidence-based intervention and treatments: a. Culture-specific interventions b. Trauma-informed delivery c. Interactive communications technology	X	X
Service coordination, referrals, and patient records	X	X
Charitable choice organizations, group homes,	X	
Workforce and licensing needs		X
Agency Gaps		
Statewide epidemiological data gaps	X	X
If available, comprehensive community plans to improve mental, emotional, and behavioral health outcomes	X	X
Compliance with federal and state laws regarding open meetings and transparency		X

Key Informant Interviews

A total of nine individual interviews, one shared interview, and one focus group were held with key stakeholders. Key informants were selected by the Steering Committee to represent diverse perspectives across the state.

Table 2: Key Informants

Name	Title	Organization
Malcolm Ahlo	Program Coordinator	Tobacco Control Program, Southern Nevada Health District
Sarah Beers	Training Coordinator at the Parenting Project	Parenting Project, Clark County Department of Family Services and Child Welfare
Dr. Reka Danko	Medical Director of St. Mary's Hospitalist Group Hospitalist Clinical Assistant Professor	St. Mary's Regional Medical Center University of Nevada, Reno School of Medicine
Darcy Davis, PhD	Quality Assurance Manager for Behavioral Services	Nevada Department of Corrections
Chris Empey	Program Specialist	Washoe County Social Services and member of the Nevada Children's Behavioral Health Consortium
Joann Flanagan	Alcohol and Substance Abuse Supervisor	Reno-Sparks Indian Colony
Jessica Flood	Regional Behavioral Health Coordinator	Carson Tahoe Behavioral Health Services
Sheila Leslie	Regional Behavioral Health Coordinator	Washoe County Social Services
Catherine O'Mara	Executive Director	Nevada State Medical Association
Lisa Staikoff	Community Member	Narcotics Anonymous
Multiple	Coalition Representatives	**See Table 3*

Table 3: Coalitions Focus Group Participants 2-24-17

Name	Coalition
Jennifer Delett-Snyder	Join Together Northern Nevada
Jessica Flood	Carson Tahoe Behavioral Health Services
Cheryl Bricker	Partnership of Community Resources
Kimberly Hargrove	The Children's Cabinet
Marco Erickson	Nevada Department of Education
Hannah McDonald	Partnership Carson City
Brooklyn Mow	Partnership Carson City
Kathy Bartosz	Partnership Carson City
Linda Lang	Nevada Statewide Coalition Partnership
Meg Matta	SAPTA

Name	Coalition
Wendy Madson	Healthy Communities Coalition
Karla Banda	CARE Coalition
Jennifer Lee	CARE Coalition
Vernalyn Willis	CARE Coalition
Amber Neff	Statewide Native American Coalition
Laura L. Oslund	PACE Coalition
Stacy Smith	Nye Communities Coalition
Jeffrey Munk	Frontier Community Coalition
Andrea Zeller	Churchill Community Coalition
Jamie Ross	PACT Coalition

Town Hall Meetings

Town Hall Meetings were held to share high-level findings from the situational analysis and solicit feedback. Themes from Town Hall meetings were used to enhance the situational analysis findings. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. Each meeting lasted a total of 1.5 hours. At each meeting, participants were asked to sign in and self-identify as consumers, family members, professionals in the field, policy makers, or advocates. A total of 64 participants were recorded on sign-in sheets.

Limitations

Information presented in this document was intended to inform planning. For each data source, there are limitations. Caution should be used when interpreting data from a single source, as various factors can contribute to the result. Data from multiple sources is presented when possible to provide a more complete picture of the current situation. Limitations that particularly effect the interpretation and presentation of a data set are noted within the document. These may include (but are not limited to):

- Some data are preliminary, particularly estimates for 2015.
- Some methods limit comparability of data across geography. For example, differences in consent models for the YRBS should be considered in comparing geographies as well as understanding overall rates presented.
- Reports from state data systems typically collect and compile information for a particular purpose and may not be comprehensive. For example, substance abuse information provided from state systems reflects state-funded programs and services, and not all seeking or using services across the state.
- Data that require self-reporting may include bias due to inaccurate recall, fear, or stigma related to reporting accurately, etc. A related issue is that while the actual demand for services isn't known, not all who meet the criteria for treatment services may be interested in receiving them. Experts note that strategies to reduce this treatment gap should focus not only on increasing

access to effective treatment but on reducing stigma, raising awareness, and providing appropriate screening and referrals (National Institute on Drug Abuse, n.d.).

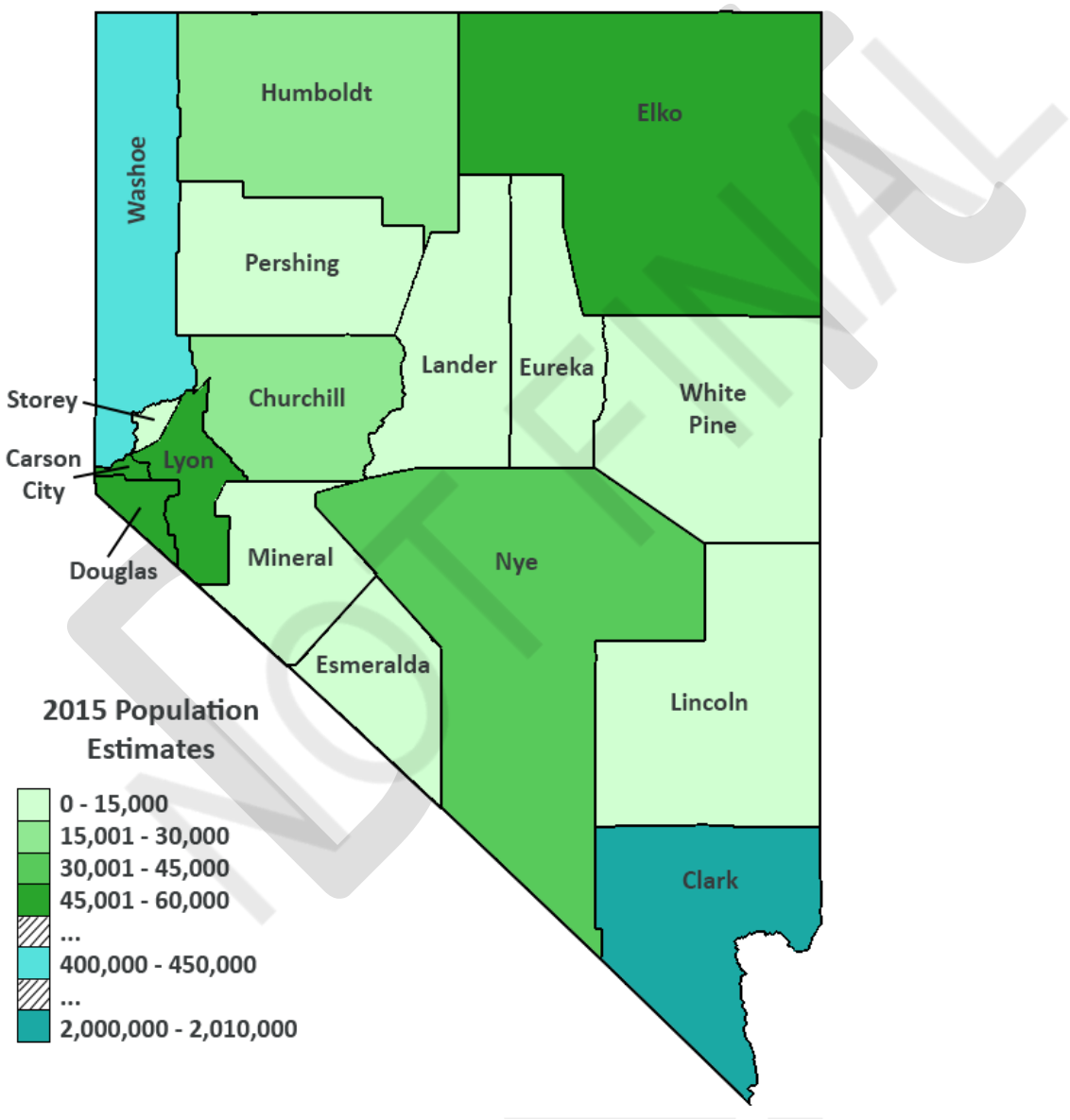
- Changes to International Classification of Diseases (ICD) codes from year to year can impact comparability through time. For example, in 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice Organization, 2017). Data sources Center for Health Information Analysis (CHIA) as well as other sources may include this limitation.
- Town Hall meetings were largely made up of professionals representing consumers, rather than by consumers and their families.
- The situational analysis is not comprehensive and does not constitute an adequate needs assessment as required by CFR 96.133. While efforts were made to compile data from many sources the following data were not available for this situational analysis:
    - Waiting list data
    - A detailed description of current prevention and treatment activities
    - Treatment capacity data
    - Incidence and prevalence data as they relate to:
        - Pregnant women with substance use disorder
        - Women with substance use disorder who have dependent children
        - Intravenous drug users
        - People with substance use disorders who have HIV or tuberculosis
    - Prevention activities by strategy
    - The availability of prevention and treatment activities, with special attention to the following groups:
        - Pregnant women with substance use disorder
        - Women with substance use disorder who have dependent children
        - Intravenous drug users
        - People with substance use disorders who have HIV or tuberculosis
    - A description of the populations at risk of becoming substance abusers

  Addressing these data gaps has been identified as a priority within the current strategic plan.

Nevada's Population

In 2015, Nevada's population was just below 2.8 million (U.S. Census Bureau, 2015). Nevada has experienced considerable growth in recent years, second only to Utah during the period from July 1, 2015 to July 1, 2016. Nevada's State Demographer noted that it may be possible to reach 3 million people by 2017 (Brean, 2016). Nevada's population has grown through migration and births. On average, there are 35,654 live births per year in Nevada (Divsion of Public and Behavioral Health, State of Nevada, 2016).

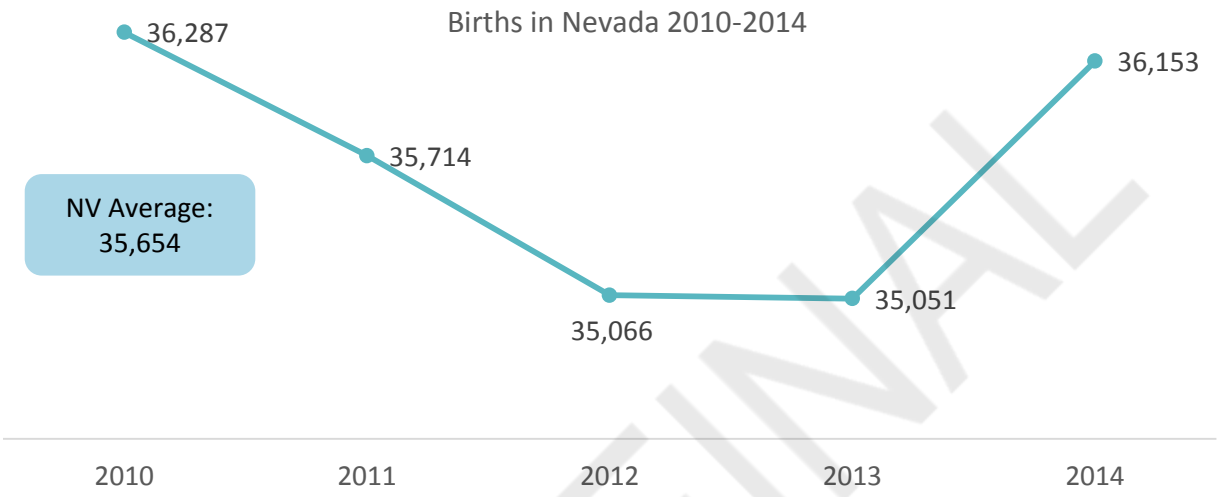
Figure 1: 2015 Population by County



Source: The above map used the most recent population estimates from the American Community Survey (ACS) 1-Year Estimates for 2015.

Births in Nevada averaged 35,654 between 2010 and 2014. Of these 74% took place in Clark County, 15% in Washoe County, and 11% in the balance of the state.

Figure 2: Births in Nevada



Source: (Office of Public Health Informatics and Epidemiology)

Children and youth make up a large portion of the state's population, with people 19 and under comprising 26% of the population. Adults ages 19-64 make up 60% of the population, and older adults age 65 and above make up 14% of the population in 2015 (U.S. Census Bureau, 2015).

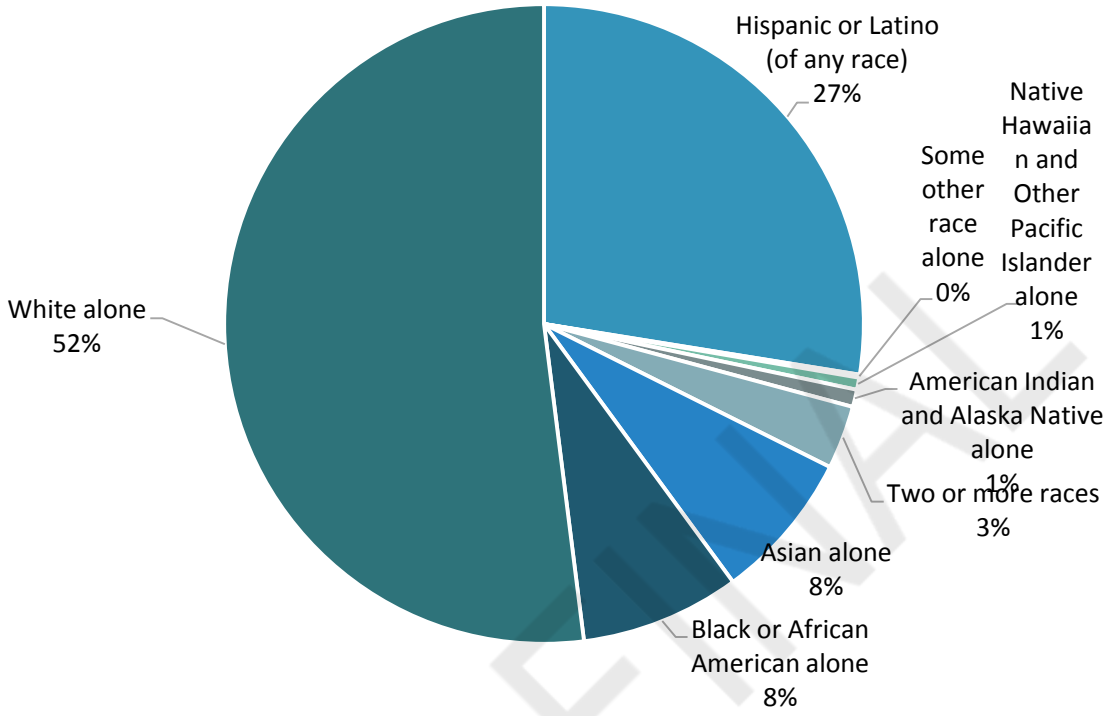
Table 4: Population by Age

Total Population by Age	Number	Percentage
<19	726,719	26%
19-65	1,691,211	60%
65+	380,706	14%
Total	**2,798,636**	100%

Source: (U.S. Census Bureau, 2015)

Nevada's population is also racially and ethnically diverse. People that are 'white alone' make up just over half of the state's population, and people that are Hispanic or Latino of any race make up 27% of the population.

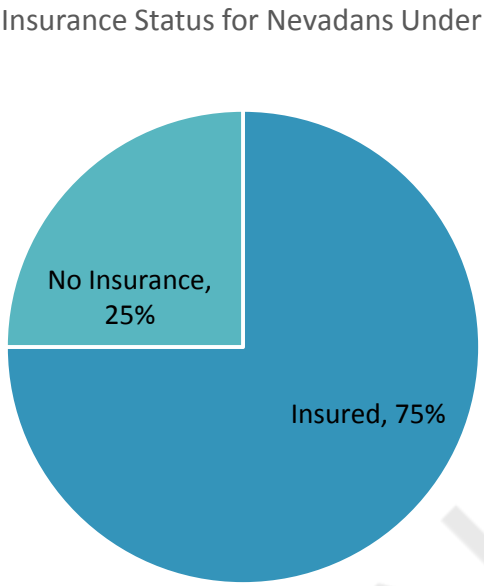
Figure 3: Race and Ethnicity of Nevada's Population



Source: (U.S. Census Bureau, 2015)

Insurance is important for people who need care. According to the 2015 *Nevada Health Gaps* report, 25% of people under 65 are uninsured, with county ranges from 22-32% (Robert Wood Johnson Foundation, 2017).

Figure 4: Nevadans with Health Insurance



Source: (Robert Wood Johnson Foundation, 2017)

The number of people who were uninsured decreased in recent years, largely due to the Affordable Care Act. In 2016, a total of 631,843 people had Medicaid as their insurance. This represents nearly double the population insured in 2013, prior to statewide Medicaid expansion (Division of Public and Behavioral Health, 2016).

Table 5: Medicaid in Nevada

Nevada Medicaid Population Demographics (June 2016)		
	#	%
North	83,324	13.2%
South	485,251	76.8%
Rural	63,268	10.0%
Total	631,843	

Source: (Division of Public and Behavioral Health, 2016)

Other Important Subpopulations

Pregnant Women and Women with Dependent Children

While the count of pregnant women is not available, 36,000 births per year provide an estimate of pregnancies. Women with dependent children can be estimated both in terms of the number of total families with children under the age of 18, as well as female headed households with no spouse in the home. Of 1,016,709 households in Nevada (2011-2015 average), 293,110 were households with their own children under age 18, and 75,400 were female headed households with no husband present and with children under 18 years (U.S. Census Bureau, 2016).

Adverse Childhood Experiences

While the estimated rates of substance use are discussed later in this document, the situations that contribute to negative behavioral health outcomes are discussed here. Adverse childhood experiences, or, "ACEs" have been associated with problems later in life, including substance use disorder and mental illness. In Nevada, it is estimated that 40% of children aged birth to 17 experienced one or two ACEs, and 13% experienced three or more. ACEs in Nevada were compared to the national average where 54% experienced no ACES, 35% one to two, and 11% three or more. This information points to the probability that Nevada's need for behavioral health care will be higher than the national average (Sacks, Murphey, & Moore, 2014). ACEs also point to the opportunity to create 'upstream' prevention strategies through work with children and their families.

Table 6: ACEs among Nevadans

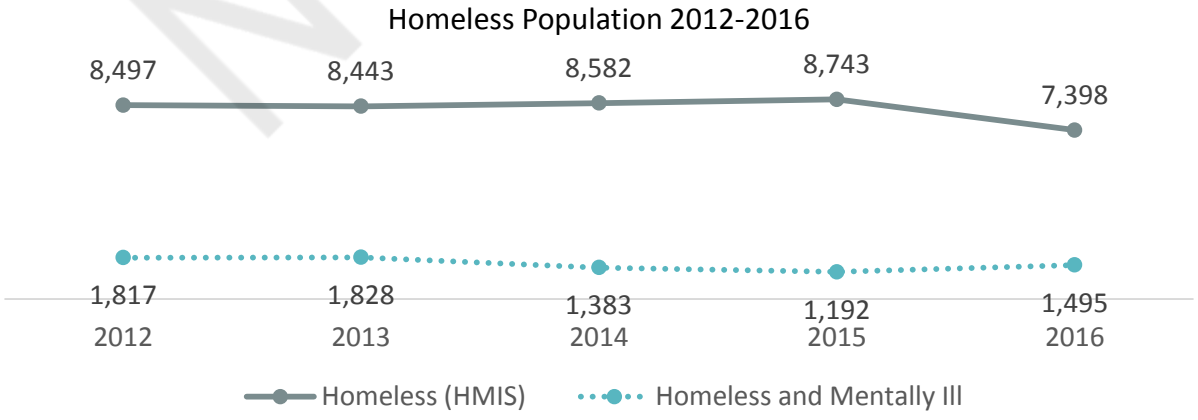
Total Population by Age	No (0) ACES	1-2 ACES	3+ ACES
Nevada	47%	40%	13%
U.S.	54%	35%	11%

Source: (Sacks, Murphey, & Moore, 2014)

People that are Homeless

Nevada's Homeless Information Management System (HMIS) tracks information about the number of people that are homeless including special circumstances and conditions. While counts may have some limitations, the overall trends and percentages of people that are mentally ill and also homeless provide a starting point for understanding needs and planning appropriate services. For some, untreated mental illness and substance misuse can be a cause of homelessness, and continued lack of treatment along with homelessness can exacerbate the situation. Between January and December 2016, there were 17,827 unduplicated clients, 5,020 of whom reported having a mental health condition upon entry to the program or services. This includes clients in emergency shelter, transitional housing, permanent supportive housing, safe havens, other permanent housing projects, and rapid re-housing projects across Nevada (BitFocus Datasystem, 2017).

Figure 5: Annual "Point in Time Count" of People who are Homeless (shows trends through time but counts are only a portion of people who are homeless)

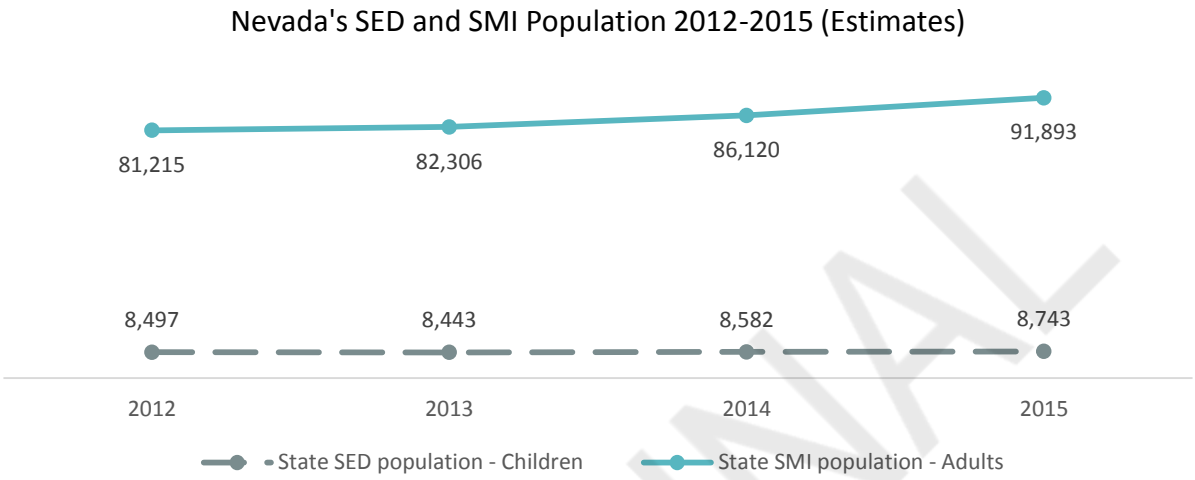


Source: (Office of Public Healh Informatics and Epidemiology)

People with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI)

Early intervention for people with serious mental illness offers an important opportunity for harm reduction. Additionally, substance abuse often co-occurs with mental illness. The number of people with SED and SMI is estimated for Nevada based on population and prevalence rates.

Figure 6: Estimates of SED and SMI

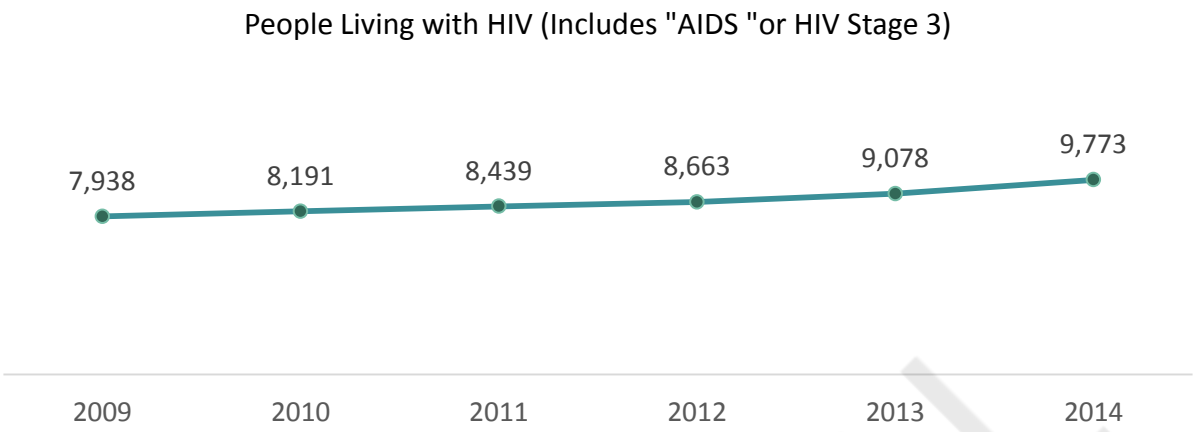


Source: (Office of Public Health Informatics and Epidemiology)

People with HIV/AIDS

The Substance Abuse Prevention and Treatment Block Grant (SABG) program includes provisions for public health services, i.e., tuberculosis services and early intervention services for HIV. Services through the block grant are not intended to be comprehensive but rather "the minimum needed to encourage a substantial number of substance abusers to learn of their HIV infection, educate them in ways to avoid transmission of HIV to others, and maintain their health" (SAMHSA). Data on HIV, which includes AIDS, shows that the rate of people with HIV has increased over time. There are several factors that contribute to this, including continued transmission and people who have been diagnosed with HIV living longer.

Figure 7: HIV and AIDS in Nevada

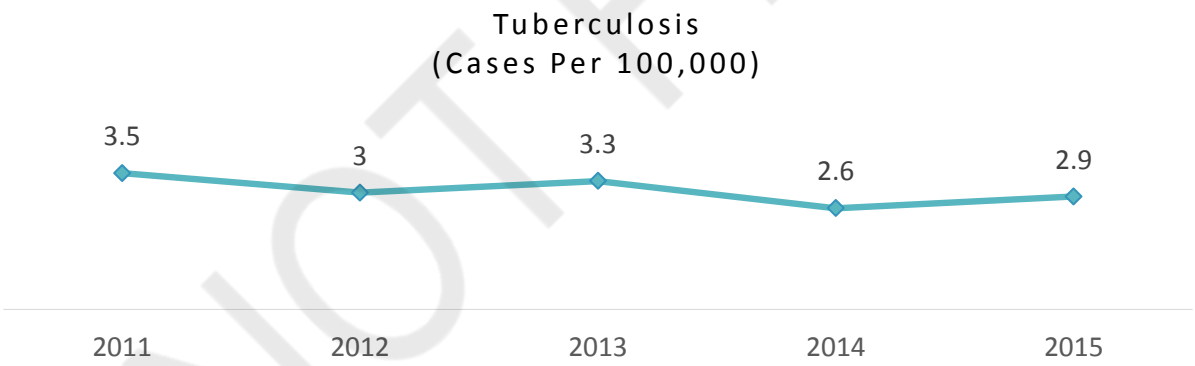


Source: (Division of Public and Behavioral Health)

People with Tuberculosis

The Substance Abuse Prevention and Treatment Block Grant (SABG) program includes provisions for public health services, i.e. tuberculosis services (SAMHSA). Nevada's rate of tuberculosis within the population was 2.9 per 100,000 in 2015. This rate has improved in recent years (Feng, 2016).

Figure 8: Tuberculosis Rate



Source: (Feng, 2016)

People with Co-Occurring Disorders

The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders (previously referred to as dual diagnoses). In 2014, approximately 7.9 million adults in the United States had co-occurring disorders (SAMHSA, n.d.). Specific data for Nevada are not available, in part because co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. Often people receive treatment for one disorder while the other disorder remains untreated. Integrated treatment is helpful for people with co-occurring disorders (SAMHSA, n.d.). Diagnosis and treatment of co-occurring disorders was low in Nevada compared to the national rate, suggesting an opportunity to better diagnose and treat people that experience both mental illness

and substance use disorder (SAMHSA). A lack of clarity around how best to diagnose, refer and treat people with co-occurring disorders was identified as a gap within the state. Nationally, nearly one in for adults with serious mental illness also experienced a substance us disorder in the previous year (23.3%, 2014) (Center for Behavioral Health Statistics and Quality, 2015).

People with Involvement with Criminal and Juvenile Justice

In Nevada, the prison population in 2016 was 13,286, of which 5,858 were white; 3,887 black; 2,793 Hispanic; 365 Asian; and other races and ethnicities represented by smaller numbers (Robison, 2016). People who come in contact with law enforcement and the criminal or juvenile justice systems are likely to have a mental and/or substance use disorder. Nationally, SAMHSA states that "according to a 2006 Bureau of Justice Statistics report, approximately 74% of state prisoners, 63% of federal prisoners and 76% of jail inmates met the criteria for a mental health disorder. An estimated 42% of state prisoners and 49% of jail inmates met the criteria for both a mental health and substance use disorder. Studies have found that for youth in the juvenile justice system, 50% to 70% met criteria for a mental disorder and 60% met criteria for a substance use disorder. Of those youth with co-occurring mental and substance use issues, almost 30% experienced severe disorders that impaired their ability to function" (SAMHSA, 2016).

Persons Who Inject Drugs

While not available for the whole population, demographics are available by service type where an individual was classified as an intravenous drug user. The years provided are from 2010 to 2014 due to a few providers transitioning to their own Electronic Health Records (EHRs) during 2015, so this time period would be more representative of the state-funded providers. Note that data is for admissions and so an individual may appear multiple times during one year (may include duplicates). Slight increases are observed between 2010 and 2014.

Table 7: IV Drug Use by Service Type

Service Type	2010	2011	2012	2013	2014
Detoxification, 24-hour service, Free-Standing Residential	684	753	729	714	797
Residential Treatment, Short-Term	498	620	618	620	484
Residential Treatment, Long-Term	0	0	0	0	6
Intensive Outpatient	280	324	373	325	303
Outpatient	781	747	954	845	794

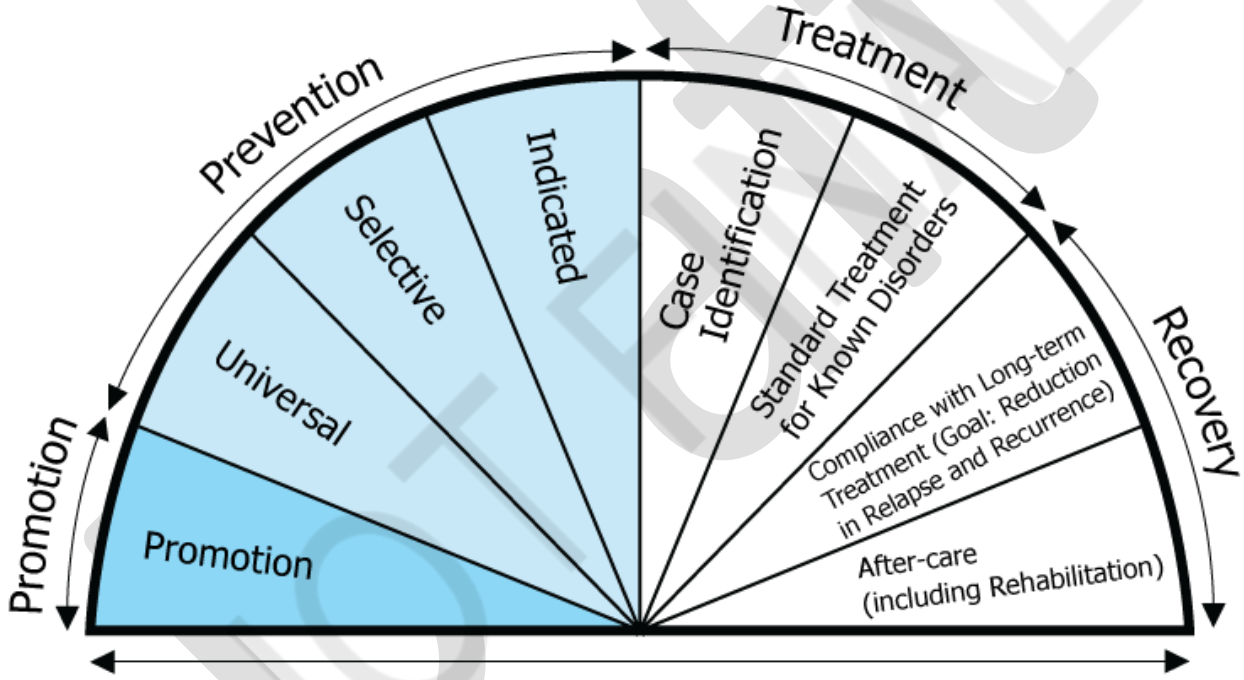
Source: (Office of Public Health Informatics and Epidemiology (OPHIE))

Nevada's Services and Systems

Nevada's Substance Abuse, Prevention and Treatment Agency (SAPTA) is a component of the Behavioral Health, Wellness and Prevention Bureau within the Division of Public and Behavioral Health (DPBH). The executive team that leads DPBH is comprised of the Administrator, Chief Medical Officer, Medical Epidemiologist, and State Epidemiologist (Department of Health and Human Services, 2016).

SAPTA works with partners across the state to fulfill its mission and mandates. The Substance Abuse Block Grant (SABG) under the Substance Abuse and Mental Health Services Administration (SAMHSA) helps states to plan, implement, and evaluate activities that prevent and treat substance abuse.

Figure 9. SAMHSA Continuum of Promotion, Prevention, Treatment, and Recovery



The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant serves as a foundation for Nevada's substance abuse outreach, prevention, intervention, treatment, and recovery system. The grant is allotted to states by a formula based on the overall level set by Congress each year. The allotments for the SAPT Block Grant for Nevada are included below (National Association of State Alcohol and Drug Abuse Directors, Inc., 2016):

- FY 2013: $13,015,618
- FY 2014: $16,462,188
- FY 2015: $16,698,170
- FY 2016: $16,890,047

Nevada's Workforce

The state's workforce that helps to treat and prevent substance abuse has changed in recent years. A 2015 rural health report states that in 2014, "there were 1,227 licensed alcohol, drug, and gambling counselors in Nevada, including 158 licensed alcohol, drug, and gambling counselors in rural and frontier counties – since 2004, the number of licensed alcohol, drug, and gambling counselors in Nevada has decreased by 6 or -0.5% and the per capita number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 43.4 per 100,000 population" (Nevada State Office of Rural Health, 2015).

Additionally, in a 2016 report, DPBH noted that "despite unprecedented access to healthcare coverage in Nevada, the infrastructure of the system of care to improve access to high-quality care is still evolving and remains heavily dependent on high-cost services provided by emergency rooms (ER) and inpatient psychiatric hospitalizations. Meanwhile, community-based treatment and recovery services remain uncoordinated with physical health services and difficult to access due to significant workforce shortages and lack of providers offering a continuum of care options ranging from crisis services to assertive community treatment and peer services" (Division of Public and Behavioral Health, 2016).

Provider shortages are a persistent challenge in Nevada, especially in rural and frontier areas. All people (100%) living in rural and frontier areas are in Health Provider Shortage Areas (HPSAs). In urban areas, this falls to 48%. For the state overall, 38% of the population live in behavioral health shortage areas (State of Nevada, 2016).

Table 8: HPSAs in Nevada

Region Type	Primary Medical	Behavioral Health
Rural and Frontier		
% of Population in HPSAs	50.6%	100%
Number in HPSAs	40	39
Urban		
% of Population in HPSAs	31.8%	48.1%
Number in HPSAs	31	22
State		
% of Population in HPSAs	33.7%	38.1%
Number in HPSAs	71	61

Source: (State of Nevada, 2016). *For primary care the population to provider ratios must be at least 3,500 to 1 (3,000 to 1 if there are usually high needs: For mental health care, it must be 30,000 to 1 (20,000 to 1 if there are unusually high needs).*

Advancements such as telemedicine hold promise for the rural and frontier areas. For example, the National Frontier and Rural Addiction Technology Transfer Center (ATTC) focusing on telehealth technology funded by SAMHSA is helping to address shortage issues in rural and frontier areas (National Frontier and Rural ATTC, n.d.).

Compensation for providers was identified as an issue among key informant interviews. Levels of compensation may not be adequate to recruit and maintain qualified staff in public systems. Reimbursement for providers through payers is another challenge for community-based providers.

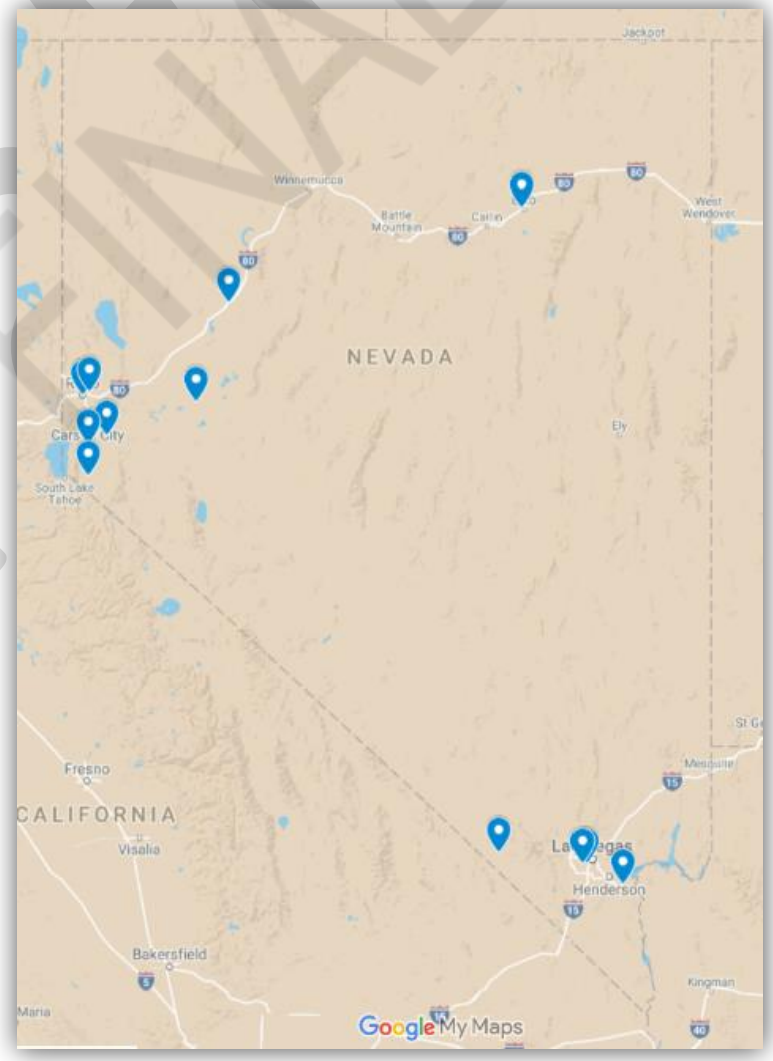
Some key informants also pointed to the lack of incentives for a workforce on the frontlines and noted the high turnover rate in the field. Other key informants identified training as challenge. One mentioned the difficulty of practicing within a limited scope of practice while helping clients with co-occurring behavioral health disorders. Another identified the lack of knowledge amongst providers and prescribers about substance use disorders.

Primary Prevention Strategies

Nevada has an established system of local prevention providers and substance abuse coalitions. They are the foundation of substance abuse prevention in Nevada. In 2014, DPBH developed operating standards to assist these providers in providing high-quality services (Nevada Division of Public and Behavioral Health, 2014). Coalitions in Nevada work to prevent substance abuse for all ages through advocacy, education, reduction of stigma, support, and outreach.

Certified Coalitions

- Statewide Coalition Partnership (Statewide)
- Care Coalition (Clark County)
- Churchill Community Coalition (Churchill County)
- Coalition Partners Allied for Community Excellence Coalition (PACE) (Elko, Eureka, White Pine Counties)
- Frontier Community Coalition (Humboldt, Lander, Pershing Counties)
- Healthy Communities Coalition (Lyon, Storey, Mineral Counties)
- Join Together Northern Nevada (Washoe County)
- Community Prevention Coalition (Rural Clark County)
- NyE Communities Coalition (Nye, Lincoln, and Esmeralda Counties)
- PACT Coalition for Safe & Drug Free Communities (Clark)
- Partnership Carson City (Carson)
- Partnership of Community Resources Coalition (Douglas County)
- Statewide Native American Coalition (Statewide)



Each coalition partners with local organizations and institutions for the purpose of prevention. Several key informant interviews identified these coalitions as great strengths within the state system.

Certified prevention programs also exist across the state providing prevention through alternative activities, environmental factors, information dissemination, education, and problem identification and referral. Prevention education is the most common service type among Nevada's certified providers. Prevention providers may target youth (preschool-elementary), adolescents, adults, and, the general public.

SAPTA also works with prevention programs across the state. In 2016, a total of 61 certified prevention programs operated in Nevada, with 51 of these funded through SAPTA. Prevention programs offer strategies such as environmental strategies, information, problem ID/Referral, Prevention Education, Alternative Activities (Nevada Division of Public and Behavioral Health (DPBH), 2016).

Certified Prevention Programs

In 2016, Nevada had more than 60 certified prevention programs working through prevention education, environmental strategies, information, problem identification and referral, and alternative activities.

Other Critical Components of Prevention

A critical component of a prevention system is an "infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences" (SAMHSA, 2016). Nevada's access to hospital data, including monthly extracts from BioSense and CHIA, provide agencies with the opportunity to understand existing and new issues. Data from youth surveys can help identify trends among youth and target information. State systems that track disease and treatment could also help identify areas and populations to focus resources as well as understand results of interventions. However, key informants indicate that data that is provided to the state or by the state is often not timely enough to fully understand the immediate needs of the community, nor to best support the argument for funding during grant-writing.

Treatment and Recovery Activities

In 2016, there were more than 100 certified treatment programs statewide. Roughly 50% accepted Medicaid. A portion (40%) received SAPTA funding. Additionally, a total of 95 certified detox technicians were available statewide (Nevada Division of Public and Behavioral Health (DPBH), 2016).

SAPTA certified treatment programs and detoxification technicians, and SAPTA funded and non-SAPTA funded programs are part of the larger behavioral health support system within Nevada.

Nevada has shifted from directly funding agencies to utilizing community-based providers for care. From this perspective, insurance type is key to peoples' identification of providers, particularly Medicaid.

Nevada's Behavioral Health System – New Components

Nevada is working to better serve people in communities who experience mental illness, substance abuse, or both. Many assets are emerging or in place. In a recent report by the Nevada Department of Health and Human Services (DHHS), many of these are noted (State of Nevada, 2016):

Paramedicine Efforts: Two community paramedicine efforts support fragile transitions from an inpatient to an outpatient setting.

Balancing Incentive Program (BIP): The Nevada 2-1-1 system, funded through the BIP program, helps connect individuals with resources and assists in navigating the health care system.

Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD): This expired grant program educated, supported, and incentivized patients to modify behavior and achieve targeted health improvement goals. Although expired, Nevada will leverage the success and lessons learned from this grant program.

Medicaid Electronic Health Record (EHR) Incentive Program: The federally funded Medicaid EHR Incentive Program assists providers with adoption and Meaningful Use (MU) of EHRs.

Certified Community Behavioral Health Clinics (CCBHCs): Nevada received a CCBHC grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), which will establish behavioral health clinics, promote integration of behavioral and physical health, as well as introduce value-based reimbursement for these clinics.

Children's Heart Center Healthy Hearts Program: This program promotes healthy lifestyles for the entire family with an emphasis on modifying behaviors, improving eating habits, increasing physical activity, and improving self-esteem.

The National Governors Association (NGA) Medicaid Transformation Project: This project implements an innovative, cost-effective approach to address the behavioral health issues in Nevada's youth population, age 11 to 18 years, and transitions the current crisis-based service system to a system of prevention and early intervention.

Project ECHO: Project ECHO increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. The project engages patients in a continuous learning system and partners them with specialist mentors at an academic medical center or hub.

Peer Support Specialists: Individuals with appropriate training who also are in recovery or have significant life-altering experiences assist other individuals' substance use or mental health disorders. Peer support services are available in the community through several private and public organizations.

Prevention Specialists: Certified prevention practitioners who stay abreast of the latest research findings employ science-validated practices, apply innovations in prevention methods, and follow industry trends in order to ensure that services are provided competently. Prevention is health

promotion - the "active, assertive process of creating conditions and/or fostering personal attributes that promote the well-being of people."

Mental Health Parity Addiction Equity Act: "The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits" (Centers for Medicare & Medicaid Services, n.d.).

Regional Behavioral Health Coordinators: In 2015, the DPBH awarded subgrants to fund a behavioral health coordinator in three regions of the State: (1) Clark County; (2) the "Quad County Region," which includes Carson City and Churchill, Douglas, and Lyon Counties; and (3) Washoe County. The DPBH is planning to issue additional grants to the Elko County area and other regions of the State. Funding is provided through the federal Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants.

CASAT: (Center for the Application of Substance Abuse Technologies), provides training, technical assistance, evaluation, research, and other services to support prevention, treatment and recovery in the alcohol and other drugs field. CASAT strives to improve substance abuse prevention and treatment services by helping states, organizations, agencies, and individuals apply evidence-based practices.

Peer Prevention Specialists: The Peer Support Specialist (PSS) is designed for those with "lived experience" who are interested in providing support, advocacy, wellness, and community engagement services to individuals. Program participants complete four university courses and time in the field where knowledge is put into practice within a behavioral health agency. This certificate provides students an opportunity to experience the professional side of the substance abuse and mental health treatment field and may be utilized as a stepping-stone for further career advancement.

School-based Social Workers: The Nevada Department of Education's Office for a Safe and Respectful Learning Environment awarded block grants in 2016 to the neediest schools to receive a minimum of 161 social workers and other mental health professionals to provide immediate support across 132 schools.

Embedded Eligibility Workers: Nevada State Welfare District Offices located throughout the state determine a person's eligibility for TANF, CHAP, and Medicaid. If applicants appear to be Nevada Check Up eligible, rather than Medicaid, they are appropriately referred. Out stationed sites (FQHCs, county hospitals, and local county health departments) help people apply for Medicaid or Nevada Check Up and send their applications and eligibility determination to the local Nevada State Welfare District Office. Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, community health and social services agencies, and schools.

Statewide Adolescent and Transitional Aged Youth Treatment Enhancement Plan: In order to develop a statewide plan, an interagency council has been established to improve the infrastructure for adolescents and transitional age youth substance use treatment and recovery. Their work towards creation of this plan includes addressing workforce training, improving data collection from all SAPTA

certified agencies, improving peer support services, increasing cultural and linguistic competence, and resolving potential payment problems resulting from insurance copays or deductibles.

Funding to Address the Opioid Epidemic: Nevada has received notice from United States Health and Human Services (HHS) that Nevada will receive a $5,663,328 grant to combat opioid addiction. The funding, which is the first of two rounds provided for the 21st Century Cures Act, will be provided through the State Targeted Response to the Opioid Crisis Grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Statewide Needs

A 2015 needs assessment of behavioral health identified consumers' barriers to accessing care through both surveys and focus groups. In the statewide survey of providers, five populations were identified as having high need for substance abuse services:

- Adolescents with substance abuse and/or mental health problems
- Parents with substance use and/or mental disorders who have dependent children
- Individuals with substance abuse disorders in rural areas
- Women who are pregnant and have a substance use and/or mental disorder
- Unaccompanied minor children and youth

Barriers Identified through Surveys: (Christiansen, 2015)

- Cost
- Lack of knowledge of resources
- Lack of transportation
- Lack of insurance coverage
- Lack of available providers
- Long wait lists
- Fear

Barriers Identified by Focus Group Participants: (Christiansen, 2015)

- Lack of knowledge of resources
- Lack of insurance coverage
- Stigma
- Fear
- Cost
- Perception that treatment wouldn't help
- Too much time to get services
- People that are undocumented are not able or willing to seek help for fear of being deported (Christiansen, 2015)

Ryan White Part B: Grants to States & Territories

"Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides grants to States and Territories to improve the quality, availability, and organization of HIV health care and support services.

Core medical services include outpatient and ambulatory health services, (Aids Drug Assistance Program or "ADAP", AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services."

One of the many issues identified is that the needs for behavioral health care cannot be met through current resources (State of Nevada, 2016). According to a recent report, "Behavioral Health Utilization has increased significantly as the numbers of individuals enrolled in Medicaid have also increased (see Figure 3). Lack of access to community-based crisis services contributes to high rates of utilization of

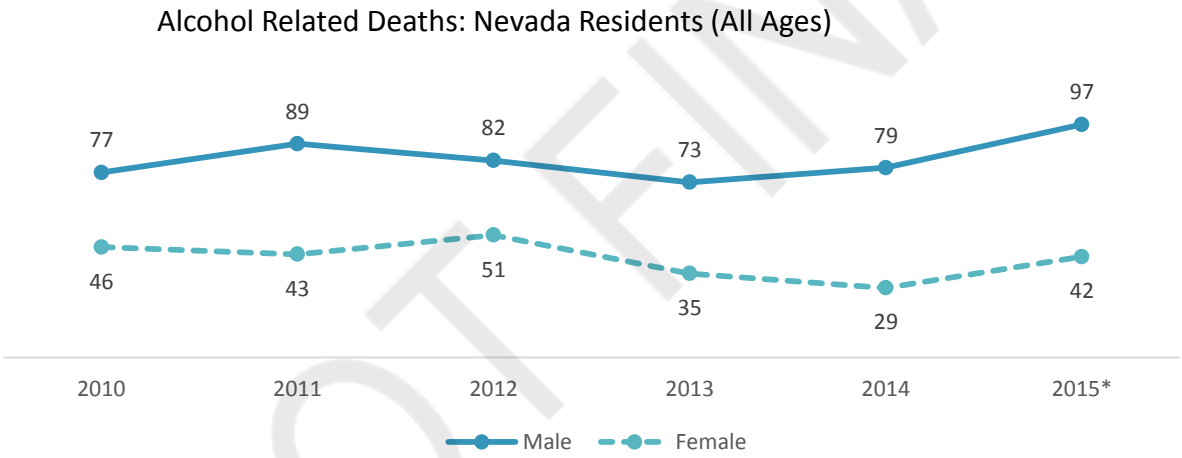
emergency room (ER) services for behavioral health needs within both fee-for-service (FFS) and managed care Medicaid. The most common primary diagnoses in individuals treated in the ER for behavioral health needs in 2015 included non-dependent abuse of substances, alcohol abuse and/or intoxication, anxiety disorders, mood disorders, suicidal ideation, and psychotic disorders. In 2015, adults in managed care had approximately 65.67 behavioral health related ER visits [per] 1,000 members, adults in FFS had approximately 108.13 behavioral health related ER visits [per] 1,000 members. Also in 2015, children in managed care had approximately 7.52 behavioral health related visits [for] every 1,000 members, approximately 16.78 behavioral health related ER visits [per] 1,000 members" (Division of Public and Behavioral Health, 2016).

Estimates of Need

Deaths Related to Drugs or Alcohol

In Nevada, over 100 people die from alcohol-related illness and injury each year. In 2015, numbers appear to have increased, although 2015 data are preliminary and subject to changes.

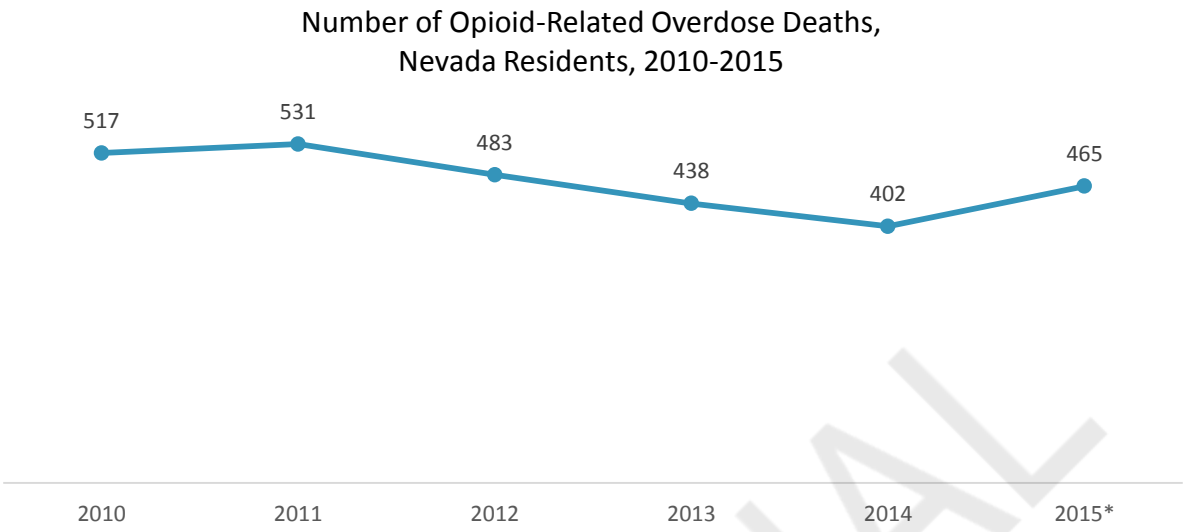
Figure 10: Alcohol Related Deaths: Nevada Residents (All Ages)



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)
**2015 data are preliminary and are subject to changes.*

Across the nation, drug overdose deaths and opioid-involved deaths continue to increase. According to the Centers for Disease Control and Prevention, more than 60% of drug overdose deaths involve an opioid. Since 1999, the number of overdose deaths involving opioids (including prescription opioids and heroin) quadrupled (Centers for Disease Control and Prevention, n.d.). In Nevada, deaths due to opioids were high compared to a decade ago, but appear to be declining since 2011 (Office of Public Health Informatics and Epidemiology, 2017). One possible source of error is the potential for differences among coroners in reporting opioid deaths across the state. The opportunity to standardize reporting to improve data was identified in Governor Brian Sandoval's Prescription Drug Abuse Prevention Summit (Social Entrepreneurs Inc., 2016).

Figure 11: Opioid-Related Overdose Deaths, Nevada Residents, 2010-2015



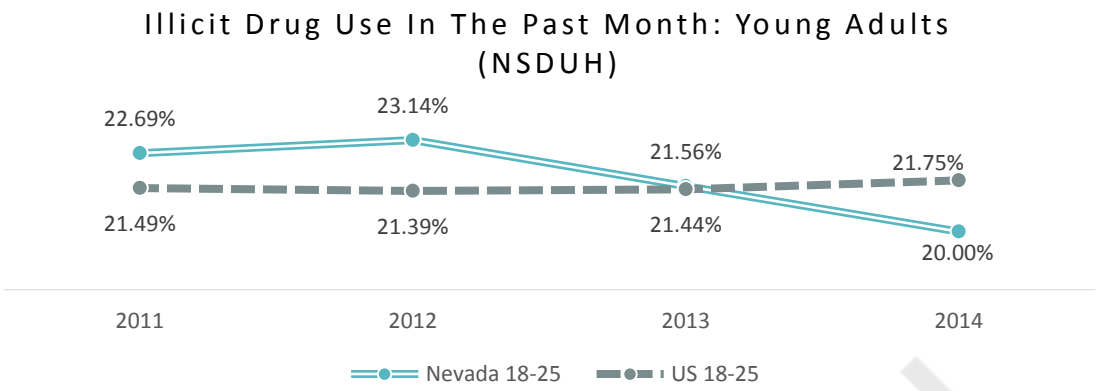
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)
**2015 data are preliminary and are subject to changes.*

Young Adult and Adult Population

Illicit drug use and binge alcohol use among Nevada's young adult (ages 18-25) and adult populations may be on the decline. From 2011-2014, the rate of reported illicit drug and binge alcohol use has begun to fall more in line with national trends. Regardless, there is still a significant problem in the state, where nearly one in 10 adults report dependence or abuse on alcohol or illicit drugs, and for young adults, the problem is even greater. In addition to greater rates of dependence and abuse, young adults report needing but not receiving treatment for that dependence more frequently than their older counterparts.

Self-reported illicit drug use in the young adult population has decreased slightly from 2011-2014, but increased somewhat in adults. In 2014, the percentage of young adults in Nevada who reported drug use in the past month before the survey was slightly below that of the national rate.

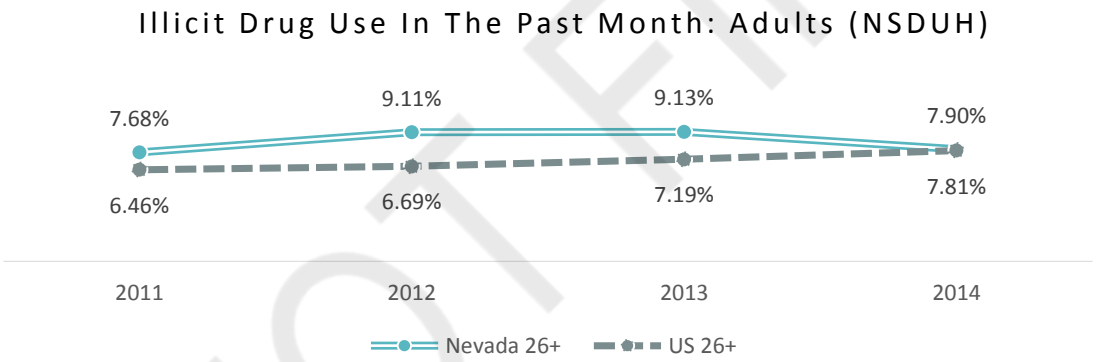
Figure 12: Young Adult Illicit Drug Trends



Source: (SAMHSA, n.d.)

Adult Nevadans above age 26, however, decreased illicit drug use from a 2013 high of 9.13% to 7.9% in 2014. While the national percentage of adults reporting illicit drug use seems to be increasing slightly year over year, Nevada's percentages have come closer to the national rate.

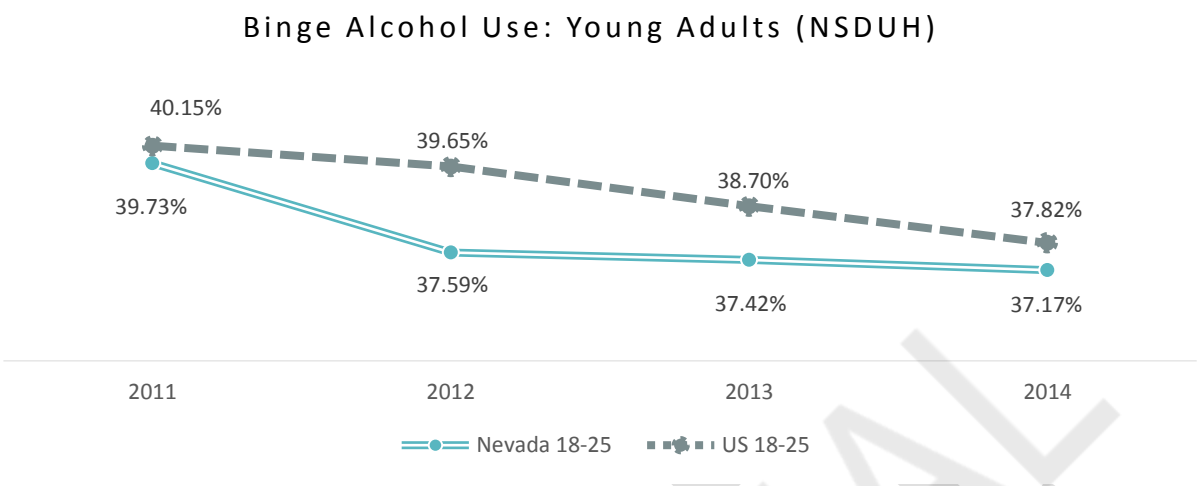
Figure 13: Adult Illicit Drug Trends



Source: (SAMHSA, n.d.)

Binge alcohol use for young adults seems to be lower in Nevada than in the nation as a whole and on the decrease.

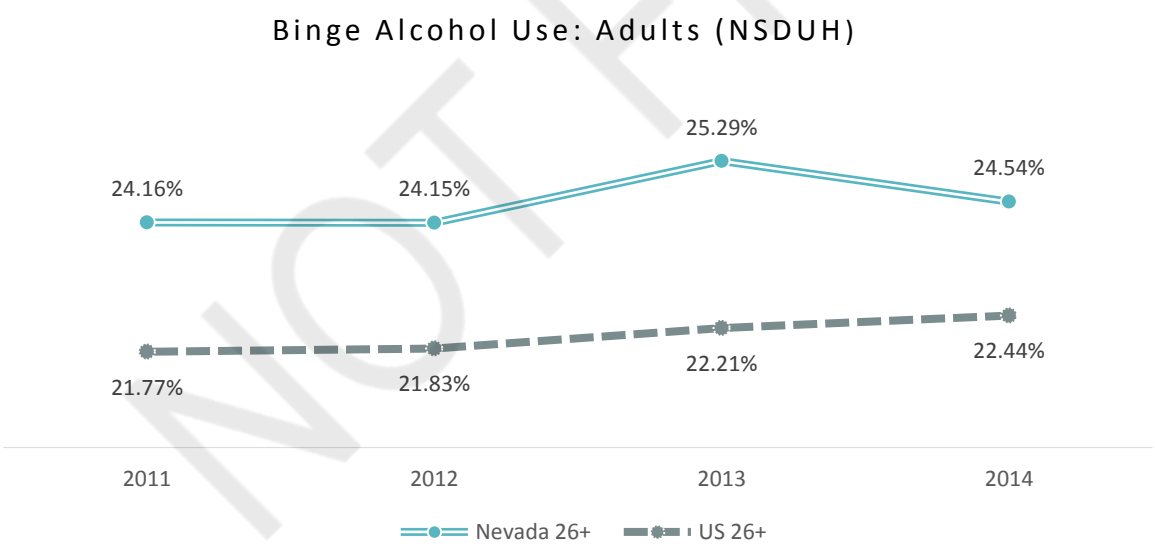
Figure 14: Young Adult Binge Alcohol Trends



Source: (SAMHSA, n.d.)

Unfortunately, Nevada's adults' binge alcohol use had remained rather flat from 2011-2014 and well-above the national rates.

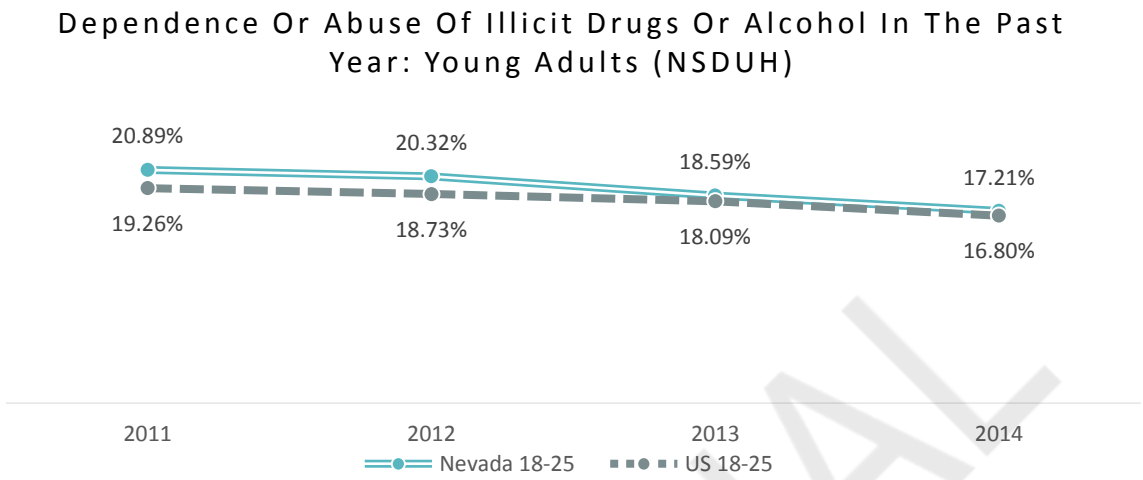
Figure 15: Adult Binge Alcohol Trends



Source: (SAMHSA, n.d.)

Dependence on or abuse of these substances for each population has declined since 2011. For young adults, dependence has decreased by nearly 3%. While the decrease in the percentage of adults who report dependence or abuse is not nearly as striking (at a little more than 1%), the decrease in these years may be a positive sign.

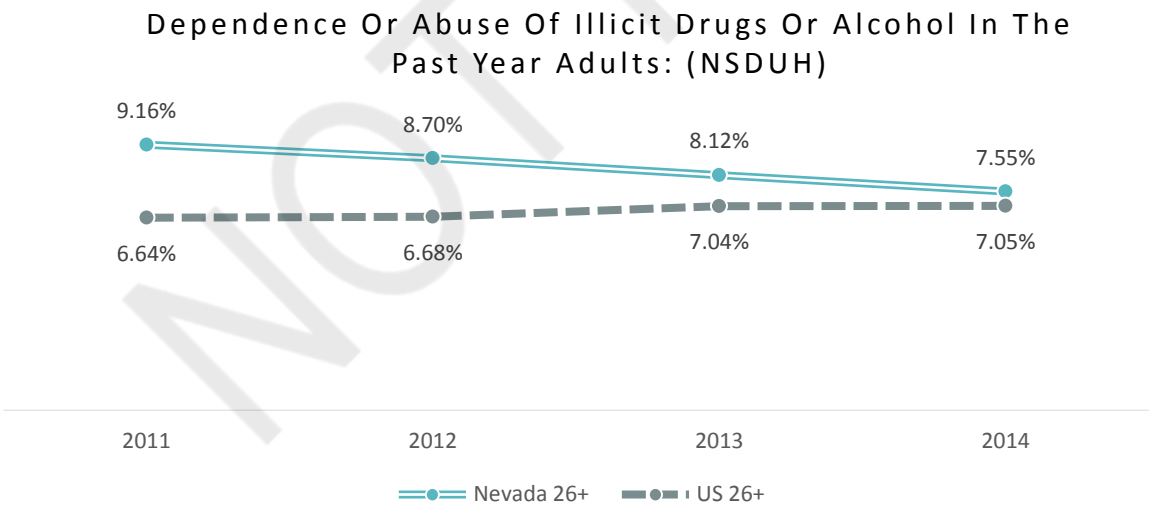
Figure 16: Young Adult Dependence Trends



Source: (SAMHSA, n.d.)

Adult rates of dependence have decreased between 2011 and 2014 in Nevada, while rates nationwide increased slightly.

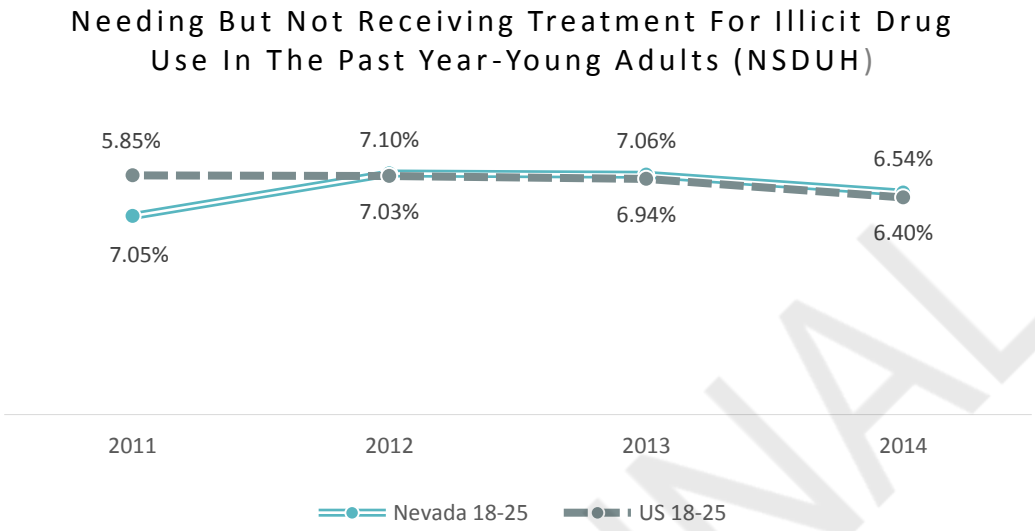
Figure 17: Adult Dependence Trends



Source: (SAMHSA, n.d.)

Young adults needing but not receiving treatment within the past year was 6.5% in Nevada, similar to the national rate.

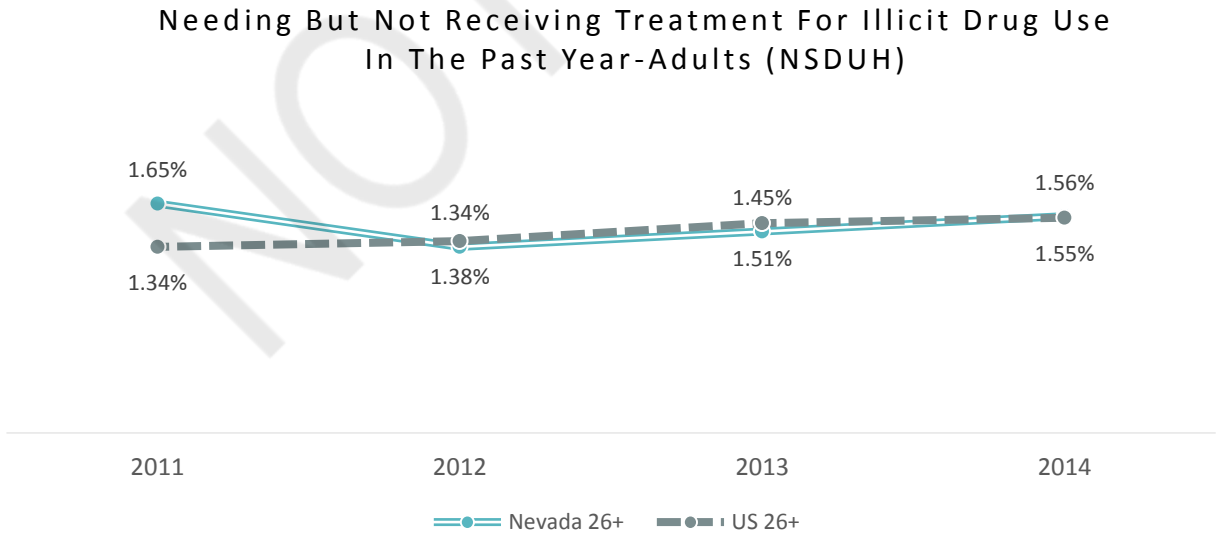
Figure 18: Young Adult Unmet Needs-Drugs



Source: (SAMHSA, n.d.)

Adults needing but not receiving treatment within the past year was 1.6% in Nevada, similar to the national rate.

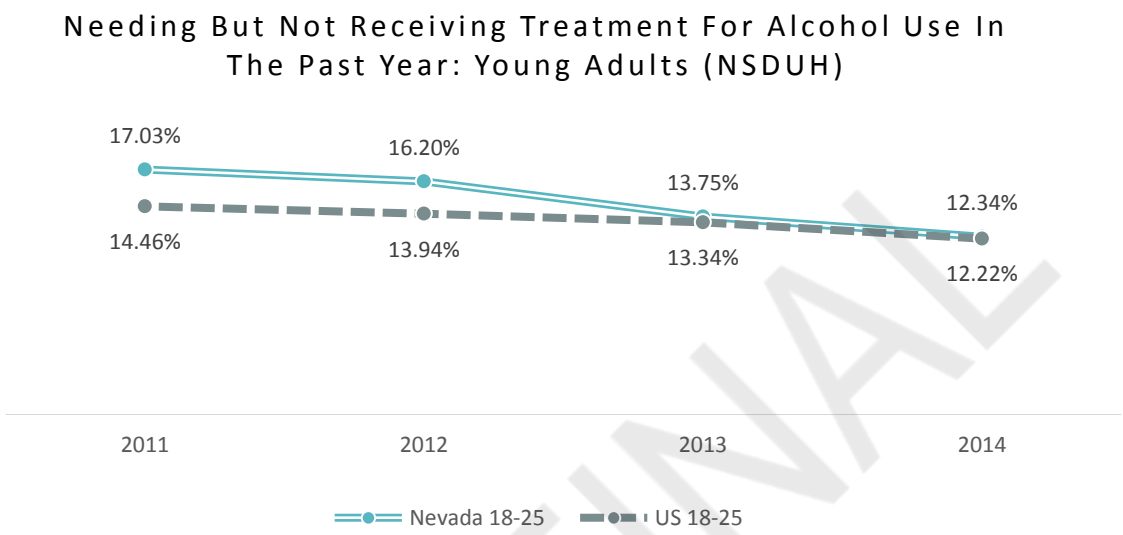
Figure 19: Adult Unmet Needs-Drugs



Source: (SAMHSA, n.d.)

Young adults are at very high risk of needing but not receiving treatment for alcohol. Despite improvements in recent years both nationally and statewide, more than one in 10 Nevadans between the age of 18 and 25 needs help for alcohol use and does not get it.

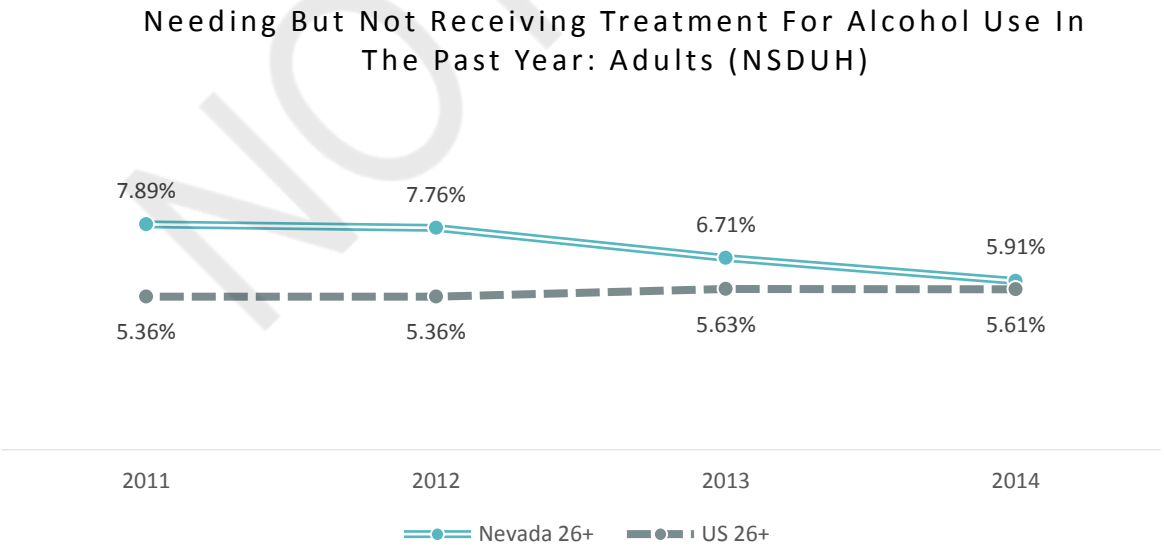
Figure 20: Young Adult Unmet Needs-Alcohol



Source: (SAMHSA, n.d.)

The rate of adults that needed treatment for alcohol but did not receive it declined between 2011 and 2014.

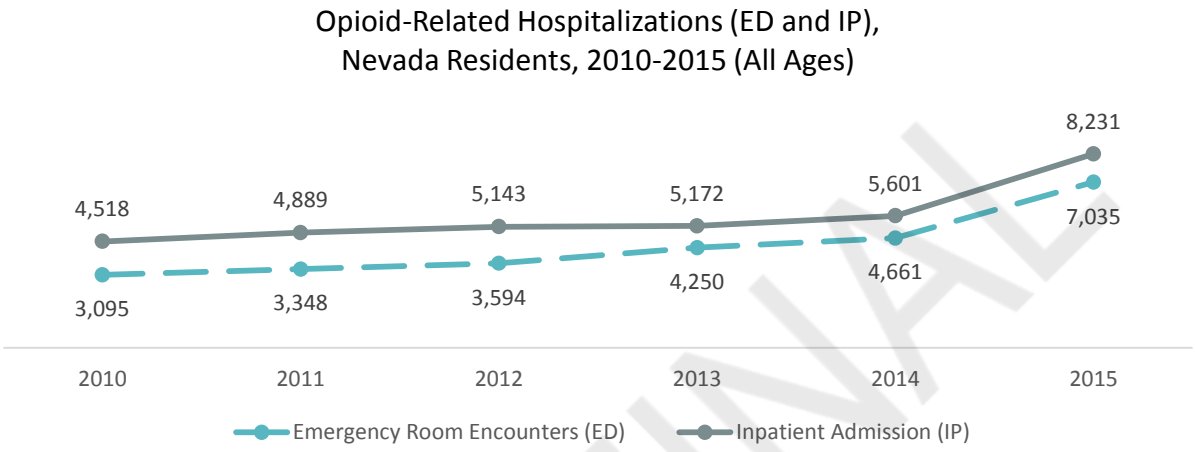
Figure 21: Adult Unmet Needs-Alcohol



Source: (SAMHSA, n.d.)

Opioid-related hospitalizations have increased dramatically in recent years. Between 2010 and 2015, there was a 114% percent change in emergency room rates, and, 72% increase inpatient admissions *(Office of Public Health Informatics and Epidemiology, 2017)*. Adults ages 25-34 are particularly at risk; however, adults of all ages, especially older adults, are also experiencing issues with opioids *(Office of Public Health Informatics and Epidemiology, 2017)*.

Figure 22: Opioid-Related Hospitalizations - All Ages

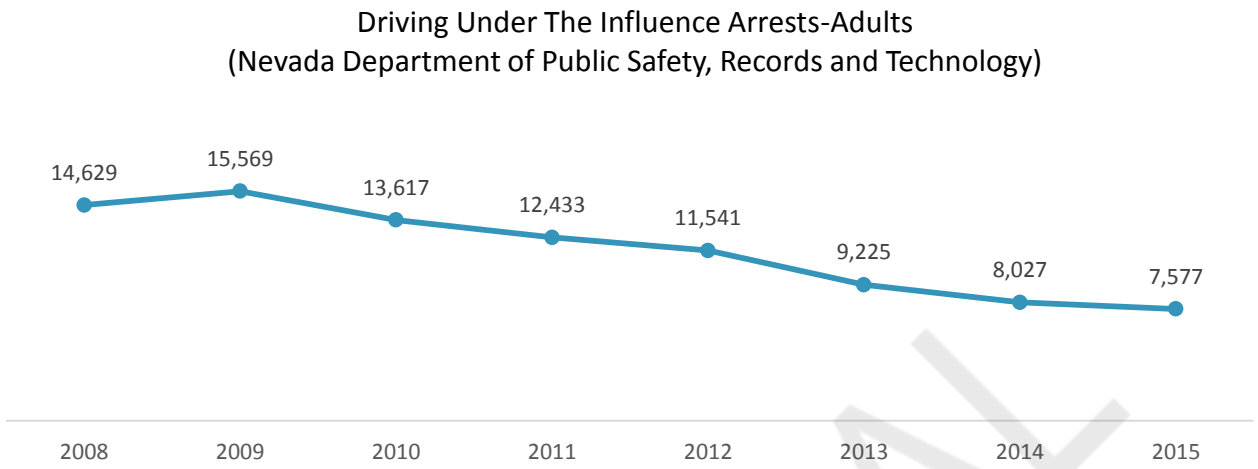


Source: (Office of Public Health Informatics and Epidemiology, 2017)

Law enforcement information related to arrests can also help illustrate substance use in the state. Many of these numbers have declined in recent years. However, it is important to note that policies and funding for law enforcement can influence the increase or decrease in the number of arrests, and so caution should be taken in interpreting the following data.

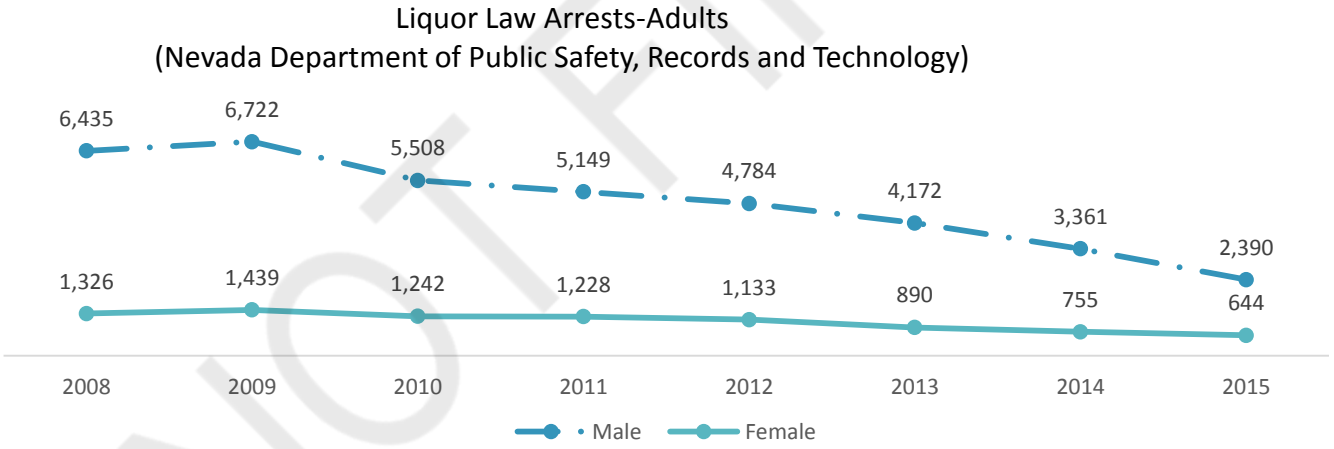
As figures 22 and 23 demonstrate, the number of adult DUI's has declined in recent years along with the number of liquor law arrests. Males were considerably more likely to be arrested on liquor law charges compared to women.

Figure 23: Adult DUI



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

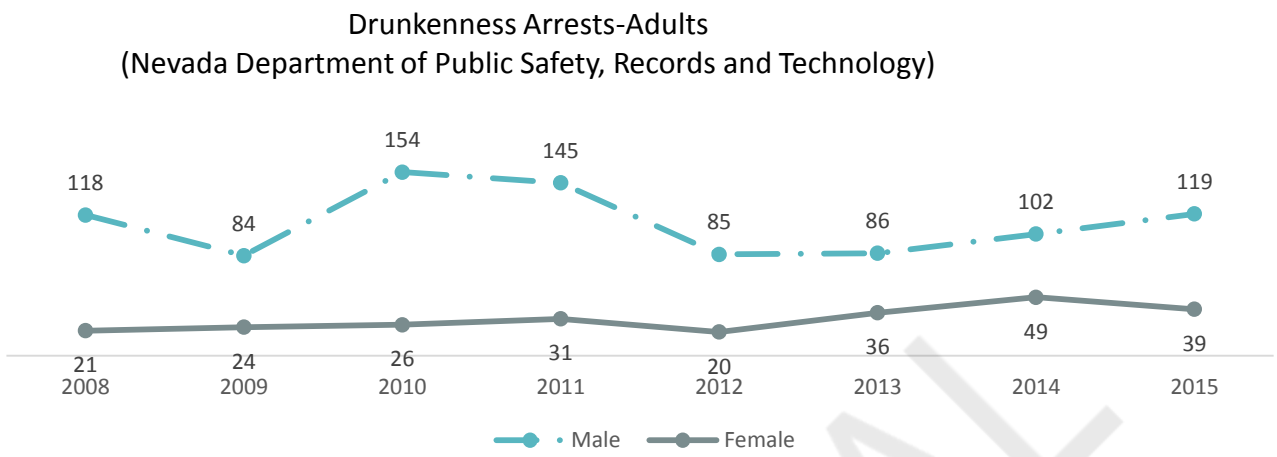
Figure 24: Adult Liquor Law Arrests



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

It is interesting to note that the numbers of drunkenness arrests decreased for males between 2010 and 2012 but increased steadily between 2012 and 2015. Additionally, the number of arrests for women increased between 2012 and 2015.

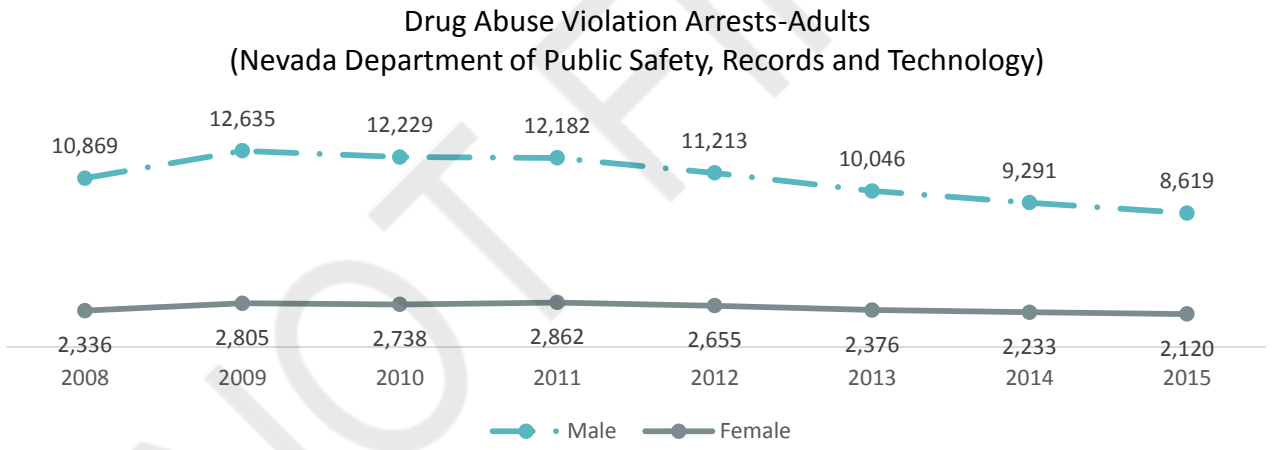
Figure 25: Adult Drunkenness Arrests



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Arrests due to drug abuse violations have declined since 2011.

Figure 26: Ault Drug Abuse Violations



(Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

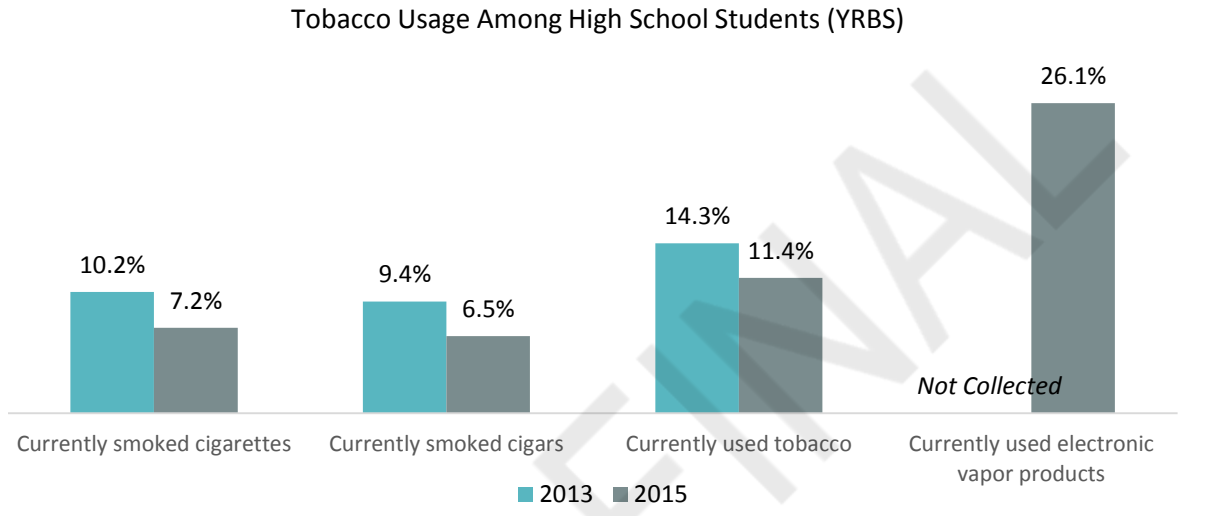
Recovery and Treatment Outcomes

Key informants indicated that waiting time for services is long for adults. They may not get the level of care that is needed or may be awaiting a type of care that does not necessarily fit their needs because they are not properly screened. Data from the National Outcome Measures (NOMS) through the SAMHSA Uniform Reporting System provide some insights into outcomes for adults that interface with the state mental health system. Improving linkages among data systems and enhancing capacity to analyze and report on treatment outcomes can help to identify trends and build on what is working.

Youth Population

Survey data provides information about youth ages 12-17. Several substance use trends are shown in the following charts. In general, youth rates are higher in Nevada compared to the nation, but for many situations the gap appears to be narrowing. The Youth Risk Behavior Survey (YRBS) also provides information to inform outreach, prevention, intervention, treatment and recovery needs. Other information from public safety and crime reporting is also used to understand trends.

Figure 27: High School Figure Tobacco Use

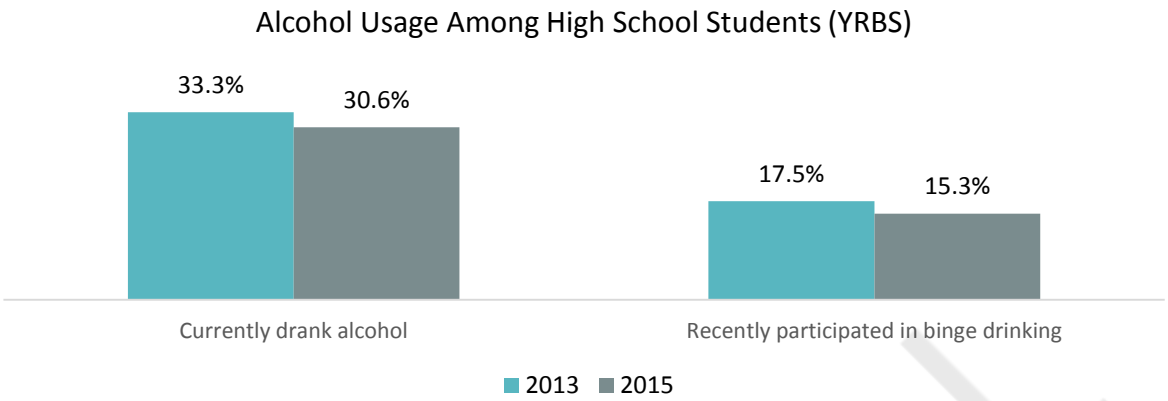


Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Use of cigarettes and other tobacco products like cigars have declined in recent years. However, use of vapor products has become widespread and poses serious risks. Nationally, e-cigarettes are very popular among youth. Added flavors make them especially attractive to kids and teens (O'Neill Institute for National & Global Health Law, 2016). The impacts of this practice are not well known; while nicotine is highly addictive, a recent study showed that majority e-cigarettes and vaping devices did not include nicotine. Harmful chemicals are still involved in vaping, with limited information about their effects (Ingraham, 2016). According to key informants, other substances are often used through vaping devices, including alcohol and marijuana.

Between 2013 and 2015, there were slight declines measured through YRBS among teens drinking and binge drinking. Slightly less than one in three reported that they 'currently drink alcohol' and 15% had recently participated in binge drinking. There are many risks to youth that drink alcohol, including increased likelihood to experience issues such as school problems, physical and sexual assault, and abuse of other drugs (Centers for Disease Control and Prevention, n.d.).

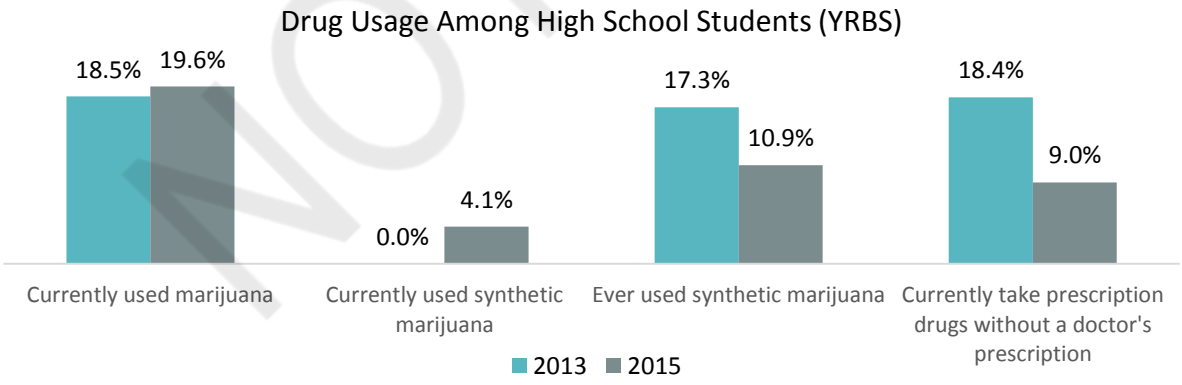
Figure 28: Alcohol Use among High School Students



Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Among high school students, YRBS showed that use for many drugs is declining; however, marijuana was slightly up between 2013 and 2015. Data from surveys showed significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used MDMA,' and 'ever used synthetic marijuana.' Factors- including prevention efforts - are likely contributing to these declines. These data follow national trends, with marijuana use up among youth and many other substances decreased in recent years (Centers for Disease Control and Prevention).

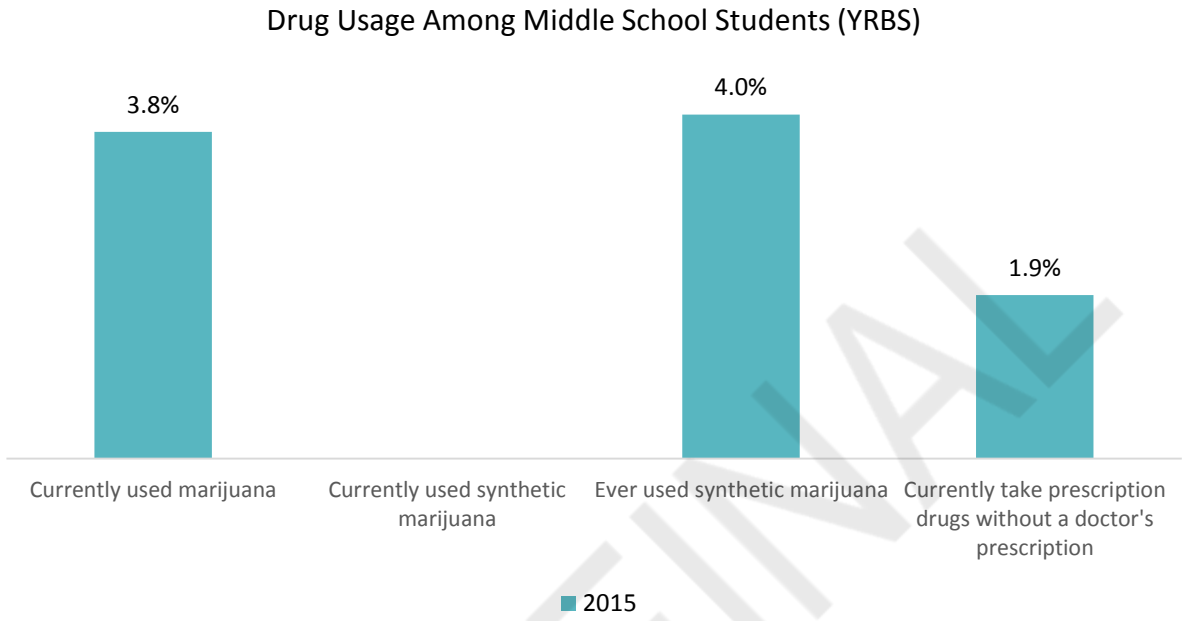
Figure 29: High School Drug Use



Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Data on substance use by middle schoolers was collected in 2015 as the starting year. Drug use in the early years is associated with negative outcomes including substance use disorder.

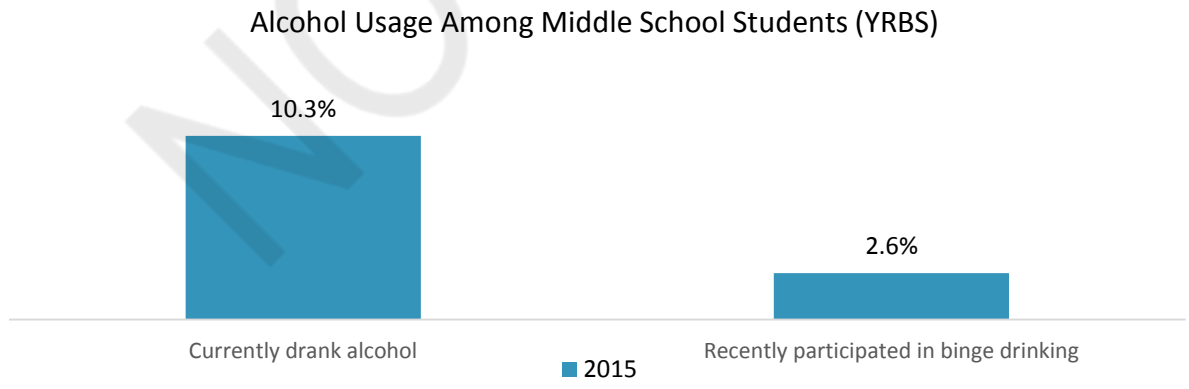
Figure 30: Middle School Drug Use



Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Data on substance use by middle schoolers was collected in 2015 as the starting year. Alcohol use in early years is associated with negative outcomes including addiction.

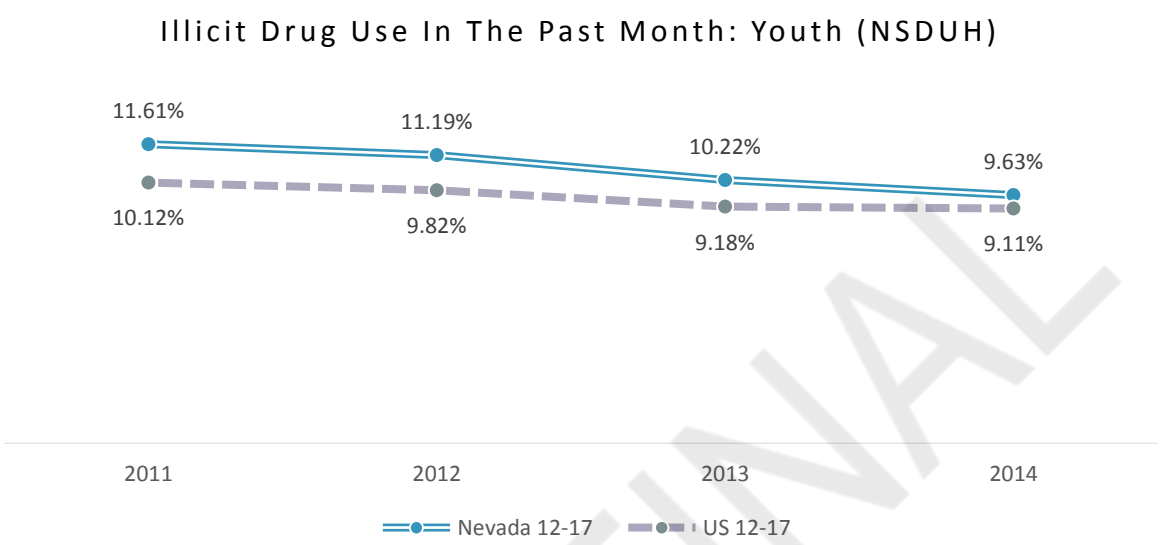
Figure 31: Middle School Alcohol Use



Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

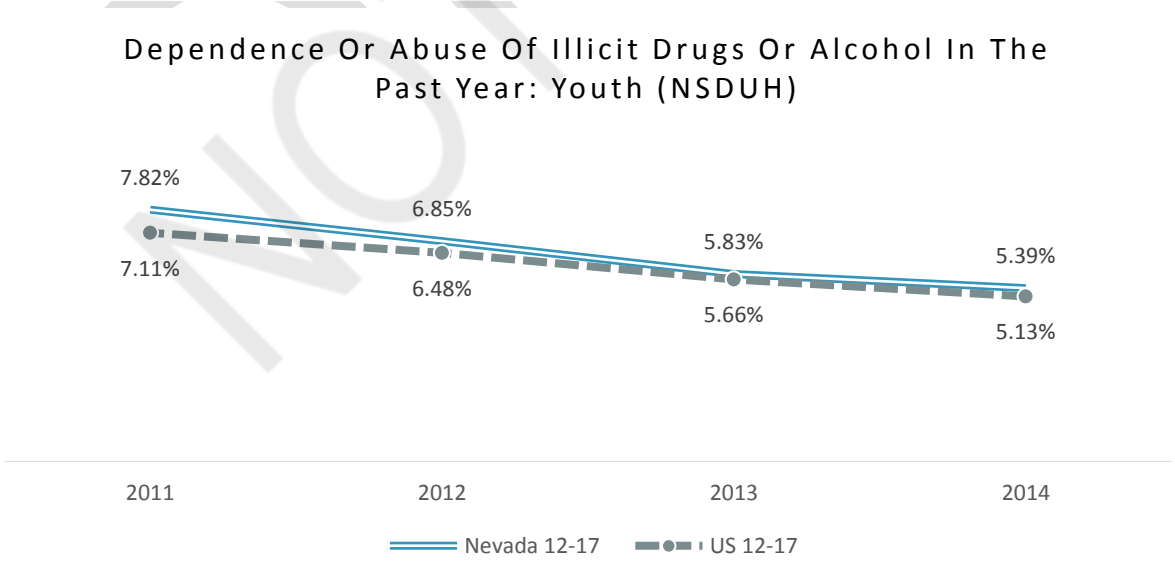
The National Survey on Drug Use and Health (NSDUH) provides another source to view youth behaviors for Nevada. Slight downward trends for use of and dependence on illicit drugs among youth was reported between 2010 and 2014, as shown in the figures below.

Figure 32: Youth Drug Use



Source: (SAMHSA, n.d.)

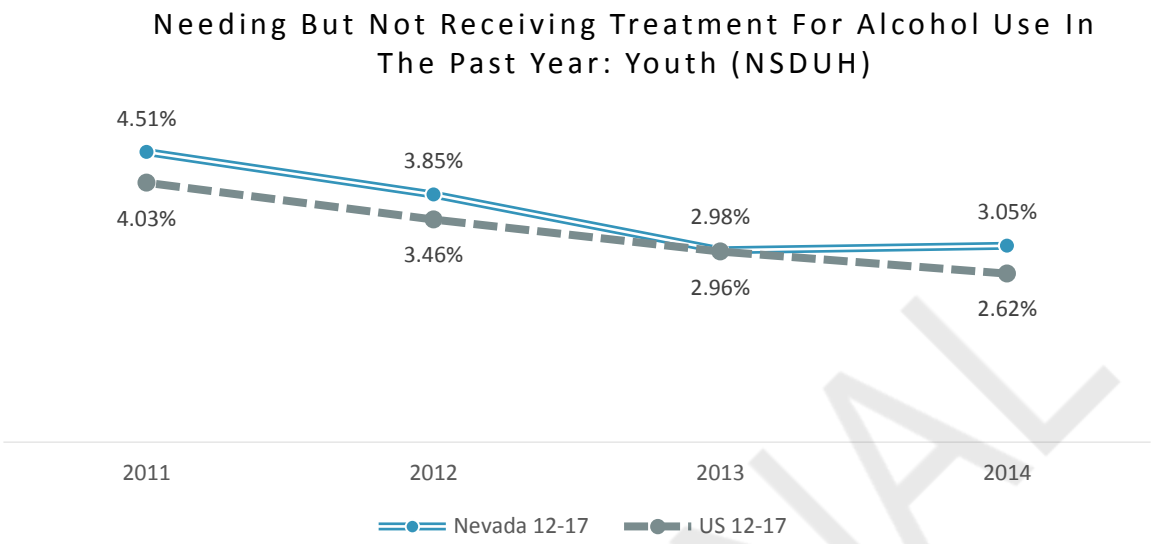
Figure 33: Youth Dependence



Source: (SAMHSA, n.d.)

The percentage of youth needing but not receiving care for alcohol declined between 2010 and 2014.

Figure 34: Youth Alcohol Use



Source: (SAMHSA, n.d.)

Similarly, the percentage of youth needing but not receiving care for illicit drug use between 2010 and 2014.

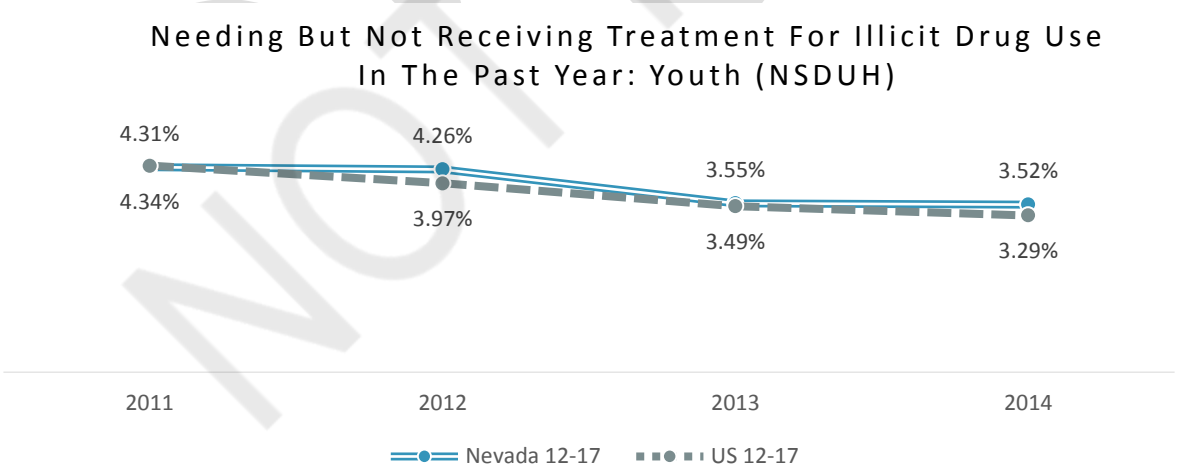
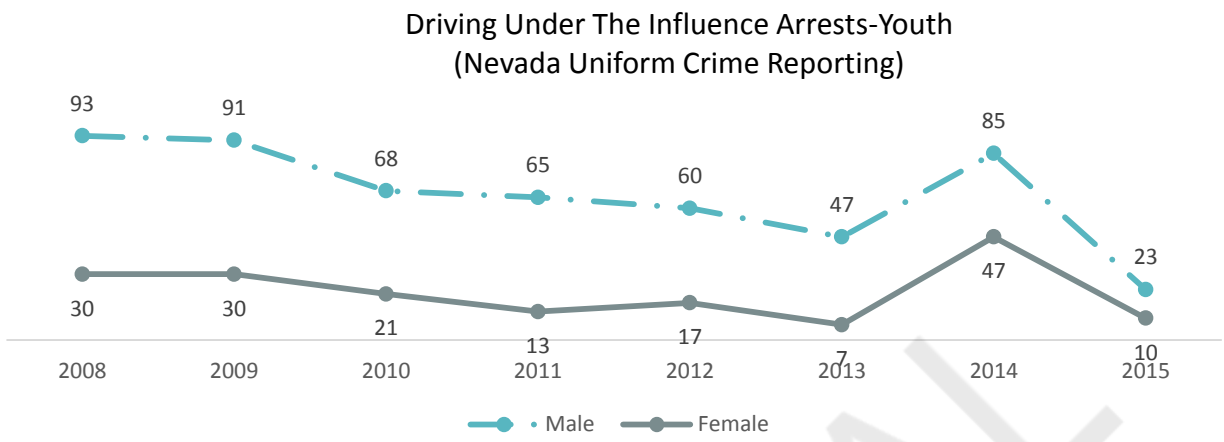


Figure 35: Youth Drug Use

Source: (SAMHSA, n.d.)

Interaction with law enforcement can also help to understand youth substance use. Again, it is important to note that policies and funding for law enforcement may affect the arrest rates seen in the following figures. Youth arrests for drug violations have been more dynamic. Variances in arrest by gender are observed among youth, with females less likely to be arrested for DUI.

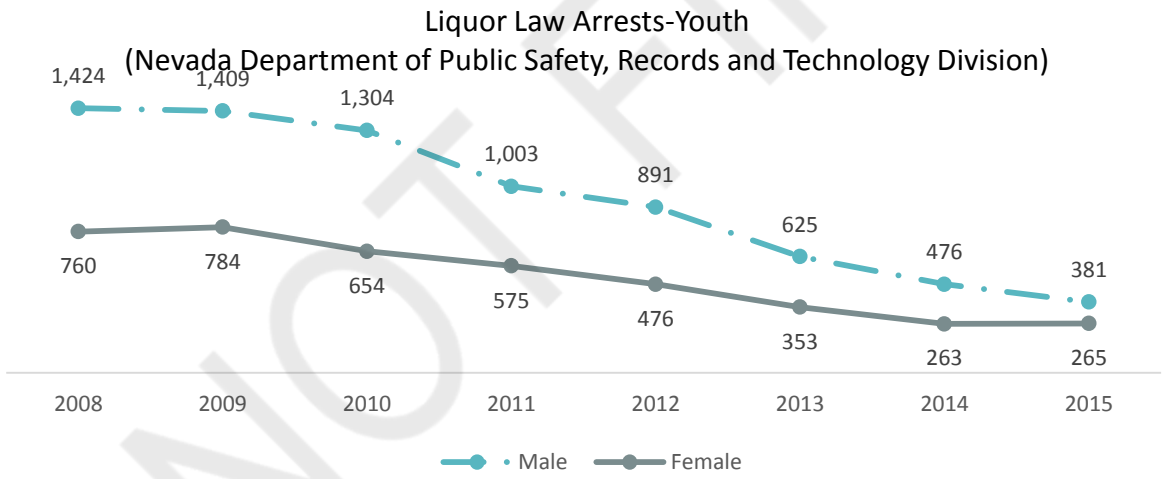
Figure 36: Youth DUI



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for liquor law violations have decreased in recent years.

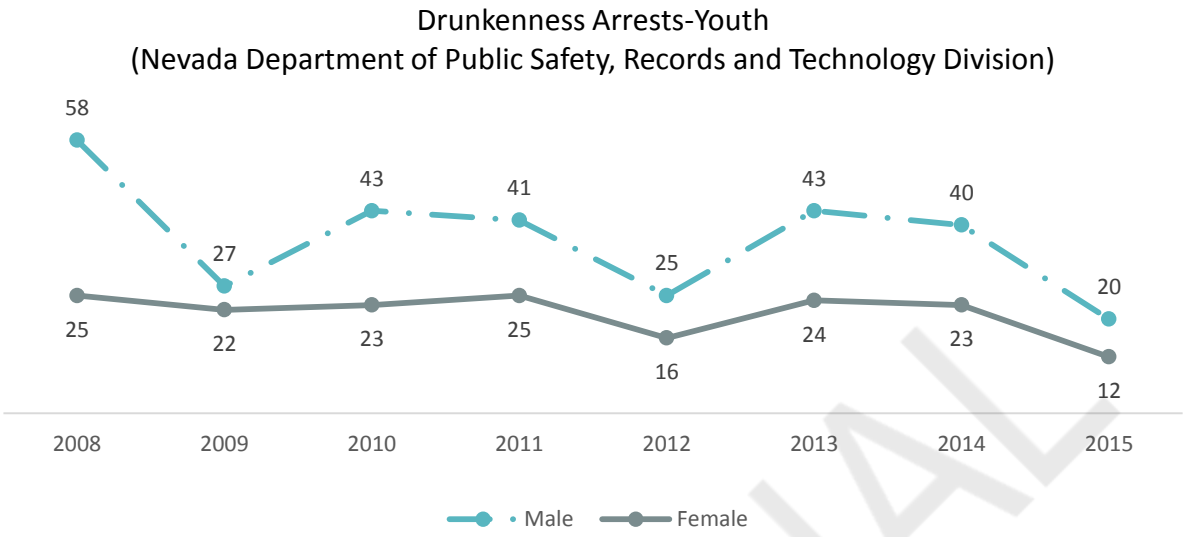
Figure 37: Youth Liquor Law



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for drunkenness have fluctuated.

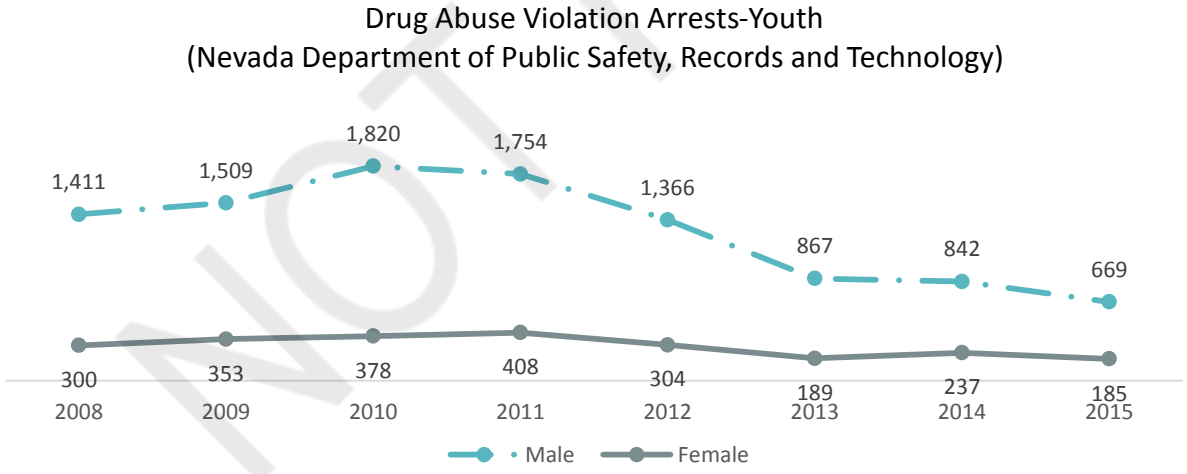
Figure 38: Drunkenness Arrests - Youth



Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for drug violations have decreased in recent years.

Figure 39: Youth Drug Arrests



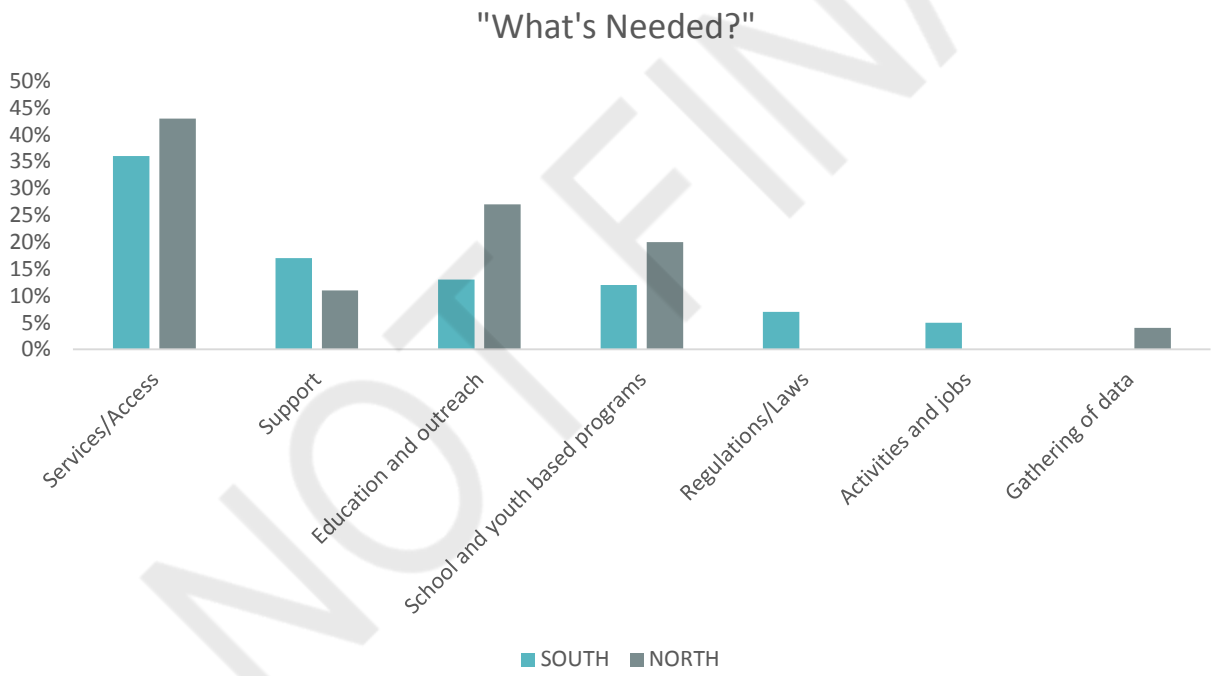
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Recovery and Treatment Outcomes

Key informants indicated that more services specific to adolescents are needed, waiting time for services is long and that the level of care may be insufficient. Specific treatment options noted included residential/inpatient care but not many outpatient services for youth.

During the January 2017 Youth and Family Mental Health Engagement Summit, participants responded to a qualitative group survey with open-ended prompts about "what helps," "what harms," and "what's needed" in regards to substance abuse in Nevada. Responses were separated according to which region participants were from, either southern Nevada or northern Nevada. Participants across the state indicated that social supports, access to services, and educational opportunities help with the issue of substance abuse for youth in the state. When asked what harms, peer pressure and negative environments, as well as lack of education and awareness were the top two topics indicated. Finally, when asked what was needed, of 129 responses, many needs were indicated, with the majority of responses centered around services and access.

Figure 40: What's Needed for Substance Abuse



Source: (Division of Child and Family Services, March 9, 2017)

Data from NOMS through the SAMHSA Uniform Reporting System provide some insights into outcomes for youth that are engaged with the state mental health system. In 2015, 78.3% of child/family consumer measures were positive about outcomes, compared the US rate of 69.7%. However, for hospital readmission rates were high compared to the nation.

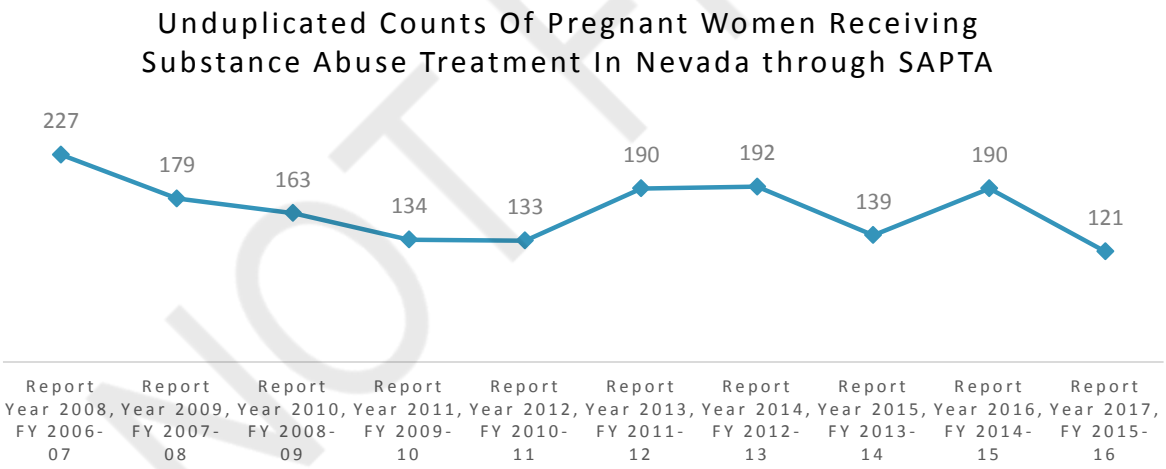
Diagnosis and treatment of co-occurring disorders was low compared to the national rate, suggesting an opportunity in Nevada to better diagnose and treat children that experience both mental illness and substance use (SAMHSA).

Pregnant Women and Women with Dependent Children

To be able to serve pregnant women in accordance with 45 CFR 96.131, it is particularly vital to understand the population requiring these services, and more importantly, ensure it has the capacity for compliance with this regulation. However, data regarding drug use and abuse by pregnant women can be difficult to accurately report given the existing data collection tools employed by the state. Currently, the state examines the number of pregnant women receiving treatment in state facilities. It also uses self-reported birth certificate information. Both sets of data may prove to underestimate the number of pregnant women using or abusing drugs in Nevada, but the sets do serve to help create a basic understanding of Nevada's mothers and expectant mothers' use or abuse of drugs.

In Fiscal Year 2016, the state reported to the Substance Abuse Block Grant reporting system (SAMHSA, n.d.) (WebBGAS) 121 pregnant women receiving treatment. Figure 41 represents the count of unduplicated pregnant women receiving services since 2006. The state has indicated that the reported numbers may not accurately reflect the number of pregnant women receiving services. They are currently working to improve the system to better account for this and other data.

Figure 41: Service Counts of Pregnant Women



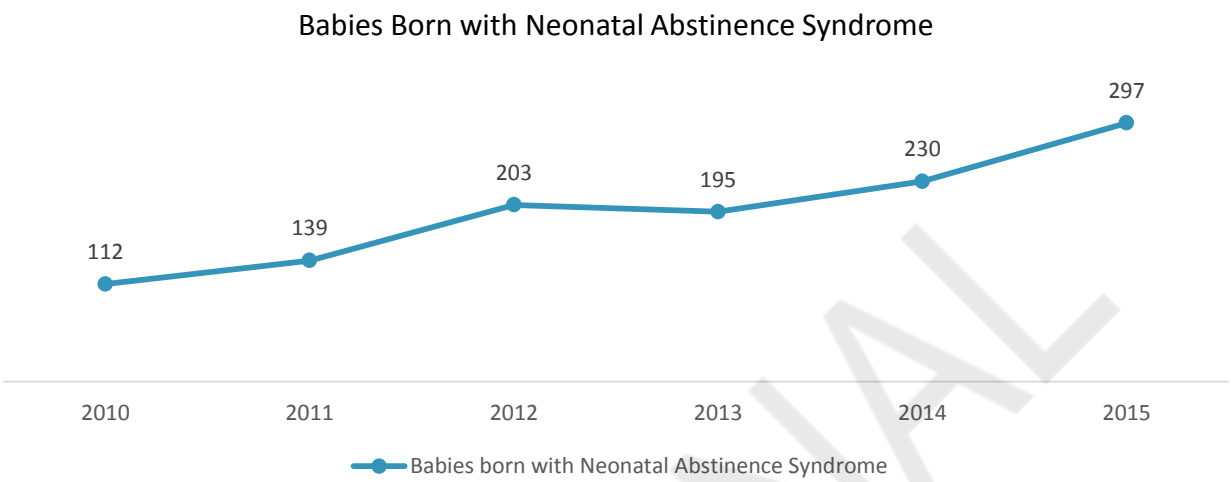
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

It is important to note that the count of women receiving services does not indicate need in the state. Rather it speaks more to the state's capacity for services and ability to identify and treat pregnant women.

Additional data from the Center for Health Information Analysis (CHIA) can be found using the World Health Organization's International Classification of Diseases (ICD) codes. In 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice

Organization, 2017). This will make it difficult to compare information from 2016 to information from the previous years.

Figure 42: Babies Born with NAS in Nevada

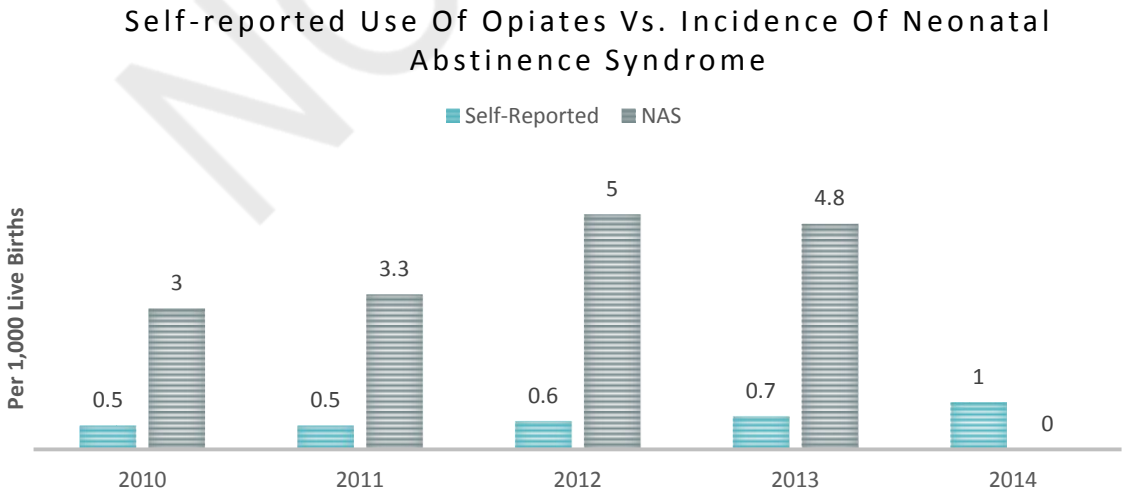


(Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Hospital inpatient billing data was used to count numbers of neonatal abstinence syndrome among Nevada births. The following codes were used: 779.5 (ICD-9), P96.1, and P96.2 (ICD-10) for this inquiry. Note that since 2010, the number increased more dramatically, more than doubling in a five-year period.

Figure 43 shows the contrast between the self-reported use of opiates and the number of children affected by opiate use at birth, per 1,000 births.

Figure 43: Comparison of Self-Report to NAS



Source: (Ko, et al., 2016) and (Office of Public Health Informatics and Epidemiology (OPHIE)).

This contrast may point to a need to better identify women with substance abuse disorders who are also pregnant and provide effective treatment options, which could prevent NAS from occurring.

Mental Health

In Northern Nevada, mental health clinics serve people with a variety of diagnosis, including poly-substance dependence. As mentioned previously, mental health and substance abuse are often co-occurring.

Almost one in five adults in Nevada have some kind of mental illness. This is comparable to other states where the percentage of adults with mental illness ranged from 16% to 21%. The most recent estimates of prevalence rate of any mental illness among adults was 18.52% by the Substance Abuse and Mental Health Services Administration in 2014. This is an increase since the 2011 estimate of 16.48%.

Table 9: Estimated Adults with Mental Illness

Year	Total Population Ages 18+	Estimated Adults with Mental Illness*	SAMHSA Estimation of Prevalence Rate
2011	2,011,277	331,458	16.48%
2012	2,040,581	327,513	16.05%
2013	2,067,996	380,098	18.38%
2014	2,100,484	389,010	18.52%

Source: (U.S. Census Bureau, 2016)

*Estimate is based off an 18.52% prevalence rate of adults in Nevada. Source: (Substance Abuse and Mental Health Services Administration (SAMHSA), 2016): http://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf

Service Delivery and Capacity

Nevada's service delivery and capacity were assessed in a three-part outreach process. First, key informant interviews were conducted and included in the draft situational analysis. Then, a review of a working draft of the situational analysis conducted with the Steering Committee helped to establish critical issues. Finally, during a series of Town Hall Meetings held from March 10-14, 2017, the public was given the opportunity to confirm those issues identified by the Steering Committee and further identify any additional state needs.

Key Informants

Through key informant interviews and focus groups, systems strengths and challenges were identified. Additionally, key informants recognized potential opportunities and/or strategies to meet these challenges. A synthesis of key informants' perspectives appears in this section.

Systems Strengths

Prevention

- The sub granting process allows the coalitions to work with local partners collaboratively, bringing them together to serve their communities, distribute work and funds, and facilitate "statewide conversation" and collaboration.
- The coalitions facilitate relationships for the benefit of the community.
- Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities that are youth-driven.
- Community champions exist in every county and support the coalitions.
- Prevention Specialist Certification and Community Health Worker Certifications help to legitimize the efforts of individuals as well as provide the training needed for these members of the workforce.
- The use of environmental strategies for prevention including programs, policies, and practices makes a difference.
- The Department of Education has implemented state management teams to bridge prevention services and funding.
- At the state level, DPBH administration and staff understand community-based decision making. There are people who are willing to ask tough questions and get to the root of problems.
- Use of apps and websites for communication can be effective tools to target sub-populations with information. For example, web applications for tobacco cessation are more appropriate than call lines for youth. Social branding has shown promise for prevention among subpopulations including LGBTQ.
- In most communities, law enforcement has a reputation as an ally and assists with prevention efforts.
- The promotion and use of safe disposal sites and distribution of lockboxes is seen as very helpful.

Treatment and Recovery

- The statewide effort to address the opioid epidemic has focused efforts across many sectors. Several interviewees noted aspects of the work that were making a difference in public awareness, treatment, and recovery.

- Many public systems are using evidence-based practices. For example, the Department of Corrections uses evidence-based frameworks, and invests in training for its providers. Many other programs use or are expanding use of EBP.
- Data collection and tracking have improved in recent years, helping to provide actionable information. For example, electronic health records, surveillance systems, and shared data systems (Avatar, HMIS) collect information across providers and systems. While this was noted as an improvement, key informants agreed much work has yet to be done to improve data collection.
- Recent system advances such as Regional Behavioral Health Care Coordinators and Community Health Workers are seen as effective strategies to address Nevada's needs.
- Where they exist, wraparound services are described as working well. For example: The Division of Child and Family Services' Wraparound In Nevada (WIN) program is recognized nationally as a promising practice that helps children.
- The majority of providers are viewed as passionate about helping people and person-focused in their approach.
- Continuing Medical Education (CME) and Continuing Education Units (CEUs) offer opportunities for professional learning in areas related to substance misuse. Training and education were noted as helpful to providers in addressing issues and needs.

Issues and Challenges

Prevention

- Within different communities there are systematic barriers that prevent the coalitions from accessing youth: these barriers include school hours, a need to build effective partnerships with youth and create productive and mutually beneficial relationships with schools and school districts.
- Demand for prevention education is high and the coalitions cannot meet the demand, especially in rural areas where a dispersed population is difficult to reach. Coalitions also expressed concern about driving a great distance to give a presentation for very few people.
- Marijuana prevention efforts are challenging in the face of legalization of recreational marijuana statewide.
- For coalitions and treatment providers, federal funding priorities can stand in the way of meeting community needs.
- Coalitions feel that youth engagement is made challenging by school district barriers, the way that programs have been pushed to after-school hours, and liability issues associated with transportation after-school. It is difficult to incentivize participation because of funding limitations (e.g. can't provide snacks, at one point couldn't provide t-shirts, etc.).
- Data collection specific to prevention is problematic and may affect funding and information dissemination. Data is reported to the state, but then cannot be accessed to further prevention efforts or support funding requests.

Treatment and Recovery

- There is a lack of recognition of the signs and symptoms of substance use and abuse. Trainings have been provided but continued attention is needed in this area.

I think everyone in substance abuse prevention and treatment [field] knows that there's never enough funding to do what we want to do or what we should do. But I think if we collaborate and we don't duplicate efforts, I think we can make a big, big impact. So, I think as long as people don't feel ownership and territorial over their product or their service, then I think we're in

- More information about available services is needed for those seeking to help to connect with services.
- Adolescent service providers have struggled because many families don't access them. Parents can be reluctant to recognize their child has a problem and may not be open to asking for help outside the family. The 24/7 environment in Nevada can also impede people's ability to access treatment, including parents helping their children to get to treatment.
- More residential programs are needed to meet demand. Treatment and recovery should begin when a person is ready. When a person needs treatment, an hour can be a long time – waiting times can be weeks, or even months. People often have to leave their communities to get care.
- People need assistance transitioning from inpatient care and more intensive services to step-down services.
- The Affordable Care Act has been built into many improvements to Nevada's system for care. Threats to repeal the ACA have major consequences for programs that have been planned and developed that leverage provisions of the ACA.
- Housing and transportation can be considerable barriers, especially for difficult to serve populations such as former offenders and people with mental health problems.
- More opportunities for people to get medically-assisted treatment are needed. Providers lack education about medically-assisted treatment and additionally, are concerned with the regulatory burden of offering it.
- More outreach, programs, and services that are culturally and linguistically relevant are needed. There is a lack of culturally specific services, especially for the Native American population.
- The state needs more providers including behavioral health and primary care physicians as well as specialists (psychiatrists, pain management specialists, etc.), especially those that are able to effectively address co-occurring disorders.
- More consideration should be given to the social determinants of health and addressing those.
- Insurance and availability of services are often a barrier to person-centered planning because they limit patient choice.

Cross-Cutting Issues

- Uncertainty about the ACA's future raises concerns for treatment delivery systems under development.
- There is a lack of awareness about resources available, for example reimbursement for case management through Medicaid and SAPTA funding.
- Lack of effective communication across state divisions, data systems, and funding sources contributes to challenges in implementing data-driven solutions.
- Stigma exists for people needing care and treatment. This can also extend to families.
- Compensation is often not adequate to attract and maintain the workforce.
- Medicaid reimbursement rates are too low – and delays for payment as well as other payment issues can be a disincentive or make it too difficult for providers to make their budget work.
- Many physicians won't repeat medically-assisted treatment if it has failed.
- There is need to continue to improve technology including electronic health records, data systems to facilitate better referral, outcomes management, and understanding of needs.
- Some key informants suggested that the change to Medicaid-funded service was the cause of increased admissions to emergency rooms and jails – as people aren't able to get the help they need and are interfacing with these systems.
- Laws and policies are not always adequate to support public health approaches to services.

- Communication, understanding of community needs, and consistency at a state level is also a problem. The state can be disconnected from the realities of the diverse communities' specific needs.
- Lack of institutional knowledge capture makes it so that coalitions have to continuously reeducate about their programs because there is turnover at the state level. Regulations are interpreted differently, confusion of state directives result in punitive measures for the coalitions, providers, or both.
- There are too few effective measurements for success. As one person said: "It takes longer than a quarter to effect change."
- Inconsistencies in reporting and budgeting requirements can be a challenge to building effective systems.
- In conjunction with communications with the state, funding is always a challenge.
- Coalitions feel that youth engagement is made challenging by school district barriers, the way that programs have been pushed to after school hours, and liability issues associated with transportation after-school.
- Grant recipients may not be certified, eligible for funding, capable or willing.

Recommendations for Planning

Key informants also addressed aspects of the system that could be improved.

Planning

- Include the Strategic Prevention Framework in design and planning of systems.
- Utilize collective impact to strengthen results of collaborative efforts.
- Use the public health model where people are viewed holistically.
- Many states are innovating, including Nevada. Nevada can learn from other states to improve policies, systems, and practices for more effective outcomes related to behavioral health. However, Nevada has unique needs, and plans and practices need to be tailored to Nevada specifically.

Build Sustainability

- Identify opportunities to develop funding that addresses community needs.
- Better define rural, urban, and frontier at the state level and how they affect funding, etc.
- Look at Grants Management Advisory Council (GMAC) sub grants to leverage their system to meet coalition needs.
- Look at the Department of Education's 21st century grant and E-page.
- Ensure that grant funded programs that are effective can continue into the future.
- Create a sustainability plan.

Strengthen Use of Data

- Improve accuracy of data and the reports for legislative and other purposes.
- Improve data sharing between state and the agencies themselves.
- Improve comparability of data.
- Streamline duplicative requests.
- Use data for planning and learning.
- Develop systems that can support evaluative learning.

Enhance Communication and Relationships

- Improve interdepartmental communication. Consider more mid-level employees at the state to allow for better distribution of the work.
- State workers need a way to see the programs in action and connect their administrative work to the programs on the ground; "they need to understand how they are part of the team."
- Strengthen continuity of knowledge at state level, including steps to reduce turnover.
- Move the agency from an 'enforcement role' to a collaborative relationship with coalitions and providers.
- Address what is and what is not working well in advisory boards; consider opportunities to further develop these structures for public engagement.
- Enhance public awareness, especially around the issues of potential harm from addiction to opioids. Individuals and their doctors can work together to prevent potential problems related to substance use disorder.

Expand Effective Programs and Services

- Key informants identified many practices that hold promise for improved outcomes, including:
    - Targeted outreach and messaging for prevention
    - Assistance with navigation and coordination for services
    - Interventions that utilize family members and peer support
    - Medically-assisted treatment, including walk-in clinics
    - Trauma-informed approaches to care
    - Cognitive behavioral therapy and related practices
    - Best practices for working with people recovering from opioid addiction
    - Supportive transitions through levels of treatment
    - Web-based prevention resources
    - Wraparound Services

> The people who work in the field are really passionate about it, whether it is treatment or prevention. They are not doing it for the paycheck…. We do a good job of recruiting people who are truly passionate about helping families and working with our kids.

- The agency can help to support widespread use of treatments to meet emerging needs through training and support. Reimbursement for providers to attend should be considered to help address financial barriers faced by providers (especially those in small practices and the not for profit sector).

Improve Systems and Structure

- Institutionalize the coalitions as the state has done with Family Resource Centers
    - Allow for baseline funding to create stability.
- Optimize 2-1-1 so that it is the first return when someone searches for a term; ensure directories are up to date

Strengthen Workforce

- Identify opportunities for providers to strengthen their knowledge and resources in EBP, and provide funding for providers to attend trainings. Without it, they may not be able to attend.
- Partner with other divisions on issues of reimbursement, funding, and coordination.

- Include opportunities for cross-sector education where there is an opportunity to share practices and understanding.
- Identify opportunities to reduce turnover and bolster workforce morale both at the agency and among providers statewide.
- Enhance cultural competency all around—rural, frontier, urban, socioeconomic, etc. Identify opportunities to not only increase the number of providers, but to enhance diversity.

Steering Committee

A draft of this Situational Analysis that included data and key informant information was presented during the third Steering Committee meeting on March 3, 2017. Using this draft as a basis for discussion, the Steering Committee completed a SWOT analysis. The SWOT analysis was a facilitated discussion seeking to identify organizational and systemic strengths and weaknesses, as well as potential opportunities and external threats. After completing this analysis, the group identified six critical issues to address in the Strategic Plan.

Strengths

- Medicaid expansion is working to help more people.
- There has been improvement of the certification system as well as the criteria for certification.
- There is long-term leadership at the state level.
- The administrative restructuring process that began in 2013 has helped the agency.
- On the ground level, providers are ensuring that every person is receiving treatment because SAPTA is functioning as a safety net for Medicaid denied claims.

Weaknesses

- There has been a failure to comply with federal Block Grant requirements. For example, no Needs Assessment has been conducted in recent years.
- There is a lack of institutional knowledge and cross-training, and high turnover at the state level lead to loss of grant funding and missed grant opportunities.
- There is a lack of subject matter expertise at state level.
- There has also been a failure to comply with federal regulations:
    - No referrals given to pregnant women when a program is full (not meeting requirement for priority admission)
    - No outreach for IV users
    - No capacity management system
    - No strategy for monitoring compliance for sub grantees
    - While there is a point in time survey, there needs to be better systems
- There are barriers to the public to knowing what's available and how to access it.
  There is a lack of alignment within the state across bureaus, divisions, and departments.
- There has been a lack of supervision of behavioral health services.
- The advisory councils don't meet regularly and have trouble getting quorum when they do.
- Systems for oversight are needed.
- Medication assisted treatment is not tracked or certified and is underutilized.
- Serious data gaps inhibit the function of the agency. These data gaps include the following:
    - Waiting list data that identifies the extent to which demand for treatment exceeds the resources available.
    - Statute-required data on the evaluation, treatment, and transitional housing available for adolescents.
    - The Epidemiological Profile developed through the Strategic Prevention Framework grant from SAMHSA.

- An accurate number of pregnant women who received substance abuse treatment through the SABG.
- The number of pregnant women who received substance abuse treatment funded by Nevada Medicaid.

Opportunities

- SAPTA could be the single state authority to provide high level coordination of services and oversight, working to integrate and consolidate community resources.
- Promote and update resources available.
- The agency could work to become the single point of entry or increasing points of access to improve system navigation.
- The potential expansion of Medicaid-funded treatment would benefit the community.
- Leverage and build upon strong collaborative processes and systems.
- Increase the functionality of 2-1-1.
- The State Targeted Response to Opioids Grant provides many opportunities for the state to improve efforts.
- Federal Grants are on the horizon to further develop the workforce, including Nevada Works and Workforce Connection.
- Harm reduction strategies related to marijuana could be developed.

Threats

- Potential elimination of the ACA and Medicaid expansion may cause complications.
- Funding reductions at a national level are a potential threat.
- Legalization of recreational marijuana is a threat for public health, treatment, and youth. Research suggests that marijuana impairs critical thinking and memory functions and, that regular marijuana use in the early teen years lowers IQ into adulthood (National Institutes of Health , 2014).

Critical Issues

Critical issues central to the achievement of the vision were identified by the Steering Committee based on the draft of the situational analysis and the S.W.O.T. These issues are high impact, strategic areas that cannot be addressed easily or resolved in the near-term.

1. State Capacity

A critical issue is the state's capacity to assess need, manage available resources, and report on utilization and outcomes. The capacity gap includes state-level subject matter expertise, knowledge capture, and the transfer of institutional knowledge.

2. Lack of Compliance

A critical issue (related to 1) is the lack of compliance with federal regulations and federal grant requirements. This issue contributes to lack of integration as specified in statute and has the potential to impact much-needed funding.

3. Workforce Issues

A critical issue is lack of workforce across the state to meet demand. The bureau can help address this through grants, collaboration, certification, and cross-agency initiatives.

4. Service Gaps

A critical issue is the gap in services needed for prevention, outreach, intervention, treatment, and recovery in Nevada, including (but not limited to):

a. Lack of wraparound services
b. Lack of person-centered planning and recovery supports
c. Services for adolescents
d. Services to address needs in justice systems

5. Insufficient Funding and Sustainable Resources for Evidence-Based and Integrated Approaches

A critical issue is the need for funding to sustain and strengthen the evidence-based practices that have been adopted by the bureau and its partners.

6. Public Education and Information

A critical issue is insufficient public education and information that addresses stigma and promotes the availability of resources to allow for better navigation of the system.

Town Hall Meetings

The purpose of the town hall meetings was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the Steering Committee. Each meeting lasted a total of 1.5 hours. At each meeting, participants were asked to sign in and self-identify as consumers, family members, professionals in the field, policy makers, or advocates. A total of 64 participants were recorded on sign in sheets. The results of each individual meeting appear in the appendix of this document.

Table 10: Town Hall Meeting Attendance

	Las Vegas March 10, 2017	Carson City March 13, 2017	Elko March 14, 2017
Total Participants	26	26	12
Consumer			
Family Member			
Professional	12	14	5
Policy Maker		1	
Advocate	2	5	4
Multiple	2	1	

Designations			
Unmarked	2	3	3
Other		2 (Educators)	

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by each of the groups.

Timely treatment and workforce development were suggested as additional potential values.

Needs

Each town hall group agreed with the majority of the overview of the situational analysis as presented, emphasizing the importance of treatment for youth, workforce shortages, the challenge of housing and transportation, and challenges related to data sharing and use. People in all locations underscored the importance of wraparound services and case management and reducing stigma associated with substance abuse. Each group also recognized the lack of information available to professionals and the public about providers and services.

Each group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to their region and some of them were acknowledged as problematic for the whole system.

- Information about the service system is needed so that people (including providers) can make appropriate referrals.
- The resources available to people with co-occurring disorders are lacking. More information, training, and resources are needed to effectively treat co-occurring disorders.
- Burnout is common in the workforce—especially in rural areas—because people are trying to help with such a broad spectrum of issues.
- Provider collaboration is lacking in many areas of the state.
- Substance use and other mental health issues are inextricably linked—from problem gambling to suicide. The state needs to consider how to address people holistically.
- There is a need for flexibility in the plan because of upcoming changes, including federal and state. The legalization of marijuana and changes to the ACA will affect how any plan is implemented.
- Social determinants of health along with substance abuse need to be addressed, including the influence of poverty on substance abuse.
- Seniors, Native Americans, and Veterans are special populations that should not be ignored. Services for youth had already been identified. Nevada's large population of people that are Hispanic (Latino) is also an important population to consider. People that are considered extremely hard to serve, people who are homeless, and, people who are under-insured are examples of other groups noted as important to consider in planning resources and improving the service system.
- There is a need to understand the unintended impact of regulation and the opioid crisis on prescribers.

- Health systems are not connected and so cannot serve people fully, e.g. dental, behavioral, etc.
- Individualizing care is challenging given what is available via providers and what is dictated by insurance. Insurance can cause problems with continuity of care, especially if there are insurance coverage gaps.
- Legislative advocacy is needed to support policies that promote health and do not worsen substance misuse trends. Gambling and the casino culture contribute to the substance abuse problem. Local decisions--for example zoning for liquor sales--play a role in promoting healthy behaviors (or conversely, encouraging unhealthy behaviors).
- Nurses, first responders, and other professionals do not have the training nor the funding to support training for substance abuse issues.

Critical Issues and Opportunities

Each group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY

- Difficult to compare data across communities.
- Inconsistent communication from the state about what's funded, what's available, and what's happening.
- Outsourcing should be to qualified and high-quality resources.
- Data needs to be used to inform funding.

#2: LACK OF COMPLIANCE

- Further define what is meant by "statute specified plan integration."

#3: LACK OF WORKFORCE TO MEET DEMAND

- Knowledge capture and transfer is a problem among the workforce itself.
- Include cross-systems initiatives.
- Reciprocity is a barrier to entry. The vetting process for Nevada is not realistic.

#4: SERVICE GAPS

- Lack of youth and family services, especially services to support youth whose parents are in treatment.
- Better wraparound services are needed.
- Transportation to and from providers, even within communities, but especially between rural and urban is a challenge for providing complete care.
- Early intervention.
- Appropriate levels of care.
- Recovery services are needed.
- Basic barriers to entry into the system, like having an address.
- Lack of training for overdose.
- Special populations include but are not limited to youth, veterans, Native Americans, LGBTQ, racial and ethnic minorities, women, and seniors. Also, it is important to consider those hardest

to serve (e.g. people who are homeless) and those that may have some access to care but are underinsured / not getting appropriate care (working poor and professionals).

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- The problem is not that funding is insufficient; it is that money is not well-used or well-placed.
- Medicaid reimbursements are too low.
- Awareness about the funding provided by SAPTA needs to increase.
- Bundled and unbundled services make billing difficult.
- No grant-writing assistance or technical assistance from the state to increase funding.
- Grants are not regionalized.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Lack of time and staff to receive the training and knowledge that already exists within the community. Professionals across the spectrum, including first responders, nurses, etc., need to be given time to participate in trainings to address stigma, suicide prevention, etc.
- The problem affects the entire population including all classes and all people.
- There are barriers to getting information into schools.

SUGGESTED ADDITIONAL CRITICAL ISSUE

- Silos exist that create obstacles to an effective system of referral and care for people needing treatment and recovery.

Opportunities

The group identified several opportunities or potential strategies for the state. These fall under key themes listed below:

State System

- Enhance local and regional and local ability to be responsive to the needs of local populations, assist with local education and prevention, certify and develop programs, and disburse funding. (“One size does not fit all!”).
- Align data systems so that entry for the same information happens into one system. Improve two-way communication from data systems.
- Encourage and support meaningful coordination and collaboration, especially for early intervention, treatment, and recovery.
- Clarify language related to the field. Define what terms like substance abuse, mental illness, co-occurring disorders actually mean so that everyone uses them the same way.
- Improve infrastructure for telehealth needs to better serve rural and frontier areas.
- Improve grant transparency to allow for a better understanding of what is available, who else is working on the same type of project, and potential collaborations to better leverage funding. Improve long-range planning for funding.
- Strengthen training opportunities in evidence-based practices (including financial supports for providers). Additional training and support for co-occurring disorders is an example of where additional training and resources would be helpful within communities.

Consumers

- Provide consumers with immediate access to evidence-based treatment.
- Look at people holistically. Bridge services from the hospital to treatment so that people don't have to navigate the system on their own. Improve care management and wraparound services (and work toward recovery oriented system of care).
- Create a system that allows consumers to provide regular feedback about what they need.

Corrections

- Improve screening and assessment to get individuals where they need to be instead of sending them to jail.
- Establish a diversion program to keep people out of jails.
- Enhance mental health and substance use resources in jails.

Workforce

- Promote the use of community college-level educated workforce who can be supervised by masters-level providers, especially in rural areas.
    - Engage educational institutions in creating a program that helps build community health workers.
- Leverage expertise across systems for cross training (e.g. medical, social services, dental, law enforcement).
    - Better use and training of "force multipliers," including mobile units, peer support services, first responders, law enforcement, etc.
    - Educate providers about trauma-informed care. Funding should be allocated to get providers the right training they need.
    - More training for naltrexone for overdoses.
- Improve peer support supervision and training.

Providers

- Create a comprehensive directory of providers, listing who is doing what in the community, what insurance they accept. Perhaps CCBHC's could help with this.
- Educate providers about how they can collaborate. Incentivize the providers to collaborate and meet standards. A strong provider association could possibly use the coalition model. Already a few groups or associations in the works.
- Educate providers about chronic pain management without opioids.

General or Systemic

- Address other root causes like poverty and supply of illegal substances into communities.
- Help people through better 'upstream' interventions – prevention and early intervention as well as appropriate levels of care within communities.
- Improve understanding of trauma and its effect on the lifespan.
- Begin prevention in early childhood with healthy attachment, stable families, and family support and parenting help. Connect prevention to all levels of education.
- Use the coalitions to identify and address duplications within communities.
- Partner with universities to provide education, training, and other system supports.
- Look to rural and frontier systems because they are creative and innovative with more engaged communities.

- Share information more broadly using technology to allow for more knowledge transfer, especially important when it comes to changes at the federal level. Leverage the information that is available from national resources and other states to improve practices within Nevada.

Appendices

Town Hall Meetings to Assess Critical Issues

Town Hall Meeting Summary: Las Vegas

Date: March 10, 2017
Time: 1:30 pm - 3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts and values for the Strategic Plan, the needs identified via the Situational Analysis, and the critical issues recognized by the committee.

The meeting lasted a total of 1.5 hours.

Participants

26 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	12
Policy Maker	
Advocate	2
Multiple/Designations:	2
Unmarked	10

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group, with participants nodding in assent. One person suggested adding workforce development (education, training, investment, expansion) as a potential value.

Needs

The group agreed with the needs of the community identified in the presentation, emphasizing the importance of treatment for youth, workforce issues, housing and transportation, funding, and data capacity. Additionally, the group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to Southern Nevada and some of them were acknowledged as problematic for the whole system.

Las Vegas Specific Needs:

- Southern Nevada needs better representation at the state level in committees and workgroups.
- Provider collaboration is lacking:
    - Working together to provide the best service to clients. Some providers say: "If someone needs care, instead of losing a client, I will hold on to someone as long as I can even if I don't have space."
    - Sharing programs and services.
    - Focusing on funding versus the good of the community
- Some fraud exists within systems.
- People living in tunnels beneath the city represent a very hard to reach group with extreme needs.
- The sheer number of people in need of treatment or intervention is too great to be treated by demand.
- Gambling and the casino culture contribute to the substance abuse problem.

System-wide Needs:

- Problem gambling needs to be screened for as a co-occurring disorder.
- Some people are resistant to getting the help they need.
- Individualizing care is challenging given what is available via providers and what is dictated by insurance.
- Services in the community are unknown and unverified.
- There is discomfort in providing referrals to unknown services.
- People are unable to navigate the system after discharge. This often leads to cycling back into intensive programs and criminal justice systems instead of moving into recovery.
- Legislative advocacy is needed to help support policies that promote health and reduce substance misuse and dependency (and stand against those that promote substance misuse or contributed to source issues).
- Loss of federal funding to prevent underage drinking is problematic and is anticipated to result in increased problems among children and youth.

Critical issues and Opportunities:

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY

- Outsource to qualified and high-quality resources.

- Data for treatment episodes and recovery services to support funding.

#2: LACK OF COMPLIANCE

- There was no feedback about this critical issue.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Include cross-systems initiatives.
- Reciprocity is a barrier to entry. The vetting process for Nevada is not realistic.

#4: SERVICE GAPS

- Early intervention.
- Appropriate levels of care.
- Unequal funding of treatment and recovery services.
- Family recovery and support are lacking.
- Program evaluation has to be evidence-based.
- Basic barriers to entry in the system, like having an address.
- Lack of training for overdose.
- Special populations: Veterans, Native Americans, LGBTQ, African Americans, Women.

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- No grant-writing assistance or technical assistance.
- Grants are not regionalized.

#6: INSUFFICIENT PUBLIC EDUCTAION AND INFORMATION

- The problem affects the entire population including all classes and all people.
- There are barriers to getting information into schools.

Additional Critical Issues

The group identified "silioing" as a critical issue citing trust issues, lack of coordination, competition for funding, inability to coalesce around important advocacy issues, etc. Instead the group would like to see a focus on outcomes for people and the community.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Provide consumers with immediate access to evidence-based treatment.
- Expand use of "force multipliers," including mobile units, peer support services, first responders, etc.
- Ensure that medical professionals have access to reliable information about the resources available to people. A referring source should be specific, speak to both treatment types and outcomes, and have up to date information about how to connect people to the resources needed.
- Create a comprehensive directory of providers, listing who is doing what in the community, what insurance they accept. Perhaps CCBHC's could help with this in effort.
- Enhance collaboration among prevention and treatment providers.
- Bridge services from the hospital to treatment so that people don't have to navigate the system on their own.
- Look to rural and frontier systems because they are creative and innovative with more engaged communities.

- A strong provider association is necessary to promote collaboration and improved outcomes; it may be possible use the coalition model. There are already a few groups that could be strengthened to accomplish this goal.
- Empower the community at a grassroots level. Advocacy within the community.
- Connect prevention to all levels of education.
- Prevent overcrowding in places like the ER, jail, etc.
- Partner with universities to provide needs assessments, etc.
- Improve peer support supervision and training.
- Invest in telehealth services.
- Provide more training for naltrexone for overdoses.
- Educate providers about how they can collaborate. Incentivize the providers to collaborate and meet standards.
- Regionalize grants to ensure that they are aligned with local needs.
- Look at people holistically.

Town Hall Meeting Summary: Carson City

Date: March 13, 2017
Time: 1:30 pm - 3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. At the end, they were asked to provide any further comments.

The meeting lasted a total of 1.5 hours.

Participants

26 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	14
Policy Maker	1
Advocate	5
Multiple Designations	1
Other: Educator	2
Unmarked	3

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group.

Needs

The group agreed that people are becoming more comfortable with talking about the issue of substance misuse and so there is more awareness in general in the community. However, the group identified several needs that they did not see reflected in the overview of the Situational Analysis.

Data Suggestions:

- Utilize youth probation data to better understand needs.
- Share key informant list to see representation of stakeholder groups.
- Review data by job type to understand trends among professionals that are in need of treatment.

System-wide Needs:

- It is not clear what funding exists and how to connect people to resources that are available. Resources listed on the State website are out of date and there is not a reliable source of information.
- Health systems are not connected and so cannot server people fully, e.g. dental, behavioral, etc.
- Stigma is still strong among the Latino population, and this needs to be addressed to better serve people in Northern Nevada.
- There is a lack of funded programs that support treatment for opioid issues. This includes the population that is not considered 'highest need' financially but has everything to lose through dependency (e.g. the working poor and professionals with inadequate insurance).
- There is no direct funding to help the children of those with substance use disorders. Support for the family is important to recovery and also prevent related problems for other family members.
- Nurses and other professionals need additional training and funding for substance abuse issues.
- Funding is needed for more treatment services.
- Targeted case management is needed as part of treatment services.
- People with substance abuse issues are marginalized, even by some 'supportive' services. Stigma exists among some providers as well as the public at large.
- Insurance reimbursement is driving treatment options but is not necessarily delivering what people need.
- The cost of housing and lack of transitional housing is barrier.

Critical Issues and Opportunities

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY

- Difficult to compare data across communities.
- Two-way communication with coalitions is a challenge.

#2: LACK OF COMPLIANCE

- Statute specified plan integration needs to be addressed.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Knowledge capture and transfer is a problem among the workforce itself.
- Lack of rural workforce.
- Lack of trauma-informed care.

#4: SERVICE GAPS

- Lack of basic services like housing, transportation, and food can impede recovery.
- Very little prenatal and perinatal help for substance use.
- Prevention and intervention services needed.
- Transitional planning is not available from the corrections system.

- In rural and frontier areas, where the workforce may get injured in physical labor, there is a greater use of opioids. Workforce compensation claims are not being adequately handled by the state and contribute to these issues.

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- The problem is no that funding is insufficient; it is that money is not well-used or well-placed.
- Medicaid reimbursements are too low.
- Awareness about the funding provided by SAPTA needs to increase.
- Unbundled services are especially difficult to bill.
- Providers can't attend trainings because they have limited resources and can't bill for this time away. Need to help financially support providers to get the additional information and training they need.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Opioid patients are getting mixed information from their providers about best practices.
- Personal connections are required to help navigate the system.

Additional Critical Issues

The group emphasized the importance of regional and local control to address the needs of the populations, assist with local education, and certify and develop programs.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Strengthen progress made by partnerships with law enforcement to have an expanded role and impact in prevention and early intervention.
- Clarify language related to the field. Define what terms like substance abuse, mental illness, co-occurring disorders actually mean so that everyone uses them the same way.
- Share information more broadly using technology to allow for more knowledge transfer, especially important when it comes to changes at the federal level. Leverage the information that is available from national resources and other states to improve practices within Nevada.
- Use the coalitions to reduce duplications and identify service needs.
- Promote protective factors in communities to help prevent substance misuse.
- Develop grant transparency that will allow for a better understanding of what is available, who else is working on the same type of project, potential collaborations to better leverage funding, and improve long-range planning for funding.
- Provide accurate information to providers to refer.
- Promote the use of community college-level educated workforce who can be supervised by Masters level providers, especially in rural areas.
    - Engage educational institutions in creating a program that helps build skills of community health workers.
- Explore and support chronic pain treatment (trainings, best practices) that doesn't center on opioids.
- Enhance telehealth mechanism for rural Nevada.
- Leverage expertise across systems for cross training (e.g. medical, social services, dental, law enforcement).

- Educate providers about trauma-informed care.
- Help people through prevention, early intervention and with the right levels of care to avoided more expensive and difficult situations.
- Allocate funding to get providers the right training.
- Address underlying issues through awareness and training on trauma, ACEs, etc.
- Begin prevention in early childhood with healthy attachment, stable families and family support and parenting.
- Improve care management and wraparound services.
- Build in flexibility of this plan to address emerging issues, understand what is happening in communities and consider block grants to the community to disburse. ("One size does not fit all!")
- Revisit state integrated systems for concrete, collaborative actions.
- Create a system that allows consumers to provide regular feedback about what they need. This could be through interviews, a form completed by funded providers, or, other mechanisms. Review this data to help inform system improvements.

Town Hall Meeting Summary: Elko

Date: March 14, 2017
Time: 1:30 pm -3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. At the end, they were asked to help prioritize these issues.

The meeting lasted a total of 1.5 hours.

Participants

12 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	5
Policy Maker	
Advocate	4
Multiple Designations	
Unmarked	3

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group. One person suggested timely treatment as an important aspect of the value regarding effective and quality treatment.

Needs

The group agreed that the local community is engaged in the issues. However, the group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to the frontier region or Elko and some of them were acknowledged as problematic for the state as a whole.

Data Suggestions:

- Review regional assessments developed by coalitions.

Frontier/Elko Specific Needs:

- Frontier communities have unique challenges and need flexibility to meet those needs. Many of the solutions that work in urban or even rural areas are not feasible in frontier communities.

- It is difficult for providers to get sufficient education locally including CEU's and higher level education.
- The location makes it challenging to maintain a workforce. Professionals who are brought to the community from other areas often don't stay long. They are trained, organizations or agencies invest time and money in training them, and as soon as they find a job somewhere else they leave. Being able to recruit and train people within our community for our community shows promise for creating and maintaining a qualified workforce.
- Telehealth shows promise but cannot be used with some populations including children and those with the most acute needs. Improvements to internet infrastructure are also needed for telehealth to fulfill its promise.
- While a strength of frontier communities is the ability of people to 'wear many hats,' burnout is common because people are trying to help with such a broad spectrum of issues and cover so many needs.

System-wide Needs:

- People ending up incarcerated when they really needed treatment instead.
- There is not sufficient capacity to address co-occurring disorders. Training and professional development is needed, including how to properly diagnose and refer people with co-occurring disorders.
- There is a high suicide rate, and this relates to substance use disorders (and people not getting the help that they need).
- Need to have information about what the legalization of recreational marijuana looks like and mitigate negative impacts.
- Providers experience paperwork overload, working in multiple data system (often to report the same data for different requirements). Providers cannot bill for their time completing the documentation required. Also, this communication is 'one-way'; it is not provided back in a way that supports providers to improve outcomes.
- Many funding cycles are built using data that is several years old, and therefore, solutions are reactive instead of proactive.
- Insurance causes problems with continuity of care, especially if there are insurance coverage gaps. Additionally, insurance doesn't necessarily cover what a patient needs.
- Changes to insurance coverage often result in provider changes. People often have to request and be responsible for their own records. Transitions of providers can also be very difficult.
- People in poverty are people at risk of substance misuse. The lifestyle supported by selling can be a draw and difficult to exit, especially when it is very difficult to get by on low-paying, low-skilled jobs.
- The older adult population has emerging needs; for example, people are affected by prescription misuse. It is also important to consider that adults with substance misuse age, but if untreated, their issues continue. Managing multiple prescriptions can be a challenge as well; while there is a database that connects pharmacists, the system is not perfect. People also may cross state lines for care which makes coordination of providers and medications more challenging.

- Pain medication is a complex issue. While it is important to control access, and reduce the possibility of dependency, people needing medication can have difficulty getting it or face stigmatization in requesting what they need. Doctors face challenging decisions with little information about how to make the best decisions with and for their patients.

Critical Issues and Opportunities

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow. The group had nothing further to add to the first two critical issues as they were presented, nor to the fifth.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Knowledge capture and transfer is a problem among the workforce itself.

#4: SERVICE GAPS

- People with acute conditions are sent to Reno. There is no local acute treatment or long-term care, and many people have no transportation to return to Elko. This can be especially problematic for youth.
- There is a lack of youth and family services, especially services to support youth whose parents are in treatment. It is critical that families have support when a parent has left the area, including appropriate information.
- Better wraparound services are needed.
- Transportation even with the local area is a challenge for providing complete care.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Lack of time and staff to receive the training and knowledge that already exists within the community. Professionals across the spectrum, including first responders, etc. need to be given time to participate in trainings to address stigma, suicide prevention, etc.

Additional Critical Issues

The group emphasized the importance of regional and local control to address the needs of the populations, assist with local education, and certify and develop programs.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Help people get in touch with the correct resources.
- Expand mental health and substance use treatment in jails.
- There are many best practices in the Elko area, but there are not always resources or assistance to support monitoring and evaluation. As a result, the process (utilization of the best practice) and outcomes are not well understood.
- Identify barriers at the local level and work on them to work better together. Elko is in the process of developing a needs assessment that will help to inform decisions.
- Improve screening and assessment to get individuals where they need to be instead of sending them to jail. Additionally, establish a diversion program to keep people out of jails.
- Invest in local people as the workforce and help them to grow professionally and serve their community. Expand local educational opportunities through Great Basin Community College.

- Address awareness in families and in schools and educate about risk factors like trauma in early childhood.
- Address root causes like poverty and social determinants of health. Also consider opportunities to cut or reduce the supply of illegal drugs into the area.
- Improve infrastructure for telehealth needs including internet resources and provider training.
- Employ a rural coordinator.

Priorities

The group identified more beds for treatment and more providers as a key priority, as well as prevention efforts.

Center for Community Capacity Development Prioritization Criteria

On July 14, 2015, the Behavioral Health Planning and Advisory Council met to review Nevada's behavioral health, gaps and priorities, and recommendations meta-analysis summary report and Nevada's Behavioral Health Barometer. Following the presentation of data and discussion by the Council, public comment on both documents was heard.

A rating tool, based on Illinois's Public Health Institute, Center for Community Capacity Development Prioritization Criteria was used to rate priority issues as outlined in the meta-analysis summary and quantified in the Behavioral Health Barometer. Needs and gaps were rated as high, medium and low by Council members using the following criteria:

- Important to the Community/Seriousness of not addressing
- Size of the problem
- Feasibility
- Disparities and subpopulation needs

Results of the ratings were presented back to the Council for further deliberation. The top needs and gaps adopted by the Council included:

1. The need for Behavioral Health Capacity building related to: (a) costs, (b) degree program capacity, (c) recruitment and retention, (d) clinical supervision, and (e) clinical site availability to address the behavioral health workforce shortage, poor workforce retention/high staff turnover rates, low wages and front line staff burnout,
2. The need to enhance prevention of substance abuse and mental illness including limited crisis intervention services, early intervention services and early identification and intervention for at-risk populations,
3. The need to enhance person-centered planning and recovery supports including lack of affordable housing options, peer support services, habilitative services and supports, and to confront cultural and community stigma associated with needing or seeking services

Recommendations in the meta-analysis were rated by Council members with each member submitting their top five recommendations. The results were presented back to the Council for further deliberation. The recommendations adopted by the Council included:

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

1. Improve screening, assessment, and referral services for at-risk populations
2. Support earlier access to prevention and early intervention services
3. Increase community-based services across the system of care

Strategic Initiative #2: Health Care and Health Systems Integration

1. Provide behavioral health services in primary care and non-traditional settings
2. Enhance collaboration between behavioral health and other systems of care

Strategic Initiative #3: Trauma and Justice via Trauma-informed Approach

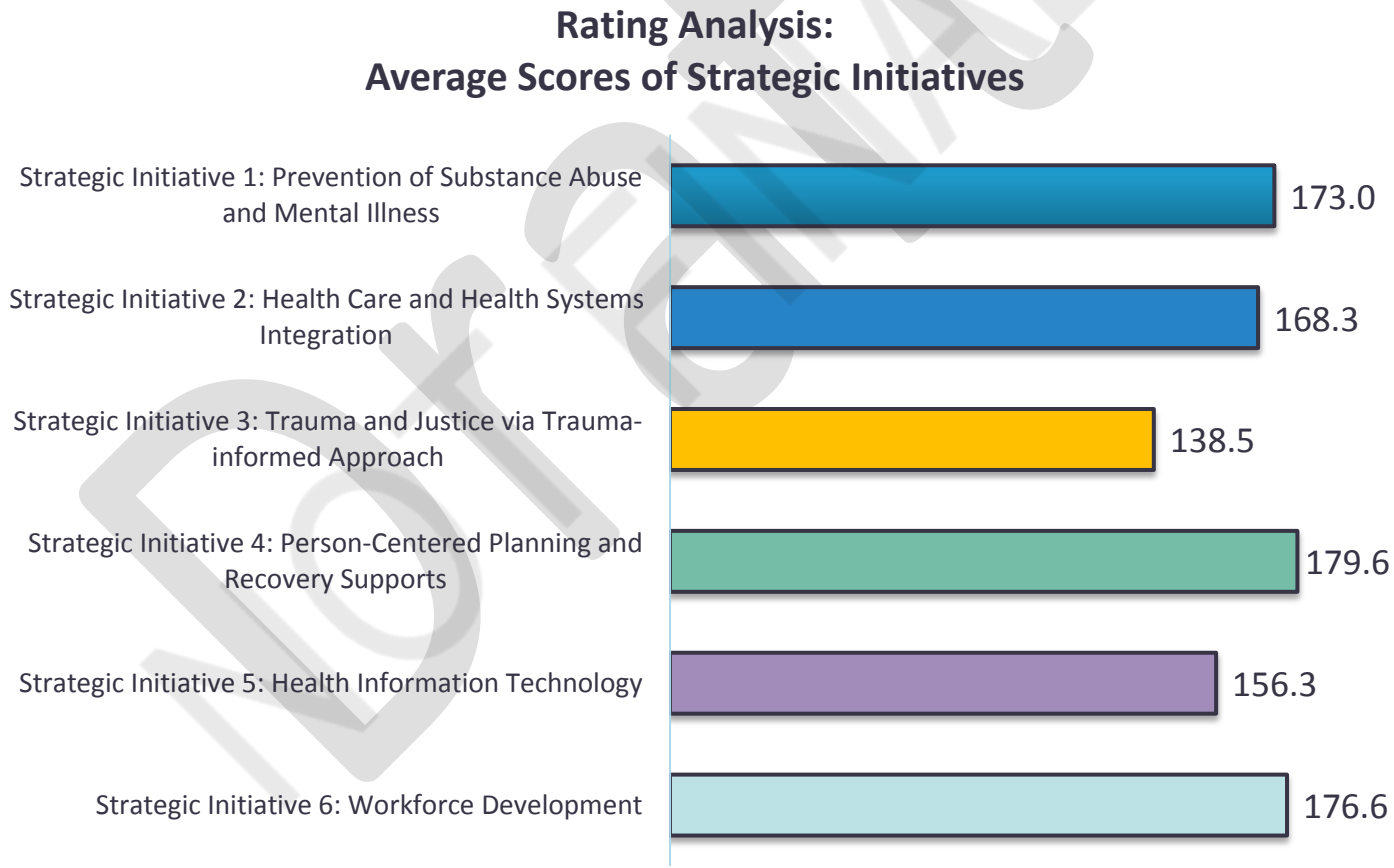
1. Provide community-based intervention and support to address trauma and prevent incarceration

Strategic Initiative #4: Person-centered Planning and Recovery Supports

1. Prioritize community-based strategies and solutions that enhance the system of care
2. Improve discharge planning and transition support

Strategic Initiative #6: Workforce Development

1. Increase the number and quality of behavioral health professionals in Nevada
2. Remove barriers to behavioral health professional licensure and certification



Certified Community Behavioral Health Clinics Focus Group Summary

Focus groups were also recently completed for the Community Behavioral Health Clinics Focus Group (CCBHC) planning process. Several needs were identified and are summarized here:

Service Needs

- Need for mobile, in-home (including home visiting programs for children and families) and on-line services
- Satellite clinics throughout the community also suggested in Elko
- Jail based assessment and support identified at both rural and urban sites
- 24/7 linkage to crisis services and a "live person" identified by both rural and urban sites and providers and consumers
- Need for more of all services identified by both rural and urban sites and providers and consumers with focus on volume in urban areas and infrastructure in rural areas

Focus Group Results: Workforce and Staffing

- Workforce shortage issues identified by all groups and linked to wait times for services
- Psychiatrists, Clinical Psychologists, School Social Workers in need
- Emphasis on Peer Support
- Specialty staffing needs vary by site but include geriatric and children's services specialists including developmental screening
- Other staffing needed included job developers, community points of contact for Information and Referral (I&R), Transportation aids

Care Coordination to Date

- Enhanced collaboration, coordination and communication including shared data and access to electronic records identified by both rural and urban sites and providers and consumers
- Ongoing care and care coordination in the form of agreements, barrier reduction and facilitation of access was a universal theme
- Linkages to specialty courts, jails, hospitals, schools and primary care physicians identified by all sites and in varying degrees by both types of participants
- More school social workers identified as a need at both rural and urban focus groups

Scope of Services to Date

- Evidence Based Practices concepts were supported by all groups and sites
- More prevention and treatment options were also supported by all groups and sites
- School based and jail based services specifically identified
- Crisis services and training of all provider types both on resources, eligibility and how to manage persons in crisis was a universal theme
- Peer and family support services were also suggested by all groups and sites
- Supportive services including education assistance, job training, life and basic skills, more 12 step options were all identified to varying degrees at all sites and by both types of participants
- Lack of sufficient gambling addiction services noted at both rural and urban locations
- Lack of housing options identified at every focus group with emphasis varying based on location or type (homeless, homeless youth, sex offenders, domestic violence)

Other Issues Identified

- Lack of cultural and linguistic services, especially Spanish speaking providers, assessors, therapists etc.
- Need for Behavioral Health Coordinator in Elko
- Social stigma and community and provider education identified at all sites and by all groups
- Need for veteran specific services and access to VA Hospital (Elko)

Glossary of Terms

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

CFR: Code of Federal Regulations

Charitable Choice: Provisions of the SAMHSA Charitable Choice regulations are designed to strengthen the capacity of faith-based and other neighborhood organizations to deliver services effectively to those in need and provide people with a choice of SAMHSA-supported substance use prevention and treatment programs. Provisions also ensure that funding administered by SAMHSA is accomplished without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries.

Co-Occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. Substance use disorder. A substance use disorder includes. Alcohol or drug abuse (Behavioral Health Evolution, n.d.)

DPBH: Division of Public and Behavioral Health

NAC: Nevada Administrative Code

NRS: Nevada Revised Statutes

Person-and Family-centered Planning: According to SAMHSA, “Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible.”

Prevalence: is a measure of disease that allows us to determine a person's likelihood of having a disease. Therefore, the number of prevalent cases is the total number of cases of disease existing in a population.

Recovery Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada's Substance Abuse and Treatment Agency

SED: Serious emotionally disturbed

SMI: Serious mental illness

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015)

SUD: Substance Use Disorder

Trauma-Informed Approach: According to SAMHSA, a trauma-informed approach, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015)

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Substance Use During Pregnancy Provider Toolkit

National Governors Association to Improve Birth Outcomes

October 1, 2017

Table of Contents

Special Thanks

It is with deep appreciation to the many individuals and organizations who participated in the Nevada National Governors Association to Improve Birth Outcomes Reducing Exposure to Alcohol, Drugs, and Tobacco work group.

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July 10, 2017

TO WHOM IT MAY CONCERN:

Since December 2013, Nevada has been participating in the National Governors Association Learning Network on Improving Birth Outcomes with the mission of improving birth outcomes and the health of children in Nevada. This Network focuses on implementing policies and initiatives related to the improvement of birth outcomes, as well as adopting best practices in its implementation. One of its key goals is to reduce negative birth outcomes resulting from maternal substance use through education, prevention, and intervention efforts.

The Division of Public and Behavioral Health, and more specifically, the Bureau of Behavioral Health Wellness and Prevention and the Bureau of Child, Family and Community Wellness have provided funds to prevention and treatment providers across the State to address this growing concern, provide access to services and support recovery for pregnant women and women with dependent children who struggle with substance abuse.

As a medical professional, you are in a unique position to identify substance use disorder in the patients you see every day. The enclosed packet has been assembled to provide information to assist you in assessing and linking these patients with resources. We appreciate your willingness to partner with us as we strive to support those families struggling with substance abuse.

Sincerely,

Kyle Devine, Chief
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FACT SHEET

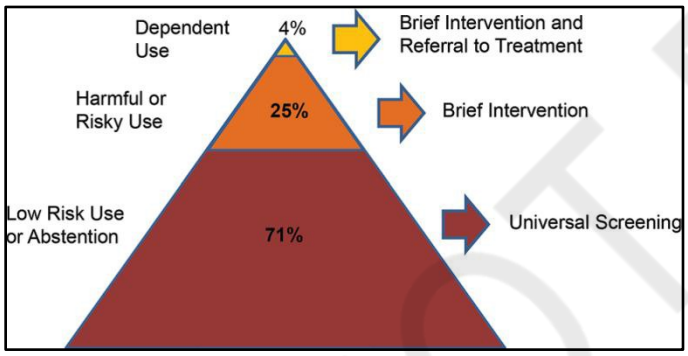
Office of National Drug Control Policy (ONDCP)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

A Comprehensive Public Health Approach

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive public health approach for delivering early intervention and treatment services to people with, or at risk of developing, substance use disorders. Healthcare providers using SBIRT ask patients about substance use during routine medical and dental visits, provide brief advice, and then, if appropriate, refer patients who are at risk of substance use problems to treatment. Release of the Institute of Medicine report *Broadening the Base of Treatment for Alcohol Problems*[1] provided recognition that alcohol and drug abuse occur along a continuum of both level of consumption and consequences. This recognition is illustrated by a treatment pyramid (shown above) that has been developed to depict the role of SBIRT in addressing needs across the continuum of use.



Studies show the need for a tool such as SBIRT:

- Results of the most recent National Survey on Drug Use and Health (NSDUH) show that an estimated 22.1 million people aged 12 or older have a diagnosable alcohol or illicit drug use disorder.[2]
- In 2010, according to NSDUH, 8.1 percent of the population aged 12 or older – about 20.5 million people – needed but did not receive substance use treatment at a specialty facility in the past year.[3]
- In 2006, excessive drinking cost the United States $223 billion.[4] Factoring in public health, public safety, and lost productivity, illicit drug use cost the Nation an estimated $193 billion in 2007.[5]

Elements of SBIRT

Healthcare practitioners have the important responsibility of looking after their patients' general health and welfare. In this role, they must be vigilant in identifying a host of potential health problems. It is critical, therefore, to focus resources and efforts on expanding the continuum of care health practitioners provide for their patients.

SBIRT at a Glance

Step 1

Screen Patients

Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Screenings take place in trauma centers, emergency rooms, community clinics, health centers, dental clinics, and school clinics. Screening can be done through one to five pre-screen questions based on evidence from NIDA and NIAAA.

Steps 2 and 3

Conduct Brief Intervention and Brief Therapy

Brief Intervention and Brief Therapy use motivational interviewing techniques to increase a person's awareness of substance use and encourage changes in behavior.

Step 4

Refer to Treatment

Referral to treatment offers access to specialty care for individuals who are in need of treatment for substance abuse.

With SBIRT, substance abuse screening is incorporated into mainstream healthcare settings, such as college health clinics, hospitals, trauma centers, and dental clinics, as well as into tribal and military healthcare settings. Practitioners screen patients to assess substance use, then, based on the screening results, provide the appropriate intervention.

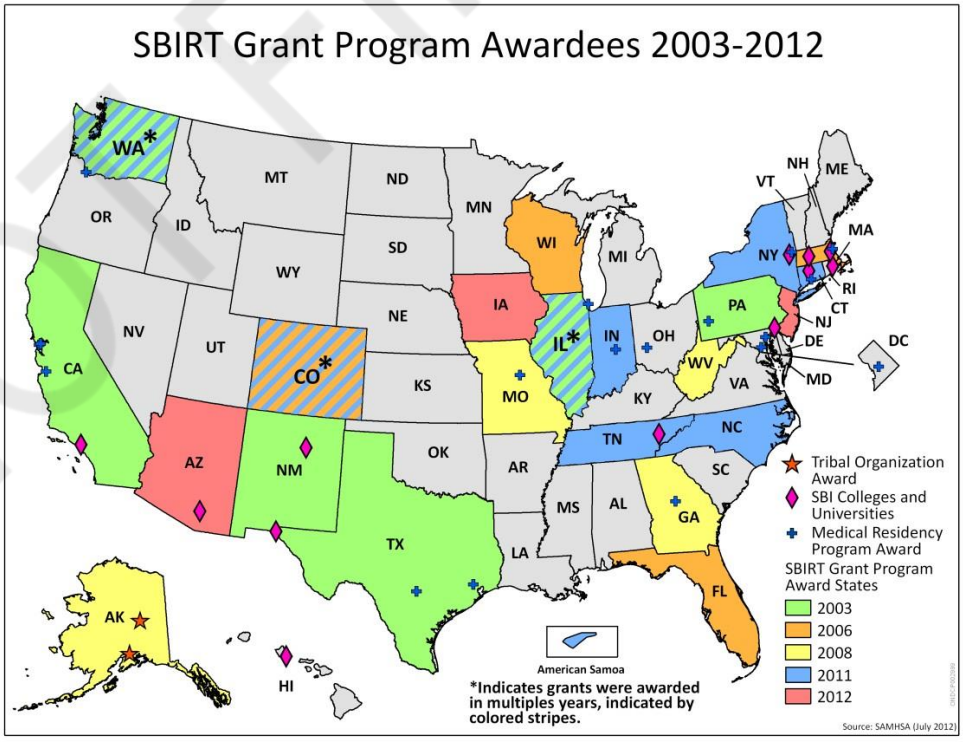
SBIRT is a four-part process:

- **Universal screening** assesses substance use and identifies people with substance use problems.
- **Brief intervention** is provided when a screening indicates moderate risk. Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of substance use and its consequences and motivating them toward positive behavioral change.
- **Brief therapy** continues motivational discussion for persons needing more than a brief intervention. Brief therapy is more comprehensive and includes further assessment, education, problem solving, coping mechanisms, and building a supportive social environment.
- **Referral to treatment** provides a referral to specialty care for persons deemed to be at high risk.

A key aspect of SBIRT is the integration and coordination of screening, early intervention, and treatment components into a system of care. This system links community health care and social service programs with specialty treatment programs. In each of the SBIRT grantee programs, healthcare professionals and clinical support staff conduct universal screening that targets risky to harmful use, thereby helping to reduce the number of people who move from substance use to addiction.

History of the Federal SBIRT Program

In 2003, the Federal Government established the SBIRT grantee program within the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment to implement SBIRT services in primary care and community health settings for adults with substance use disorders[6] (see grantee map at right). To date, SAMHSA has fully or partially funded four portfolios for SBIRT grantees: (1) SBIRT Cooperative Agreements to Single State Authorities (SSAs) for Substance Abuse Services; (2) SBIRT implementation on college campuses; (3) a pilot project for SBIRT implementation within Federally Qualified Health Centers (FQHCs); and (4) SBIRT implementation within medical residency programs. These real-world implementations build on findings of more than 100 research studies conducted over the past 30 years that have supported development of reliable screening tools, empirically proven brief interventions, and implementation and technology transfer research.



Effectiveness of SBIRT

Research on SBIRT's effectiveness for alcohol and drug problems indicates the approach clearly leads to short-term health improvements and, though not fully demonstrated, may also yield substantial long-term benefits.[7,8] One study found that, in some instances, a brief motivational intervention appears to facilitate abstinence from heroin and cocaine use at a 6-month follow-up interview, even in the absence of specialty addiction treatment.[9]

Data from SAMHSA grant programs[10] help demonstrate the impact of SBIRT on patient health through documented:

- Reduction in alcohol and drug use 6 months after receiving intervention (41 percent of respondents reported abstinence from drugs and/or alcohol at follow-up, compared to just 16 percent at baseline);
- Improvement in quality-of-life measures, including employment/education status, housing stability, and 30-day past arrest rates (95 percent of respondents reported no arrests in the past 30 days at follow-up, compared to 88 percent at baseline); and
- Reduction in risky behaviors, including fewer unprotected sexual encounters (injection drug use decreased from 3.2 percent at baseline to 1.5 percent at follow-up).

SBIRT also reduces the time and resources needed to treat conditions caused or worsened by substance use, making our health systems more cost-effective.[11] For example, participants in the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program who received a brief intervention experienced a reduction in total Medicaid costs ranging from $185-$192 per month. Participants admitted as hospital inpatients after emergency department visits saw reductions in associated costs ranging from $238-$269 per month.[12]

Seeking Local Solutions

State and local level actions:

- Healthcare professionals can learn screening techniques to identify patients with, or at risk for, substance use problems and talk to them about consequences and behavioral change. To learn more about SBIRT, visit www.integration.samhsa.gov/clinical-practice/sbirt.
- More training can be made available to primary healthcare providers and staff to ensure fidelity to evidence-based practices such as SBIRT. Training and webinars on SBIRT are available at www.integration.samhsa.gov/clinical-practice/sbirt.
- Parents can talk to their children about the consequences of alcohol and illicit drug use. Advice and information about teen drug use is available online at http://www.theantidrug.com.
- Community anti-drug coalitions can apply for Federal grants through ONDCP's Drug Free Communities Support Program (http://www.whitehouse.gov/ondcp/drug-free-communities-support-program).

Codes for Reimbursable SBIRT Services

The chart below lists codes approved by the American Medical Association (CPT Codes) and the Centers for Medicare and Medicaid Services (G and H Codes) to be used by healthcare practitioners for reimbursable SBIRT services.[13]

Payer	Code	Description
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicaid	H0049	Alcohol and/or drug screening
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes

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Resources for Codes for Reimbursable SBIRT Services

Private Insurance

- More information about Current Procedural Terminology (CPT) codes for private insurance is available from SAMHSA at http://www.samhsa.gov/prevention/SBIRT/index.aspx

Medicare and Medicaid

- More information about Medicare and Medicaid G and H codes is available from SAMHSA at http://www.samhsa.gov/prevention/SBIRT/index.aspx and from the Centers for Medicare & Medicaid Services at http://www.cms.gov/.
- More information on Codes for Reimbursable SBIRT Services is available from the Medicare Learning Network at http://www.cms.gov/MLNgeninfo/.

Physicians

- AMA Healthier Life Steps™: Coding for Routine Adult Lifestyle Screening, Early Intervention, and Motivational Interviewing, published in *cpt Assistant: Your practical guide to current coding (2009),* is available online from the American Medical Association at http://www.ama-assn.org/ama1/pub/upload/mm/433/cpt-assistant.pdf.

Other SBIRT Resources

- To learn more about substance use and SBIRT, visit the websites for SAMHSA (www.samhsa.gov) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at www.niaaa.nih.gov.
- *Screening for Drug Use in General Medical Settings: Quick Reference Guide,* National Institute on Drug Abuse, 2009. Available online at http://m.drugabuse.gov/sites/default/files/files/screening_qr.pdf
- *Screening for Drug Use in General Medical Settings: A Resource Guide for Providers,* National Institute on Drug Abuse. Available online at www.nida.nih.gov/nidamed/resguide/resourceguide.pdf
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), developed by the World Health Organization (WHO), is designed to help healthcare providers detect and manage substance use and related problems in primary and general medical care settings. More information about this screening tool is available on WHO's website at http://www.who.int/substance_abuse/activities/assist/en/
- Wisconsin created a coding, billing, and reimbursement guide (http://www.wiphl.com/uploads/media/SBIRT_Manual.pdf)

Notes

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RESEARCH SNAPSHOT

NOVEMBER 2013

Hospital SBIRT: THE REASONS

Rules

Some hospitals are required to do SBIRT

To retain accreditation, Level I and Level II trauma centers are now required to have a mechanism to identify patients whose drinking is unhealthy. Level I centers must have the capacity to help these patients.[1]

The VA mandates routine screening for risky alcohol use system-wide.

The Joint Commission, the accrediting body for 95% of the hospital beds in America, has approved four measures of SBIRT in its core set of measures. Hospitals may select to report the SBIRT measures as part of their accreditation.[2]

Reimbursement

You can get paid to do SBIRT

Hospitals have been reimbursed for SBIRT since 2007. There are commercial, Medicare, and Medicaid codes for SBIRT services (check to see if they are turned on your state).[3]

For psychiatric hospitals and psychiatric units of general hospitals, CMS will start a Medicare incentive payment process in January 2014.[4]

Reform

The Affordable Care Act creates carrots (and sticks) for the use of SBIRT

SBIRT helps meet 14 CMS Accountable Care Organization quality measures.[5]

SBIRT helps fulfill dozens of patient-centered medical home recognition criteria.[6]

SBIRT helps hospitals address ACA-required community health needs assessments, which often find high rates of community binge drinking and prescription drug misuse.

The ACA's CMS Hospital Readmissions Reduction Program [7] reduces payments to IPPS hospitals with excess readmissions; SBIRT can play a role in reducing readmissions.[8]

The ACA's move toward bundled payments creates a strong incentive to reduce costly episodes of care; SBIRT can play a role in reducing these costs.

Under the ACA, hospitals must provide US Preventive Health Task Force recommended screens (including SBIRT) with no co-pays.[9]

Results

Patient outcomes are better when substance use is addressed using SBIRT.[10]

In 2012, the USPSTF found adequate evidence that brief counseling interventions in adults with screening-detected risky or hazardous drinking positively affect several unhealthy drinking behaviors, including heavy episodic (binge) drinking, high average weekly intake of alcohol, and consumption above recommended intake limits.[11]

Washington state ER data showed 1.2 days reduction in hospital days with the use of SBIRT.[12]

Patients who need SBIRT show up in hospital ERs. Among SAMHSA's SBIRT grantees, around 20% of adult patients in EDs screen positive for substance use disorders.[13]

Retention

Staff express satisfaction with the use of SBIRT[14]

"Before we started using SBIRT, we didn't know what to do with certain patients. We knew some were drug-seeking... and they just kept coming back."

— Tami Slain, RN (Nurse Educator, Allegheny General Hospital, Pittsburgh, PA)

Resources

The federal government in particular has thrown a lot of support behind SBIRT.

A wealth of information exists for SBIRT implementation in hospitals.

Here are two ways to get started:

Join BIG Hospital Initiative by visiting http://hospitalsbirt.webs.com and selecting "Get Involved"

Connect with the National SBIRT ATTC by subscribing to The SBIRT Alert, our monthly(ish) newsletter: http://ireta.org/enewsletter-subscribe

SBIRT

Screening, Brief Intervention and Referral to Treatment

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COLORADO CLINICAL GUIDELINES COLLABORATIVE
IS NOW...
HealthTeamWorks

Fetal Alcohol Spectrum Disorder (FASD) Supplement: *Screening*

sbirt COLORADO

Who to screen? *All women of childbearing age.*

1) preconception; 2) during pregnancy; 3) at the time of delivery; 4) in postnatal period - especially if breastfeeding; 5) at all GYN and health visits. Rescreen every year or following life changes or increase in stressors. Parental screening by pediatric providers is recommended by the American Academy of Pediatrics.

Why screen?

- Fetal Alcohol Spectrum Disorders (FASD) are completely preventable.
- Fetal Alcohol Syndrome (FAS) is the leading preventable cause of mental retardation.
- FASD occurs in approx. 10/1,000 births: in Colorado that equals ~700 cases/yr. This outranks Down syndrome and autism in prevalence.
- 50% of pregnancies are unplanned.
- A woman can expose a pregnancy to alcohol even before she knows she is pregnant.
- **There is no known time or amount of alcohol that is safe during pregnancy.**

Definition/Problem:

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term that describes the range of effects that can occur to an individual whose mother drank during pregnancy. These include physical, mental, behavioral, and learning disabilities. Fetal Alcohol Syndrome (FAS) is on the severe end of the spectrum and characterized by facial dysmorphia, growth restriction, and CNS abnormalities. However, most individuals affected by prenatal exposure do not display the facial dysmorphia or growth deficits of FAS.

- **Alcohol is a teratogen**. Adverse effects of alcohol on the fetus may be exacerbated by other teratogens.
- Maternal factors such as nutrition and mental illness may mitigate or exacerbate effects of alcohol.

1. Assess alcohol use +

Use SBIRT Guideline at www.healthteamworks.org.

Brief Screen for Alcohol:

1. When was the last time you had more than 3 drinks in one day?
   Positive *= in past 3 months*

2. How many drinks do you have per week?
   Positive *= more than 7*
   Recommendation*: verify quantity and frequency of usual alcohol intake - do the math!*

Any alcohol use is a positive screen for a pregnant woman, a woman trying to become pregnant, or an adolescent.

For positive Brief Screen, do further screening using a Brief Assessment Instrument such as the AUDIT.

2. Assess risk for pregnancy =

- Able to get pregnant? (no = hysterectomy or permanent sterilization)
- Sexually active with a male or planning pregnancy by other method?
- Non-use or incorrect use of contraception?
- Use of non-effective method of contraception?

Ask (can be self-administered):

- Are you pregnant? ❒ Yes ❒ No ❒ Don't Know
- Are you able to get pregnant?
  ❒ Yes ❒ No ❒ Don't Know
- In the last year have you had sex with a male?
  ❒ Yes ❒ No
- When you have sex do you use something to prevent pregnancy:
  ❒ all the time
  ❒ most of the time
  ❒ sometimes
  ❒ not at all
- What method(s) do you use to prevent pregnancy?

3. Alcohol Exposed Pregnancy (AEP) Risk

- Did the patient use an effective method of pregnancy prevention? ❒ Yes ❒ No
- Was the method used 100% correctly? ❒ Yes ❒ No
  » If no, was a backup method used every time? ❒ Yes ❒ No
- Is the patient planning to become pregnant in the next year?
  ❒ Yes ❒ No
- Is the patient at risk for unintended sexual contact due to alcohol and/or drug use? ❒ Yes ❒ No

Negative AEP Risk:

- *Correctly using an effective contraceptive method, not planning a pregnancy in the next year and not at risk for unintended sex* ***-or-*** *Unable to get pregnant*
  -and-
- *Negative alcohol screen* ***-or-*** *No alcohol use in a pregnant woman*

Do a brief intervention to:

- Address hazardous or harmful use of alcohol and refer to treatment, if indicated.
- Address pregnancy prevention.

COUNSEL: ***No amount of alcohol is considered safe during pregnancy. Pregnancy should be delayed until individuals are alcohol free.***

Myths about alcohol and pregnancy

- **Science is unclear about the effects of alcohol on the developing fetus: FALSE.**
  3,000+ research studies since 1973 describe the risks of alcohol during pregnancy. The conclusion is overwhelming and clear. Since 1982 the United States Surgeon General has advised women to abstain from alcohol during pregnancy to prevent birth defects. (NOFAS, 2010)
- **Only heavy or binge drinking can harm the fetus: FALSE.**
  Effects of prenatal alcohol exposure occur on a continuum. Rather than a threshold, there is a dose-response effect. Also, harm may occur at all stages of pregnancy. (NOFAS, 2010)
- **Only hard liquor is harmful. Beer and wine are okay: FALSE.**
  All alcohol acts as teratogen. Since some individuals and cultures do not view beer as alcohol, it is important to specify all forms of alcoholic drinks when screening patients. (NOFAS, 2010)
- **Health professionals infrequently see patients with Fetal Alcohol Syndrome and FASD is no longer a significant health issue: FALSE.**
  Individuals with FASD are in every system of care. As of 2008, only ~6 medical schools offered training on FASD. Many practitioners have not been educated on addiction medicine or trained to diagnose FASD in children or adults. (NOFAS, 2010)

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SA. Completed on August 26, 2010.

Fetal Alcohol Spectrum Disorder (FASD) Supplement: *Intervention*

GOAL:
To encourage behavior change(s) to decrease risk of alcohol exposed pregnancy.

- » ***Ask permission before providing feedback.***
- » ***Remain neutral and factual.***
- » ***Elicit reaction before and after each step.***

A. Provide feedback about screening results

Alcohol Use +
Review moderate and risky drinking levels.

Feedback (2002 BRFSS):
- ~47% of women 18-44 yrs drink at moderate levels
- ~ 13% of women 18-44 yrs drink at risky levels

Pregnancy Risk =
Review effectiveness of current contraception and effectiveness of use.

Feedback, in the United States:
- 50% of all pregnancies in the are unplanned
- 82% of pregnancies in the 15-19 yr. old age group are unplanned

Risk for an Alcohol Exposed Pregnancy (AEP)
Feedback:
- Because you are at risk for pregnancy and using alcohol you are at risk of an AEP
- Many women do not find out they are pregnant until the 6th-8th week
- No known safe time /no known safe amount of alcohol during pregnancy

Offer brochures/fact sheets on AEP and FASD.

B. Discuss options to decrease risk; Patient chooses behavior(s)

***Decrease risk of AEP by changing alcohol use, increasing effective contraception used correctly, or both.**

Options: Pregnant patient
- *Stop drinking*
- Improve nutrition
- Decrease stress
- Stop other drug use
- Stop tobacco use
- Maintain pre-natal care

Options: Not pregnant/not wanting pregnancy
- *Use effective contraception correctly*
- Drink below risk levels
- Stop other drug use
- Stop tobacco use

Options: Not pregnant/wanting pregnancy
- *Stop drinking*
- Stop tobacco
- Stop other drug use
- Improve nutrition
- Decrease stress
- *Use effective contraception correctly until pre-conceptual health achieved*

C. Assess motivation; Set goals and plan

1. **Assess Motivation to change**: use 0-10 ruler to assess Importance, Readiness for identified targeted behavior(s), and Confidence. (If pregnant, choose a behavior other than birth control.)
   > Ask patient "Why this number and not a lower or higher number?"
   > Listen for change talk:
   D *(desire)* **A** *(ability)* **R** *(reason)* **N** *(need)* **C** *(commitment)* **A** *(activation)* **T** *(taking steps).*
   > Respond to change talk:
   E *(elaborate)* **A** *(affirm)* **R** *(reflect)* **S** *(summarize)*. Probe for anything else.

2. **Set Goals and Develop a Plan**
   Consider referral to treatment if patient is motivated or having difficulty setting/achieving goals.

D. Follow up at every visit for women at risk for an AEP

All patients:
- Assess urges, cravings, high risk situations, and alcohol use
- Develop and review emergency plan for high risk situations.
- Monitor stressful life events and significant life changes
- Assess motivation for treatment or engagement in treatment
- Designate support person

Pregnant patient:
- Monitor need to add other behaviors to the plan
- Engage in activities and information to increase bond with the baby
- Consider need for more frequent visits

Not pregnant/not wanting pregnancy:
- Encourage contraception compatible with lifestyle
- Monitor for correct use, side effects, difficulty in use
- Include back up plan
- Consider whether alcohol/drugs are interfering with plan
- Monitor contraception use monthly until stable

Not pregnant/wanting pregnancy:
- Evaluate importance, readiness, confidence for healthy pregnancy
- Encourage contraception compatible with life style until pre-conceptual health achieved, and alcohol/drug free
- Monitor for correct use, side effects, difficulty in use
- Include back-up plan

Substance Abuse Services for Women

1. **Regional Managed Service Organizations (MSOs)**: Can assist with locating an appropriate treatment agency or with referral to a Division of Behavioral Health (DBH) accredited treatment program:
   - Region 1: Northeast region of the state: Signal Behavioral Health Network, Inc. 1-888-607-4462
   - Region 2: Denver Metropolitan Area: Signal Behavioral Health Network, Inc. 1-888-607-4462
   - Region 2: Boulder County: Boulder County Health Department 303-441-1292
   - Region 3: Colorado Springs Service Area: Connect Care 1-719-572-6133 or 1-888-845-2881
   - Region 5 & 6: Central Mountain and Western Slope Services: West Slope CASA 1-800-804-5008

2. **Personal DECISIONS**: Resource for providers and women in the community who are drinking and want to change their behavior. A woman who calls will be assessed for AEP risk and other concerns and then sent a packet of information with resources, referral information, and self-guided change information. Once the woman completes the packet she may share it with her provider for a more focused brief intervention. 1-888-724-3273. The message is in both English and Spanish.

3. **Specialized Women's Services (SWS)**: To learn about funding and services set aside for women in CO who use or abuse substances:
   http://www.cdhs.state.co.us/adad/PDFs/ItemsfortheWomenstreatmentWebsite.pdf

Legal and Confidentiality Considerations

1. Pregnant women have priority status for treatment in Colorado.
2. Confidentiality regulations for substance use/abuse are different than HIPAA, know the law.
3. Drinking during pregnancy in and of itself is not a violation of the law. Women need treatment for substance abuse.
4. Separate and specific release of information is required for alcohol and drugs.

Assessment and Diagnosis of FASD

Colorado FASD Diagnostic Clinics:
- Sewall Child Development Center: Diagnostic & Evaluation (up to age 10): 303-399-1800
- The Children's Hospital Child Development Unit: 720-777-6630

This supplement is designed to assist clinicians in alcohol screening and management. It is not intended to replace a clinician's judgment or establish a protocol for all patients with a particular condition.

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SoberMomsHealthyBabies.org

Program Overview

The Sober Moms Healthy Babies (SMHB) website is part of an effort launched by Maternal and Child Health (MCH) Programs and the Substance Abuse Prevention and Treatment Agency (SAPTA). The SMHB website focuses on preventing substance misuse during pregnancy and providing women, their families, and providers information on resources and treatment options.

As Nevada receives federal funds from the Substance Abuse Prevention and Treatment Block Grant and the state must meet the requirements of 45 CFR 96.131, *Treatment services for pregnant women*, which states: *"The State is required to, in accordance with this section, ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admissions to treatment facilities receiving funds pursuant to the grant. In carrying out this section, the State shall require all entities that serve women and who receive such funds to provide preference to pregnant women."*

Program Challenges

Perinatal substance misuse (licit and illicit) is a growing public health problem. It has been linked to preterm birth, very low birth weight, infant mortality, and babies born with a range of birth defects. Substance using women (pregnant and not pregnant) are found in all socioeconomic groups and place a serious burden on health care systems. However, estimating the full extent of the consequences of maternal substance misuse is difficult for many reasons, but all consequences of maternal substance misuse are **100% preventable**. The best approach to reducing the tremendous toll substance abuse exacts on individuals, families, and communities is to prevent the damage before it occurs.

Collaboration

Nevada's public health approach to maternal substance misuse aims to prevent substance misuse in pregnant women and provide information to women of childbearing age, providers, and concerned family and friends. The National Governor's Association (NGA) Learning Network to Improve Birth Outcomes Collaborative has four workgroups focused on improving birth outcomes; 1. Promoting Maternal, Child and Adolescent Health, 2. Expanding Healthcare Access, 3. Reducing Exposure to Alcohol, Drugs, and Tobacco, and 4. Extending Gestational Periods. The third workgroup, Reducing Exposure to Alcohol, Drugs, and Tobacco, utilizes the SMHB website and media campaign to increase awareness and resources to providers, partner agencies, and the public. The Maternal and Infant Health Program assists, collaborates with, and supports both the SMHB website and NGA workgroup, along with other organizations with similar goals and objectives.

Program Contact

Christina Turner
Maternal and Infant Health Program Coordinator
Division of Public and Behavioral Health
christinaturner@health.nv.gov
(775) 684-4134
http://sobermomshealthybabies.org/

SOUTHERN NEVADA
Addictive Disorders Training Project

ONLINE & SELF-PACED SBIRT TRAINING OPTIONS

SAMHSA (FREE)
SAMHSA offers a 5-hour online training module through Ideas Exchange. This training is intended for a general audience. Interested parties may contact Project Coordinator, stephanie.borene@unlv.edu for registration information.

University of Missouri (FREE)
https://adept.missouri.edu/ 2-Hour training that has been used to train medical, public health and social work students.

Health-e-knowledge (FREE)
http://healtheknowledge.org/course/index.php?categoryid=50 Health-e-knowledge offers a 1.5 hour Dentistry SBIRT Training, a 1.5 hour Foundations of SBIRT Training and a 4 hour SBIRT for Health & Behavioral Health Professionals.

IRETA (FREE)
http://ireta.org/improve-practice/addiction-professionals/online-courses/sbirt-101/
IRETA offers a 10-12 hour SBIRT 101 training. They also offer an SBIRT for Adolescents course that is 3 hours.

KOGNITO (FEE BASED)
https://www.kognito.com/products/sbi/ This is an online training with avatars. It teaches adult and adolescent SBIRT.

SOUTHERN NEVADA
Addictive Disorders Training Project

REFERRAL RESOURCES*

Southern Nevada Addiction Treatment Providers and Support Groups (PDF)

HELPLINES
24-Hour Nevada Substance Abuse Helpline: 1-800-450-9530
24-Hour Nevada Problem Gamblers Helpline: 1-800-522-4700

TREATMENT LOCATORS
Foundation for Recovery – Nevada Resource Directory
http://www.forrecovery.org/nv-resource-directory/

SAMHSA Behavioral Health Treatment Services Locator
https://findtreatment.samhsa.gov/

SAPTA Certified Treatment Providers
http://dpbh.nv.gov/Programs/ClinicalSAPTA/dta/Providers/SAPTAProviders/

Problem Gambling Resource Locator
http://www.nevadacouncil.org/get-help-now/resource-locator/

SUPPORT GROUPS
For the client/patient:
Alcoholics Anonymous
Narcotics Anonymous
Gamblers Anonymous
Celebrate Recovery

For loved ones:
Al-Anon
Nar-Anon
Gam-Anon

*Inclusion of any agency, organization or individual as a resource should in no way be construed as an endorsement of its services, nor should exclusion be construed to constitute disapproval.

Screening and Brief Intervention with Referral to Treatment (SBIRT) Trainings & Resources

Online Trainings

CASAT – Frontier Regional FASD Training Center

Webinar Library

Institute for Research, Education, & Training in Addictions (IRETA)

Online Courses Upcoming
Webinars Webinar Library

Pacific Southwest Addiction Technology Transfer Center (ATTC)

Foundations of SBIRT

Saint Louis University

The Role of the Obstetrician/Gynecologist in the Prevention of FASD

SBIRT Oregon

OHSU SBIRT Primary Care Residency Initiative

University of Missouri

ADEPT Training

Yale School of Medicine

SBIRT Training in Yale Residency Programs

Resources

The American Congress on Obstetricians and Gynecologists (ACOG)

Committee Opinion Number 633 - At-Risk Drinking and Illicit Drug Use: Issues in Obstetric and Gynecologic Practice

Committee Opinion Number 473 - Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist

Committee Opinion Number 496 - At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications

Drinking and Reproductive Health: A FASD Prevention Tool Kit

Centers for Disease Control and Prevention (CDC)

Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use

Institute for Research, Education, & Training in Addictions (IRETA)

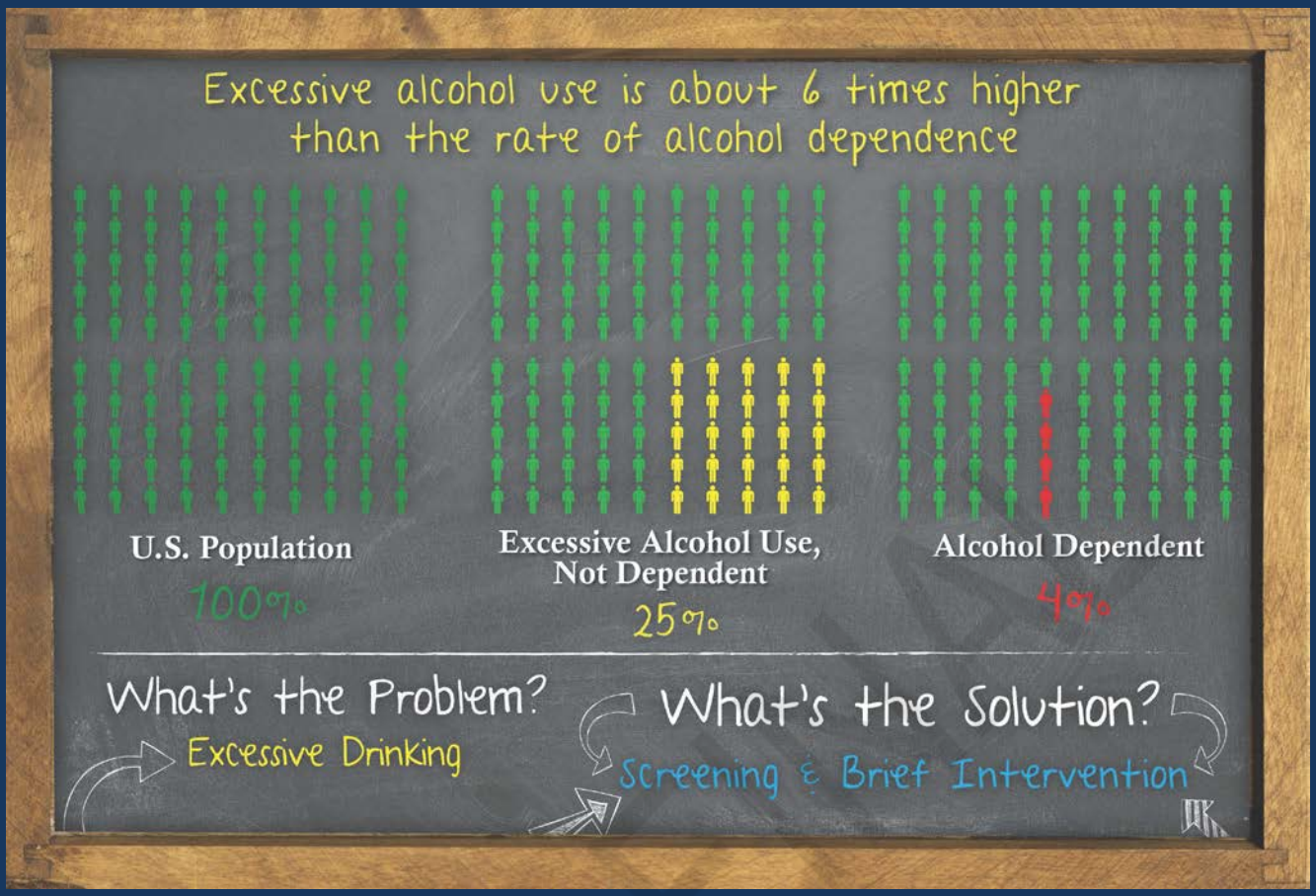
SBIRT Toolkit

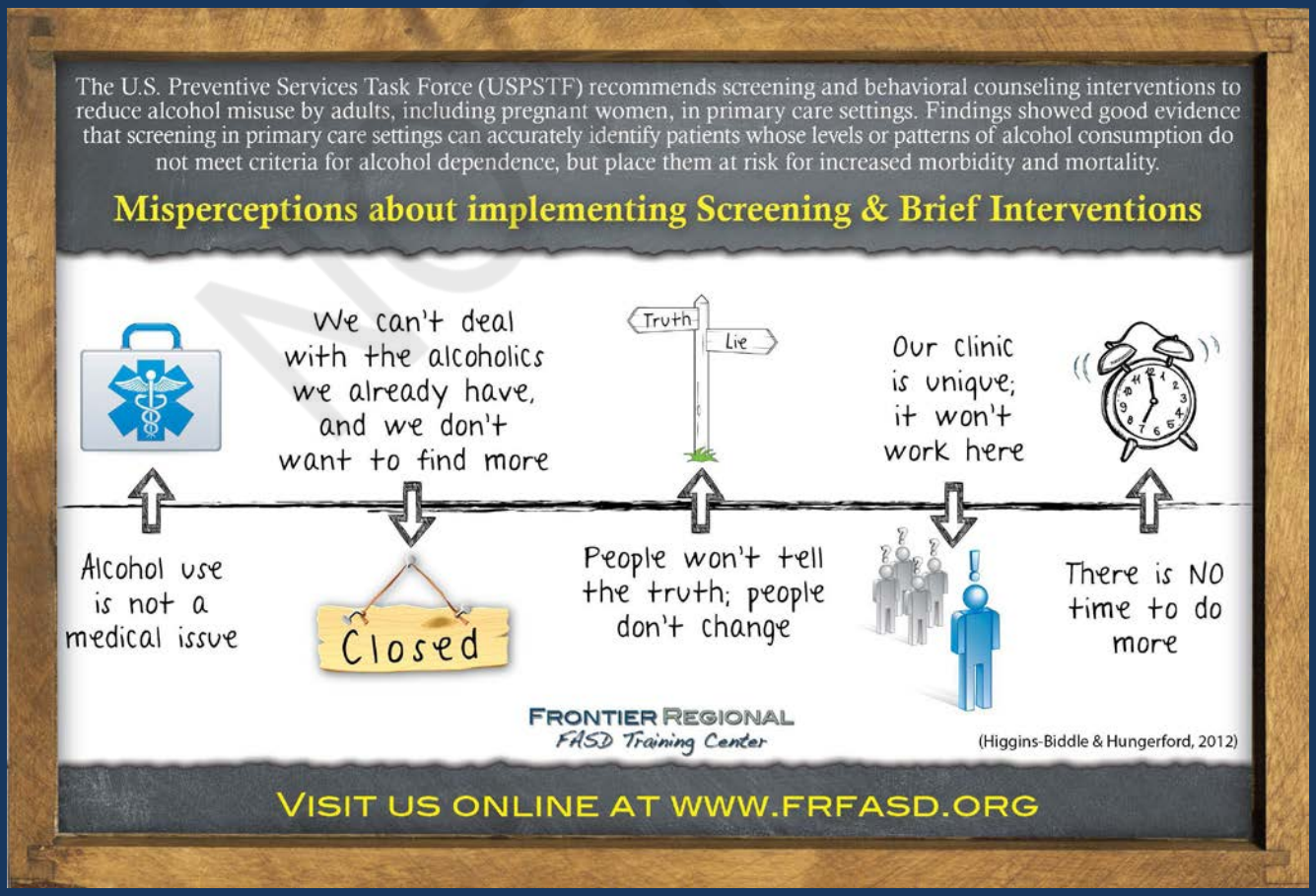
National Institute on Alcohol Abuse and Alcoholism (NIAAA)

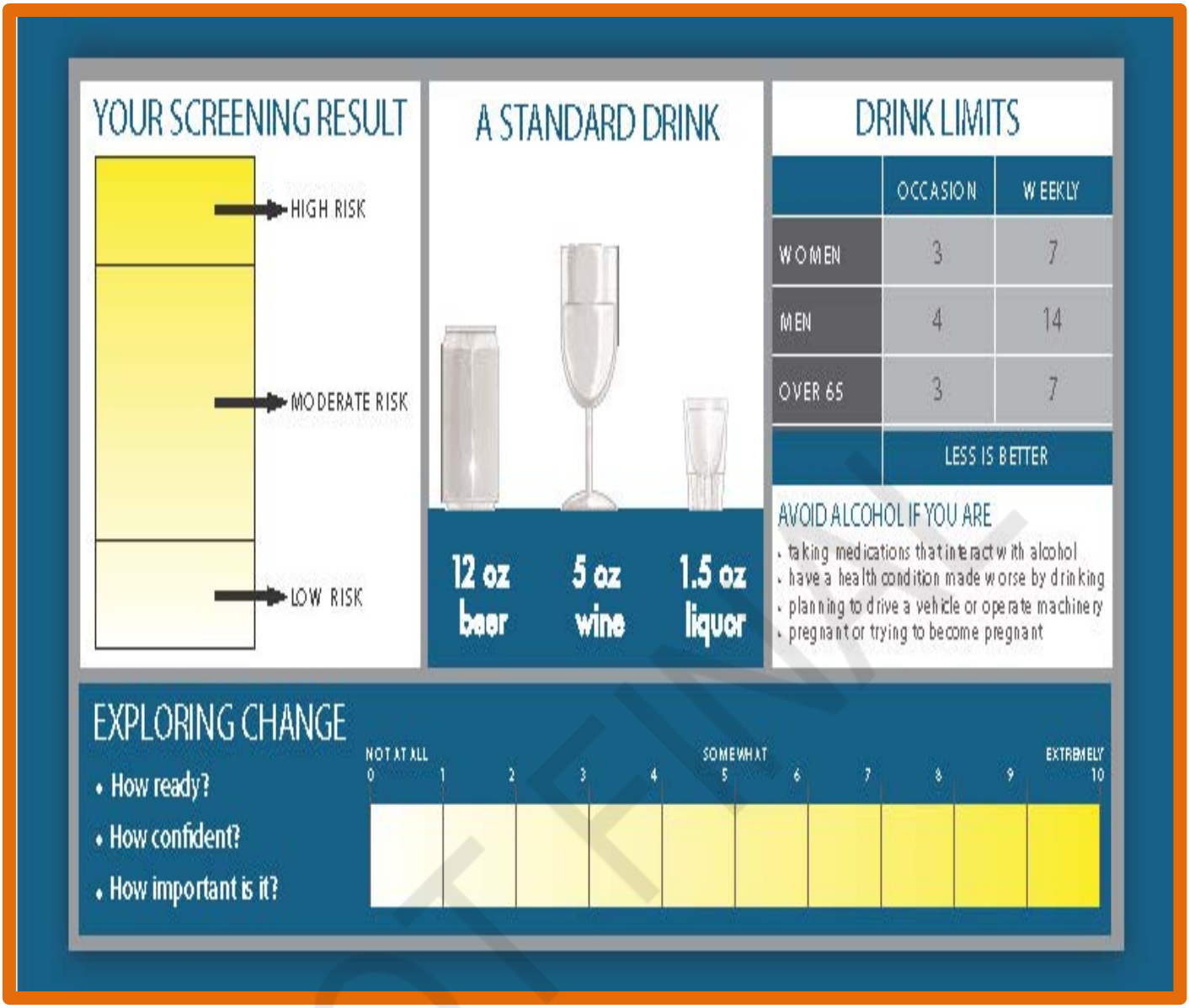
Helping Patients Who Drink Too Much: A Clinician's Guide

SAMHSA-HRSA Center for Integrated Health Solutions

SBIRT for Clinical Practice


Excessive alcohol use is about 6 times higher than the rate of alcohol dependence
U.S. Population
100%
Excessive Alcohol Use, Not Dependent
25%
Alcohol Dependent
4%
What's the Problem?
Excessive Drinking
What's the Solution?
Screening & Brief Intervention


The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Findings showed good evidence that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity and mortality.
Misperceptions about implementing Screening & Brief Interventions
Alcohol use is not a medical issue
We can't deal with the alcoholics we already have, and we don't want to find more
Closed
Truth
Lie
People won't tell the truth; people don't change
Our clinic is unique; it won't work here
There is NO time to do more
FRONTIER REGIONAL FASD Training Center
(Higgins-Biddle & Hungerford, 2012)
VISIT US ONLINE AT WWW.FRFASD.ORG



Screen
Women of All Ages, and Men ≥ 65
In the past year, have you had 4 or more drinks in a day?
In a typical week, do you have more than 7 drinks?
Men < 65
In the past year, have you had 5 or more drinks in a day?
In a typical week, do you have more than 14 drinks?
Women and Men: In the past year, have you…
used pot, other street drugs **or** Rx drugs for non-med. reasons?
drank more than you meant to?
thought about cutting down on your drinking or drug use?
been intoxicated on alcohol/drugs when you could hurt yourself or others?

Low Risk Limits	Drinks/Day	Drinks/Week
Women/Men ≥ 65	3	7
Men < 65	4	14

Probable Risk* and Recommended Action	
*Actual risk can only be determined by assessment	
No **"YES"** responses	Low
Exceeds Daily **or** Weekly Limit	Moderate
ANY of the below: • Exceeds daily + weekly limit • Drank more than intended • Thought of cutting down • Intoxicated when could have hurt self/others	Higher
Yes to illicit/Rx drug misuse	TBD by Assessment

Low Risk	Reinforce
Moderate Risk	Brief Intervention
Higher Risk	Brief Intervention + Assess for SUD + Consider Referral

The Cost of Opioid Use in Pregnant Women

The number of infants born to American mothers addicted to prescription pain medications is rising, and so are the costs of treating those babies.

60%

of babies exposed to painkillers developed Neonatal Abstinence Syndrome (NAS), which includes withdrawal symptoms and complications.

A healthy, drug-free baby stays in the hospital for 1-2 days

Babies with NAS remain in the hospital for an average of **23 days**

$55k

The cost of treating newborns with NAS.

Compared to the cost of caring for healthy newborns, an additional **$4.1 million** was spent in 3 years from the care of NAS babies.

Most of the treatment for babies suffering from NAS is paid for by state Medicaid programs.

Help us reduce prescription drug abuse.

JTNN

Join Together Northern Nevada

jtnn.org

Source for all information : Opioid Use in Pregnant Women and the Increase in Neonatal Abstinence Syndrome: What is the Cost?, Journal of Addiction Medicine, May 2015

Help is Available!

If you feel that you may have a dependence to opioid medications and would like help, contact your physician immediately And/Or...

Know your Resources!

New Frontier Treatment Center
1490 Grimes Avenue | Fallon, Nevada 89406
P.O. Box 1240 | Fallon, Nevada 89407
Phone: (775) 423-1412
Fax: (775) 423-4054
Toll Free: 1-800-232-6382
24 Hour Line: (775) 427-4040
E-mail ccoad@cccomm.net

Soloman's Porch
295 E. Williams Ave, Fallon, NV 89406
(775) 867-5615

The Churchill Community Coalition is not affiliated with, and does not support any business or individual mentioned in this flyer. Churchill Community Coalition cannot be held liable for any and/or all claims, demands, damages, injuries, actions, causes of action or suits of any kind or nature whatsoever that any person and/or business may have resulting from or in relation to any encounter or circumstance with any business and/or individual listed in this flyer. It is always good to use discretion in choosing the appropriate forms of therapy and right provider.

"Supporting Drug Free Communities & The Partnership For Success"

CHURCHILL COMMUNITY COALITION
WWW.CHURCHILLCOALITION.COM

Ask your Doctor about safe, alternative, NATURAL pain management options.

The Effects of Opioids on Women

During Childbearing Years, Pregnancy & Infant Opioid Dependence

• Hydrocodone • Oxycodone • Oxycotin •
• Codine • Vicodin •

And Many More...

Churchill Community Coalition
90 N. Maine St
Fallon, NV 89406
www.churchillcoalition.com

Like us on Facebook!
www.facebook.com/RxDrugAbusePrevention

CHURCHILL COMMUNITY COALITION

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The Dangers Of Rx Drug Abuse To Women

During Childbearing Years, Pregnancy & Infant Opioid Dependence

During Childbearing Years

If you are a woman of childbearing age, here are some important facts you should know about prescription painkillers (opioids):

- **Opioids are highly addictive; many women are prescribed opioids not knowing this information, and many unintentionally become addicted.**
- **Opioid medication can effect reproductive hormone levels making it difficult for women to get pregnant**
- **In some cases opioid use can cause infertility**

During Pregnancy

****Opioids have the most harmful impact on the fetus within the first few weeks of pregnancy****

This is especially dangerous because many women do not know they are pregnant until after those crucial first few weeks . In this time the opioids have already affected the fetus with irreversible and often severe birth defects such as Spina bifida, congenital heart defects (the number one cause of infant death in the U.S.), Clef lip and palate, low birth weight, seizures, preterm labor, and even miscarriage.

Infant Opioid Addiction

Some studies are showing that greater than 50% of mothers who use opioids during pregnancy were prescribed opioids for medical reasons and less than 50% were illicit use. Aside from opioid induced birth defects as mentioned, many of these infants suffer painful opioid withdrawal, known as Neonatal Abstinence Syndrome (NAS), shortly after birth. NAS can last in infants anywhere from one week, up to six months. Long-term damage and effects on individuals born with exposure to opioids and medications used in NAS treatment are unknown.

What Is Considered an Opioid?

An Opioid is a substance that acts on the nervous system in a similar way to an opiate such as morphine and codeine. In the medical field the term usually means medications that are artificially made rather than extracted from the opium plant directly.

- Methadone
- Morphine
- Buprenorphine
- Heroin
- Hydrocodone
- Oxycodne

Popular Brand Names of Opioids

- OxyContin
- Percocet
- Palladone
- Vicodin
- Percodan
- Tylox
- Demerol
- Norco
- Dilaudid
- Kadian

And Many More...

Prescription Drug Abuse PREVENTION Project

www.churchillcoalition.com

IF YOU ARE PREGNANT, CONSIDERING GETTING PREGNANT, OR THINK YOU MIGHT BE PREGNANT, ASK YOUR DOCTOR TO PRESCRIBE YOU SAFER, NON-ADDICTIVE PAIN RELIEVERS.

Do you suffer from opioid dependence?

Signs & Symptoms	Effects of Opioid Abuse	Symptoms of Withdrawal
• Psychosis	• Chest pain	• Nausea
• Depression	• Depressed respiration and difficulty breathing	• Stomach pain
• Irritability	• Bronchospasm	• Cold sweat
• Anxiety attacks	• Breathlessness	• Agitation
• Decreased appetite	• Constipation	• Anxiety
• Increased heart rate	• Fatigue	• Chills
• Lowered motivation	• A sense of elation	• Enlarged pupils
• Difficulty sleeping	• Confusion	• Shaking or quivering
• Over arousal and hyper-vigilance	• Death (often due to use of more than one substance)	• Diarrhea
• Physical agitation		• Trouble sleeping
• Increased sensitivity to sensory stimuli		• Pain in the bones
• High blood pressure		• Physical and psychological cravings

The Dangerous Effects On Young Children, Infants, and Unborn Babies

Babies born to opioid addicted mothers can experience some or all the following symptoms:

- Severe Pain During Withdrawal
- Birth Defects
- Low Birth Weight
- Seizures
- Premature Birth
- Irritable Behaviors
- Learning Disabilities

"Taking opioid medications early in pregnancy can cause birth defects and serious problems for the infant and the mother,"

- CDC Director
Tom Frieden, M.D., M.P.H

Marijuana and Your Baby

What is **Marijuana?**

Marijuana is made from the dried leaves and flowers of the hemp plant *cannabis sativa*. Tetrahydrocannabinol (THC) is the substance in hemp which causes people to get "high." THC is stored in fatty tissue. The brain consists largely of fats. When using marijuana, large amounts of THC will be stored in the brain, impacting cell membrane production. Medical marijuana is the SAME as street marijuana, except street marijuana may be mixed with other components or treated with unknown pesticides. A person using medical marijuana has received a card from the Division of Public and Behavioral Health; a person may also be using legal recreational marijuana purchased from a licensed vendor.

What happens when I use **Marijuana**?

The effects of marijuana change with the strength, dose, and how much THC is in the hemp. Although THC is the main compound that causes the high, there are also over 60 different compounds which can affect your brain. They can cause feelings of being afraid, fast heart rate and delusions, lasting two to three hours. The effects on your motor control can last longer. THC stays in the body for roughly one week. There is no way to know how much THC you have in your body. Smoking marijuana exposes mother and baby to harmful smoke; using marijuana edibles or vaporized still exposes baby to THC.

How **does Marijuana affect pregnancy**?

Marijuana can cause problems for a developing baby. Studies have found babies exposed to marijuana weighed less and had smaller head sizes.[1] Being born too small or too early are leading causes of serious health problems and death for infants under one year of age. Early research shows children born to mothers who used marijuana often have trouble concentrating.[2] This could make school harder for them.

How **does Marijuana affect breastfeeding**?

Everything a mother eats, drinks, or smokes enters breast milk. If a woman is breastfeeding, THC will be passed to her baby and the baby may experience certain effects of the drug. THC and the other 60+ compounds will enter into the baby's fat tissue as and brain, leading to developmental problems, such as delay in crawling or grasping finger foods. Experts also think early exposure to drugs may lead to early use of experimentation with them.

How **does Marijuana affect parenting**?

Use of marijuana by parents, even for medical reasons, can affect how they interact with their child. The parent may not be fully aware of the infant's basic needs such as signs of hunger, needing a diaper change or wanting to be cuddled. Times to play Peek-A-Boo or reading to their baby may be missed. These activities are an important way children learn about the world around them.
It is strongly advised marijuana not be mixed with pregnancy, breastfeeding or parenting. The American Academy of Pediatrics lists marijuana as a drug which is very harmful to infants.[3]

[1] E.E. Hatch and M.B. Bracken, "Effect of Marijuana Use in Pregnancy on Fetal Growth," America Journal of Epidemiology 124 (1986): 986-993
[2] N. L. Day et al., "Effect of Prenatal Marijuana Exposure on the Cognitive Development of Offspring at Age Three," Neurotoxicology and Teratology 16 (1994): 169–175
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MARIJUANA PREGNANCY AND BREASTFEEDING GUIDANCE FOR HEALTH CARE PROVIDERS

SCREENING QUESTIONS

Marijuana is now legal in Nevada. In addition to asking about alcohol, tobacco and other drug use (including prescription drugs), we recommend asking all teens and women who could become pregnant about marijuana use.

1. ***Have you used marijuana in the last year?***
   If no: Go to question 2.
   If yes: ***When was the last time you used marijuana? How do you use marijuana? What form of marijuana do you use? How often do you use and how much?***
   If pregnant: ***How has your use of marijuana changed since finding out you are pregnant?***
   If concerned about substance abuse: Use the free Cannabis Use Disorder Test (CUDIT) and referral recommendations found in the resource section.
2. ***Does anyone in your home use marijuana?***
   If yes or no: ***It is important to ensure your home is safe for your child. Make sure any potentially harmful substances are out of reach of your child, including marijuana, alcohol, prescription drugs or household substances.***
   If yes: Provide additional education on the avoidance of secondhand smoke and safe storage.

PRENATAL CARE

It is important to reassess substance use at each visit, because many women continue using substances throughout pregnancy or may begin or resume using substances during pregnancy.

Discuss the importance of cessation of marijuana and other potentially harmful substances during pregnancy and breastfeeding.

Discuss the patient's plan for marijuana use after pregnancy: ***Tell me about whether you intend to use marijuana after delivering your baby.***

Discuss breastfeeding and marijuana: ***Are you planning to breastfeed your child?*** If yes, see the breastfeeding section for more information.

Please inform your patient: ***Marijuana is now legal for adults over 21. This <u>does not</u> mean it is safe for pregnant women or babies.***

As a prenatal provider, if you are concerned about a patient's substance use, you can recommend testing a mother during prenatal care and/or delivery, or testing the newborn at birth.

Newborn testing information:

- Meconium testing generally identifies maternal marijuana use after 24 weeks gestation.
- Urine testing generally identifies maternal marijuana use after 32 weeks gestation.
- Umbilical cord testing generally identifies maternal marijuana use after 24 weeks gestation.

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WELL WOMAN VISITS

Discuss contraception options if the patient wants to continue marijuana, alcohol or other substance use and/or does not desire pregnancy.

If a patient desires a pregnancy, discuss the importance of cessation of marijuana and other potentially harmful substances. Consider use of contraception while the patient is working towards cessation of substances.

AT DELIVERY

- Use marijuana screening questions at delivery.
- Be aware of your facility's guidelines regarding drug testing of mothers and newborns and issues of consent.
- Urine drug screens (maternal or newborn) can be falsely positive. A positive test in the absence of reported maternal drug use should be confirmed by gas chromatography/mass spectrometry (GS/MS) or liquid chromatography/mass spectrometry/mass spectrometry (LC/MS/MS).
- Alternative newborn testing includes meconium or umbilical cord sampling.
- Discuss risks regarding marijuana use after pregnancy and/or during breastfeeding with your patient.

POSTPARTUM SCREENING

Inform your patient: ***Marijuana is now legal in Nevada for adults 21 years and older. In Nevada, we are asking all patients about marijuana use because we want to keep children safe.***

1. ***Before you knew you were pregnant, how much marijuana did you use?***
2. ***How much marijuana did you use during your pregnancy?***
3. ***How much marijuana have you used since the birth of your child?***
4. ***Does anyone in your home use marijuana?***
5. ***Are you currently breastfeeding?***

TALKING TO YOUR PATIENTS ABOUT MARIJUANA

Can you tell me about why you are using marijuana? How does marijuana help you?

If using marijuana to treat a medical issue: ***Talk to your prenatal health care provider about the use of other treatments for medical issues during pregnancy.***

If a patient is using for nausea, anxiety or sleep: ***There are safer options to deal with these issues during pregnancy.***

Address potential alternative treatments, if appropriate, and talk about transitioning to alternative treatments or cessation. ***Do you want to stop using marijuana? How difficult do you think it will be to stop using marijuana? Do you think you can stop? If you need help, it is available. Refer to the resources found at the end of this document.***

Health care providers can use Screening, Brief Intervention, and Referral to Treatment (SBIRT) tools or provide the patient with additional referrals from the resource section, including 2-1-1 and SoberMomsHealthyBabies.org. ***For your health and your baby's health, I will ask you about this at your next appointment.***

TALKING TO PATIENTS: THE EFFECTS OF MARIJUANA

There is no known safe amount of marijuana use during pregnancy.

Tetrahydrocannabinol (THC) is passed from the mother to the unborn child through the placenta. The unborn child is exposed to THC used by the mother.

THC is the chemical in marijuana which makes people feel "high." Using marijuana while you are pregnant passes THC to your baby.

Use of marijuana during pregnancy is associated with negative effects on exposed children, no matter when it is used during pregnancy. The negative effects include decreased academic ability, decreased cognitive function and decreased attention. These effects may not appear until adolescence.

Using marijuana while pregnant may harm your baby. It may make it hard for your child to pay attention and learn. This also may make it harder for your child to do well in school.

Smoking marijuana has the added risk of harmful smoke exposure to the mother and baby. However, using marijuana in edible or vaporized form still exposes the baby to THC. There is no known safe amount of marijuana use during pregnancy.

Some people think using marijuana in a vape pen or eating marijuana is safer than smoking marijuana. Marijuana in any form may be harmful.

BREASTFEEDING AND MARIJUANA

Marijuana use should be addressed in a discussion of breastfeeding plans, especially if the mother used prior to pregnancy or during pregnancy.

Breastfeeding has many health benefits for both the baby and the mother.

However, any THC consumed by the mother enters her breastmilk and can be passed from the mother's milk to her baby, potentially affecting the baby.

THC in marijuana passes to breastmilk and may affect your baby.

THC is stored in the body in fat, and babies have a high percent of body fat, including their developing brains. THC remains in the body for a long time because it is stored in body fat.

THC is stored in body fat. A baby's brain and body may store THC for a long time, which is why you should not use marijuana while you are breastfeeding.

The American Academy of Pediatrics states marijuana should not be used while breastfeeding.

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If a mother wishes to breastfeed, use the referral options outlined in the resources section to help her stop using marijuana.

At this time, there is limited research on breastfeeding and marijuana use, including: the amount of THC in breast milk, the length of time THC remains in breast milk and effects on the infant.

It is unknown when it is safe to resume breastfeeding after use of marijuana or how long THC remains in breast milk after occasional or regular use.

It is unknown how long it takes for THC to clear from the breast milk. Some mothers may be motivated to "pump and dump" their breast milk in order to maintain milk production while waiting for THC to be eliminated from breast milk.

THC stays in your body for long periods, because it is stored in body fat.

Some facilities test a mother's urine to determine drug use in order to inform breastfeeding advice. The link between THC levels in maternal urine and breast milk is unknown.

PARENTING AND MARIJUANA

Marijuana can affect a person's ability to care for a baby. It is appropriate to ask about marijuana or other substance use before letting a person care for a baby.

Being "high" while caring for a baby is not safe. Do not let anyone who is under the influence care for your baby. It is not safe for your baby to sleep with you, especially if you have used marijuana.

MYTHS ABOUT MARIJUANA

Myth: **Marijuana is safe to use while pregnant or breastfeeding.** Using marijuana in any form while pregnant or breastfeeding passes THC to your baby and may be harmful. There is no known safe amount of marijuana use in pregnancy or while breastfeeding.

Myth: **Since it is legal, it must be safe.** Not all natural substances or plants are safe. Tobacco and poisonous berries are examples. Marijuana contains THC, which may harm your baby.

Myth: **Since some people use marijuana as a medicine, it must be safe.** Marijuana can be recommended by a doctor in special cases. A doctor decides whether the benefits are greater than the risks. It is unsafe to use any medications while pregnant or breastfeeding which are not recommended by a health care provider. This includes marijuana. Talk to your health care provider about safer choices which will not risk harming your baby.

Myth: **Marijuana can be good for your baby.** Researchers found marijuana may be bad for children whose moms used marijuana during pregnancy. Some children did not do well in school when they were older. It may also make it harder for your child to pay attention and learn.

Myth: **Marijuana-like (cannabinoid) chemicals occur in the body, so it must be safe.** Some cannabinoids, called endocannabinoids, occur naturally in the body and in breast milk. These endocannabinoids help your nerve cells communicate better. However, THC from marijuana is much

stronger than your natural endocannabinoids. THC can upset the natural endocannabinoid system in your body. Pregnant and breastfeeding mothers should not use marijuana to avoid any risks of THC.

Myth: **Marijuana is a safe treatment for nausea during pregnancy.** THC in marijuana may harm your baby. Talk to your health care provider about safer choices which will not risk harm to your baby.

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RESOURCES

- www.SoberMomsHealthyBabies.org
  Sober Moms Healthy Babies aims to help pregnant women struggling with substance use (tobacco, alcohol, marijuana, prescription drugs and illegal drugs). This public awareness campaign includes a website with educational and treatment resources for women who are using, concerned friends and family, and providers. The website emphasizes the importance of women identifying they are pregnant when entering Substance Abuse Prevention Treatment Agency (SPATA) funded substance use treatment, as they receive top priority for service.
- Nevada 2-1-1, a program of the Financial Guidance Center, is committed to helping Nevada citizens connect with the services they need by phone, text or website:
  - Call 2-1-1 or 1-866-535-5641
  - Text your zip code to 898211
  - www.nevada211.org
- Cannabis Use Disorder Identification Test (CUDIT-R)
  - http://www.otago.ac.nz/nationaladdictioncentre/pdfs/cudit-r.pdf
    Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.
- Substance Abuse Hot Line
  - 775-825-4357 or 1-800-450-9530
- Substance Abuse Prevention and Treatment Agency (SAPTA) administers programs and activities providing community-based prevention and treatment.
  - http://dpbh.nv.gov/Programs/ClinicalSAPTA/Home_-_SAPTA/
  - 775-684-4190
- The Crisis Call Center offers a 24-hour crisis line to provide a safe, non-judgmental source of support for individuals in any type of crisis.
  - 775-784-8090
  - Text "ANSWER" to 839863
- LactMed is an online database to determine medicine compatibility with breastfeeding.
  - https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- National Institute on Drug Abuse (NIDA)
  https://www.drugabuse.gov/drugs-abuse/marijuana

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- Retail Marijuana Public Health Advisory Committee; *Monitoring Health Concerns Related to Marijuana in Colorado:* 2014. https://ncnorml.files.wordpress.com/2015/02/report_mj-monitoring-health-concerns-related-to-marijuana-in-co-2014.pdf
- American Academy of Pediatrics, Policy statement in Pediatrics 2012, *Breastfeeding and the Use of Human Milk Pediatrics:*
  http://www2.aap.org/breastfeeding/policyOnBreastfeedingAndUseOfHumanMilk.html

Pregnant women have admission and substance use treatment priority at treatment programs funded by the SAPTA Block Grant (per 45 CFR Part 96).

SAPTA Block Grant funded non-profit centers must not deny substance use treatment to persons unable to pay, and may provide sliding scale payment options and serve Medicaid-eligible clients.

The substance use treatment centers listed on the following pages are all SAPTA funded and give pregnant women admission and treatment priority. They cannot deny substance use treatment based on the ability to pay.

SAPTA FUNDED PROVIDERS

Facility Name	Facility Address	Facility Phone Number
Battle Mountain		
New Frontier Treatment Center	145 W. 3rd St. Battle Mountain, NV 89820	(775) 423-1412
Caliente		
New Frontier Treatment Center	100 Depot Ave. Caliente, NV 89008	(775) 726-3525
Carson City		
Community Counseling Center	205 S. Pratt St Carson City, NV 89701	(775) 882-3945
The Life Change Center	1201 N. Stewart Street #120 Carson City, NV 89701	(775) 350-7250
Paragon Counseling Services	2874 N. Carson St., Ste. 215 Carson City, NV 89706	(775) 885-7717
Vitality	900 E. Long St, 2nd floor Carson City, NV 89706	(775) 461-0999
Dayton		
Rural Nevada Counseling	120 Pike St. Dayton, NV 89403	(775) 246-6214
Elko		
New Frontier Treatment Center	401 Rilroad St., Ste. 202 Elko, NV 89801	(775) 753-6962
Vitality	3740 Idaho St. Elko, NV 89801	(775) 738-8004
Ely		
New Frontier Treatment Center	399 1st St. Ely, NV 89301	(775) 289-4905
Fallon		
New Frontier Treatment Center	1490 Grimes Ave Fallon, NV 89407	(775)427-4040 24 hour line (775) 426-1412
Fernley		
Rural Nevada Counseling	415 Hwy 95A, Ste. E 501 Fernley, NV 89408	(775) 575-6191
Gardnerville		
China Springs Youth Camp	225 China Springs Rd. Gardnerville, NV 89410	(775) 265-5350
Tahoe Youth & Family Services	1512 US Hwy 395, Ste. 3 Gardnerville, NV 89410	(775) 782-4202
Lake Tahoe		
Vitality - Sierra Recovery Center Lake Tahoe	1137 Emerald Bay Rd. South Lake Tahoe, CA 96150	(530) 541-5190
Las Vegas		
Adelson Clinic for Drug Abuse Treatment & Research	3661 S. Maryland Pkwy, Ste. 64 Las Vegas NV, 89169	(702) 735-7900
Bridge Counseling	1640 Alta Drive, Ste. 4 Las Vegas, NV 89106	(702) 474-6450
Community Counseling Center	714 E. Sahara Ave., Ste. 101 Las Vegas, NV 89104	(702) 369-8700

HELP of Southern Nevada	1640 E. Flamingo Rd., Ste. 100 Las Vegas, NV 89119	(702) 369-4357
HELP of Southern Nevada - Shannon West Homeless Youth Shelter	1417 Las Vegas Blvd. North Las Vegas, NV 89119	(702) 385-3776
Las Vegas Indian Center	2300 W. Bonanza Rd. Las Vegas, NV 89106	(702) 647-5842
Vitality - Restorations Las Vegas	6885 W. Charleston Blvd, Ste. B Las Vegas, NV 89117	(702) 629-7799
WestCare Nevada Inc - Community Involvment Center Las Vegas Campus	323 North Maryland Parkway Las Vegas, NV 89101	(702) 385-3330
WestCare Nevada Inc - Women and Children's Campus	5659 Duncan Dr. Las Vegas, NV 89130	(702) 385-3332
WestCare Nevada Inc - Las Vegas Community Triage Center	930 N. 4th St. Las Vegas, NV 89101	(702) 383-4044
WestCare Nevada Inc - Harris Springs Ranch	1200 Harris Springs Rd Las Vegas, NV 89124	(702) 872-5382
Pahrump		
WestCare Nevada Inc - Community Involvment Center Pahrump Campus	1161 S. Loop Road, Ste. B Pahrump, NV 89048	(775) 751-6990
Pioche		
New Frontier Treatment Center	1 Main St. Pioche, NV 89043	(775) 289-4905
Reno		
Bristlecone Family Resources	704 Mill Street Reno, NV 89502	(775) 954-1400
The Empowerment Center	7400 S. Virigina Street Reno, NV 89511	(775) 853-5441
Northern Nevada HOPES	580 West 5th St. Reno, NV 89503	(775) 786-4673
Quest Counseling	3500 Lakeside Ct, St. 101 Reno, NV 89509	(775) 786-6880
Quest Counseling	1453 Pass Dr Reno, NV 89509	(775) 786-6880
Ridge House	900 West First St, Ste. 200 Reno, NV 89503	(775) 322-8941
Step 1	1015 N Sierra St. Reno, NV 89503	(775) 329-9830
Step 2	3700 Safe Harbor Way Reno, NV 89512	(775) 787-9411
The Empowerment Center	7400 S. Virginia St. Reno, NV 89511	(775) 853-5441
Vitality - Footprints	1135 Terminal Way, Ste. 112 Reno, NV 89502	(775) 322-3668
WestCare Nevada Inc - Reno Community Triage Center	315 Record St #103 Reno, NV 89502	(775) 348-8811
WestCare Nevada Inc - Reno Adult Re-entry Services	315 Record St #103 Reno, NV 89502	(775) 786-2418
WestCare Nevada Inc - Reno Homefront Veteran's Transitional Living	316-340 Maine St Reno, NV 89502	(775) 996-1989

Silver Springs		
Rural Nevada Counseling	1080 S. Highway 95A Silver Springs, NV 89429	(775) 575-6191
Sparks		
The Life Change Center	1755 Sullivan Lane Sparks, NV 89431	(775) 355-7734
Wendover		
New Frontier Treatment Center	915 N. Wells Ave., Ste. 7 W. Wendover, NV 89883	(775) 388-2696
Winnemucca		
New Frontier Treatment Center	512 Melarkey St. Ste. 206 Winnemucca, NV 89445	(775) 623-4596
Vitality - Silver Sage	530 Melarkey St. Ste. 206 Winnemucca, NV 89445	(775) 623-3626
Yerington		
Rural Nevada Counseling	720 South Main St., Unit C Yerington, NV 89447	(775) 463-6597

SAPTA CERTIFIED PROVIDERS

Facility Name	Facility Address	Facility Phone Number
Carson City		
Cinper Evaluation Center	2874 N. Carson St., Ste. 215 Carson City, NV 89706	(775) 885-7717
Henderson		
ABC Therapy	7 Water St., Ste. B Henderson, NV 89015	(702) 568-5971
Central Recovery Henderson	600 Whitney Ranch, Ste A3 Henderson, NV 89129	(702) 515-1373
Choices Group, Inc.	309 W. Lake Mead Pkwy, #100A Henderson, NV 89015	(702) 564-0764
Desert Treatment Clinic	1546 W. Warm Spring Rd, #130 Henderson, NV 89014	(702) 248-0000
Henderson Assessment Center	243 Water St., Lower Level Henderson, NV 89015	(702) 267-1350
Las Vegas Recovery Center	600 Whitney Ranch, Suite A3 Henderson, NV 89014	(702) 880-8230
Mission Treatment Centers, Inc	704 W. Sunset Rd., Ste. B-9 Henderson, NV 89015	(702) 558-8600
Pathways Therapy and Wellness Center	2298 W. Horizon Ridge Pkwy, #201 Henderson, NV 89052	(702) 363-7284
Las Vegas		
A Better Today Recovery Services	6655 W. Sahara Ave, #D208 Las Vegas, NV 89146	(702) 823-5228
ABC Therapy	730 N. Eastern Ave., Ste. 130 Las Vegas, NV 89101	(702) 598-2020
B.D.D. Counseling LLC	3909 S. Maryland Pkwy. Ste. 211 Las Vegas, NV 89119-7520	(702) 384-2960

Center for Addiction Medicine	4445 S. Jones, Ste. 3 Las Vegas, NV 89103	(702) 873-7800
Center for Behavioral Health	3050 E. Desert Inn Rd., Ste. 116 Las Vegas, NV 89121	(702) 796-0660
Center for Behavioral Health	2290 McDaniel Street, Suite 1C Las Vegas, NV 89121	(702) 796-0660
Central Recovery Las Vegas	3321 N. Buffalo Dr. Ste 100 Las Vegas, NV 89129	(702) 515-1373
Choices Group, Inc	2725 E. Desert Inn Rd., Ste 180 Las Vegas, NV 89121	(702) 252-8342
Clark County Court Education Program	200 Lewis Ave. 4th Floor, Ste. 4326 Las Vegas, NV 89155-1722	(702) 671-3317
Comprehensive Empowerment Group	1555 E. Flamingo Road, Suite 158 Las Vegas, NV 89119	(702) 385-9097
Cornerstone Counseling Center	5825 W. Sahara Ave Las Vegas, NV 89146	(702) 433-4357
Desert Hope Center	2465 E. Twain Ave. Las Vegas, NV 89121-4011	(702) 789-6201
Desert Hope Center	3441 S. Eastern Ave. Las Vegas, NV 89169	(702) 306-2505
Eagle Quest	3680 N. Rancho Dr., Ste #101 Las Vegas, NV 89130	(702) 646-5437
Freedom House Sober Living, In	3832 / 3852 Palos Verdes Street Las Vegas, NV 89119	(702) 485-1300
Horizon Ridge Clinic, LLC	3160 W. Sahara Ave., B22 Las Vegas, NV 89102	(702) 489-2889
Inspirations Nevada LLC	3440 E. Russell Rd. Ste. 206 Las Vegas, NV 89120	(702) 826-0530
Las Vegas Municipal Court	200 Lewis Ave. Las Vegas, NV 89101	(702) 647-5842
Las Vegas Recovery Center	3321 N. Buffalo Drive Las Vegas, NV 89129	(702) 515-1373
Las Vegas Recovery Center (Women's Facility)	7525 W. Gowan Road Las Vegas, NV 89129	(702) 515-1373
Las Vegas Recovery Center (Mens Facility)	7535 W. Gowan Road Las Vegas, NV 89129	(702) 515-1373
LRS Systems, Ltd.	2077 E. Sahara Ave. Ste. B Las Vegas , NV 89104	(702) 732-0214
Mission Treatment Centers, Inc	1800 Industrial Rd., Ste. 100 Las Vegas, NV 89102	(702) 474-4104
Nevada Homes for Youth (Boy's Campus)	525 S. 13th St. Las Vegas, NV 89119	(702) 380-2889
Nevada Homes for Youth (Girl's Campus)	1306 Tamerack Ave. Las Vegas, NV 89101	(702) 380-2889
New Beginnings Counseling Center	3376 S. Eastern Ave., Ste. #148 Las Vegas, NV 89169	(702) 538-7412
Silver Rock Recovery	4011 McLeod Drive Las Vegas, NV 89121	(844) 262-6993
Smart Choices	914 S. Valley View Road Las Vegas, NV 89033	(702) 308-7414
Vencer Youth Services	4955 South Durango #207 Las Vegas, NV 89148	(702) 267-6277

North Las Vegas		
Center for Behavioral Health	3470 Cheyenne Rd., Ste. 400 N. Las Vegas, NV 89032	(702) 636-0085
North Las Vegas Municipal Court	2332 N. Las Vegas Blvd. N. Las Vegas, NV 89030	(702) 633-1130
Salvation Army	211 Judson Ave. N. Las Vegas, NV 89030	(702) 399-2769
N. Las Vegas, NV 89030		
Shoshone Paiute Tribes of Duck Valley	State Highway 225 Owyhee, NV 89832	(775) 757-2415
Pahrump		
ABC Therapy	3351 E. Jennifer Street Pahrump, NV 89061	(775) 727-9749
Reno		
A Positive Path Drugs and Alcohol Evaluation Center	205 S. Sierra Street, #301 Reno, NV 89501	(775) 771-7753
A-1 Evaluation Center	3650 Warren Way Reno, NV 89509	(775) 823-4080
Carol's Counseling, DUI	223 Marsh Ave. Reno, NV 89509	(775) 240-5251
Center for Behavioral Health	160 Hubbard Way, Ste. A Reno, NV 89502	(775) 829-4472
Family Counseling Service of No. NV	575 E. Plumb Ln., Ste. 100 Reno, NV 89502-3543	(775) 329-0623
Lynne Daus Evaluation Center	421 Hill St., Ste. 3 Reno, NV 89501	(775) 348-7550
Lynne Daus Evaluation Center	1 South Sierra Street Reno, NV 89501	(775) 348-7550
Northern Nevada Evaluation Center	505 S. Arlington, #108 Reno, NV 89501	(775) 329-5006
Reno Sparks Tribal Health Center	1715 Kuenzli St. Reno, NV 89502	(775) 329-5162
Silver Springs		
Western Nevada Regional Youth Center (WNRYC)	3550 Graham Ave Silver Springs, NV 89429	(775) 577-4200
Sparks		
Aloha Evaluation	420 S. Rock Sparks, NV 89431	(775) 359-9000

The following list of substance use treatment centers provide care, but do not guarantee admission for pregnant women.

SOUTHERN NEVADA
Addictive Disorders Training Project

UNLV CSN Nevada State College

Las Vegas Area Addiction Treatment Providers and Support Groups

702-895-0090 Rev. November 2016

24 Hour Substance Abuse HelpLine: 1-800-450-9530

Centennial	
Canyon Ridge Christian Church 6200 W. Lone Mountain Rd. Las Vegas, NV 89130 702-658-2722 www.canyonridge.org	Offers Celebrate Recovery support group meetings and a church counseling ministry comprised of dedicated lay people who have taken 'Church Counselor Training' and receive ongoing supervision. Celebrate Recovery is a Christ-centered 12-step recovery program.
Diane D'Amore, MS, MFT, LADC 7495 W. Azure Dr. Ste. 238 Las Vegas, NV 89130 702-838-0132	Offers counseling to individuals, couples, and families. Performs court ordered substance abuse evaluations, child custody evaluations, reunification, and more. Specializes in grief/loss, depression, and parenting.
Solutions Recovery Inc. 2975 S. Rainbow Blvd. Las Vegas, NV 89146 702-228-8520 www.solutions-recovery.com	Residential treatment for alcohol and drug abuse, prescription pills and chronic pain. Intensive outpatient programs available in Pahrump and Downtown Las Vegas. Accepts Medicaid.
Westcare – Residential Treatment for Women 5659 Duncan Dr. Las Vegas, NV 89130 702-385-2020 www.westcare.com	Residential treatment center for alcohol and drug abuse including short term stays (30 days or less) and long term stays (30 or more days). Children beds are available as well. Detoxification services available. Treatment for women and children. Spanish speaking providers available.
Westcare Youth Stabilization Young F.A.C.E.S. 5660 Duncan Dr. Las Vegas, NV 89130 702-385-2020 www.westcare.com	Residential treatment center for alcohol and drug abuse including short term stays (30 days or less) and long term stays (30 or more days). Spanish speaking providers available.
Downtown	
ABC Therapy (Associated Bilingual Counselors) 730 N. Eastern Ave. Ste. 130 Las Vegas, NV 89101 702-598-2020 www.abctherapy.com	Outpatient services along with early intervention for adults. Spanish speaking providers available.
Aid for Aids of Nevada 1120 Almond Tree Lane Las Vegas, NV 89104	Medical case management, medical transportation, education and prevention, housing program and financial assistance available for those who are living with Aids.

702-382-2326 www.afanlv.org	
Bridge Counseling Associates 1640 Alta Dr. Ste. 4 Las Vegas, NV 89106 702-474-6450 www.bcalv.com	Outpatient services for adults and youth. Spanish speaking providers available. Accepts Medicaid.
Center for Behavioral Health of Las Vegas 1311 S. Casino Center Blvd. Las Vegas, NV 89104 702-382-6262 www.centerforbehavioralhealth.com	Outpatient, dual diagnosis, and Opioid treatment available for adults. Accepts Medicaid.
Central Recovery – Henderson 600 Whitney Ranch Dr. Ste. A Henderson, NV 89104 702-515-1374 www.centralrecoveryhenderson.com	Outpatient services for adults and youth. Early intervention for youth available.
Community Counseling Center (Main Office) 714 E. Sahara Ave. Las Vegas, NV 89104 702-369-8700 www.cccofsn.wix.com/ccc-new	Outpatient, early intervention, intensive outpatient, and aftercare services available for adults and youth. Spanish speaking providers available. Accepts Medicaid.
Community Counseling Center (By Appt. Only) 1785 E. Sahara Ave. Ste. 145 Las Vegas, NV 89104 702-369-8700 www.cccofsn.wix.com/ccc-new	Outpatient, early intervention, intensive outpatient, and aftercare services available for adults and youth. Spanish speaking providers available. Accepts Medicaid.
Copes Comfort Care Behavioral Health 1230 West Owens #6 Las Vegas, NV 89106 702-636-5373 www.copescomfortcare.org/index.html	Outpatient services for adults. Accepts Medicaid.
Gary Alexander, MFT, LADC Vegas Therapy 801 S. Rancho Dr. Ste. E-8 Las Vegas, NV 89106 702-285-9447	Provides therapy and counseling for individuals, couples, and families for problems such as sexual addiction, substance abuse, adult children of alcoholics (ACOA), and codependency.
Las Vegas Family Clinic 1311 Casino Center Dr. Las Vegas, NV 89104 702-382-6262 www.centerforbehavioralhealth.com	Outpatient, dual diagnosis, and Opioid treatment available for adults and youth. Accepts Medicaid.
Las Vegas Indian Center 2300 W. Bonanza Rd. Las Vegas, NV 89106	Outpatient services for adults. Accepts Medicaid.

702-647-5842 www.lasvegasindiancenter.org	
Nevada Treatment Center 1721 E. Charleston Blvd. Las Vegas, NV 89104 702-382-4226	Alcoholism treatment program.
Silkworth House 2021 Pinto Ln. Las Vegas, NV 89106 702-380-6919 www.silkworthhouse.org	Recovery home for men. 12-step meetings are held daily for residents.
The Samaritan House 1001 N. 4th St. Las Vegas, NV 89101 702-382-8437 www.thesamaritanhouse.weebly.com/index.html	Christian based treatment facility. Outpatient and prevention education services for adults. Residential treatment center for alcohol and drug abuse including short term stays (30 days or less) and long term stays (30 or more days). Low cost or free treatment available. Facility acts as a shelter as well.
Toni's House(Transitional Living Communities) 210 N. 10th St. Las Vegas, NV 89101 702-387-1331 www.tonishouse.com	Recovery home for people in the transitional process towards a healthy lifestyle.
We Care 2216 S. 6th St. Las Vegas, Nv 89104 702-369-0613 www.wecarehouse1961.wix.com/wecare	Recovery home for women with 12-step rehabilitation program. Small groups available.
Westcare – Las Vegas 930 N. 4th St. Las Vegas, NV 89101 702-385-3642 www.westcare.com	Outpatient and detoxification services for adults. Spanish speaking providers available. Accepts Medicaid.
Westcare Nevada – Day Treatment 401 S. Martin Luther King Blvd. Las Vegas, NV 89106 702-385-3330 www.westcare.com	Outpatient and prevention education services for adults and youth. Facility uses a holistic approach to treatment. Accepts Medicaid.
East	
Center for Behavioral Health of Las Vegas 3050 E. Desert Inn Rd. Ste. 116 Las Vegas, NV 89121 702-796-0660 www.centerforbehavioralhealth.com	Outpatient, family counseling, Methadone, and Opioid treatment services for adults and youth. Spanish speaking providers available. Accepts Medicaid.
Choices Group, Inc. 2725 E. Desert Inn Rd. Ste. 180 Las Vegas, NV 89121 702-252-8342	Outpatient counseling for adults and youth. Intensive outpatient services for adults. Early intervention services for youth. Accepts Medicaid.
Church of Scientology & Celebrity Centre	Scientology faith-based recovery services. Narconon program.

2761 Emerson Ave. Las Vegas, NV 89121 702-731-1500 www.scientology-cclasvegas.org	
Corner Stone Sober House 4984 Marin St. Las Vegas, NV 89122 702-451-0574	Recovery home for women. Sober living home, transitional living home, halfway house, and SLE.
David M. Kramer, MFT, LADC 3430 E. Flamingo Rd. Ste. 204 Las Vegas, NV 89121 702-527-3055	Marriage and Family Therapist and LADC who specializes in relationship issues, depression, and addiction.
Deer Valley Recovery 5891 Deer Valley Dr. Las Vegas, NV 89156 702-287-7356	Short term residential living and halfway house/sober living for adult men.
Desert Hope Treatment Center 2465 E. Twain Ave. Las Vegas, NV 89121 888-329-1359 www.deserthopetreatment.com	Outpatient and detoxification services for adults. Residential treatment center for alcohol and drug abuse including short term stays (30 days or less) and long term stays (30 or more days). Holistic treatment approach.
El Cid House 4225 El Cid Way Las Vegas, NV 89121 702-764-6581	Recovery home for men and women.
New Beginnings Counseling Center 2035 E. Lake Mead Blvd. Ste. 3 North Las Vegas, NV 89115 702-834-8319 www.newbeginningscounselingcenters.com	Outpatient services for adults. Heroin, Oxycodone, Lortab, Percodan, Percocet, Methadone and other opiate-based substances treatment. Individual and group counseling. Accepts Medicaid.
Ron Hennessey 2860 East Flamingo Road Las Vegas, NV 89121 702-733-7200	Psychologist with a focus on mental, emotional and behavioral health issues. Uses psychotherapy and other counseling skills in his practice.
Green Valley/ Henderson	
ABC Therapy 7 Water St. Ste. A Henderson, NV 89105 702-568-5971 www.abctherapy.net	Outpatient services along with early intervention for adults. Spanish speaking providers available.
Bruce Parsons, MFT Summit Family Counseling, LLC 220 E. Horizon Drive Ste. G Henderson, Nv 89015 702-568-5888	Provides clinical treatment for individuals, couples, and families and substance abuse treatment.

Central Christian Church 1001 New Beginnings Dr. Henderson, NV 89011 702-735-4004 www.centralchristian.com	Christian faith-based recovery services. Celebrate Recovery program for men and women and childcare is available.
Congregation Ner Tamid 55 N. Valle Verde Dr. Henderson, NV 89074 702-733-6292 www.lvnertamid.org	Jewish faith-based recovery services.
Desert Treatment Clinic 1546 W. Warm Springs Rd. #130 Henderson, NV 89014 702-336-6296 www.deserttreatment.com	Outpatient and Methadone treatment services for adults.
Gen Wallace, LMFT, LADC 2298 W. Horizon Ridge Pkwy Ste. 201 Henderson, NV 89052 702-776-9038	Licensed Marriage and Family Therapist and LADC who specializes in relationship issues, anxiety, children, and adolescents. Offers addiction, alcohol abuse, drug abuse, dual diagnosis, and substance abuse counseling.
Green Valley Christian Center 711 Valle Verde Ct. Henderson, NV 89014 702-454-2722 www.gvchristian.com	Christian faith-based recovery services.
Harmony Healthcare 3005 W. Horizon Ridge Pkwy Henderson, NV 89052 702-739-8722 www.harmonyhc.com	Outpatient services for adults and youth including group therapy and medication management.
Mission Treatment Centers, Inc. 704 W. Sunset Rd. Ste. B-9 Henderson, NV 89011 702-558-8600 www.missiontreatment.com	Outpatient services for adults. Accepts Medicaid.
New Life Medical Center – Henderson 704 W. Sunset Rd. Ste. B-9 Henderson, NV 89011	Outpatient and Methadone treatment services for adults. Spanish speaking providers available. Accepts Medicaid.
Seven Hills Behavioral Institute 3021 W. Horizon Ridge Pkwy Henderson, NV 89052 702-646-5000 www.sevenhillsbi.com	Outpatient, intensive outpatient, detoxification, dual diagnosis, and medication management services. Treatment available for adults, youth, and families.
Pathways Therapy & Wellness Center 2298 W. Horizon Ridge Pkwy Henderson, NV 89052 702-363-7284 www.pathwaystherapynv.com	Outpatient services for adults and youth. Accepts Medicaid.
Westcare – Henderson	Outpatient services for adults. Accepts Medicaid.

921 American Pacific Dr. Ste. 30 Henderson, NV 89014 702-385-3642 www.westcare.com	
North Las Vegas	
Center for Behavioral Health of Las Vegas 2290 McDaniel St. North Las Vegas, NV 89030 702-399-1600 www.centerforbehavioralhealth.com	Outpatient, Methadone, and Opioid treatment services for adults. Individual and family counseling. Accepts Medicaid.
Center for Behavioral Health of Las Vegas 3470 W. Cheyenne Ave. Ste. 400 North Las Vegas, NV 89032 702-636-0085 www.centerforbehavioralhealth.com	Outpatient, Methadone, and Opioid treatment services for adults. Individual and family counseling. Accepts Medicaid.
Fresh Start Family Services 4224 Arcato Way Ste. A North Las Vegas, NV 89030 702-633-5525 www.freshstartfamilyservices.com	Outpatient services for youth. Spanish speaking, ASL, and other hearing impaired assistance available. Holistic approach.
LDS Family Services Nevada Agency 4455 Allen Ln. Ste. 130 North Las Vegas, NV 89031 702-385-1072 www.providentliving.org/familyservices/strength	Mormon faith-based recovery services. 12-step program.
Salvation Army – Adult Rehabilitation Center 211 Judson Ave. North Las Vegas, NV 89030 702-399-2769 www.salvationarmysouthernnevada.org/#!adult-rehabilitation-center/c1lgc	6 month inpatient Adult Rehabilitation Center for men and women with alcohol and drug dependency issues
Salvation Army – Women's Program 35 W. Owens North Las Vegas, NV 89030 702-399-4403 www.salvationarmysouthernnevada.org/#!adult-rehabilitation-center/c1lgc	6 month inpatient Adult Rehabilitation Center for women with alcohol and drug dependency issues
VA Southern Nevada Healthcare System 6900 North Pecos Road North Las Vegas, NV 89086 702-791-9000 ext.15211 www.mentalhealth.va.gov	Individual and group therapy, medication management, AA groups, Methadone treatment, residential treatment, outpatient and intensive outpatient services, medically managed detoxification, MFT counseling, and aftercare available.
Southeast	
A Better Today 6655 W. Sahara Ave. #D202 Las Vegas, NV 89119 702-823-5228	Outpatient, detoxification, intensive outpatient, and intervention services for adults. Residential 30-90 day treatment. Individual, family, and group counseling.

www.abtrs.com	
Adelson Clinic 3661 S. Maryland Pkwy. Ste. 64 Las Vegas, NV 89169 702-735-7900 www.adelsoncliniclasvegas.com	Outpatient services for youth and adults. Spanish speaking providers available. Accepts Medicaid.
B.D.D. Counseling LLC 1516 E. Tropicana Ave. Ste. 160 Las Vegas, NV 89119 702-384-2960 www.bddcounseling.com/Home.html	Outpatient, intensive outpatient, and aftercare services for adults. Group therapy available.
Freedom House 3852 Palos Verdes St. Ste. 40 Las Vegas, NV 89119 702-485-1300 www.freedomhousesoberliving.com	Outpatient services for adults. Residential treatment for men and women.
Nevada Homes for Youth 525 S. 13th St. Las Vegas, NV 89119 702-380-2889 www.nevadahomesforyouth.org	Outpatient and residential services for youth.
New Beginnings Counseling Centers 4225 S. Eastern Ave. Ste. 11 Las Vegas, NV 89119 702-538-7412 www.newbeginningscounselingcenters.com	Outpatient and dual diagnosis services for adults. Heroin, Oxycodone, Lortab, Percodan, Percocet, Methadone and other opiate-based substances treatment. Individual and group counseling. Accepts Medicaid.
Shannon West Homeless Youth Shelter – Help of Southern Nevada 1640 E. Flamingo Ste. 100 Las Vegas, NV 89119 702-385-3776 www.helpsonv.org/programs-youth.php	Residential facility for youth ages 16-24 with 24-hour staffing for supervision and transportation of the residents. Outpatient and dual diagnosis services for youth.
The PRACTICE: A UNLV Community Mental Health Clinic 4505 S. Maryland Pkwy William D. Carlson Education Building (CEB), Rm. 226 Las Vegas, NV 89154-3033 702-895-1532 www.unlv.edu/thepractice/	Services available include individual counseling and psychotherapy, group and couples therapy, and psychological and psychoeducational assessments. Specializes in anxiety, trauma, depression, anger, life stress, grief, learning or succeeding in school, parenting, healthy relationships, selective mutism, making positive changes or healthy choices, and managing emotions or coping.
Southwest	
Good Samaritan Lutheran Church 8425 W. Windmill Ln. Las Vegas, NV 89113 702-873-3589 www.gslclasvegas.org	Faith based recovery services for adults. 12-step program available.

Harmony Healthcare 9140 W. Post Rd. Ste. 100 Las Vegas, NV 89148 702-251-8000 www.harmonyhc.com	Outpatient services for adults and youth. Individual and group therapy. Support groups for adults and youth. Medication management.
Judy Winreb, MA, MFT, LADC 5940 S. Rainbow Blvd. Las Vegas, NV 89118 702-362-0860	Specialties include addiction and recovery, gambling addiction, and many others.
Spring Valley	
Center for Addiction Medicine 4445 S. Jones Blvd. Ste. 3 Las Vegas, NV 89103 702-873-7800 www.addictionhelp.com	Outpatient, detoxification, and dual diagnosis services for adults and youth.
Choices Group, Inc. 800 S. Valley View Blvd. Las Vegas, NV 89107 702-252-8342 www.provcorp.com	Outpatient services for adults and youth. Accept Medicaid.
Cornerstone Counseling Center 5825 W. Sahara Ave. Las Vegas, NV 89146 702-433-4357 www.cornerstonecounsel.com	Outpatient services for adults. Individual and group counseling sessions. Spanish speaking providers available.
Family and Child Treatment of Southern Nevada (FACT) 6431 W. Sahara Ste. 200 Las Vegas, NV 89146 702-258-5855 www.factsnv.org	Outpatient services for youth. Individual and family therapy. Spanish speaking providers available.
Fawn Residence 6016 Fawn Ave. Las Vegas, NV 89107 702-353-7279	Recovery home for women. Sober living home, transitional living, halfway house, SLE, and other recovery services.
Foundation for Recovery 4800 Alpine Pl. Ste. 7 Las Vegas, NV 89107 702-257-8199 www.forrecovery.org/index.html	Early intervention services for adults and youth.
Melanie Bison, PhD, LCADC Bison Diversity Wellness Center 6655 W. Sahara Avenue Ste. D-102 Las Vegas, NV 89146 702-714-1353	Specializes in addiction, domestic abuse, trauma, and PTSD.
Mission Treatment Centers, Inc. 1800 Industrial Rd. Ste. 100	Outpatient services for adults. Accepts Medicaid.

Las Vegas, NV 89102 702-474-4104 www.missiontreatment.com	
Montevista Hospital 5900 W. Rochelle Ave. Las Vegas, NV 89103 702-364-1111 www.montevistahospital.com/programs-overview/substance-abuse-services/	Intensive outpatient, partial hospitalization, dual diagnosis, inpatient, detoxification, rehabilitation, aftercare, and 12-Step program services for adults. Drug and alcohol counselors on site.
New Life Medical Center Las Vegas 1800 Industrial Rd. Las Vegas, NV 89102 702-474-4104 www.newlifemedicalcenter.com	Outpatient and Methadone treatment services for adults. Spanish speaking providers available. Accepts Medicaid.
Oxford-Jones Circle 6161 Jones Circle Las Vegas, NV 89107 702-373-7944	Recovery home for women and youth.
Oxford-Thompson Circle 4408 St. Andrews Circle Las Vegas, NV 89107 702-646-8173	Recovery home for women.
Problem Gambling Center 2680 S. Jones Blvd. Ste. 1 Las Vegas, NV 89146 702-363-0290	Evaluation, individual, and group counseling services to persons with gambling problem along with their families.
Rassler House Recovery Home 6212 Rassler Ave. Las Vegas, NV 89107 702-742-9325 www.cleanandsoberhome.yolasite.com	Recovery home for men and women. 12-step program and daily support meetings held.
Sober Living 4712 Lorna Place Las Vegas, NV 89107 702-368-5140	Recovery home for men.
Solutions Recovery Inc. 2975 S. Rainbow Ste. J Las Vegas, NV 89146 702-228-8520 www.solutions-recovery.com	Outpatient, detoxification, and aftercare for adults and youth. Residential treatment center for alcohol and drug abuse including short term stays (30 days or less) and long term stays (30 or more days) for men and women over the age of 18. Accepts Medicaid.
Stepping Stones 2975 S. Rainbow Ste. K Las Vegas, NV 89146 702-574-5233	Recovery home for women and youth.
Vitality Unlimited 1550 Western Ave. Las Vegas, NV 89102	Outpatient services for adults and youth. Holistic approach. Accepts Medicaid.

702-629-7799	
Walter Hoving Home 3353 Red Rock St. Las Vegas, NV 89146 702-386-1965 www.walterhovinghome.org	Long term (30 or more days) residential treatment for women.
Summerlin	
Bobby's House 3321 N. Buffalo Dr. Ste. 200 Las Vegas, NV 89129 702-515-1374	Recovery home for men.
Carol Lee Cathey, MS 9402 W. Lake Mead Blvd. Las Vegas, NV 89134 702-714-1971	Marriage and Family Therapist, MS, LMFT, LADC, RN. Specialized training and experience with Emotionally Focused Couples Therapy.
Central Recovery Las Vegas 3321 N. Buffalo Dr. Ste. 100 Las Vegas, NV 89129 702-515-1373 www.centralrecovery.com	Outpatient, residential, and early intervention services for youth and adults.
Debora Tretiak, MS 9402 W. Lake Mead Blvd. Las Vegas, NV 89134 702-644-6463	Specializes in substance abuse counseling.
Donna Cook, Ph.D Kayenta Therapy Centers 9402 W. Lake Mead Blvd. Las Vegas, NV 89134 702-832-2910	Licensed Clinical Psychologist. Specializes in testing and evaluation, ADHD, and learning disabilities. Offers substance abuse counseling.
Emily Burggraff, L.C.S.W. Steps for Success 2764 Lake Sahara Dr. Ste. 110 Las Vegas, NV 89117 702-220-7386	Licensed Clinical Social Worker who specializes in personality disorders, depression, co-dependency, and abuse. This counselor is endorsed by Canyon Ridge Christian Church on the basis that she is Christian and has a desire to help people get healthy while moving them towards spiritual growth.
Frank J. Szabo, Jr., LADC 3321 N. Buffalo Ste. 125-C Las Vegas, NV 89129 702-538-0717	Solution-Focused therapist. Offers addiction and codependency counseling services.
Hammock 7301 Sinburry Circle Las Vegas, NV 89129 702-409-7234	Recovery home for women.
International Church of Las Vegas 8100 Westcliff Dr. Las Vegas, NV 89145	Faith-based recovery services.

702-242-2273 www.iclv.com	
Jack Cathey, MA, MFT, LADC 9402 W. Lake Mead Blvd. Las Vegas, NV 89134 702-254-0090	LADC practicing in the Las Vegas area.
Las Vegas Recovery Center 3371 N. Buffalo Rd. Las Vegas, NV 89129 702-515-1373 or 800-790-0091 www.lasvegasrecovery.com	Detoxification services for adults. Residential services available for adults.
Las Vegas Recovery Center 7525 W. Gowan Rd. Las Vegas, NV 89129 702-515-1373 www.lasvegasrecovery.com	Residential services for adults.
Linda Ann Waggoner, MFT, LADC Intern The Wellness Center at ICLV 3425 Cliff Shadows Pkwy. Las Vegas, NV 89129 702-673-4745	MFT and LADC Intern who has advanced EFT training. Specializes in alcoholism, anxiety, anger management, career, children, child abuse, and co-dependency. This counselor is endorsed by Canyon Ridge Christian Church on the basis that she is Christian and has a desire to help people get healthy while moving them towards spiritual growth.
Serenity House 5066 Edna Ave. Las Vegas, NV 89129 702-418-9285	Recovery home for men.
Shadow Hills Baptist Church 7811 Vegas Dr. Las Vegas, NV 89128 702-880-7811 www.shadowhills.org	Faith-based recovery services
Shonna Erickson, MFT, LADC Steps for Success 2764 Lake Sahara Dr. Ste. 110 Las Vegas, NV 89117 702-220-7386	MFT and LADC who specializes in marital issues, mood disorders, addictions, and abuse. This counselor is endorsed by Canyon Ridge Christian Church on the basis that she is Christian and has a desire to help people get healthy while moving them towards spiritual growth.
Spring Mountain Treatment Center 7000 W. Spring Mountain Rd. Las Vegas, NV 89117 702-873-2400 www.springmountaintreatmentcenter.com	Outpatient, dual diagnosis, and intensive outpatient services for adults and youth. Medication management services.
Sydney's House 3321 N. Buffalo Dr. Ste. 200 Las Vegas, NV 89129 702-515-1374	Recovery home for women.
Support Groups	

AA Central Office – Las Vegas 1431 E. Charleston Ste. 15 Las Vegas, NV 89104 702-598-1888 www.lvcentraloffice.org	Voluntary and worldwide organization of men and women who meet together to attain and maintain sobriety. Meetings available in Southern Nevada.
Adult Children of Alcoholics 310-534-1815 www.adultchildren.org	12-step program that includes adults who grew up in an alcoholic or dysfunctional home who exhibit identifiable traits of past abuse or neglect. Meetings available in Southern Nevada.
Al-Anon www.nevadaal-anon.org	Family groups of relatives and friends of alcoholics who share their experiences. The groups practice the 12-step program. Meetings available in Southern Nevada.
Alateen 800-425-2666 www.al-anon.alateen.org	Part of Al-Anon Family Groups that includes young Al-Anon members whose lives have been affected by someone else's drinking. Meetings available in Southern Nevada.
American Lung Association of Nevada 3552 West Cheyenne Ave. Ste. 130 Las Vegas, NV 89032 702-431-6333 www.lung.org	Courses available to help you stop smoking or manage your asthma.
Boys Town Nevada 821 North Mojave Road Las Vegas, NV 89101 702-642-7070 www.boystown.org	Services for children with serious emotional or behavioral problems.
Buddhist Recovery Network www.buddhistrecovery.org	Utilizes Buddhist teaching and practices to recover from addictive behaviors. Meetings available in Southern Nevada.
Celebrate Recovery www.celebraterecovery.com	Christ-centered 12-step program accompanied by Scriptures and the 8 Principles based on the Beatitudes. Meetings available in Southern Nevada.
Cocaine Anonymous 702-758-5139 www.snvca.org	Group of men and women who share experiences with one another regarding their common problem of addiction. Members must have a desire to stop using cocaine and all other mind-altering substances. Meetings available in Southern Nevada.
Co-Dependents Anonymous www.sonvcoda.org/Home_Page.php	Group of men and women who share a common purpose of developing healthy relationships. Members must desire a healthy and loving relationship. Meetings available in Southern Nevada.
Crystal Meth Anonymous 855-6-384-3733 www.crstalmeth.org	Group of men and women for whom all drugs, specifically crystal meth, have become a problem. Members must maintain a desire to stop using. Meetings available in Southern Nevada.
Debtors Anonymous 800-421-2383 www.debtorsanonymous.org	For those who have unsecured debt that has become an addictive and unmanageable part of their lives. Face to face meetings available in Southern Nevada. Online and phone meetings available as well.
Depression Bipolar Support Alliance 702-750-5919 www.dbsasouthernnv.org	Groups of men and women who have been diagnosed with a mood disorder come together and talk about life's frustrations. Meetings available in Southern Nevada

Gamblers Anonymous 702-529-0202 www.gasn.info	12-step program for compulsive gamblers. Members must have a desire to stop gambling. Meetings available in Southern Nevada.
Gam-Anon 718-352-1671 www.gam-anon.org	12-step program for those who have been affected by the gambling problem of someone close to them. Meetings available in Southern Nevada.
Heroin Anonymous www.heroinanonymous.org	Members must have a desire to stop suffering from heroin addiction. Meetings available in Southern Nevada.
HYPER at UNLV 702-895-3627 unlv.collegiatelink.net/organization/HYPER	Supportive environment for students in recovery from addictive disorders.
Nar-Anon 800-477-6291 www.nar-anon.org	Groups are for those who are concerned about an addiction problem of someone close to you. Groups follow 12-steps of Nar-Anon. Meetings available in Southern Nevada.
Narcotics Anonymous 888-495-3222 www.region51na.org	Goal is to provide a 12-step solution for addiction. Las Vegas has regularly scheduled meetings and 24-hour hotline.
Overeaters Anonymous 702-593-2945 www.lvoa.org	Members must want to stop eating compulsively. Meetings available in Southern Nevada.
SAFE House Nevada 702-451-4203 www.safehousenv.org	Support groups for victims of domestic violence/Intimate Partner Violence (IPV). Transitional services including housing, resources, basic needs, and continual support.
Sex Addicts Anonymous 1-800-477-8191 www.ssa-recovery.org	Members agree to abide by the 12-step process. Electronic meetings or internet available. Meetings available in Southern Nevada.
SMART Recovery 866-951-5357 www.smartrecovery.org	Self-empowering addiction recovery support group for drug abuse, drug addiction, substance abuse, alcohol abuse, gambling addiction, cocaine addiction, prescription drug abuse, sexual addiction, and problem addiction to other substances and/or activities. Meetings available in Southern Nevada and online.

Helplines

Aids Hotline	800-842-2437
CDC STD Hotline	800-232-4636
Clark County Child Protective Services	702-399-0081
Clark County Department of Family Services	702-455-5444
Crisis Call Center	1-800-273-8255 or 775-784-8090

GLBT National Hotline	1-888-843-4564
GLBT National Youth Talkline	1-800-246-7743
National Alliance on Mental Illness of Southern Nevada	775-336-3091
National Child Abuse Hotline	1-800-422-4453
National Domestic Violence Hotline	1-800-799-7233
Nevada Council on Problem Gambling	702-369-9740
Nevada Department of Health & Human Services Division of Child & Family Services	702-486-7865
Nevada Network Against Domestic Violence	Hotline: 702-646-4981 Rural hotline: 1-800-486-7282
Nevada Tobacco Quitline	1-800-784-8669
Nevada 211	Call 2-1-1 or 1-866-535-5654
Problem Gamblers Helpline	1-800-522-4700
Relay Services for Deaf & Hard of Hearing	7-1-1 or 2-1-1
S.A.F.E. House Hotline (24 hours)	702-564-3227
Safe Nest	702-646-4981 or 800-486-7282
SAMHSA National Hotline	1-800-662-4357
Sex Workers Anonymous	Phone:213-262-9810 Email: sexworkrecovery@yahoo.com
Street Teens (24 hours)	702-809-3585
VA National Call Center for Homeless Veterans	1-877-424-3838
Online Resources	
Buddhist Recovery Network www.buddhistrecovery.org	Utilize Buddhist teaching and practices to recover from addictive behaviors. Virtual meetings available.
GLBT National Help Center www.glbthotline.org	Online peer-support chat and trans teens online talk group for ages 12-19.
The Jewish Board www.jbfcs.org	Faith-based online information about support. Contact JACS staff member to speak by phone.
Moderation Management www.moderation.org	Online chat room and community for individuals wanting to lessen their alcohol intake.
NAADAC The Association for Addiction Professionals www.naadac.org	Online directory of substance abuse providers within your area.
National Alliance on Mental Illness of Southern Nevada www.namisouthernnevada.org	Online directory of support groups and information about mental illness.
Nevada Department of Health & Human Services Division of Child & Family Services www.dcfs.nv.gov	Online resource includes information about child welfare service, child mental health, juvenile justice services, system advocates, providers, information management services, and CPS.
Nevada Partnership for Homeless Youth www.nphy.org	Online resources available to connect homeless youth to residential facilities and shelters.
Nevada Quitline www.nevada.quitlogix.org	Online directory of provider referrals and information to help individuals quit smoking.
Nevada 211 www.211nevada.communityos.org	Online state database of social service resources.

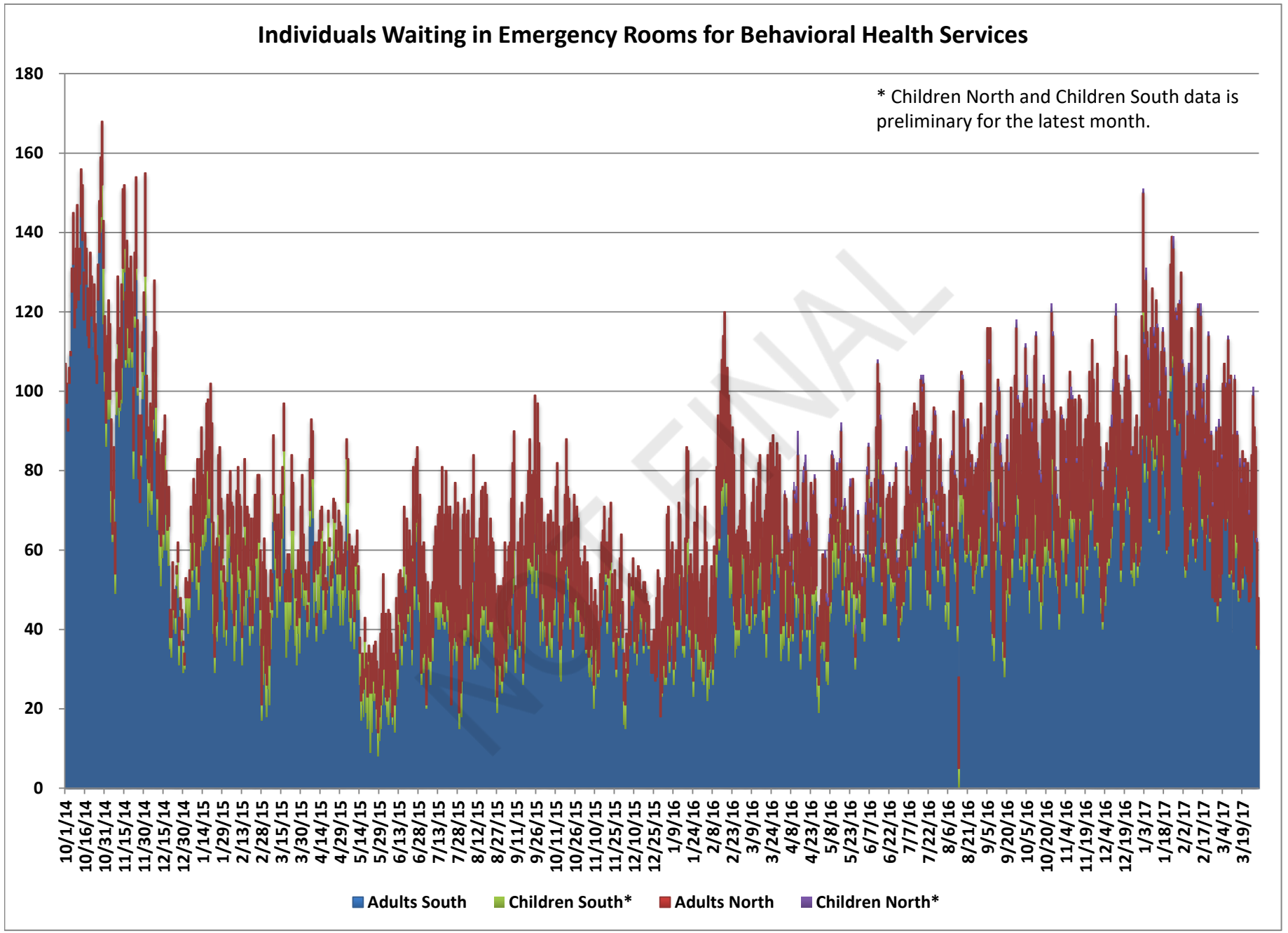
Nicotine Anonymous www.nicotine-anonymous.org	Online information about how to quit smoking. Online peer support chat option available.
SAMHSA www.findtreatment.samhsa.gov	Online locator of substance abuse providers within your area.
Teen Challenge 888-339-3193 www.teenchallenge.net	Faith based recovery services for men, women, teens, children, and families with destructive, abusive, and addictive lifestyles. Outreach and Crisis center located in Southern Nevada.
Women for Sobriety www.womenforsobriety.org	Online information for women dedicated to overcome alcoholism and other addictions. Online messaging forum.

Funding for this publication was made possible by SAMHSA Grant # 1H79TI026023-01. Inclusion of any agency, organization or individual on this list should in no way be construed as an endorsement of its services, nor should exclusion be construed to constitute disapproval.

Centennial: 89166, 89143, 89131, 89149, 89130, 89108; Downtown: 89106, 89101, 89104; East: 89115, 89156, 89110, 89142, 89121, 89120, 89122, 89112; Green Valley/Henderson: 89014, 89011, 89074, 89015, 89002,
89183, 89052, 89012, 89044; North Las Vegas: 89085, 89084, 89087, 89086, 89081, 89031, 89032, 89030; Southeast: 89109, 89169, 89119, 89123, 89154; Southwest: 89148, 89118, 89113, 89178, 89179, 89139, 89141;
Spring Valley: 89107, 89146, 89102, 89147, 89103; Summerlin: 89129, 89134, 89128, 89138, 89144, 89145, 89117, 89135.

Behavioral Health Chart Pack

April 2017


Individuals Waiting in Emergency Rooms for Behavioral Health Services
* Children North and Children South data is preliminary for the latest month.
180
160
140
120
100
80
60
40
20
0
10/1/14
10/16/14
10/31/14
11/15/14
11/30/14
12/15/14
12/30/14
1/14/15
1/29/15
2/13/15
2/28/15
3/15/15
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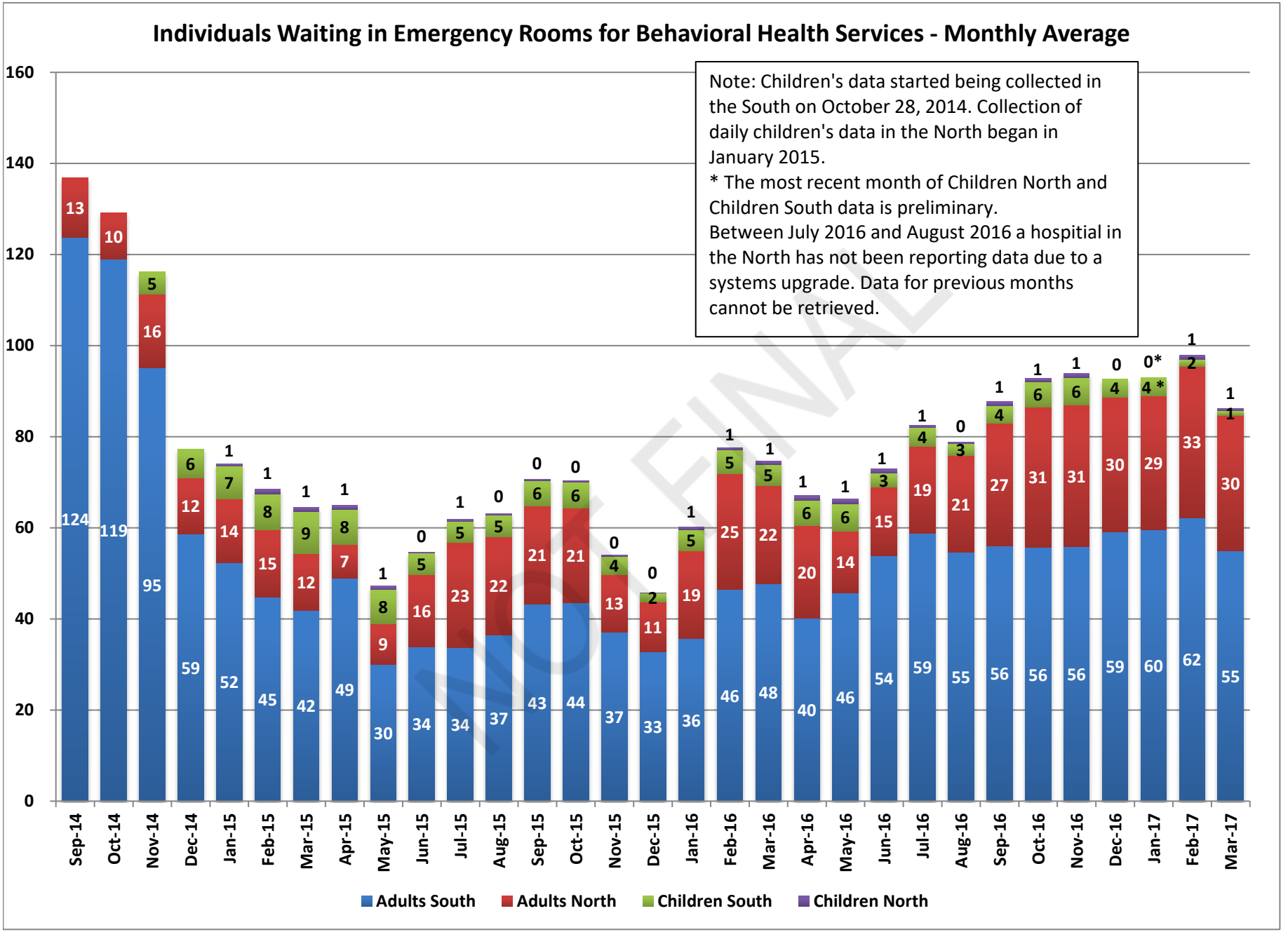
8/6/16
8/21/16
9/5/16
9/20/16
10/5/16
10/20/16
11/4/16
11/19/16
12/4/16
12/19/16
1/3/17
1/18/17
2/2/17
2/17/17
3/4/17
3/19/17
Adults South
Children South*
Adults North
Children North*

Individuals Waiting in Emergency Rooms for Behavioral Health Services

	Adults South	Children South*	Adults North	Children North*	Total
3/1/2017	53	1	37	2	93
3/2/2017	47	1	43	0	91
3/3/2017	54	0	29	1	84
3/4/2017	68	0	34	0	102
3/5/2017	73	1	33	0	107
3/6/2017	65	0	36	1	102
3/7/2017	67	1	34	0	102
3/8/2017	68	2	43	1	114
3/9/2017	53	1	48	1	103
3/10/2017	54	1	49	0	104
3/11/2017	39	0	0	0	39
3/12/2017	50	2	37	0	89
3/13/2017	68	3	32	1	104
3/14/2017	58	6	25	0	89
3/15/2017	59	3	27	1	90
3/16/2017	47	3	23	0	73
3/17/2017	48	0	33	2	83
3/18/2017	54	1	22	1	78
3/19/2017	50	3	32	0	85
3/20/2017	56	0	25	1	82
3/21/2017	57	0	26	0	83
3/22/2017	54	0	20	0	74
3/23/2017	52	0	30	0	82
3/24/2017	47	0	22	1	70
3/25/2017	48	0	29	0	77
3/26/2017	52	0	32	0	84
3/27/2017	65	1	33	2	101
3/28/2017	65	0	26	0	91
3/29/2017	62	0	24	0	86
3/30/2017	35	1	26	1	63
3/31/2017	35	0	13	0	48

** Children North and Children South data is Preliminary and will be updataed as soon as possible.*


Individuals Waiting in Emergency Rooms for Behavioral Health Services - Monthly Average
Note: Children's data started being collected in the South on October 28, 2014. Collection of daily children's data in the North began in January 2015.
* The most recent month of Children North and Children South data is preliminary.
Between July 2016 and August 2016 a hospital in the North has not been reporting data due to a systems upgrade. Data for previous months cannot be retrieved.
Adults South
Adults North
Children South
Children North

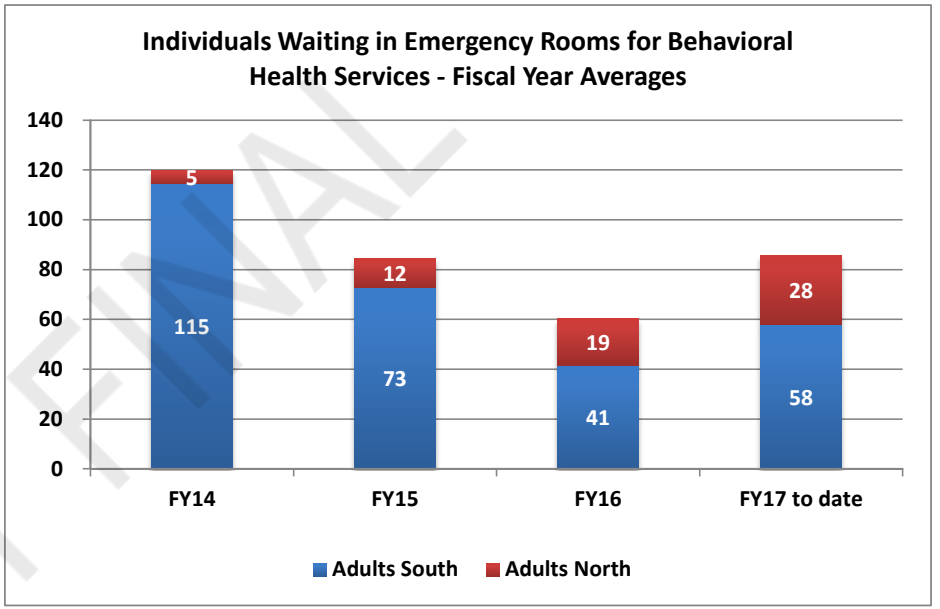
Monthly Average

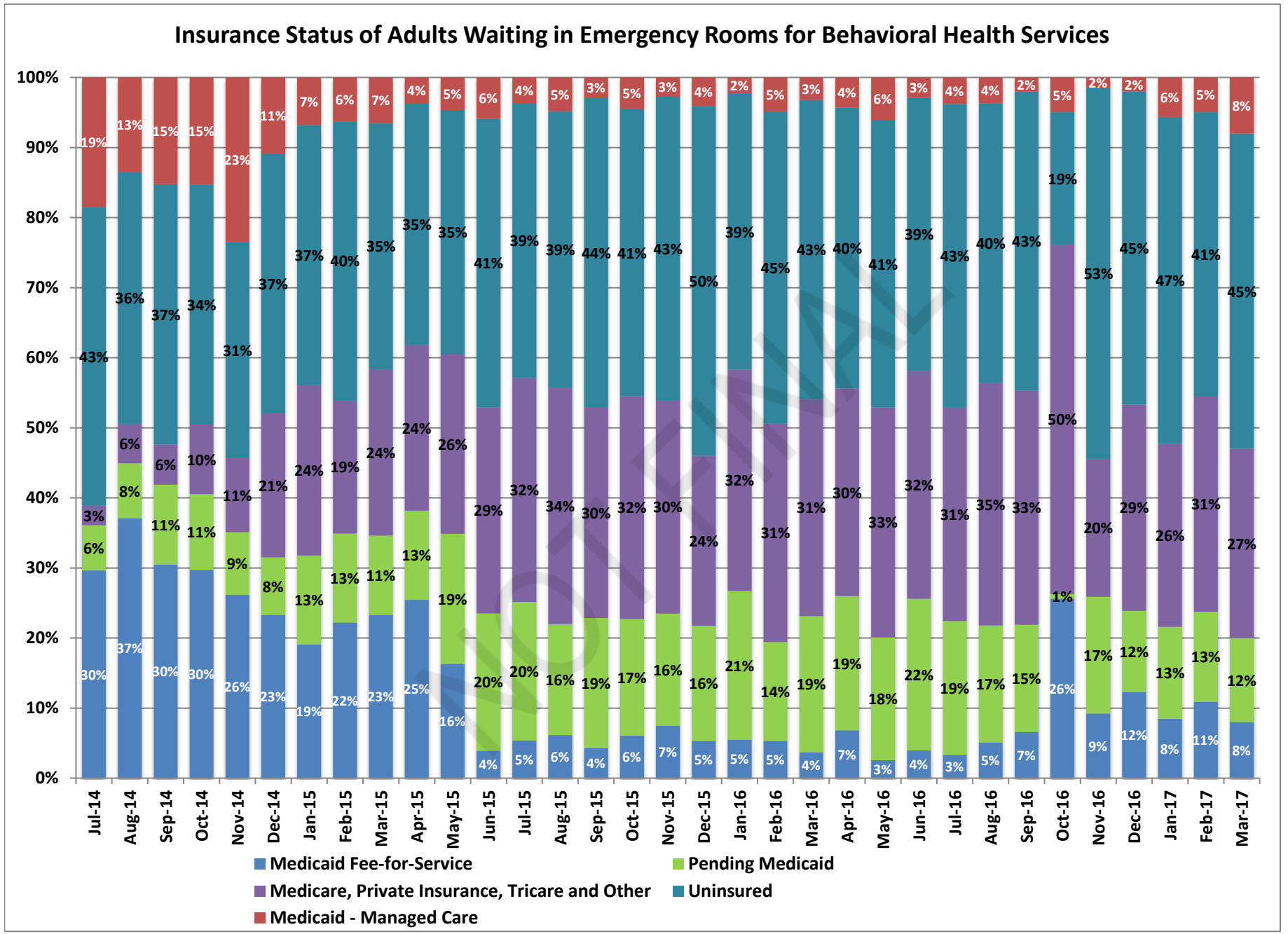
	Adults South	Adults North	Children South	Children North	Total
Jul-15	34	23	5	1	62
Aug-15	37	22	5	0	63
Sep-15	43	21	6	0	71
Oct-15	44	21	6	0	70
Nov-15	37	13	4	0	54
Dec-15	33	11	2	0	46
Jan-16	36	19	5	1	60
Feb-16	46	25	5	1	78
Mar-16	48	22	5	1	75
Apr-16	40	20	6	1	67
May-16	46	14	6	1	67
Jun-16	54	15	3	1	73
Jul-16	59	19	4	1	83
Aug-16	56	21	4	0	80
Sep-16	56	27	5	1	89
Oct-16	56	31	6	1	93
Nov-16	58	30	5	0	94
Dec-16	59	30	4	0	93
Jan-17	60	29	4*	0*	94*
Feb-17	62	33	2	1	98
Mar-17	55	30	1	1	86
Apr-17					
May-17					
Jun-17					

** Children North and Children South data is preliminary, data in the North is missing for two hospitals.*

Fiscal Year Averages

Fiscal Year	Adults South	Adults North	Children South	Children North	Total	Percent Change
FY14	115	5	7	1	119	
FY15	73	12	4	0	89	**-25%**
FY16	41	19	5	1	64	**-28%**
FY17 to date	58	28	4	1	90	**39%**




Insurance Status of Adults Waiting in Emergency Rooms for Behavioral Health Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Medicaid Fee-for-Service
Pending Medicaid
Medicare, Private Insurance, Tricare and Other
Uninsured
Medicaid - Managed Care

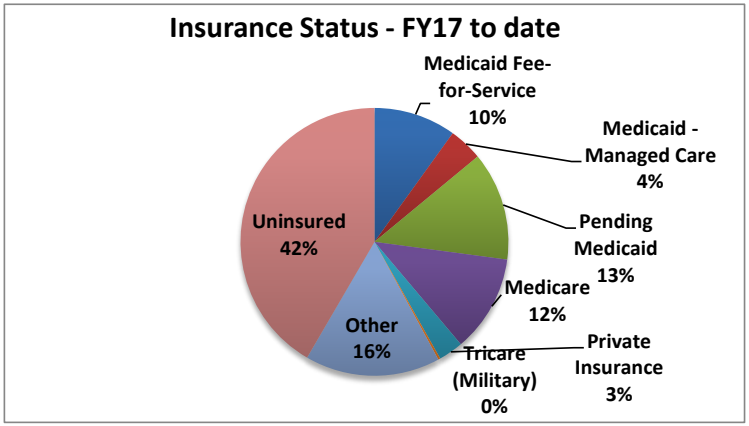
Insurance Status of Adults Waiting in Emergency Rooms for Behavioral Health Services (Monthly Average)

	Medicaid Fee-for-Service		Medicaid - Managed Care		Pending Medicaid		Medicare		Private Insurance		Tricare (Military)		Other		Uninsured	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Jul-15	3	5%	2	4%	12	20%	6	9%	1	2%	0	0%	12	20%	24	39%
Aug-15	4	6%	3	5%	10	16%	4	7%	1	2%	0	0%	15	25%	24	39%
Sep-15	3	4%	2	3%	13	19%	4	6%	0	0%	0	0%	17	24%	31	44%
Oct-15	4	6%	3	5%	11	17%	6	9%	1	2%	0	0%	14	21%	27	41%
Nov-15	4	7%	1	3%	9	16%	6	11%	1	1%	0	0%	9	17%	23	43%
Dec-15	2	5%	2	4%	8	16%	2	5%	1	3%	0	1%	7	16%	23	50%
Jan-16	3	5%	1	2%	12	21%	4	7%	1	1%	0	1%	13	23%	23	39%
Feb-16	4	5%	4	5%	11	14%	7	9%	2	2%	0	0%	15	20%	34	45%
Mar-16	3	4%	2	3%	14	19%	7	9%	1	2%	0	1%	14	19%	32	43%
Apr-16	4	7%	3	4%	13	19%	5	8%	0	1%	0	0%	14	21%	26	40%
May-16	2	3%	4	6%	11	18%	5	8%	1	2%	0	1%	13	22%	25	41%
Jun-16	3	4%	2	3%	14	22%	5	7%	1	2%	0	0%	15	23%	25	39%
Jul-16	2	3%	3	4%	13	19%	5	7%	1	2%	0	0%	15	22%	31	43%
Aug-16	3	5%	3	4%	11	17%	7	10%	1	2%	0	0%	16	23%	27	40%
Sep-16	5	7%	2	2%	11	15%	5	7%	1	1%	0	0%	18	25%	32	43%
Oct-16	7	26%	1	5%	0	1%	6	20%	0	0%	0	0%	8	29%	5	19%
Nov-16	7	9%	1	2%	13	17%	9	11%	2	3%	0	0%	5	6%	42	53%
Dec-16	11	12%	2	2%	10	12%	12	13%	5	6%	1	1%	9	10%	40	45%
Jan-17	4	8%	3	6%	7	13%	6	11%	2	4%	0	0%	6	11%	24	47%
Feb-17	11	11%	5	5%	13	13%	12	12%	6	6%	1	1%	12	12%	41	41%
Mar-17	7	8%	6	8%	10	12%	12	14%	4	4%	0	0%	8	9%	38	45%
Apr-17																
May-17																
Jun-17																

Note: This is the average for the month of the daily counts of individuals in each category.

Fiscal Year Averages

Insurance Status	FY15	FY16	FY17 to date
Medicaid Fee-for-Service	24%	5%	10%
Medicaid - Managed Care	11%	4%	4%
Pending Medicaid	12%	18%	13%
Medicare	7%	8%	12%
Private Insurance	2%	2%	3%
Tricare (Military)	0%	0%	0%
Other	8%	21%	16%
Uninsured	37%	42%	42%



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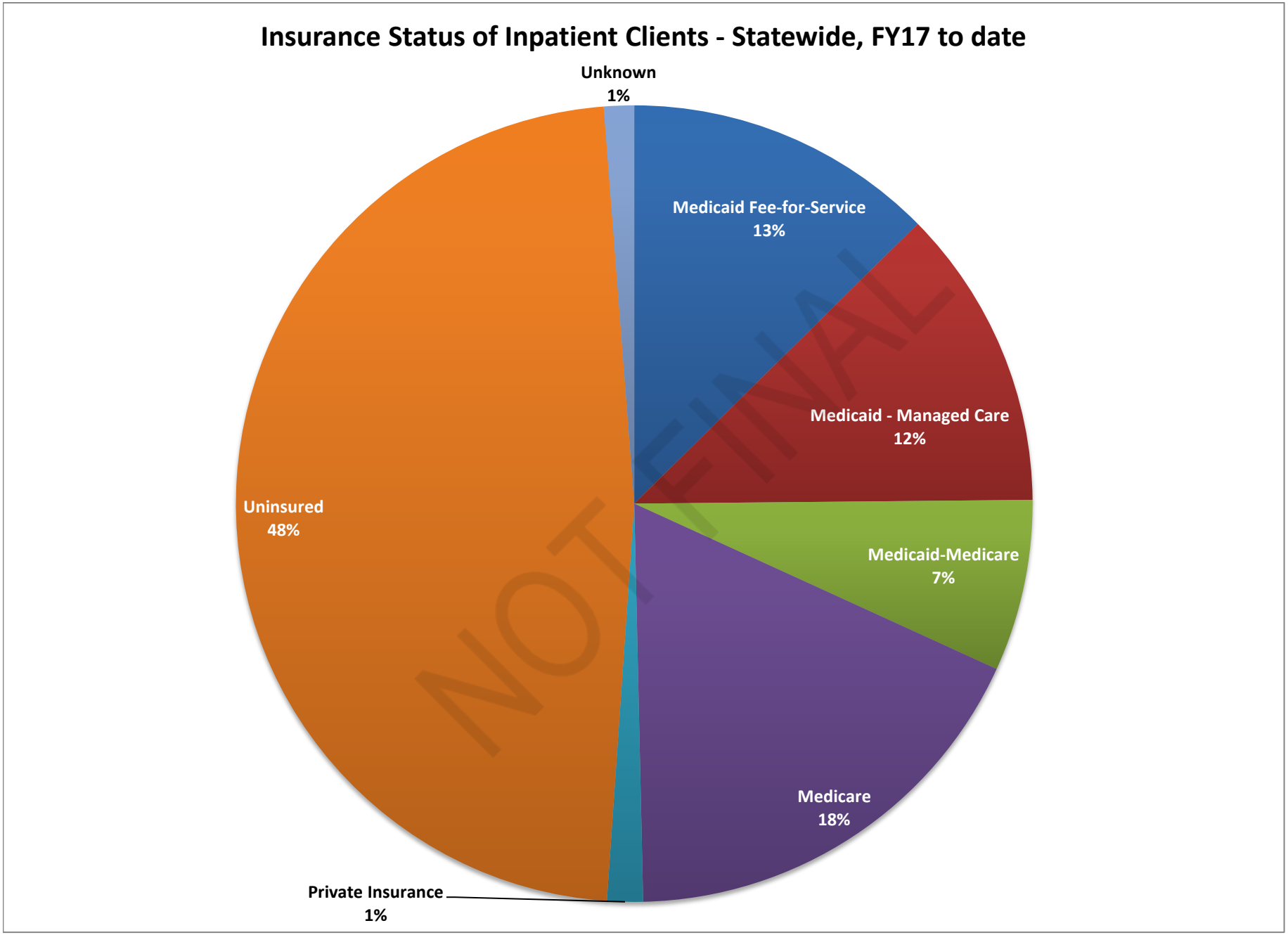

Insurance Status of Inpatient Clients - Statewide, FY17 to date
Unknown
1%
Medicaid Fee-for-Service
13%
Medicaid - Managed Care
12%
Medicaid-Medicare
7%
Medicare
18%
Private Insurance
1%
Uninsured
48%
NOT FINAL

Insurance Status of Adult Inpatient Clients (Monthly Average)

DINI-TOWNSEND (NORTH)

	Medicaid Fee-for-Service	Medicaid - Managed Care	Medicaid-Medicare	Medicare	Private Insurance	Uninsured	Unknown
Oct-15	35%	10%	16%	13%	6%	21%	0%
Nov-15	35%	4%	14%	22%	7%	19%	0%
Dec-15	31%	5%	7%	24%	5%	26%	4%
Jan-16	49%	8%	11%	17%	5%	9%	0%
Feb-16	44%	4%	6%	23%	7%	15%	1%
Mar-16	42%	5%	13%	17%	10%	11%	1%
Apr-16	41%	8%	14%	24%	8%	4%	1%
May-16	29%	11%	14%	16%	9%	21%	0%
Jun-16	31%	7%	15%	17%	9%	23%	0%
Jul-16	30%	17%	5%	14%	17%	17%	1%
Aug-16	32%	22%	3%	20%	5%	18%	0%
Sep-16	24%	20%	7%	24%	5%	20%	0%
Oct-16	31%	13%	6%	31%	5%	14%	0%
Nov-16	23%	7%	13%	27%	8%	23%	0%
Dec-16	23%	8%	14%	21%	4%	30%	0%
Jan-17	34%	11%	13%	14%	5%	22%	0%
Feb-17	40%	24%	15%	0%	1%	19%	0%
Mar-17	26%	19%	11%	21%	7%	16%	0%
Apr-17							
May-17							
Jun-17							

RAWSON-NEAL (SOUTH)

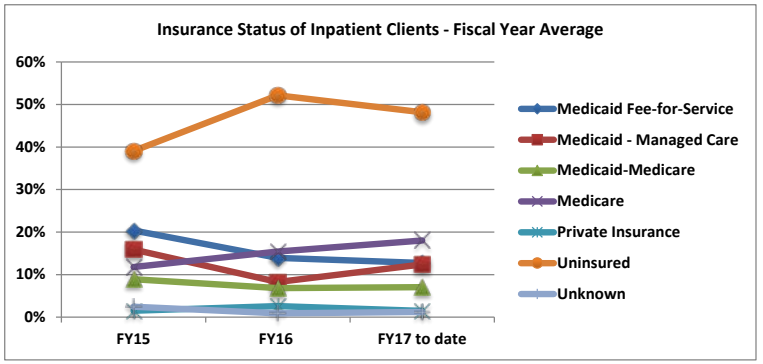
	Medicaid Fee-for-Service	Medicaid - Managed Care	Medicaid-Medicare	Medicare	Private Insurance	Uninsured	Unknown
Oct-15	10%	6%	7%	18%	2%	57%	0%
Nov-15	11%	6%	8%	19%	3%	54%	0%
Dec-15	11%	7%	7%	14%	1%	61%	0%
Jan-16	11%	9%	5%	13%	1%	60%	0%
Feb-16	10%	11%	4%	13%	1%	62%	0%
Mar-16	11%	12%	3%	14%	1%	59%	0%
Apr-16	9%	10%	3%	16%	0%	61%	0%
May-16	8%	11%	5%	17%	1%	58%	0%
Jun-16	7%	10%	4%	20%	2%	58%	0%
Jul-16	9%	9%	5%	18%	2%	57%	0%
Aug-16	10%	9%	5%	16%	2%	58%	0%
Sep-16	9%	8%	5%	17%	0%	62%	0%
Oct-16	11%	9%	2%	19%	0%	58%	0%
Nov-16	13%	13%	0%	20%	0%	54%	0%
Dec-16	11%	13%	1%	20%	0%	54%	0%
Jan-17	0%	3%	41%	10%	0%	30%	15%
Feb-17	10%	15%	2%	21%	0%	52%	0%
Mar-17	11%	18%	2%	20%	1%	48%	0%
Apr-17							
May-17							
Jun-17							

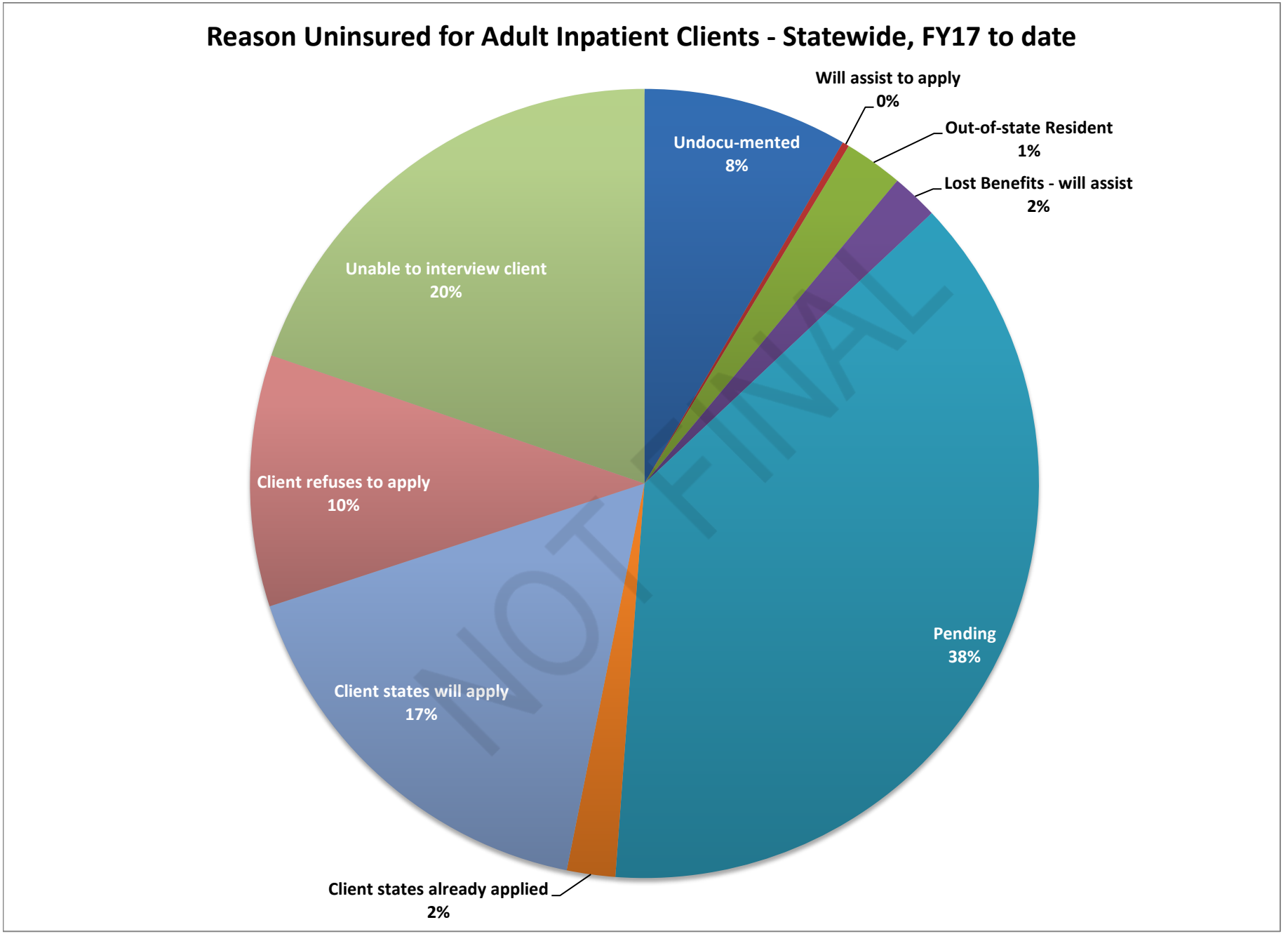
STATEWIDE

	Medicaid Fee-for-Service	Medicaid - Managed Care	Medicaid-Medicare	Medicare	Private Insurance	Uninsured	Unknown
Oct-15	14%	7%	9%	17%	3%	51%	0%
Nov-15	15%	5%	8%	20%	4%	48%	0%
Dec-15	14%	7%	7%	15%	1%	55%	1%
Jan-16	17%	9%	6%	14%	2%	52%	0%
Feb-16	15%	10%	4%	14%	2%	55%	0%
Mar-16	16%	11%	4%	14%	2%	52%	0%
Apr-16	14%	10%	5%	18%	1%	53%	0%
May-16	11%	11%	6%	16%	2%	53%	0%
Jun-16	10%	9%	5%	19%	3%	53%	0%
Jul-16	13%	11%	5%	17%	4%	50%	0%
Aug-16	13%	10%	5%	17%	2%	53%	0%
Sep-16	11%	9%	5%	17%	1%	56%	0%
Oct-16	14%	9%	2%	21%	1%	52%	0%
Nov-16	14%	20%	2%	21%	1%	50%	0%
Dec-16	13%	13%	3%	20%	0%	54%	0%
Jan-17	9%	5%	34%	11%	2%	28%	11%
Feb-17	14%	16%	4%	18%	0%	48%	0%
Mar-17	14%	18%	3%	20%	2%	43%	0%
Apr-17							
May-17							
Jun-17							

Fiscal Year Averages

Fiscal Year	Medicaid Fee-for-Service	Medicaid - Managed Care	Medicaid-Medicare	Medicare	Private Insurance	Uninsured	Unknown
FY15	20%	16%	9%	12%	2%	39%	2%
FY16	14%	8%	7%	15%	3%	52%	1%
FY17 to date	13%	12%	7%	18%	1%	48%	1%




Reason Uninsured for Adult Inpatient Clients - Statewide, FY17 to date
Will assist to apply
0%
Out-of-state Resident
1%
Lost Benefits - will assist
2%
Undocu-mented
8%
Unable to interview client
20%
Client refuses to apply
10%
Client states will apply
17%
Client states already applied
2%
Pending
38%
NOT FINAL

Uninsured Reason for Adult Inpatient Clients (Monthly Average)

DINI-TOWNSEND (NORTH)

	Undocu-mented	Will assist to apply	Out-of-state Resident	Lost Benefits - will assist	Pending	Client states already applied	Client states will apply	Client refuses to apply	Unable to interview client
Nov-15	5%	5%	0%	0%	10%	0%	5%	48%	29%
Dec-15	0%	32%	0%	0%	26%	0%	0%	29%	12%
Jan-16	0%	0%	13%	0%	0%	0%	0%	63%	25%
Feb-16	0%	24%	0%	0%	24%	0%	0%	35%	18%
Mar-16	0%	27%	0%	0%	7%	0%	0%	60%	7%
Apr-16	0%	60%	0%	0%	0%	0%	20%	20%	0%
May-16	0%	32%	0%	0%	14%	5%	5%	0%	45%
Jun-16	6%	42%	3%	0%	35%	0%	3%	6%	3%
Jul-16	13%	22%	0%	13%	0%	0%	0%	17%	35%
Aug-16	0%	25%	0%	0%	10%	45%	0%	0%	20%
Sep-16	10%	0%	0%	0%	31%	48%	0%	0%	10%
Oct-16	0%	0%	0%	0%	100%	0%	0%	0%	0%
Nov-16	10%	0%	0%	0%	60%	25%	0%	0%	5%
Dec-16	11%	2%	13%	0%	43%	2%	0%	26%	4%
Jan-17	19%	0%	12%	4%	35%	8%	0%	23%	0%
Feb-17	11%	0%	37%	0%	47%	0%	0%	5%	0%
Mar-17	25%	0%	4%	0%	58%	4%	4%	4%	4%
Apr-17									
May-17									
Jun-17									

RAWSON-NEAL (SOUTH)

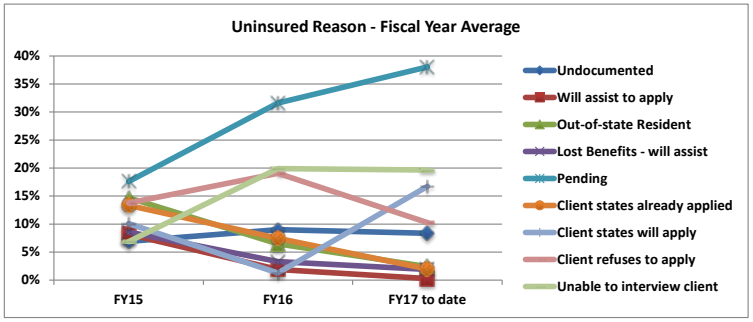
	Undocu-mented	Will assist to apply	Out-of-state Resident	Lost Benefits - will assist	Pending	Client states already applied	Client states will apply	Client refuses to apply	Unable to interview client
Nov-15	12%	0%	6%	2%	30%	11%	0%	22%	18%
Dec-15	20%	0%	2%	1%	36%	7%	1%	19%	13%
Jan-16	17%	0%	2%	3%	28%	9%	0%	20%	22%
Feb-16	14%	0%	2%	5%	36%	7%	0%	10%	26%
Mar-16	7%	0%	2%	3%	35%	5%	0%	13%	35%
Apr-16	7%	0%	2%	2%	29%	5%	0%	13%	41%
May-16	9%	0%	0%	3%	41%	3%	6%	13%	25%
Jun-16	7%	0%	0%	1%	48%	2%	7%	15%	20%
Jul-16	7%	0%	1%	2%	40%	2%	12%	11%	24%
Aug-16	5%	0%	2%	3%	34%	1%	10%	10%	35%
Sep-16	5%	0%	1%	2%	41%	2%	8%	8%	33%
Oct-16	8%	0%	3%	3%	37%	2%	12%	9%	26%
Nov-16	10%	0%	3%	3%	36%	0%	18%	13%	16%
Dec-16	13%	0%	4%	1%	38%	0%	22%	10%	13%
Jan-17	9%	0%	2%	1%	37%	0%	27%	14%	9%
Feb-17	7%	0%	1%	1%	39%	0%	0%	9%	12%
Mar-17	10%	0%	2%	1%	41%	0%	4%	8%	14%
Apr-17									
May-17									
Jun-17									

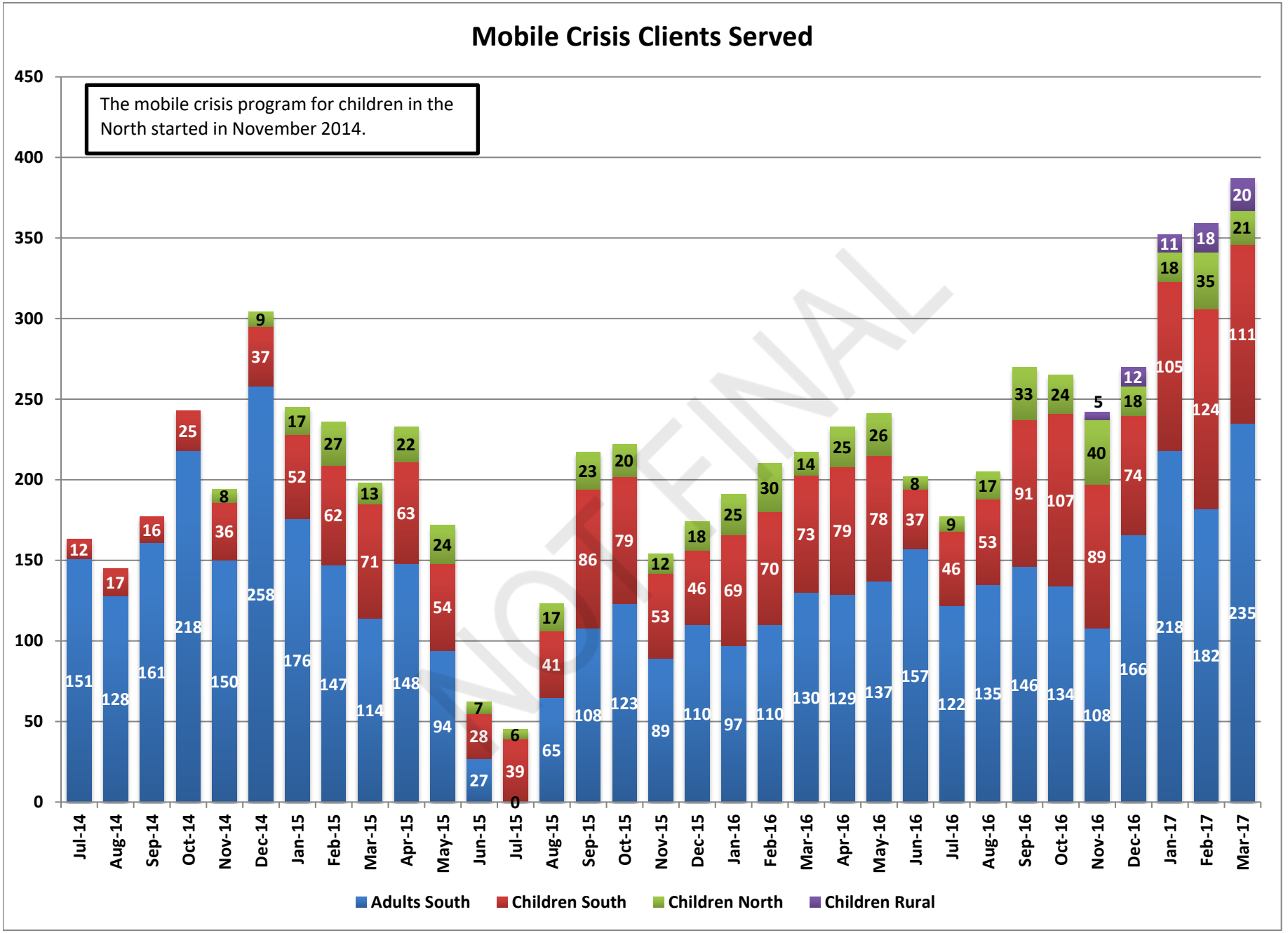
STATEWIDE

	Undocu-mented	Will assist to apply	Out-of-state Resident	Lost Benefits - will assist	Pending	Client states already applied	Client states will apply	Client refuses to apply	Unable to interview client
Nov-15	11%	0%	6%	2%	29%	10%	0%	23%	19%
Dec-15	14%	9%	2%	1%	33%	5%	1%	22%	13%
Jan-16	16%	0%	3%	3%	27%	8%	0%	21%	22%
Feb-16	13%	1%	2%	4%	36%	7%	0%	11%	26%
Mar-16	7%	1%	2%	3%	34%	5%	0%	14%	34%
Apr-16	7%	1%	2%	2%	29%	5%	0%	14%	40%
May-16	9%	2%	0%	3%	40%	3%	6%	12%	26%
Jun-16	7%	3%	1%	1%	47%	2%	7%	14%	19%
Jul-16	7%	1%	1%	3%	38%	2%	11%	12%	25%
Aug-16	4%	1%	2%	3%	33%	3%	9%	10%	34%
Sep-16	5%	0%	1%	2%	40%	4%	8%	7%	32%
Oct-16	8%	0%	3%	3%	35%	6%	11%	9%	25%
Nov-16	10%	0%	3%	2%	38%	2%	17%	12%	15%
Dec-16	12%	0%	4%	1%	39%	0%	19%	12%	12%
Jan-17	10%	0%	3%	1%	37%	1%	25%	14%	9%
Feb-17	7%	0%	3%	1%	40%	0%	28%	9%	11%
Mar-17	11%	0%	2%	1%	42%	0%	22%	7%	14%
Apr-17									
May-17									
Jun-17									

Fiscal Year Averages

Fiscal Year	Undocu-mented	Will assist to apply	Out-of-state Resident	Lost Benefits - will assist	Pending	Client states already applied	Client states will apply	Client refuses to apply	Unable to interview client
FY15	7%	8%	15%	9%	18%	13%	10%	14%	7%
FY16	9%	2%	6%	3%	32%	7%	1%	19%	20%
FY17 to date	8%	0%	2%	2%	38%	2%	17%	10%	20%




Mobile Crisis Clients Served
The mobile crisis program for children in the North started in November 2014.
NOT FINAL
450
400
350
300
250
200
150
100
50
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
151 12 128 17 161 16 218 25 150 36 8 258 37 9 176 52 17 147 62 27 114 71 13 148 63 22 94 54 24 27 28 7 65 41 17 108 86 23 123 79 20 89 53 12 110 46 18 97 69 25 110 70 30 130 73 14 129 79 25 137 78 26 157 37 8 122 46 9 135 53 17 146 91 33 134 107 24 108 89 40 5 166 74 18 12 218 105 18 11 182 124 35 18 235 111 21 20 0 39 6
Adults South
Children South
Children North
Children Rural

Children's Mobile Crisis

	Children South						Children North						Children Rural					
	Total Calls	Clients Served (Team Respond-ed)	Hospitaliza-tion	Hospital Diversion	Stabilizati-on Recomme-nded	Hospital Diversion Rate	Total Calls	Clients Served (Team Respond-ed)	Hospitaliza-tion	Hospital Diversion	Stabilizati-on Recomme-nded	Hospital Diversion Rate	Total Calls	Clients Served (Team Respond-ed)	Hospitaliza-tion	Hospital Diversion	Stabilizati-on Recomme-nded	Hospital Diversion Rate
Jul-15	51	39	9	30	12	77%	8	6	2	4	4	67%						
Aug-15	53	41	3	38	26	93%	29	17	0	17	14	100%						
Sep-15	122	86	10	76	52	88%	55	23	4	19	15	83%						
Oct-15	121	79	6	73	56	92%	54	20	1	19	17	95%						
Nov-15	95	53	9	44	37	83%	23	12	1	11	10	92%						
Dec-15	84	46	3	43	27	93%	26	18	0	18	12	100%						
Jan-16	107	69	8	61	47	88%	45	25	9	16	11	64%						
Feb-16	115	70	11	59	51	84%	55	30	6	24	17	80%						
Mar-16	121	73	7	66	54	90%	37	14	3	11	7	79%						
Apr-16	126	79	13	66	53	84%	58	25	7	18	15	72%						
May-16	127	78	10	68	50	87%	55	26	8	18	11	69%						
Jun-16	55	37	5	32	19	86%	16	8	5	3	1	38%						
Jul-16	67	46	7	39	23	85%	15	9	2	7	2	78%						
Aug-16	74	53	6	47	33	89%	34	17	4	13	10	76%						
Sep-16	129	91	9	82	64	90%	56	33	10	23	15	70%						
Oct-16	152	107	12	95	80	89%	44	24	4	20	10	83%						
Nov-16	127	89	9	80	49	90%	53	40	6	34	22	85%	6	5	1	4	2	80%
Dec-16	113	74	7	67	45	91%	46	18	3	15	8	83%	21	12	1	11	7	92%
Jan-17	136	105	14	91	75	87%	33	18	5	13	11	72%	15	11	2	9	3	82%
Feb-17	172	124	7	117	56	94%	67	35	5	30	21	86%	32	18	3	15	4	83%
Mar-17	158	111	15	96	52	86%	49	21	7	19	17	90%	28	20	2	18	7	90%
Apr-17																		
May-17																		
Jun-17																		

Mobile Crisis

Adults South				
	Clients Served	Hospitalization	Hospital Diversion	Hospital Diversion
Jul-15	0	0	0	
Aug-15	65	28	37	57%
Sep-15	108	46	62	57%
Oct-15	123	51	72	59%
Nov-15	89	30	59	66%
Dec-15	110	35	75	68%
Jan-16	97	32	65	67%
Feb-16	110	28	82	75%
Mar-16	130	47	83	64%
Apr-16	129	43	86	67%
May-16	137	47	90	66%
Jun-16	157	51	106	68%
Jul-16	122	55	67	55%
Aug-16	135	50	85	63%
Sep-16	146	45	101	69%
Oct-16	134	49	85	63%
Nov-16	108	37	71	66%
Dec-16	166	57	109	66%
Jan-17	218	70	148	68%
Feb-17	182	44	138	76%
Mar-17	235	48	187	80%
Apr-17				
May-17				
Jun-17				

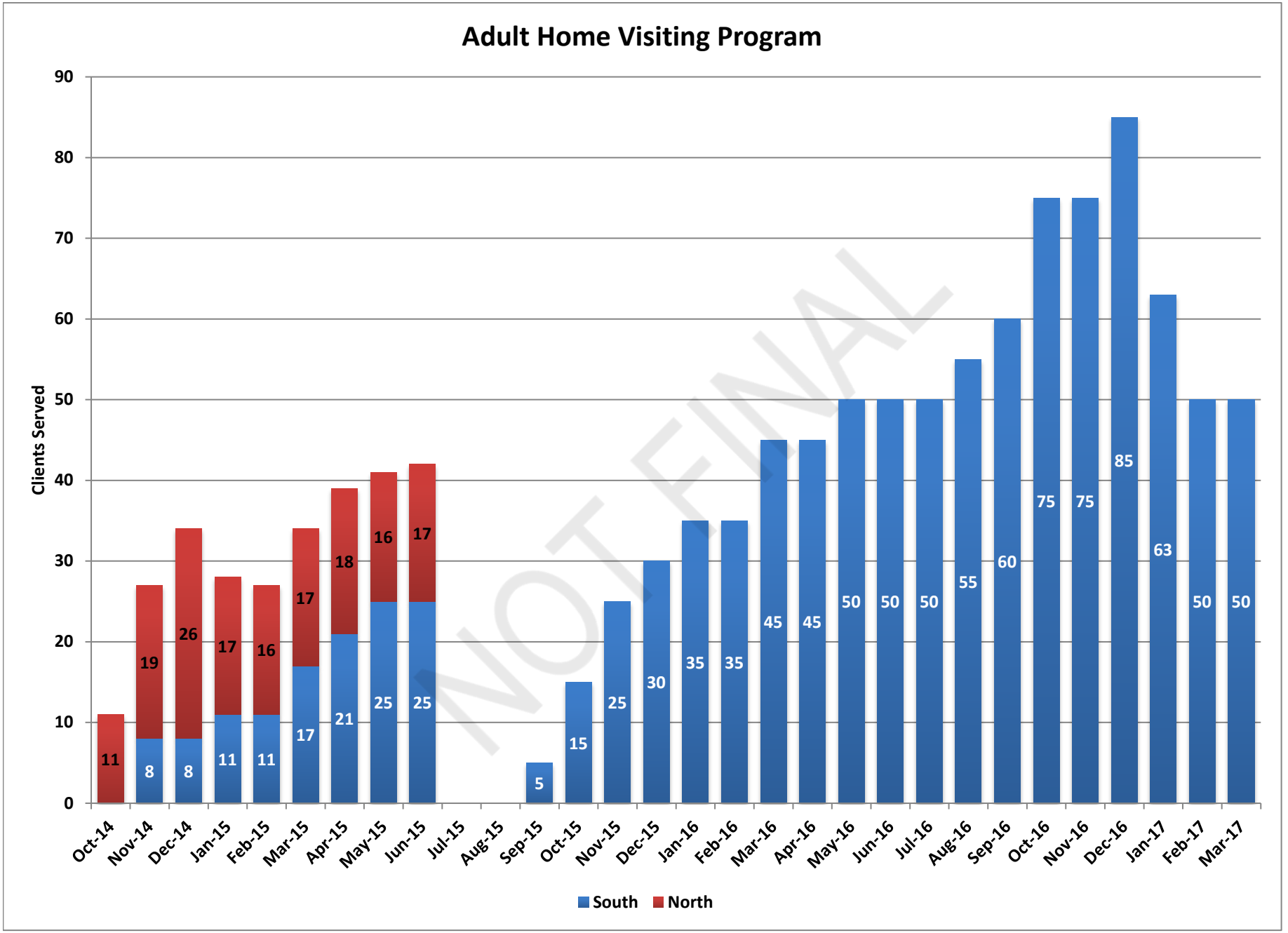
Total Clients Served					
	Adults South	Children South	Children North	Children Rural	Total
Jul-15	0	39	6		45
Aug-15	65	41	17		123
Sep-15	108	86	23		217
Oct-15	123	79	20		222
Nov-15	89	53	12		154
Dec-15	110	46	18		174
Jan-16	97	69	25		191
Feb-16	110	70	30		210
Mar-16	130	73	14		217
Apr-16	129	79	25		233
May-16	137	78	26		241
Jun-16	157	37	8		202
Jul-16	122	46	9		177
Aug-16	135	53	17		205
Sep-16	146	91	33		270
Oct-16	134	107	24		265
Nov-16	108	89	40	5	242
Dec-16	166	74	18	12	270
Jan-17	218	105	18	11	352
Feb-17	182	124	35	18	359
Mar-17	235	111	21	20	387
Apr-17					
May-17					
Jun-17					

Note: No adult mobile crisis staff were in the field in July 2015. DPBH and the social services department implemented a policy to serve on a triage basis. The staff will go to the ERs when the number of individuals without insurance exceeds 30 or when requested. They will also contact the

Fiscal Year Totals

Fiscal Year	Adults South		Children South		Children North		Children Rural		Total	
	Clients Served	Hospital Diversion Rate	Clients Served	Hospital Diversion Rate	Clients Served	Hospital Diversion Rate	Clients Served	Hospital Diversion Rate	Clients Served	Hospital Diversion Rate
FY14			96	90%						
FY15	1,772	42%	473	88%	127	81%			2,372	53%
FY16	1,255	65%	750	87%	224	78%			2,229	74%
FY17 to date	1,446	69%	800	89%	215	81%	66	86%	2,527	74%

Note: Adult South data is not available prior to July 2014. Children's Mobile Crisis Response Teams began in January 2014 in the South and November 2014 in the North.

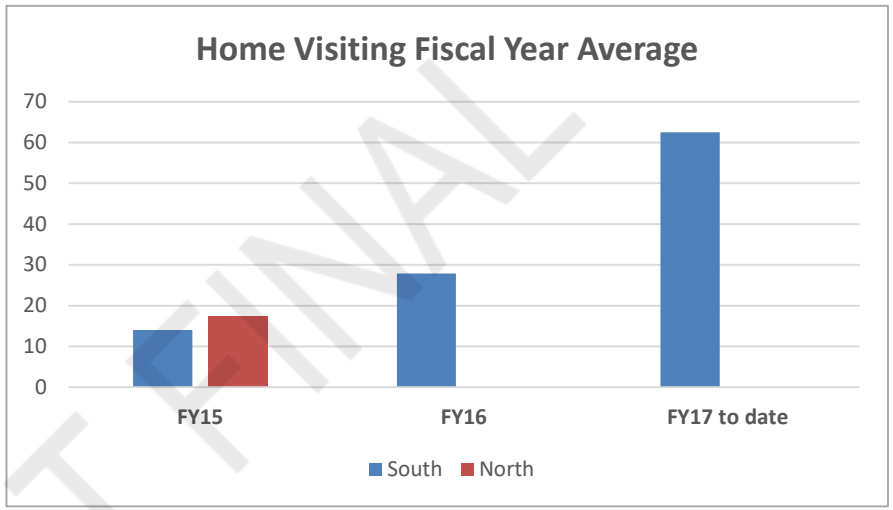

Adult Home Visiting Program
Clients Served
90
80
70
60
50
40
30
20
10
0
Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
11 8 19 8 26 11 17 11 16 17 17 21 18 25 16 25 17
5 15 25 30 35 35 45 45 50 50 50 55 60 75 75 85 63 50 50
South
North
NOT FINAL

Adult Home Visiting Program

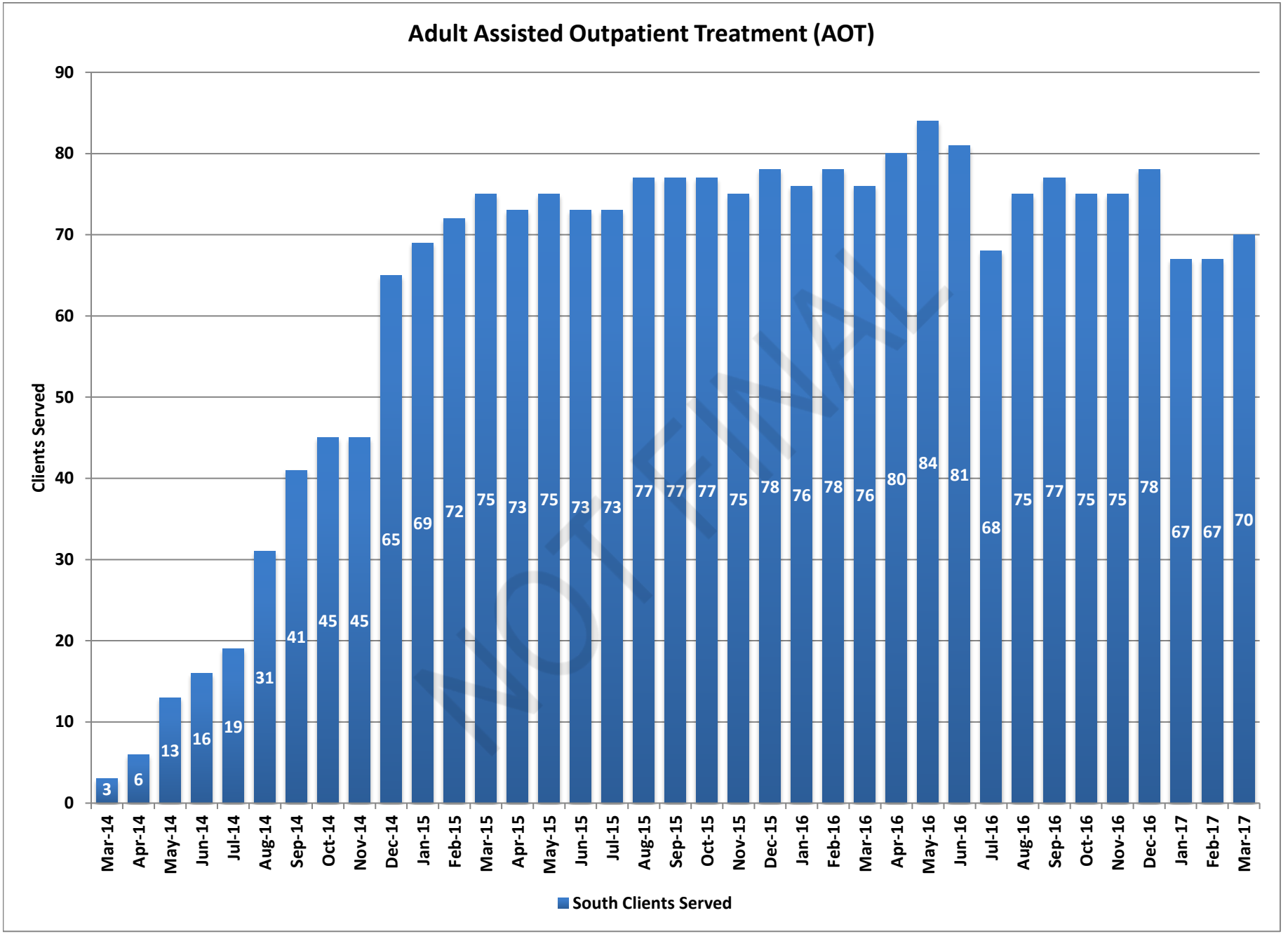
	South	North	Total Served
Jul-15	0		0
Aug-15	0		0
Sep-15	5		5
Oct-15	15		15
Nov-15	25		25
Dec-15	30		30
Jan-16	35		35
Feb-16	35		35
Mar-16	45		45
Apr-16	45		45
May-16	50		50
Jun-16	50		50
Jul-16	50		50
Aug-16	55		55
Sep-16	60		60
Oct-16	75		75
Nov-16	75		75
Dec-16	85		85
Jan-17	63		63
Feb-17	50		50
Mar-17	50		50
Apr-17			
May-17			
Jun-17			

Fiscal Year Averages

	South	North	Total Served
FY15	14	17	31
FY16	28		
FY17 to date	63		



Note: The contract ended June 30, 2015 because the services are Medicaid reimbursible. Two contracted staff have been approved for hire beginning in September, 2015 for home visitation in the South.


Adult Assisted Outpatient Treatment (AOT)
Clients Served
90
80
70
60
50
40
30
20
10
0
3
6
13
16
19
31
41
45
45
65
69
72
75
73
75
73
73
77
77
77
75
78
76
78
76
80
84
81
68
75
77
75
75
78
67
67
70
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
South Clients Served
NOT FINAL

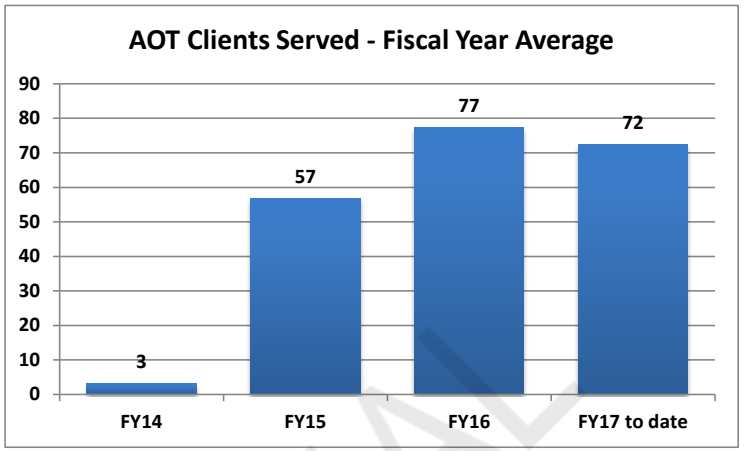
Adult Assisted Outpatient Treatment (AOT)

	South Clients Served
Jul-14	19
Aug-14	31
Sep-14	41
Oct-14	45
Nov-14	45
Dec-14	65
Jan-15	69
Feb-15	72
Mar-15	75
Apr-15	73
May-15	75
Jun-15	73
Jul-15	73
Aug-15	77
Sep-15	77
Oct-15	77
Nov-15	75
Dec-15	78
Jan-16	76
Feb-16	78
Mar-16	76
Apr-16	80
May-16	84
Jun-16	81
Jul-16	68
Aug-16	75
Sep-16	77
Oct-16	75
Nov-16	75
Dec-16	78
Jan-17	67
Feb-17	67
Mar-17	70
Apr-17	
May-17	
Jun-17	

Fiscal Year Averages

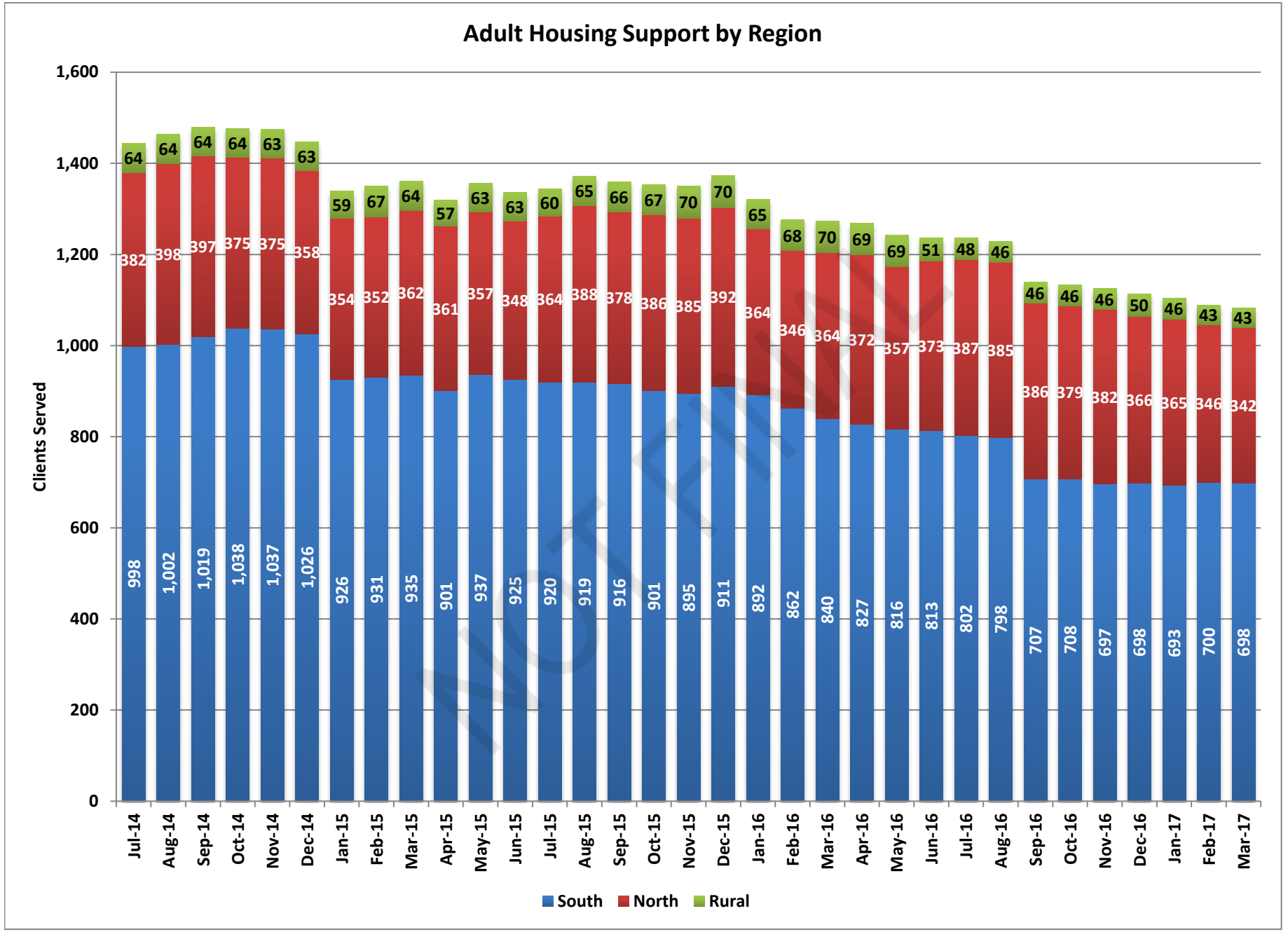
Fiscal Year	South Clients Served
FY14	3
FY15	57
FY16	77
FY17 to date	72

Note: Budgeted caseload is 75 clients.



AOT Clients by Status

	Referrals	Petitions	Court Orders	Re-petitions	Denied by AOT	Denied by Court	Terminated by Court	Graduated
Feb-16	14	3	4	6	0	1	1	4
Mar-16	14	9	1	6	0	1	1	0
Apr-16	24	9	2	10	5	1	2	0
May-16	28	16	2	14	6	0	2	2
Jun-16	7	19	3	15	0	0	0	0
Jul-16	10	14	2	10	2	0	6	4
Aug-16	17	10	6	4	5	0	0	2
Sep-16	8	7	3	5	4	0	3	0
Oct-16	6	6	4	1	1	0	0	10
Nov-16	13	6	2	4	8	0	4	1
Dec-16	23	10	3	6	5	5	0	0
Jan-17	10	9	4	3	2	0	0	0
Feb-17	7	2	5	1	4	4	1	0
Mar-17	9	4	4	0	2	0	1	1
Apr-17								
May-17								
Jun-17								

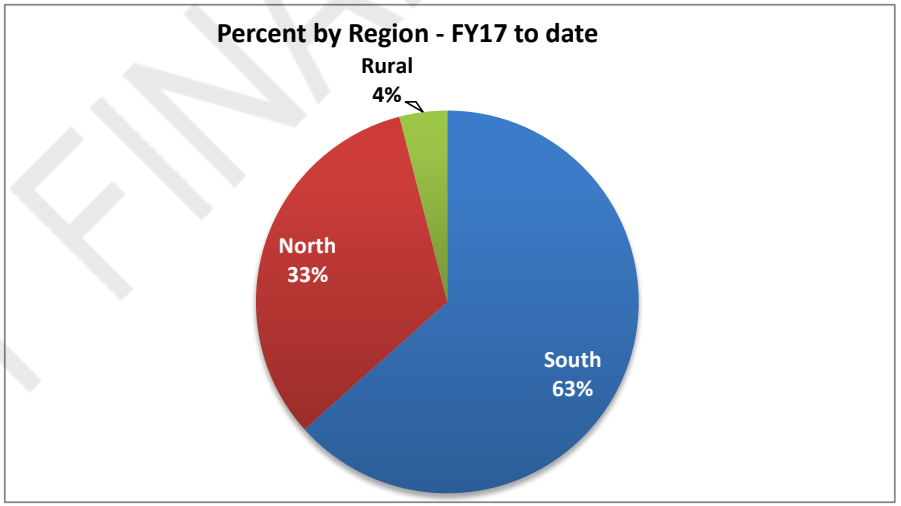

Adult Housing Support by Region
Clients Served
1,600
1,400
1,200
1,000
800
600
400
200
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
South North Rural
998 1,002 1,019 1,038 1,037 1,026 926 931 935 901 937 925 920 919 916 901 895 911 892 862 840 827 816 813 802 798 707 708 697 698 693 700 698
382 398 397 375 375 358 354 352 362 361 357 348 364 388 378 386 385 392 364 346 364 372 357 373 387 385 386 379 382 366 365 346 342
64 64 64 64 63 63 59 67 64 57 63 63 60 65 66 67 70 70 65 68 70 69 69 51 48 46 46 46 46 50 46 43 43
NOT FINAL

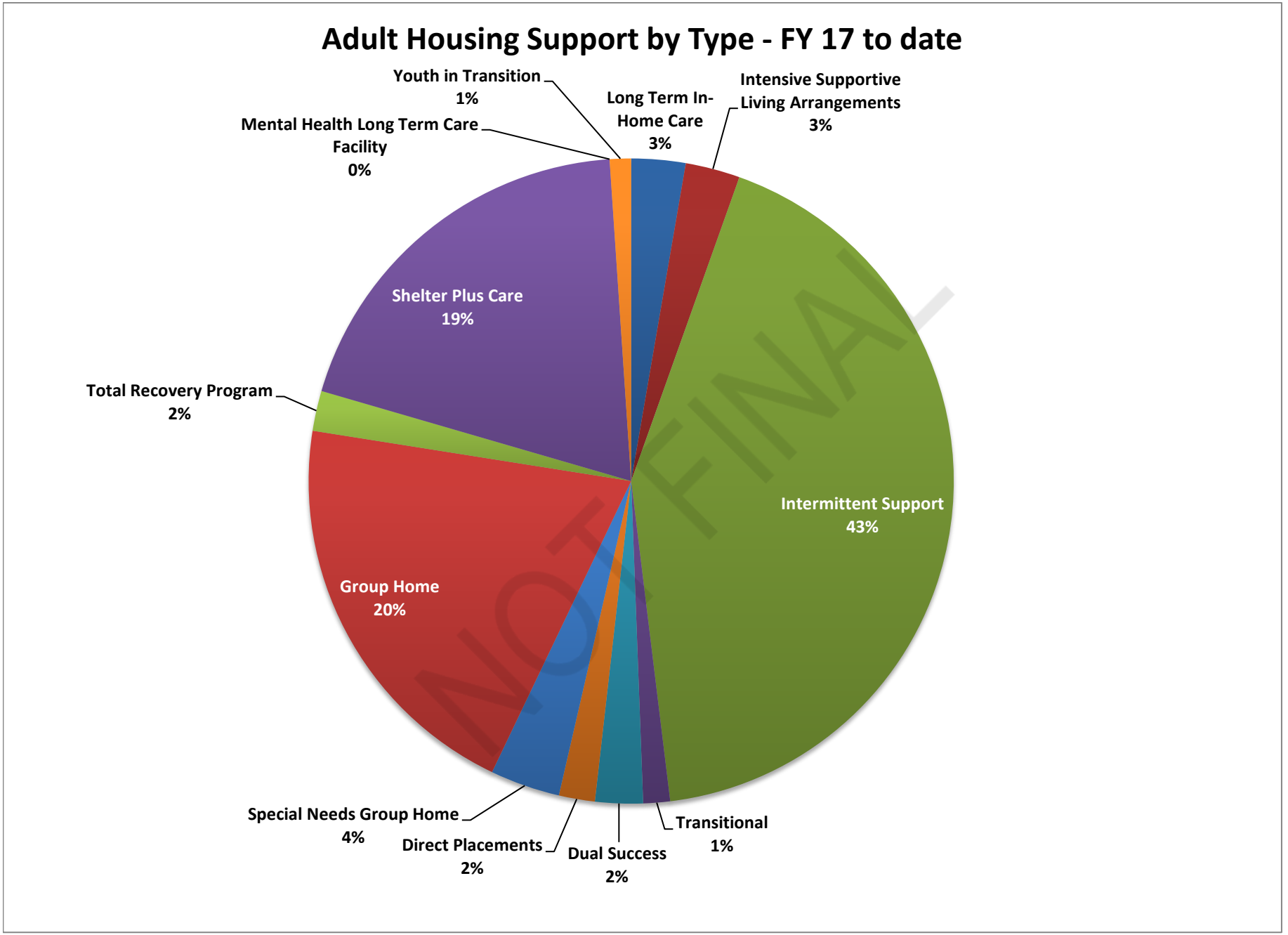
Adult Housing Support by Region

	South	North	Rural	Total Served
Jul-15	920	364	60	1,344
Aug-15	919	388	65	1,372
Sep-15	916	378	66	1,360
Oct-15	901	386	67	1,354
Nov-15	895	385	70	1,350
Dec-15	911	392	70	1,373
Jan-16	892	364	65	1,321
Feb-16	862	346	68	1,276
Mar-16	840	364	70	1,274
Apr-16	827	372	69	1,268
May-16	816	357	69	1,242
Jun-16	813	373	51	1,237
Jul-16	802	387	48	1,237
Aug-16	798	385	46	1,229
Sep-16	707	386	46	1,139
Oct-16	708	379	46	1,133
Nov-16	697	382	46	1,125
Dec-16	698	366	50	1,114
Jan-17	693	365	46	1,104
Feb-17	700	346	43	1,089
Mar-17	698	342	43	1,083
Apr-17				
May-17				
Jun-17				

Fiscal Year Averages

Fiscal Year	South	North	Rural	Total Served
FY15	973	368	63	1,404
FY16	876	372	66	1,309
FY17 to date	722	371	46	1,139



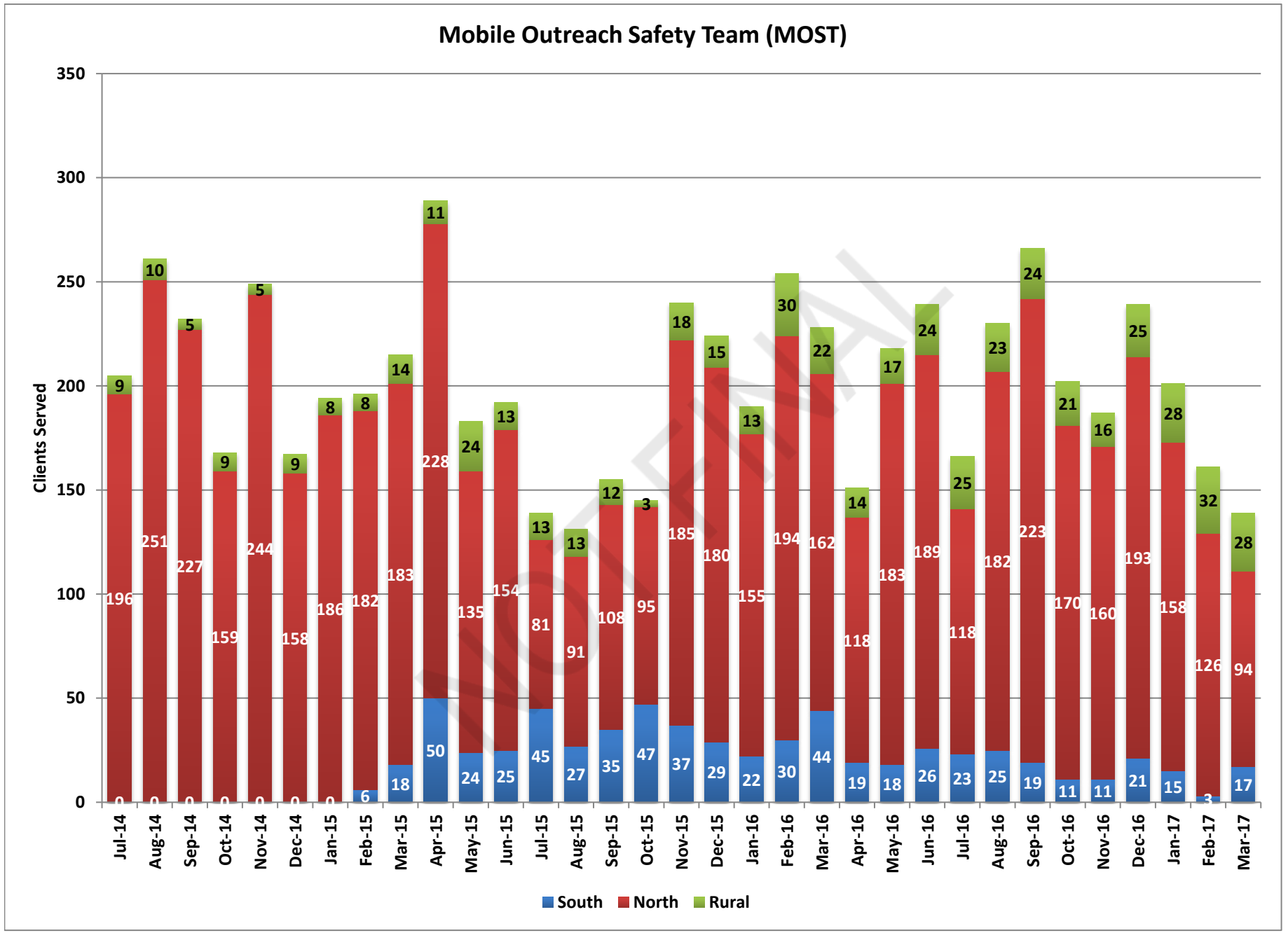

Adult Housing Support by Type - FY 17 to date
Youth in Transition 1%
Long Term In-Home Care 3%
Intensive Supportive Living Arrangements 3%
Mental Health Long Term Care Facility 0%
Shelter Plus Care 19%
Total Recovery Program 2%
Intermittent Support 43%
Group Home 20%
Special Needs Group Home 4%
Direct Placements 2%
Dual Success 2%
Transitional 1%
NOT FINAL

Housing Support by Type

	Long Term In-Home Care	Intensive Supportive Living Arrangements	Intermittent Support	Transitional	Dual Success	Direct Placements	Special Needs Group Home	Group Home	Total Recovery Program	Shelter Plus Care	Mental Health Long Term Care Facility	Youth in Transition
Jul-15	24	11	564	25	29	38	51	288	29	275	0	10
Aug-15	24	10	581	29	29	37	50	286	26	289	0	11
Sep-15	24	9	568	30	31	38	50	284	28	287	0	11
Oct-15	23	7	554	30	32	34	50	290	28	295	0	11
Nov-15	23	8	548	28	34	34	50	289	28	297	0	11
Dec-15	23	9	576	28	31	33	50	286	29	295	0	13
Jan-16	22	16	535	29	31	33	48	285	22	288	0	12
Feb-16	22	16	510	27	29	33	48	286	6	286	0	13
Mar-16	22	17	534	16	29	28	47	285	0	283	0	13
Apr-16	20	16	535	15	28	28	47	283	3	281	0	12
May-16	20	15	520	11	28	25	46	287	9	268	0	13
Jun-16	20	20	535	12	28	28	47	279	9	246	0	13
Jul-16	19	27	531	11	28	23	47	274	20	243	0	14
Aug-16	18	27	533	17	27	24	47	260	19	243	0	14
Sep-16	17	28	510	20	27	21	40	226	19	219	0	12
Oct-16	16	27	511	15	27	24	40	223	20	218	0	12
Nov-16	16	28	472	12	27	20	38	221	24	209	0	12
Dec-16	49	36	462	15	27	20	38	219	22	215	0	11
Jan-17	48	37	453	18	27	17	37	218	24	213	0	12
Feb-17	47	35	439	15	27	18	35	221	28	212	0	12
Mar-17	47	34	439	14	27	17	35	220	29	211	0	10
Apr-17												
May-17												
Jun-17												

Fiscal Year Averages

Fiscal Year	Long Term In-Home Care	Intensive Supportive Living Arrangements	Intermittent Support	Transitional	Dual Success	Direct Placements	Special Needs Group Home	Group Home	Total Recovery Program	Shelter Plus Care	Mental Health Long Term Care Facility	Youth in Transition
FY15	19	13	565	33	32	78	52	293	42	270	0	7
FY16	22	13	547	23	30	32	49	281	18	283	0	12
FY17 to date	31	31	483	15	27	20	40	231	23	220	0	12

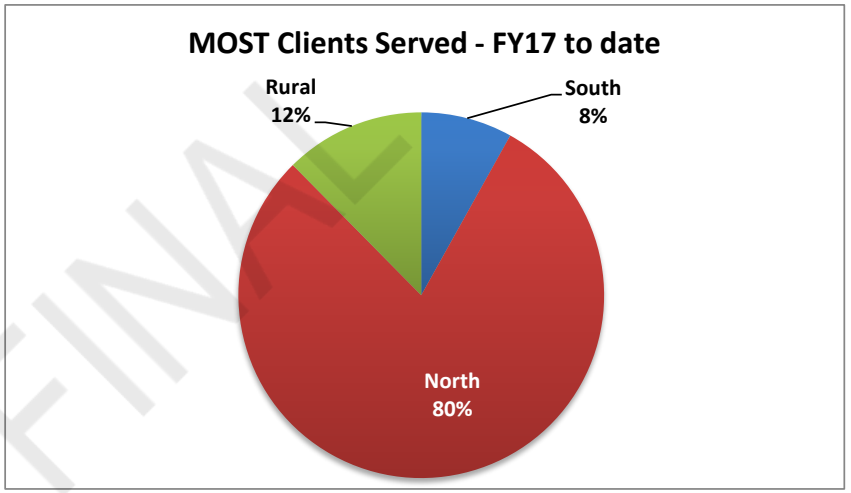

Mobile Outreach Safety Team (MOST)
Clients Served
350
300
250
200
150
100
50
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
South
North
Rural

Mobile Outreach Safety Team (MOST) Clients Served

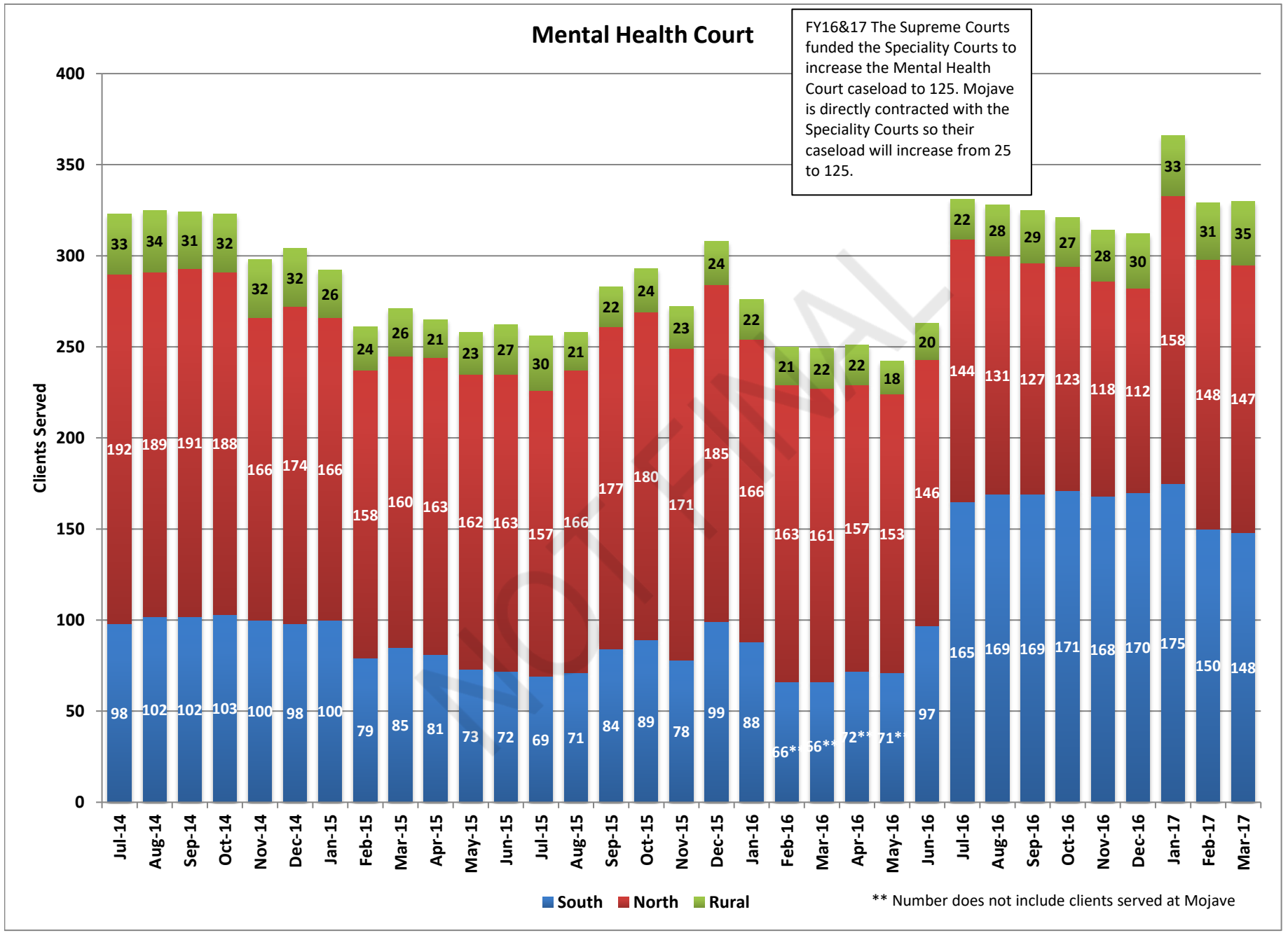
	South	North	Rural	Total
Jul-15	45	81	13	139
Aug-15	27	91	13	131
Sep-15	35	108	12	155
Oct-15	47	95	3	145
Nov-15	37	185	18	240
Dec-15	29	180	15	224
Jan-16	22	155	13	190
Feb-16	30	194	30	254
Mar-16	44	162	22	228
Apr-16	19	118	14	151
May-16	18	183	17	218
Jun-16	26	189	24	239
Jul-16	23	118	25	166
Aug-16	25	182	23	230
Sep-16	19	223	24	266
Oct-16	11	170	21	202
Nov-16	11	160	16	187
Dec-16	21	193	25	239
Jan-17	15	158	28	201
Feb-17	3	126	32	161
Mar-17	17	94	28	139
Apr-17				
May-17				
Jun-17				

Fiscal Year Averages

Fiscal Year	South	North	Rural	Total
FY15	10	192	10	213
FY16	32	145	16	193
FY17 to date	16	158	25	199



Note: Beginning in September 2015, the data for the Rural region now includes Lyon County in addition to Carson City.


Mental Health Court
FY16&17 The Supreme Courts funded the Speciality Courts to increase the Mental Health Court caseload to 125. Mojave is directly contracted with the Speciality Courts so their caseload will increase from 25 to 125.
Clients Served
South
North
Rural
** Number does not include clients served at Mojave

Adult Mental Health Court

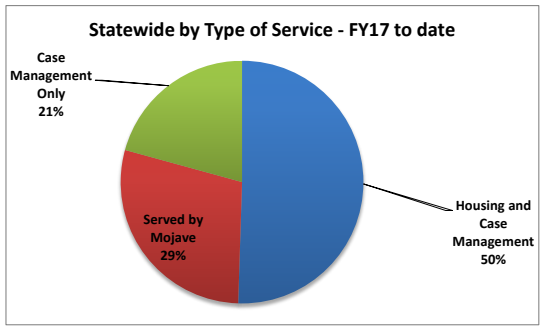
	South				North				Rural				Statewide			
	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total Clients Served
Jul-15	59	10	0	69	80	1	76	157	30		0	30	169	11	76	256
Aug-15	59	12	0	71	73	0	93	166	21		0	21	153	12	93	258
Sep-15	57	12	15	84	85	2	90	177	22		0	22	164	14	105	283
Oct-15	59	15	15	89	86	0	94	180	24		0	24	169	15	109	293
Nov-15	43	15	20	78	89	0	82	171	23		0	23	155	15	102	272
Dec-15	53	23	23	99	89	0	96	185	24		0	24	166	23	119	308
Jan-16	49	20	19	88	79	1	86	166	22		0	22	150	21	105	276
Feb-16	34	*	32	66 *	68	1	94	163	21		0	21	123	*	126	249 *
Mar-16	34	*	32	66 *	59	0	102	161	22		0	22	115	*	134	249 *
Apr-16	40	*	32	72 *	44	0	113	157	22		0	22	106	*	145	251 *
May-16	43	*	28	71 *	79	0	74	153	18		0	18	140	*	102	242 *
Jun-16	63	30	4	97	69	0	77	146	20		0	20	152	30	81	263
**Jul-16	65	100	0	165	68	0	76	144	22		0	22	155	100	76	331
Aug-16	69	100	0	169	62	0	69	131	28		0	28	159	100	69	328
Sep-16	69	100	0	169	62	0	65	127	29		0	29	160	100	65	325
Oct-16	51	100	20	171	65	0	58	123	27		0	27	143	100	78	321
Nov-16	53	100	15	168	59	0	59	118	28		0	28	140	100	74	314
Dec-16	60	100	10	170	63	0	49	112	30		0	30	153	100	59	312
Jan-17	53	100	22	175	109	0	49	158	33		0	33	195	100	71	366
Feb-17	57	75	18	150	104	0	44	148	31		0	31	192	75	62	329
Mar-17	62	75	11	148	99	0	48	147	35		0	35	196	75	59	330
Apr-17																
May-17																
Jun-17																

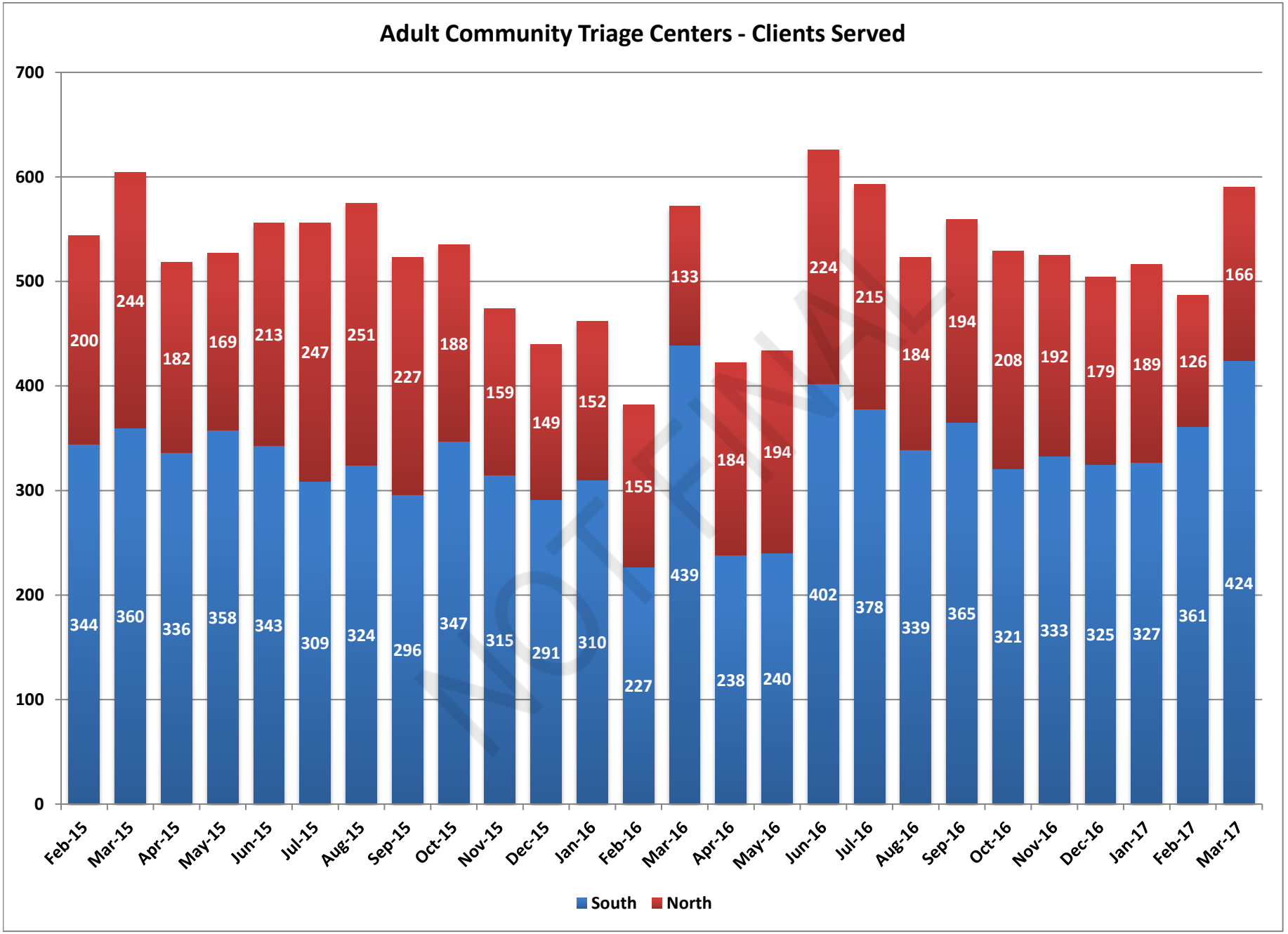
Fiscal Year Averages

Fiscal Year	South				North				Rural				Statewide			
	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total	Housing and Case Management	Served by Mojave	Case Management Only	Total Clients Served
FY15	71	17	4	91	75	1	97	173	28		0	28	174	18	100	292
FY16	49	17	18	84	75	0	90	165	22		0	22	147	18	108	276
FY17 to date	60	94	11	165	77	0	57	134	29		0	29	166	94	68	328

* The number of Mohave clients served is Unknown

** FY16&17 The Supreme Courts funded the Speciality Courts to increase the Mental Health Court caseload to 125. Mojave is directly contracted with the Speciality Courts so their caseload will increase from 25 to 125.

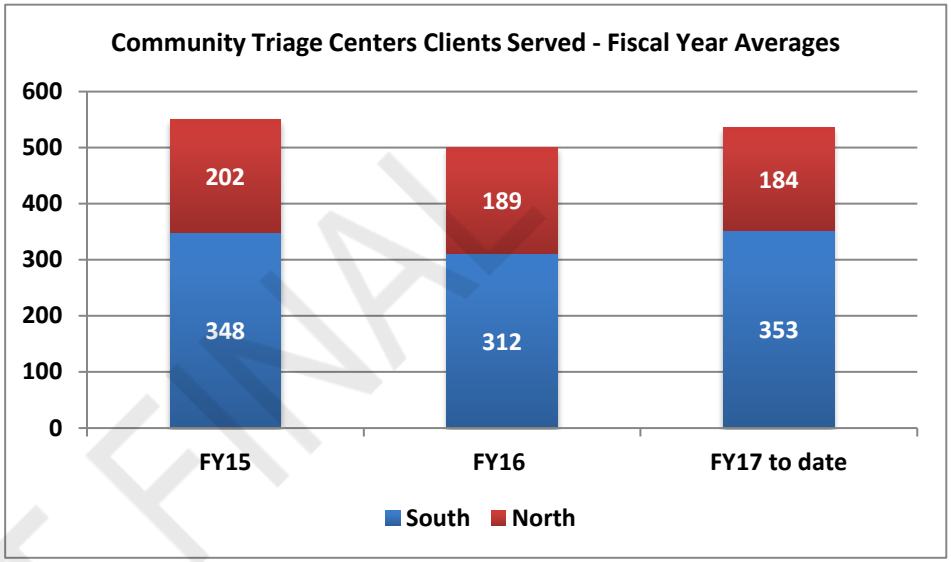



Adult Community Triage Centers - Clients Served
700
600
500
400
300
200
100
0
Feb-15 344 200
Mar-15 360 244
Apr-15 336 182
May-15 358 169
Jun-15 343 213
Jul-15 309 247
Aug-15 324 251
Sep-15 296 227
Oct-15 347 188
Nov-15 315 159
Dec-15 291 149
Jan-16 310 152
Feb-16 227 155
Mar-16 439 133
Apr-16 238 184
May-16 240 194
Jun-16 402 224
Jul-16 378 215
Aug-16 339 184
Sep-16 365 194
Oct-16 321 208
Nov-16 333 192
Dec-16 325 179
Jan-17 327 189
Feb-17 361 126
Mar-17 424 166
South
North

Adult Community Triage Centers

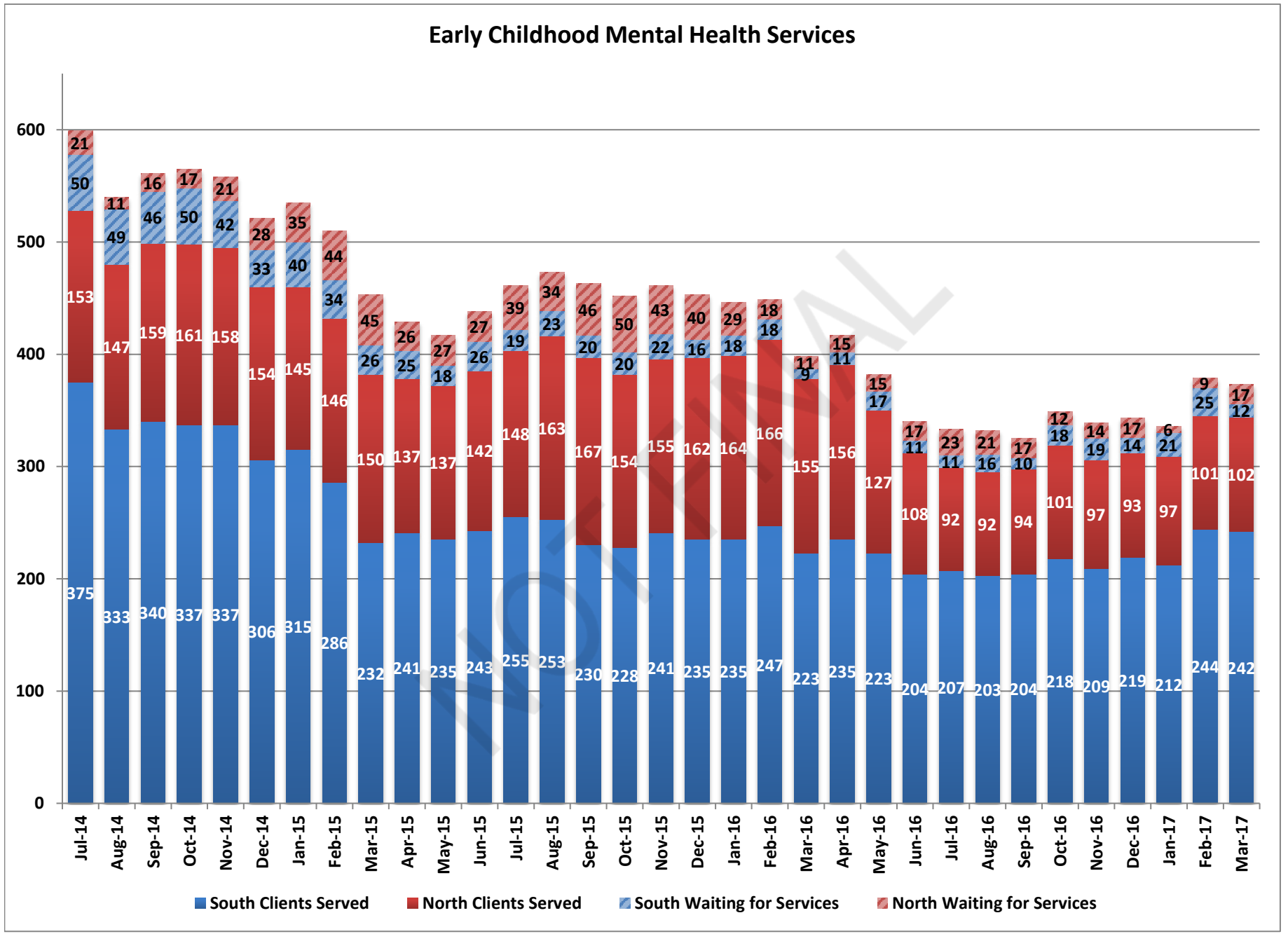
Clients Served (Unduplicated)

	South	North	Total
Feb-16	227	155	382
Mar-16	439	133	572
Apr-16	238	184	422
May-16	240	194	434
Jun-16	402	224	626
Jul-16	378	215	593
Aug-16	339	184	523
Sep-16	365	194	559
Oct-16	321	208	529
Nov-16	333	192	525
Dec-16	325	179	504
Jan-17	327	189	516
Feb-17	361	126	487
Mar-17	424	166	590
Apr-17			
May-17			
Jun-17			



Fiscal Year Averages

	South	North	Total
FY15	348	202	550
FY16	312	189	501
FY17 to date	353	184	536

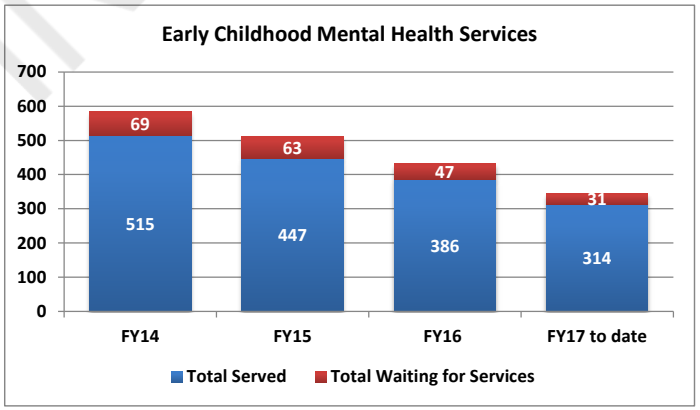

Early Childhood Mental Health Services
600
500
400
300
200
100
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
375 333 340 337 337 306 315 286 232 241 235 243 255 253 230 228 241 235 235 247 223 235 223 204 207 203 204 218 209 219 212 244 242
153 147 159 161 158 154 145 146 150 137 137 142 148 163 167 154 155 162 164 166 155 156 127 108 92 92 94 101 97 93 97 101 102
50 49 46 50 42 33 40 34 26 25 18 26 19 23 20 20 22 16 18 18 9 11 17 11 11 16 10 18 19 14 21 25 12
21 11 16 17 21 28 35 44 45 26 27 27 39 34 46 50 43 40 29 18 11 15 15 17 23 21 17 12 14 17 6 9 17
South Clients Served
North Clients Served
South Waiting for Services
North Waiting for Services

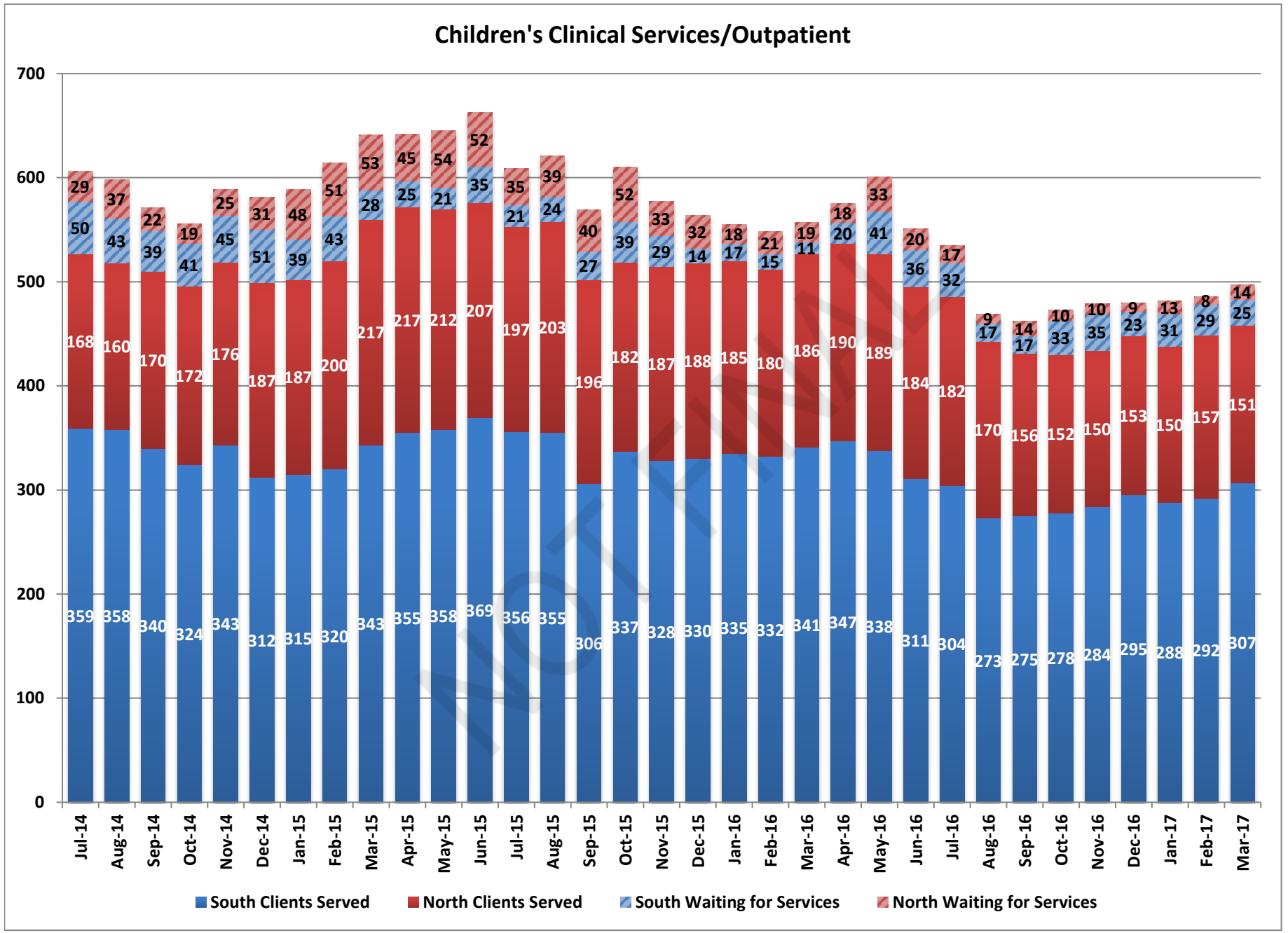
Early Childhood Mental Health Services

	South		North		Total	
	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Total Served	Total Waiting for Services
Jul-15	255	19	148	39	403	58
Aug-15	253	23	163	34	416	57
Sep-15	230	20	167	46	397	66
Oct-15	228	20	154	50	382	70
Nov-15	241	22	155	43	396	65
Dec-15	235	16	162	40	397	56
Jan-16	235	18	164	29	399	47
Feb-16	247	18	166	18	413	36
Mar-16	223	9	155	11	378	20
Apr-16	235	11	156	15	391	26
May-16	223	17	127	15	350	32
Jun-16	204	11	108	17	312	28
Jul-16	207	11	92	23	299	34
Aug-16	203	16	92	21	295	37
Sep-16	204	10	94	17	298	27
Oct-16	218	18	101	12	319	30
Nov-16	209	19	97	14	306	33
Dec-16	219	14	93	17	312	31
Jan-17	212	21	97	6	309	27
Feb-17	244	25	101	9	345	34
Mar-17	242	12	102	17	344	29
Apr-17						
May-17						
Jun-17						

Fiscal Year Averages

Fiscal Year	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Total Served	Total Waiting for Services
FY14	351	45	164	24	515	69
FY15	298	37	149	27	447	63
FY16	234	17	152	30	386	47
FY17 to date	218	16	97	15	314	31



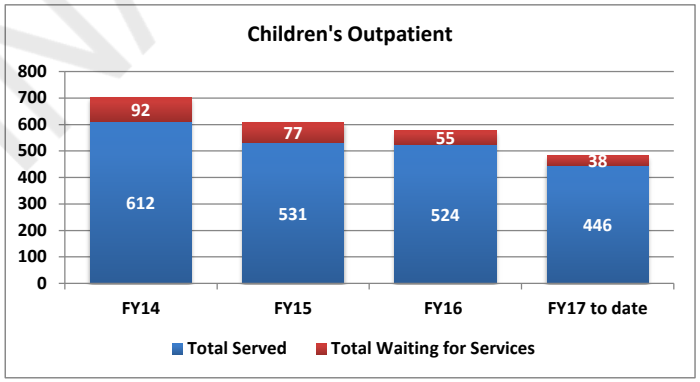

Children's Clinical Services/Outpatient
700
600
500
400
300
200
100
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
359 358 340 324 343 312 315 320 343 355 358 369 356 355 306 337 328 330 335 332 341 347 338 311 304 273 275 278 284 295 288 292 307
168 160 170 172 176 187 187 200 217 217 212 207 197 203 196 182 187 188 185 180 186 190 189 184 182 170 156 152 150 153 150 157 151
50 43 39 41 45 51 39 43 28 25 21 35 21 24 27 39 29 14 17 15 11 20 41 36 32 17 17 33 35 23 31 29 25
29 37 22 19 25 31 48 51 53 45 54 52 35 39 40 52 33 32 18 21 19 18 33 20 17 9 14 10 10 9 13 8 14
South Clients Served
North Clients Served
South Waiting for Services
North Waiting for Services

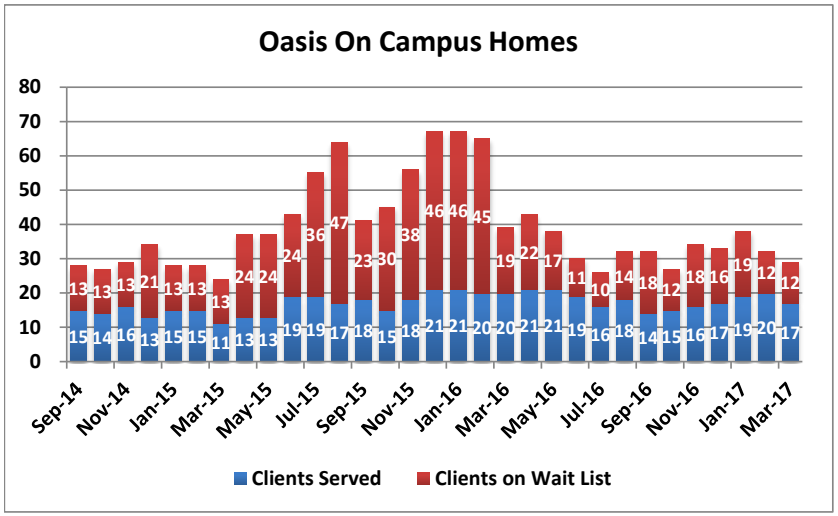
Children's Clinical Services/Outpatient

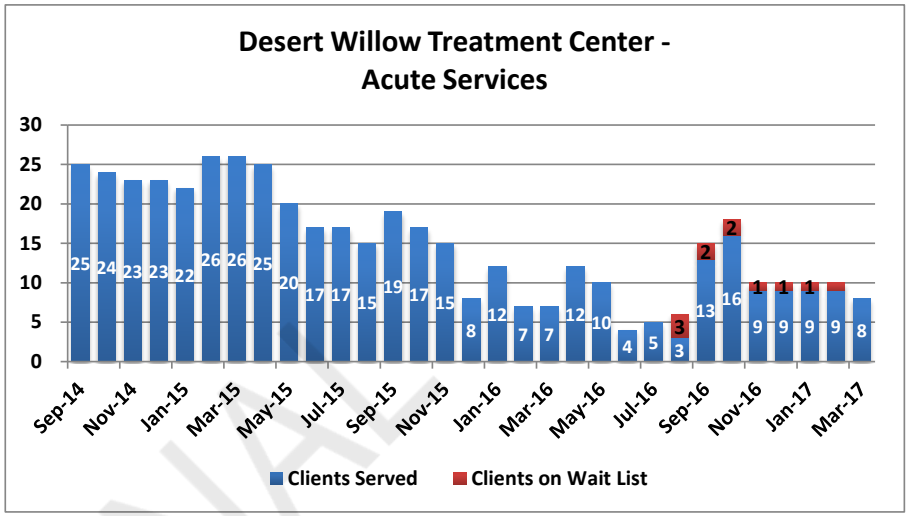
	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Total Served	Total Waiting for Services
Jul-15	356	21	197	35	553	56
Aug-15	355	24	203	39	558	63
Sep-15	306	27	196	40	502	67
Oct-15	337	39	182	52	519	91
Nov-15	328	29	187	33	515	62
Dec-15	330	14	188	32	518	46
Jan-16	335	17	185	18	520	35
Feb-16	332	15	180	21	512	36
Mar-16	341	11	186	19	527	30
Apr-16	347	20	190	18	537	38
May-16	338	41	189	33	527	74
Jun-16	311	36	184	20	495	56
Jul-16	304	32	182	17	486	49
Aug-16	273	17	170	9	443	26
Sep-16	275	17	156	14	431	31
Oct-16	278	33	152	10	430	43
Nov-16	284	35	150	10	434	45
Dec-16	295	23	153	9	448	32
Jan-17	288	31	150	13	438	44
Feb-17	292	29	157	8	449	37
Mar-17	307	25	151	14	458	39
Apr-17						
May-17						
Jun-17						

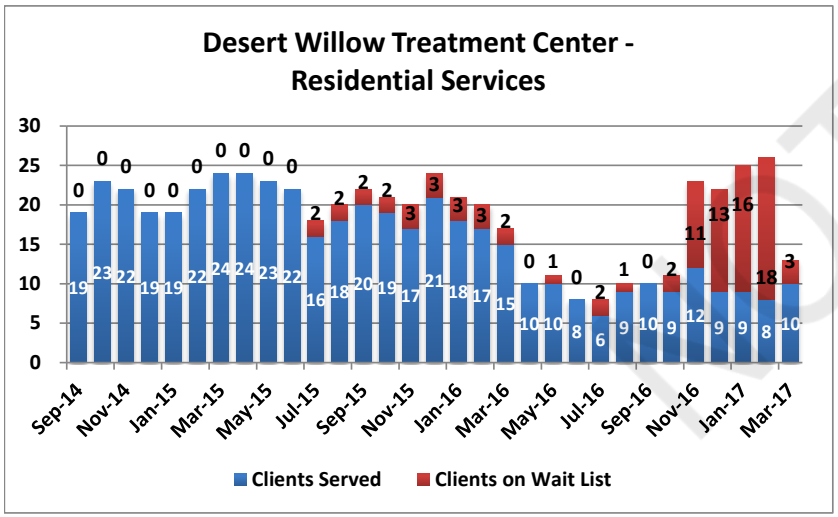
Fiscal Year Averages

Fiscal Year	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Total Served	Total Waiting for Services
FY14	398	65	214	27	612	92
FY15	341	38	189	39	531	77
FY16	335	25	189	30	524	55
FY17 to date	288	27	158	12	446	38




Oasis On Campus Homes
Clients Served
Clients on Wait List


Desert Willow Treatment Center - Acute Services
Clients Served
Clients on Wait List

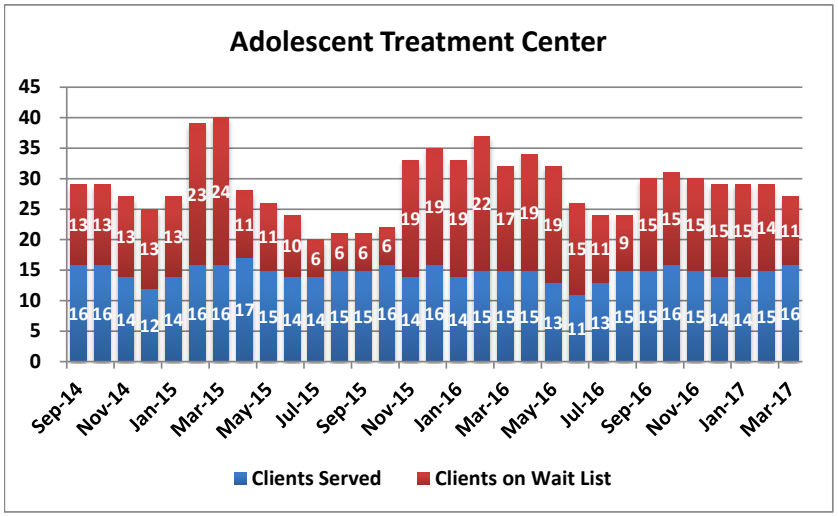

Desert Willow Treatment Center - Residential Services
Clients Served
Clients on Wait List

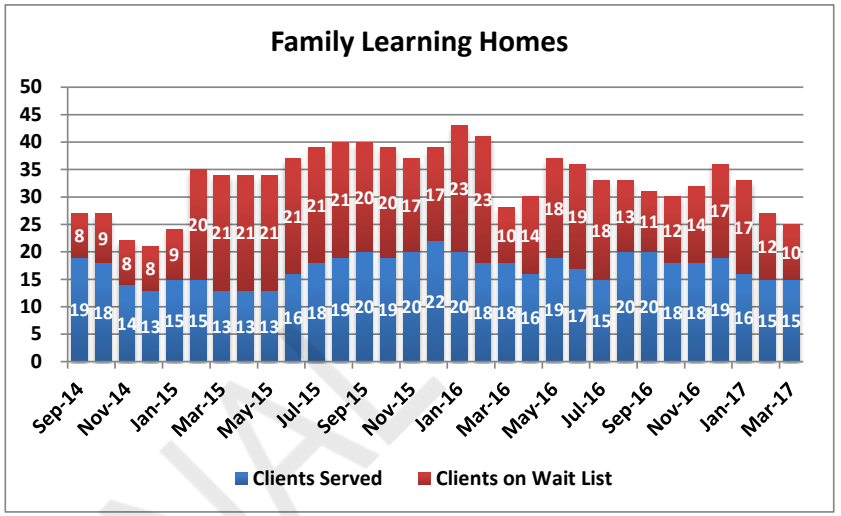
Children's Mental Health - South

	Oasis On Campus Homes			Desert Willow Treatment Center - Acute Services			Desert Willow Treatment Center - Residential Services		
	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay
Jul-15	19	36	105	17	0	116	16	2	96
Aug-15	17	47	101	15	0	115	18	2	82
Sep-15	18	23	101	19	0	45	20	2	98
Oct-15	15	30	111	17	0	66	19	2	103
Nov-15	18	38	106	15	0	80	17	3	112
Dec-15	21	46	112	8	0	174	21	3	88
Jan-16	21	46	121	12	0	140	18	3	102
Feb-16	20	45	127	7	0	199	17	3	133
Mar-16	20	19	152	7	0	230	15	2	132
Apr-16	21	22	155	12	0	108	10	0	147
May-16	21	17	186	10	0	142	10	1	123
Jun-16	19	11	155	4	0	224	8	0	92
Jul-16	16	10	197	5	0	198	6	2	41
Aug-16	18	14	170	3	3	222	9	1	39
Sep-16	14	18	194	13	2	36	10	0	42
Oct-16	15	12	179	16	2	44	9	2	54
Nov-16	16	18	171	9	1	45	12	11	71
Dec-16	17	16	112	9	1	63	9	13	74
Jan-17	19	19	86	9	1	93	9	16	98
Feb-17	20	12	104	9	1	50	8	18	125
Mar-17	17	12	119	8	0	67	10	3	106
Apr-17									
May-17									
Jun-17									

Fiscal Year Averages

Fiscal Year	Oasis On Campus Homes			Desert Willow Treatment Center - Acute Services			Desert Willow Treatment Center - Residential Services		
	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay
FY14	13	28	156	21	0	71	23	0	81
FY15	15	16	107	23	0	99	22	0	90
FY16	19	32	128	12	0	137	16	2	109
FY17 to date	17	15	148	9	1	91	9	7	72


Adolescent Treatment Center
45
40
35
30
25
20
15
10
5
0
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
Clients Served
Clients on Wait List

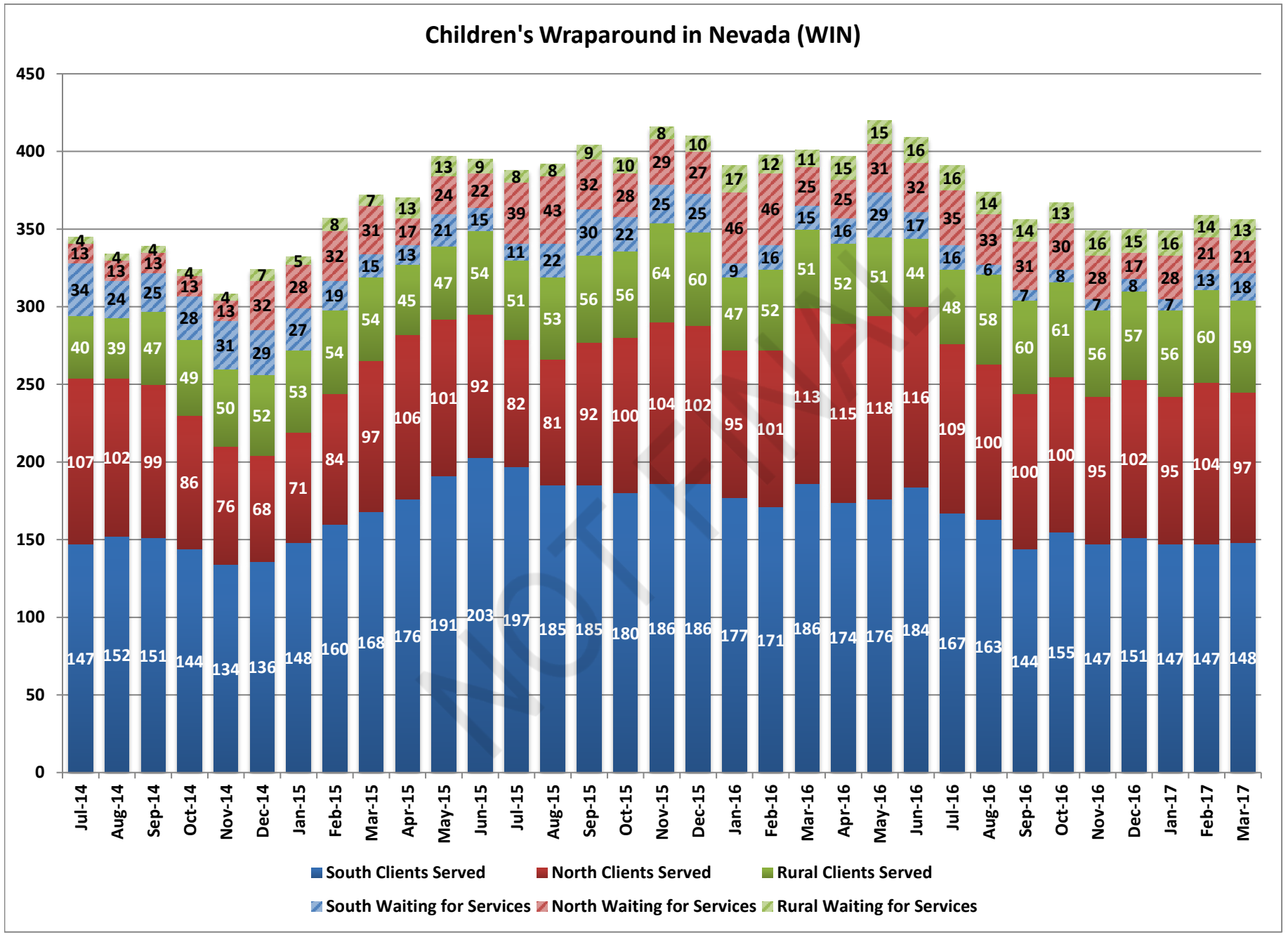

Family Learning Homes
50
45
40
35
30
25
20
15
10
5
0
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
Clients Served
Clients on Wait List

Children's Mental Health - North

	Adolescent Treatment Center			Family Learning Homes		
	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay
Jul-15	14	6	92	18	21	74
Aug-15	15	6	59	19	21	67
Sep-15	15	6	68	20	20	93
Oct-15	16	6	94	19	20	106
Nov-15	14	19	101	20	17	123
Dec-15	16	19	82	22	17	132
Jan-16	14	19	89	20	23	151
Feb-16	15	22	111	18	23	128
Mar-16	15	17	98	18	10	97
Apr-16	15	19	98	16	14	86
May-16	13	19	106	19	18	77
Jun-16	11	15	122	17	19	102
Jul-16	13	11	106	15	18	125
Aug-16	15	9	87	20	13	93
Sep-16	15	15	84	20	11	62
Oct-16	16	15	89	18	12	66
Nov-16	15	15	78	18	14	74
Dec-16	14	15	61	19	17	93
Jan-17	14	15	53	16	17	112
Feb-17	15	14	62	15	12	96
Mar-17	16	11	58	15	10	56
Apr-17						
May-17						
Jun-17						

Fiscal Year Averages

Fiscal Year	Adolescent Treatment Center			Family Learning Homes		
	Clients Served	Clients on Wait List	Average Length of Stay	Clients Served	Clients on Wait List	Average Length of Stay
FY14	15	21	87	18	14	95
FY15	15	14	93	16	14	87
FY16	14	14	93	19	19	103
FY17 to date	15	13	75	17	14	86


Children's Wraparound in Nevada (WIN)
450
400
350
300
250
200
150
100
50
0
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
147 152 151 144 134 136 148 160 168 176 191 203 197 185 185 180 186 186 177 171 186 174 176 184 167 163 144 155 147 151 147 147 148
107 102 99 86 76 68 71 84 97 106 101 92 82 81 92 100 104 102 95 101 113 115 118 116 109 100 100 100 95 102 95 104 97
40 39 47 49 50 52 53 54 54 45 47 54 51 53 56 56 64 60 47 52 51 52 51 44 48 58 60 61 56 57 56 60 59
34 24 25 28 31 29 27 19 15 13 21 15 11 22 30 22 25 25 9 16 15 25 29 17 16 6 7 8 7 8 7 13 18
13 13 13 13 13 32 28 32 31 17 24 22 39 43 32 28 29 25 46 46 35 31 31 32 16 33 31 30 28 17 28 21 21
4 4 4 4 4 7 5 8 7 13 13 9 8 8 9 10 8 10 17 12 16 15 15 16 16 14 14 13 16 15 16 14 13
South Clients Served
North Clients Served
Rural Clients Served
South Waiting for Services
North Waiting for Services
Rural Waiting for Services

Children's Wraparound in Nevada (WIN)

	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Rural Clients Served	Rural Waiting for Services	Total Served	Total Waiting for Services
Jul-15	197	11	82	39	51	8	330	58
Aug-15	185	22	81	43	53	8	319	73
Sep-15	185	30	92	32	56	9	333	71
Oct-15	180	22	100	28	56	10	336	60
Nov-15	186	25	104	29	64	8	354	62
Dec-15	186	25	102	27	60	10	348	62
Jan-16	177	9	95	46	47	17	319	72
Feb-16	171	16	101	46	52	12	324	74
Mar-16	186	15	113	25	51	11	350	51
Apr-16	174	16	115	25	52	15	341	56
May-16	176	29	118	31	51	15	345	75
Jun-16	184	17	116	32	44	16	344	65
Jul-16	167	16	109	35	48	16	324	67
Aug-16	163	6	100	33	58	14	321	53
Sep-16	144	7	100	31	60	14	304	52
Oct-16	155	8	100	30	61	13	316	51
Nov-16	147	7	95	28	56	16	298	51
Dec-16	151	8	102	17	57	15	310	40
Jan-17	147	7	95	28	56	16	298	51
Feb-17	147	13	104	21	60	14	311	48
Mar-17	148	18	97	21	59	13	304	52
Apr-17								
May-17								
Jun-17								

Fiscal Year Averages

Fiscal Year	South Clients Served	South Waiting for Services	North Clients Served	North Waiting for Services	Rural Clients Served	Rural Waiting for Services	Total Served	Total Waiting for Services
FY14	170	36	98	15	45	5	312	65
FY15	159	25	92	20	48	7	299	52
FY16	182	20	102	34	53	12	337	65
FY17 to date	152	10	100	27	57	15	310	52

BUREAU OF BEHAVIORAL HEALTH, WELLNESS AND PREVENTION

WEBINAR AND TOWN HALL MEETINGS

LOOKING FOR YOUR SUGGESTIONS AND IDEAS

The Substance Abuse Prevention and Treatment Agency (SAPTA), Bureau of Behavioral Health, Wellness and Prevention is creating a strategic plan to improve services and systems related to the prevention of and treatment for drugs, alcohol, and substance use and abuse. We need your input!

PUBLIC WEBINAR: PLAN REVIEW

Tuesday, April 18, 2017

5 pm-7pm

If you are unable to attend the second town hall series, please register using the link below to participate in the public webinar and provide feedback about the draft Strategic Plan.

https://attendee.gotowebinar.com/register/2049973840675865857

TOWN HALL SERIES B: PLAN REVIEW

During the second series of Town Hall Meetings, we will share the draft plan. Your comments and suggestions are needed to help finalize the plan.

CARSON CITY

Monday, April 24, 2017

1:30 pm -3 pm

Hearing Room 303
Division of Public and Behavioral Health

4150 Technology Way
Carson City, NV 89706

ELKO

Tuesday, April 25, 2017

1:30 pm -3 pm

MCML 222
Great Basin College

1500 College Parkway
Elko, NV 89801

LAS VEGAS

Wednesday, April 26, 2017

1:30 pm -3 pm

Training Room #B193
Rawson Neal Psychiatric Hospital

1650 Community College Dr.
Las Vegas, NV 89146

Please call 775-324-4567 or email mbaren@socialent.com for more information.

Substance Abuse Prevention and Treatment Agency

2016 Epidemiologic Profile

June 2017

Office of Public Health Informatics and Epidemiology
Division of Public and Behavioral Health
Department of Health and Human Services

Brian Sandoval
Governor
State of Nevada

Cody L. Phinney, MPH
Administrator
Division of Public and Behavioral Health

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State of Nevada

Statewide Epidemiologic Workgroup

Multidisciplinary Prevention Advisory Committee

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Data Sources/Limitations

Avatar
MyAvatar, a Netsmart product, is a database containing demographic, treatment, billing, and financial information for Nevada mental health facilities throughout the state of Nevada. This data is representative of Nevada state funded mental health facilities and is not generalizable to the rest of the population.

Behavioral Risk Factor Surveillance System (BRFSS)
BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. The survey consists of a set of federally grant funded core questions and the states may include and pay for their own questions in the survey. While the survey's focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. Since state added questions are not asked nationwide, these questions are not comparable.

Hospital Inpatient Billing (HIB)
The Hospital Inpatient Billing data provides health billing data for patients discharged from Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada to report information as prescribed by the director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data is for patients who spent at least 24 hours as an inpatient, but do not include patients who were discharged from the emergency room. The data includes demographics such as age, gender, race/ethnicity and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes (up to 33 diagnoses). In addition, the data includes billed hospital charges, procedure codes, length of hospital stay, discharge status, and external cause of injury codes. The billing data information is for billed charges and not the actual payment received by the hospital.

Nevada Health Information Provider Performance System (NHIPPS)
Web based computer application used to collect and store information about clients or participants in funded treatment and prevention programs. The data are used to satisfy the reporting requirements for the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Nevada State Legislature, and the Substance Abuse Prevention & Treatment Agency (SAPTA). This data is representative of Nevada state funded substance use treatment facilities and is not generalizable to the rest of the population.

Nevada Report Card
The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. Through the interactive Nevada Report Card website, you may access state, district and school level reports in three categories: "school and district information," "assessment and accountability" and "fiscal and technology."

Nevada State Demographer Office
The Nevada State Demographer's office is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. It is responsible for conducting annual population estimates for Nevada's counties, cities, and towns.

Nevada Syndromic Surveillance
The Syndromic Surveillance Program oversees the collection and analysis of health-related data that precede diagnosis and may warrant a public health response because it signals a sufficient probability of a case, an outbreak of disease or other public health emergency. Current syndromic surveillance systems include the National Syndromic Surveillance Platform, ESSENCE, and the National Retail Data Monitor for Public Health Surveillance. This data does not account frequent user visits or updates for the same patient, each record in this data is for one patient, for one visit.

Web-Enabled Vital Records Registry Systems (WEVRRS)
Software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death related information.

United States Census Bureau
Federal government agency responsible for the United States Census; the official decennial (10 year period) count of people living in the United States of America. Collected data is disseminated through web browser based tools like the American Community Survey which provides quick facts on frequently requested data collected from population estimates, census counts and surveys of population and housing for the nation, states, counties, and large cities. The Bureau also offers the American Fact Finder, which profiles the American population and economy every five years.

Youth Risk Behavior Survey (YRBS)
The purpose of the YRBS is to provide Nevada data to assess trends in priority health-risk behaviors among high school students; measure progress toward achieving national health objectives for Healthy People 2020 and other program and policy indicators; and evaluate the impact of broad school and community interventions at the national, state, and local level. The YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in traditional, public high schools that monitors the prevalence of health risk behaviors among youth. The survey asks students to self-report their behaviors in six major areas of health that directly lead to morbidity and mortality, these include: (1) Behaviors that contribute to unintentional injuries and violence; (2) Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other sexually transmitted diseases, and unintended pregnancy; (3) Tobacco use; (4) Alcohol and other drug use; (5) Unhealthy dietary behaviors; and (6) Physical inactivity.

Executive Summary

This report is intended to provide an overview of behavioral health in Nevada. The analysis can be used to identify issues of concern and areas that may need to be addressed.

One finding is that of the 57,920 Nevada residents who received mental health services from the Division of Public and Behavioral Health, 17% received a diagnosis of schizophrenic disorder and 14% for major depressive disorder. Another finding is number of visits to the ER by residents of Nevada for seven mental disorders, and alcohol- and other drug-related issues have all increased during the time period from 2009 to 2014. The ER visits for mental health disorders and treatment in SAPTA facilities appear to be sex-specific. For example, females made up a majority of ER visits for anxiety, depression, bipolar disorder and PTSD, while males made up the majority of ER visits for schizophrenia. In SAPTA-funded treatment facilities, an overwhelming majority of patients in treatment for alcohol abuse (35%), amphetamines/methamphetamines (28%), and marijuana/hashish (13%), and are males (62%).

Two additional trends are the decrease in death rates in mental health and substance-related deaths. Mental health-related deaths has decreased from 130.4 to 128.2 deaths per 100,000 in Nevada. Substance-related death rates have decreased slightly in Nevada from 48.0 to 45.9 deaths per 100,000.

For more information and additional publications, please visit Nevada Division of Public and Behavioral Health at http://dpbh.nv.gov/.

Demographic Snapshot

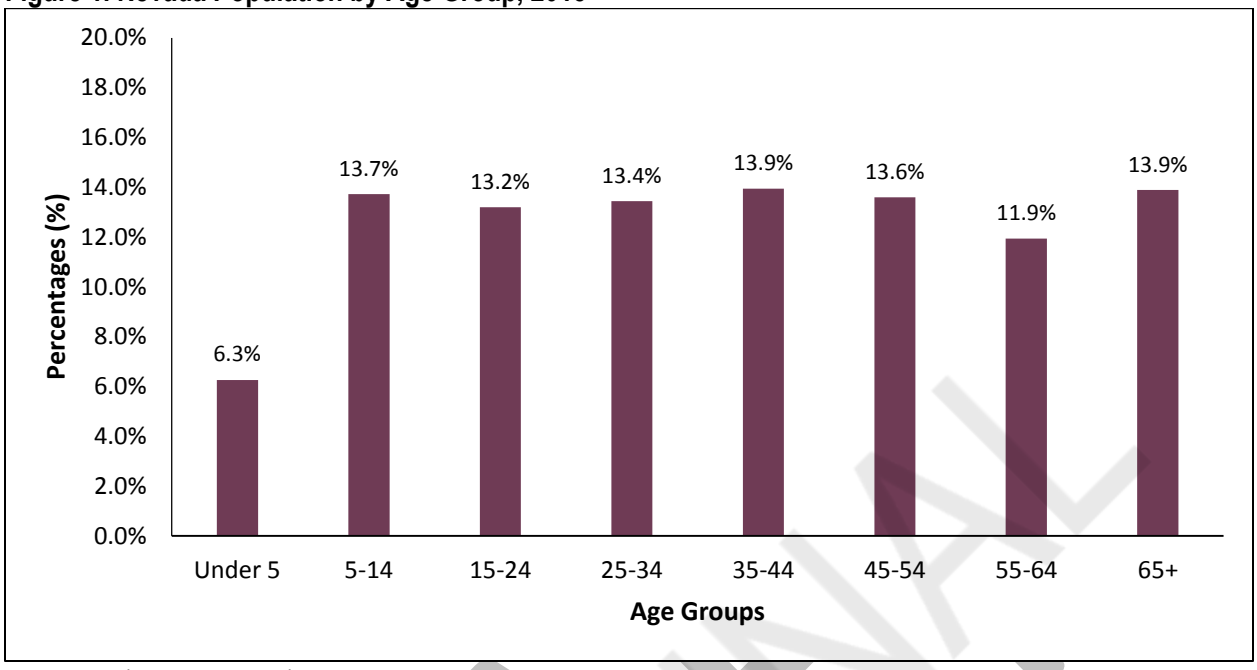
Table 1. Selected Demographics for Nevada.

	Nevada
Population, 2015 estimate*	2,874,075
Population, 2010 estimate*	2,705,845
Population, percent change*	6.2%
Male persons, estimated percent 2015*	50.3%
Female persons, estimated percent 2015*	49.7%
Land area (square miles), 2010**	109,781
Median household income**	$52,800
Persons below poverty level, percent**	15.0%

*Source: *Nevada State Demographer, Vintage 2015 and **US Census Bureau*

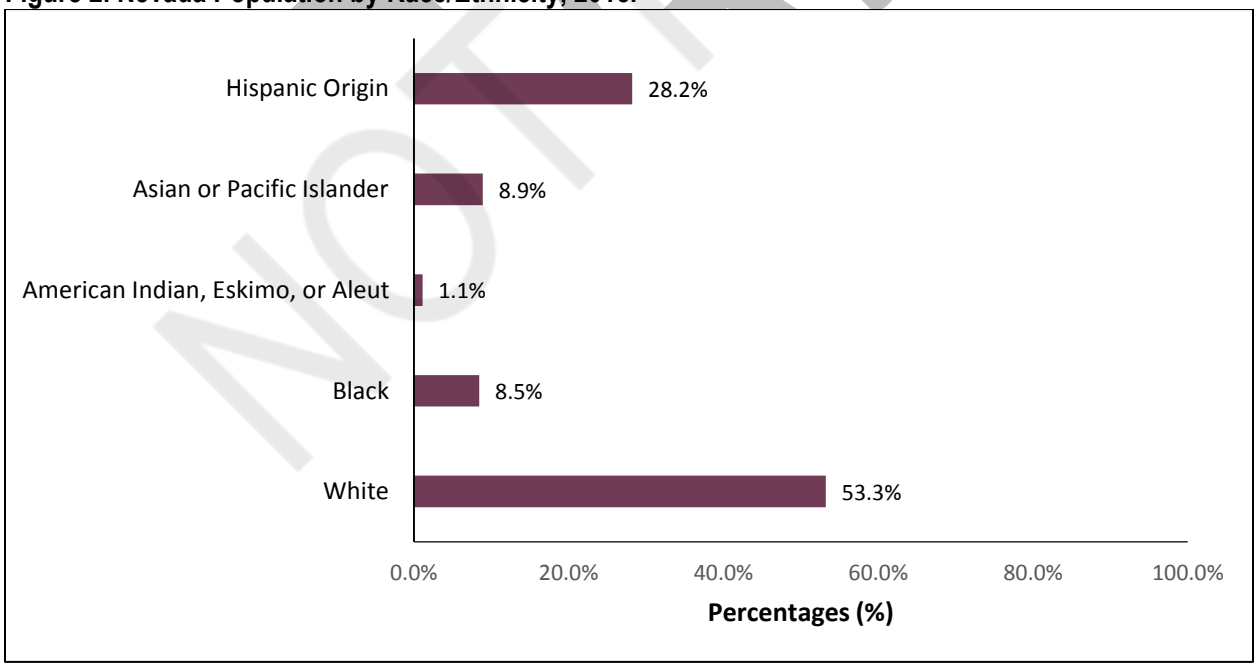
In 2015, the estimated population for Nevada was 2,874,075, a 6.2% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males. The median household income is $52,800. Over 15% of the population in Nevada live below the poverty level. Nevada's land area is approximately 109,781 square miles.

Figure 1. Nevada Population by Age Group, 2015



Source: Nevada State Demographer, Vintage 2015

Figure 2. Nevada Population by Race/Ethnicity, 2015.

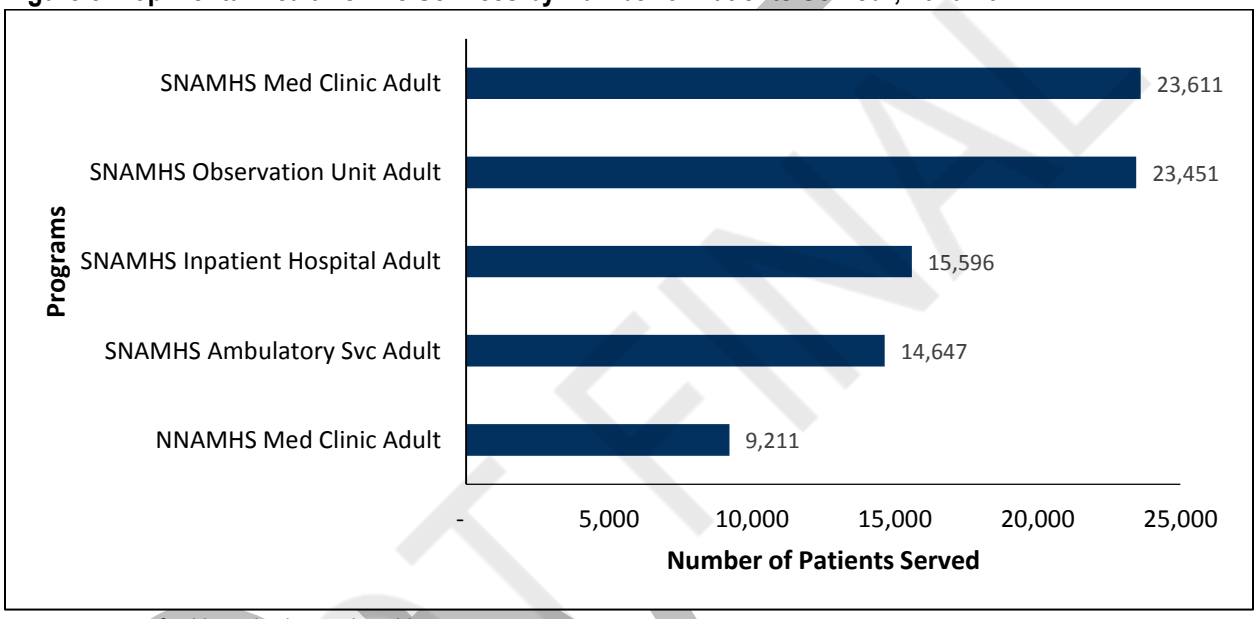


Source: Nevada State Demographer, Vintage 2015

Mental Health Clinics

The data in this section comes from Avatar, an electronic mental health medical record system used by the Division of Public and Behavioral Health (DPBH). DPBH is the largest provider of mental health services in Nevada. In Northern Nevada, DPBH clinics are categorized as Northern Nevada Adult Mental Health Services (NNAMHS). In Southern Nevada, DPBH clinics are categorized as Southern Nevada Adult Mental Health Services (SNAMHS).

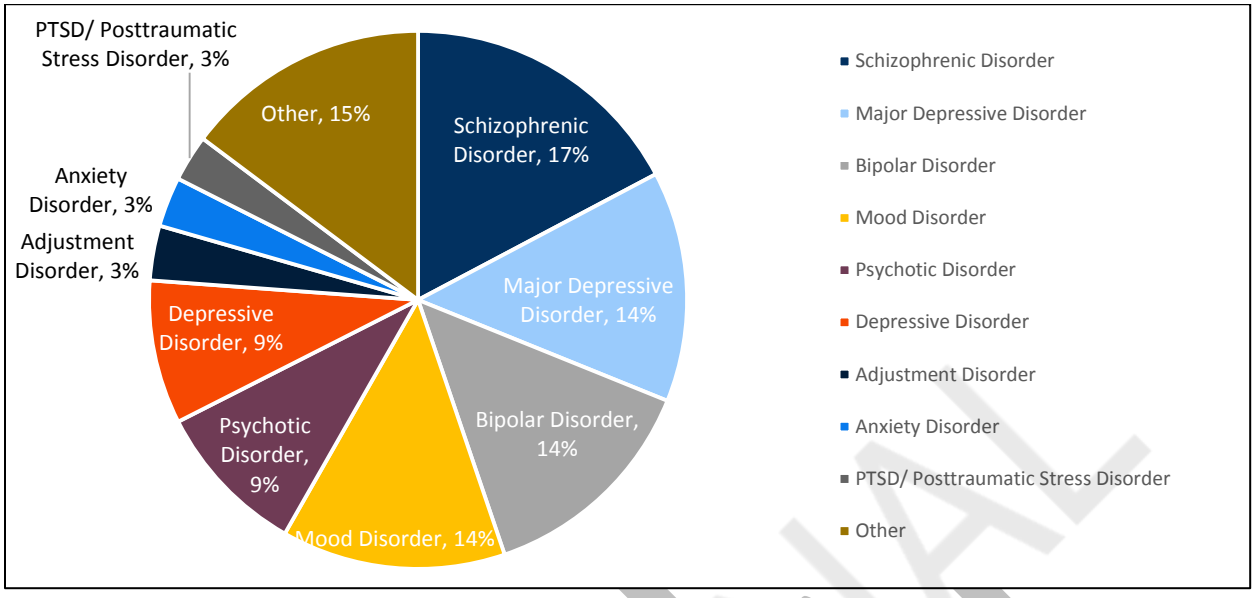
Figure 3. Top Mental Health Clinic Services by Number of Patients Served*, 2010-2014.



Source: Division of Public and Behavioral Health, Avatar
**Patient counts per service were de-duplicated, however, a patient can be counted in more than one service.*

During the time from 2010 to 2014, 57,920 Nevada adults received mental health services from DPBH. Overall services totaled 161,817, as many patients used multiple services.

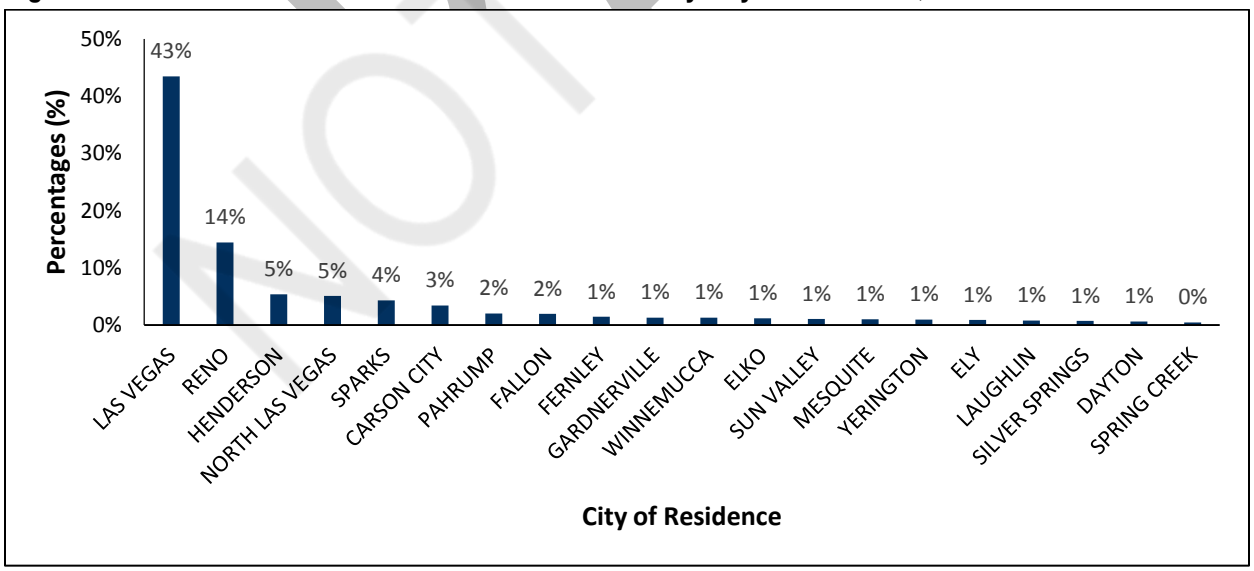
Figure 4. Most Common Mental Health Diagnoses, 2010-2014.



Source: Division of Public and Behavioral Health, Avatar

During the period of 2010 to 2014, the most common primary mental health diagnoses for a Nevada resident was schizophrenic disorder, major depressive disorder, bipolar disorder, and mood disorder. It is important to note, that patients may have multiple primary diagnoses noted during each episode.

Figure 5. State Funded Mental Health Clinics Utilization by City of Residence, 2010-2014.



Source: Division of Public and Behavioral Health, Avatar

Of the Nevada residents accessing DPBH mental health services between 2010 and 2014, 43% lived in Las Vegas.

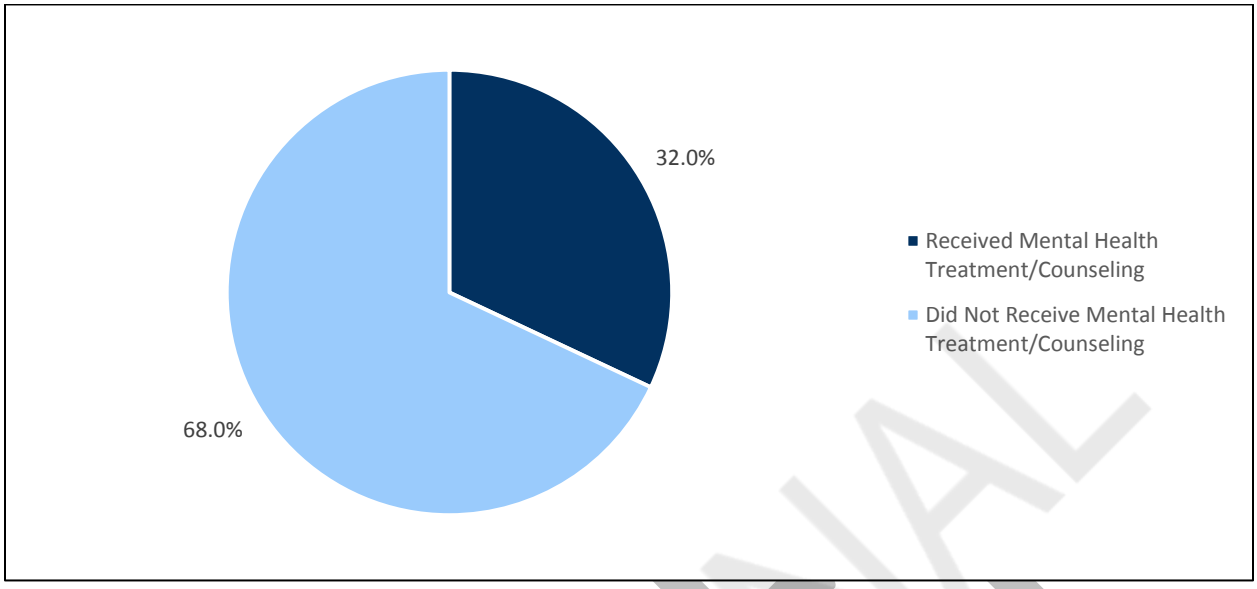
Table 2. Demographics of State Funded Mental Health Clinics Utilization, 2010-2014.

Sex	2010	2011	2012	2013	2014
Female	18,349	17,887	16,749	16,709	14,776
Male	15,582	14,965	14,029	14,157	12,598
Unknown	160	162	83	204	110
Total	34,091	33,014	30,861	31,070	27,484
Age					
0-17	995	1,017	959	1,002	1,162
18-30	7,967	7,370	6,758	6,655	5,460
31-50	15,870	15,239	14,097	13,943	11,978
51-65	8,540	8,715	8,424	8,800	8,111
66-100	701	659	614	661	756
Unknown	18	14	9	9	17
Total	34,091	33,014	30,861	31,070	27,484
Race					
White	22,099	20,961	19,511	18,763	16,342
Black	3,904	3,701	3,498	3,621	3,025
Hispanic	3,508	3,449	3,487	3,565	2,886
Asian/PI	874	860	858	823	693
American Indian/Alaskan	377	350	333	336	336
More Than 1 Race Reported	478	450	419	425	418
Other	780	750	728	743	750
Unknown	2,071	2,493	2,027	2,794	3,034
Total	34,091	33,014	30,861	31,070	27,484
Education					
No Formal Education	196	216	185	162	155
<= 12th Grade - No Diploma	7,312	6,783	6,328	6,281	5,515
High School Graduate	8,535	8,198	7,768	7,814	6,793
GED	2,973	2,858	2,628	2,677	2,239
Some College	7,311	6,910	6,669	6,424	5,483
College Undergraduate Degree	1,622	1,559	1,430	1,314	1,217
Some Graduate School	227	213	192	193	157
Graduate Degree	601	582	560	560	472
Other	1,884	1,703	1,574	1,551	1,343
Unknown	3,430	3,992	3,527	4,094	4,110
Total	34,091	33,014	30,861	31,070	27,484

Source: Division of Public and Behavioral Health, Avatar

During the 5-year period of 2010 to 2014, there were 57,920 Nevadans who accessed mental health services from DPBH. The totals in Table 2 above equal 156,520, reflecting that the some individuals used DPBH services during more than one year. Females comprised 54% of the patient population and males comprised 46%. White non-Hispanics made up 62% of the population. The most populous age group was the 31-50 year olds, accounting for 45% of the patients. High school graduates accounted for 25% of the patients, followed by "some college" (20%) and "less than 12th grade, no diploma (20%)."

Figure 6. Past Year Mental Health Treatment/Counseling Among Adults Aged 18 or Older with Any Mental Illness (AMI) in Nevada, 2010-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2014.

In Nevada, about 113,000 adults aged 18 or older with AMI (32.0% of all adults with AMI) per year from 2010 to 2014 received mental health treatment/counseling within the year prior to being surveyed.

Hospital Emergency Room

The data provided in this section are from the hospital emergency room (ER) billing data compiled by the University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). The data are based on visits, not patients, therefore a single person may represent multiple visits. The ER data are broken into three parts: mental health (depression, anxiety, PTSD, suicidal ideations, etc.), suicide attempts by method (hanging, jumping, firearms, etc.) and alcohol- and other drug-related visits.

The following ICD-9 codes were used for analysis of mental disorders:

- Anxiety: 300.0;
- Depression: 296.20-296.36, and 311;
- Bipolar Disorder: 296.40-296.89;
- PTSD: 309.81;
- Schizophrenia: 295 and V11.0;
- Suicidal Tendencies: 300.90;
- Suicidal Ideation: V62.84.

The following ICD-9 codes were used for analysis of suicide attempts by method:

- Suicide by solid or liquid: E950;
- Suicide by gases in domestic use: E951;
- Suicide by other gases and vapors: E952;
- Suicide by hanging, strangulation and suffocation: E953;
- Suicide by drowning: E954;
- Suicide by firearms, air guns and explosives: E955;
- Suicide by cutting and piercing instrument: E956;
- Suicide by jumping from high place: E957;
- Suicide by other unspecified means: E958.

The following ICD-9 codes were used for analysis of alcohol-related admissions:

- Alcohol-Induced Mental Disorders: 291;
- Alcohol Dependence Syndrome: 303;
- Nondependent Alcohol Abuse: 305.0;
- Alcoholic Polyneuropathy: 357.5;
- Alcoholic Cardiomyopathy: 425.5;
- Alcohol Gastritis: 535.3;
- Chronic Liver Disease and Cirrhosis (Alcohol Related): 571.0-571.3;
- Excessive Blood Level of Alcohol: 790.3;

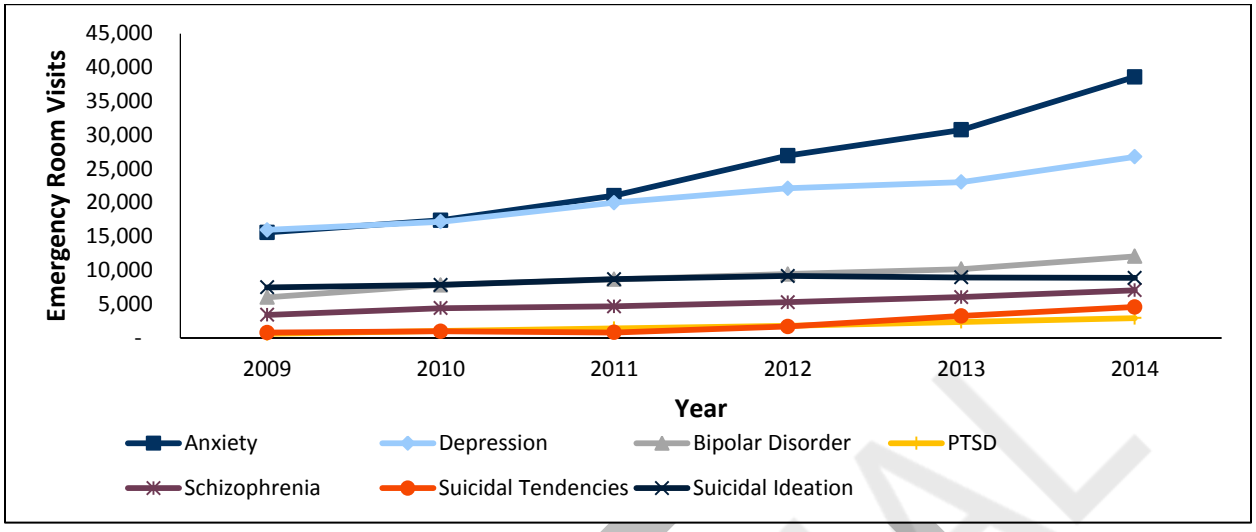
- Toxic Effect of Alcohol: 980;
- Accidental Poisoning by Alcohol: E860.

The following ICD-9 codes were used for analysis of substance-related admissions:

- Drug-Induced Mental Disorders: 292;
- Drug Dependence: 304;
- Nondependent Abuse of Drugs (excluding Alcohol, Tobacco, and Cannabis): 305.2-305.9;
- Poisoning by Analgesics Antipyretics and Antirheumatics: 965;
- Poisoning by Sedatives and Hypnotics: 967;
- Poisoning by Other Central Nervous System Depressants and Anesthetics: 968;
- Poisoning by Psychotropic Agents: 969;
- Poisoning by Central Nervous System Stimulants: 970.

There were a total of 523,667 visits related to mental health and substance use disorders among Nevada residents between 2009 and 2014 for the reasons listed above. Since an individual can have more than one diagnosis during a single ER visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive. Diagnoses related to mental disorders occurred in 341,084 ER visits, there were 147,314 ER visits related to alcohol-related issues, 114,689 ER visits with diagnoses for other drug-related issues, and 19,747 ER visit with diagnoses codes related to suicide attempts.

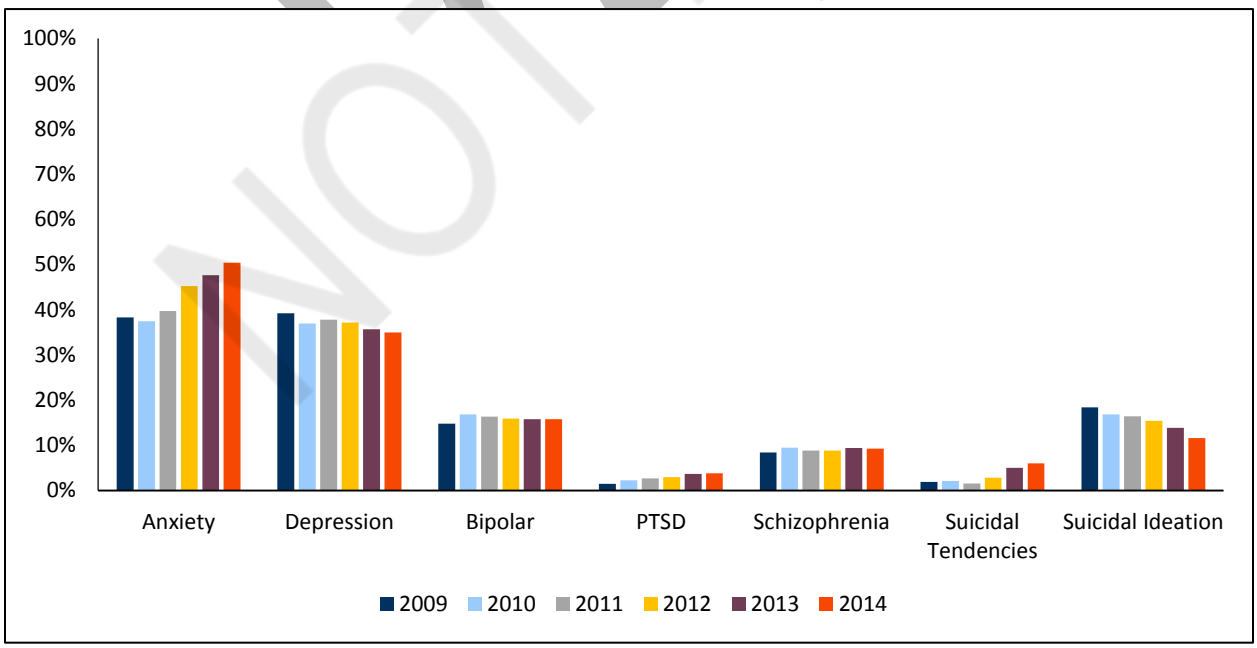
Figure 7. Select Mental Health Related Emergency Room Visits, Nevada Residents, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Anxiety disorder is the most common mental disorder seen in the ER among Nevada residents, present in 50% of the 76,623 ER visits related mental health in 2014. The number of anxiety-related ER visits increased 321% from 2009 to 2014. All visits for the selected mental disorders increased over the six year period. The rise in mental health related disorders may be due to better data collection, better coding of diagnosis codes, or general increases in mental health related disorders in Nevada.

Figure 8. Proportion of Select Mental Health Related Emergency Room Visits, Nevada Residents, 2009-2014



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Figure 8 depicts the proportion of inpatient admissions of each mental health indicators of all mental health related inpatient admissions of that year.

Table 3. Select Behavioral Health Related Emergency Room Visits by Gender, Nevada Residents, 2009-2014.

Condition	Female		Male		Unknown		Total
	N	Row %	N	Row %	N	Row %	
Anxiety	100,076	66.6	50,190	33.4	3	0.0	150,269
Depression	76,860	61.5	48,185	38.5	2	0.0	125,047
Bipolar	32,057	59.1	22,142	40.9	1	0.0	54,200
PTSD	5,655	56.0	4,443	44.0	0	0.0	10,098
Schizophrenia	11,609	37.6	19,243	62.4	1	0.0	30,853
Suicidal Tendencies	5,814	48.4	6,206	51.6	0	0.0	12,020
Suicidal Ideation	22,402	44.0	28,558	56.0	0	0.0	50,960
Alcohol Related	45,230	30.7	102,078	69.3	6	0.0	147,314
Other Drug Related	52,040	45.5	62,645	54.6	4	0.0	114,689
Suicide - Solid or Liquid	7,862	66.0	4,052	34.0	0	0.0	11,914
Suicide - Gases in Domestic Use	2	28.6	5	71.4	0	0.0	7
Suicide - Other Gases and Vapors	38	32.5	79	67.5	0	0.0	117
Suicide - Hanging, Strangulation, & Suffocation	147	33.4	293	66.6	0	0.0	440
Suicide - Cutting & Piercing Instrument	3,256	59.0	2,266	41.0	1	0.0	5,523
Suicide - Firearms, Air Guns, & Explosives	33	18.9	142	81.1	0	0.0	175
Suicide - Jumping from High Place	29	33.0	59	67.0	0	0.0	88
Suicide - drowning	7	58.3	5	41.7	0	0.0	12
Suicide - Other Unspecified Means	726	41.5	1,022	58.5	0	0.0	1,748
Total Behavioral Health Visits*	**266,328**	**50.9**	**257,319**	**49.1**	**15**	**0.0**	**523,662**

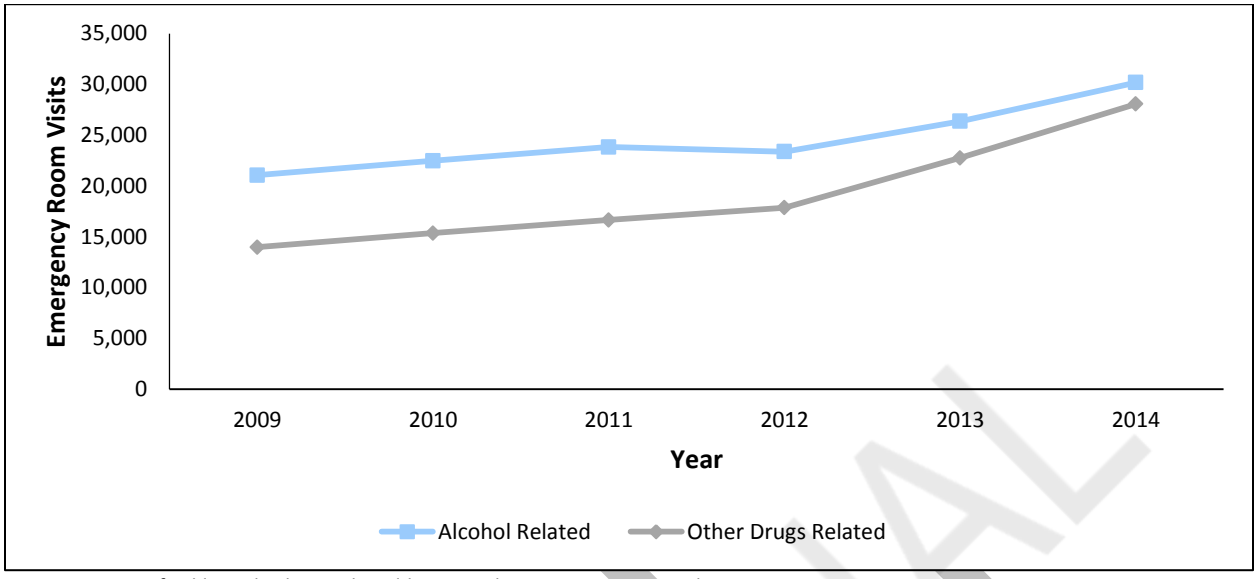
Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge
**Categories are not mutually exclusive.*

Table 4. Specific Schizophrenia Diagnoses, Emergency Room Visits by Gender, Nevada Residents, 2009-2014

Condition	Female		Male		Unknown		Total
	N	Row %	N	Row %	N	Row %	
Unspecified schizophrenia	6,769	37.6%	11,253	62.4%	1	0.0%	18,023
Personal history of schizophrenia	1,935	37.9%	3,176	62.1%	0	0.0%	5,111
Schizoaffective disorder	1,159	47.0%	1,305	53.0%	0	0.0%	2,464
Other specified types of schizophrenia	727	33.3%	1,458	66.7%	0	0.0%	2,185
Paranoid type schizophrenia	594	31.9%	1,266	68.1%	0	0.0%	1,860
Schizophreniform disorder	200	33.8%	391	66.2%	0	0.0%	591
Schizophrenic disorder, residual type	191	34.5%	362	65.5%	0	0.0%	553
Catatonic type schizophrenia	29	27.6%	76	72.4%	0	0.0%	105
Simple type schizophrenia	24	61.5%	15	38.5%	0	0.0%	39
Disorganized type schizophrenia	9	36.0%	16	64.0%	0	0.0%	25
Latent schizophrenia	7	33.3%	14	66.7%	0	0.0%	21
Total Schizophrenia	11,609	37.6%	19,243	62.4%	1	0.0	30,853

Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge
**Categories are not mutually exclusive.*

Figure 9. Alcohol and Other Drug Related Emergency Room Visits, Nevada Residents, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

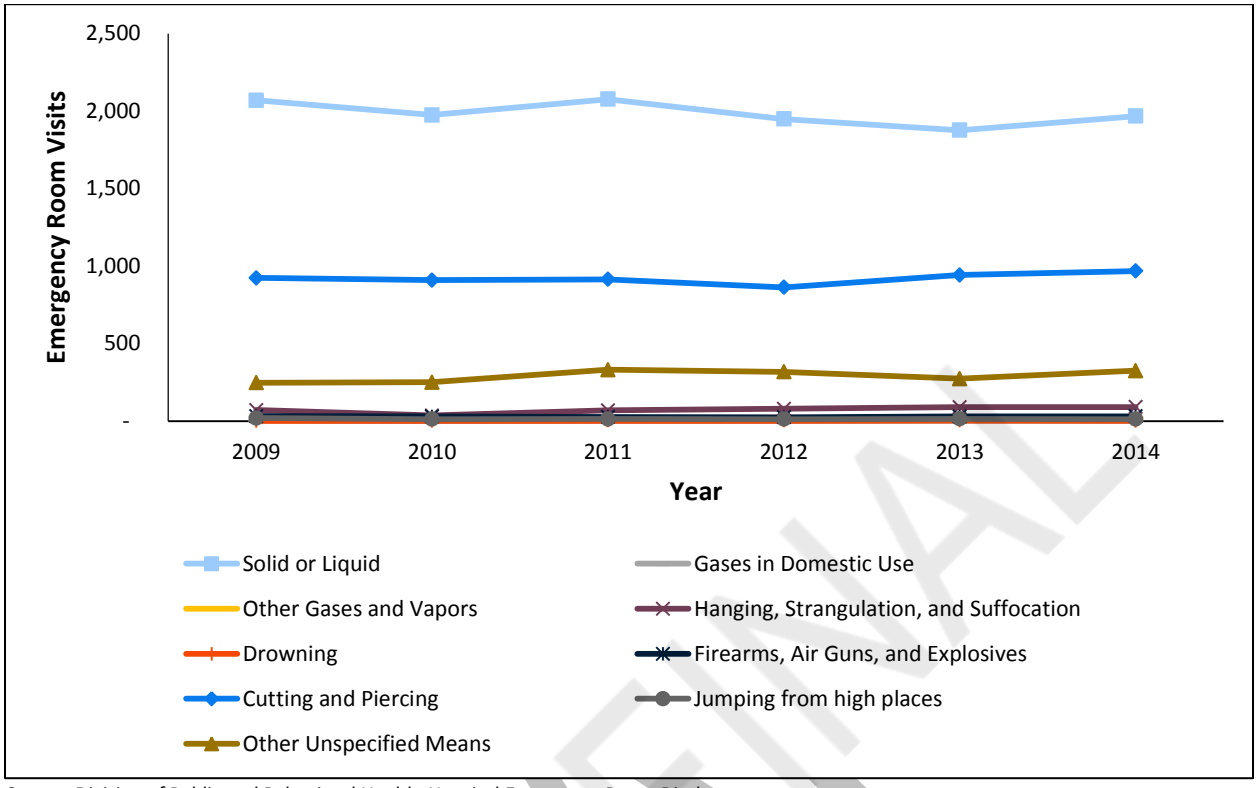
ER visits related to alcohol and other drug use from 2009 to 2014. Alcohol-related visits increased from 21,063 visits in 2009 to 30,180 visits in 2014, a 43% increase. Visits related to other drugs followed the same trend, with a low of 13,969 visits in 2009 to a high of 28,065 visits in 2014, a 101% increase.

Table 5. Demographics of Substance Related Emergency Room Visits, Nevada Residents, 2009-2014.

	Alcohol-Related		Other Substance - Related	
	N	Column %	N	Column %
Sex				
Female	45,230	30.7	52,040	45.4
Male	102,078	69.3	62,645	54.6
Race				
White	98,291	66.7	74,686	65.1
Native American	4,409	3.0	1,790	1.6
Hispanic	18,033	12.2	12,566	11.0
Asian/Pacific	2,231	1.5	1,724	1.5
Black	14,937	10.1	17,862	15.6
Other	5,341	3.6	3,921	3.4
Unknown	4,072	2.8	2,140	1.9
Age				
0-14	514	0.3	2,217	1.9
15-24	15,437	10.5	23,250	20.3
25-34	25,137	17.1	30,144	26.3
35-44	29,287	19.9	23,212	20.2
45-54	42,420	28.8	21,411	18.7
55-64	24,248	16.5	10,519	9.2
65-74	7,824	5.3	2,879	2.5
75-84	1,913	1.3	757	0.7
85+	518	0.4	299	0.3

Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Figure 10. Suicide Related Emergency Room Visits, Nevada Residents, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

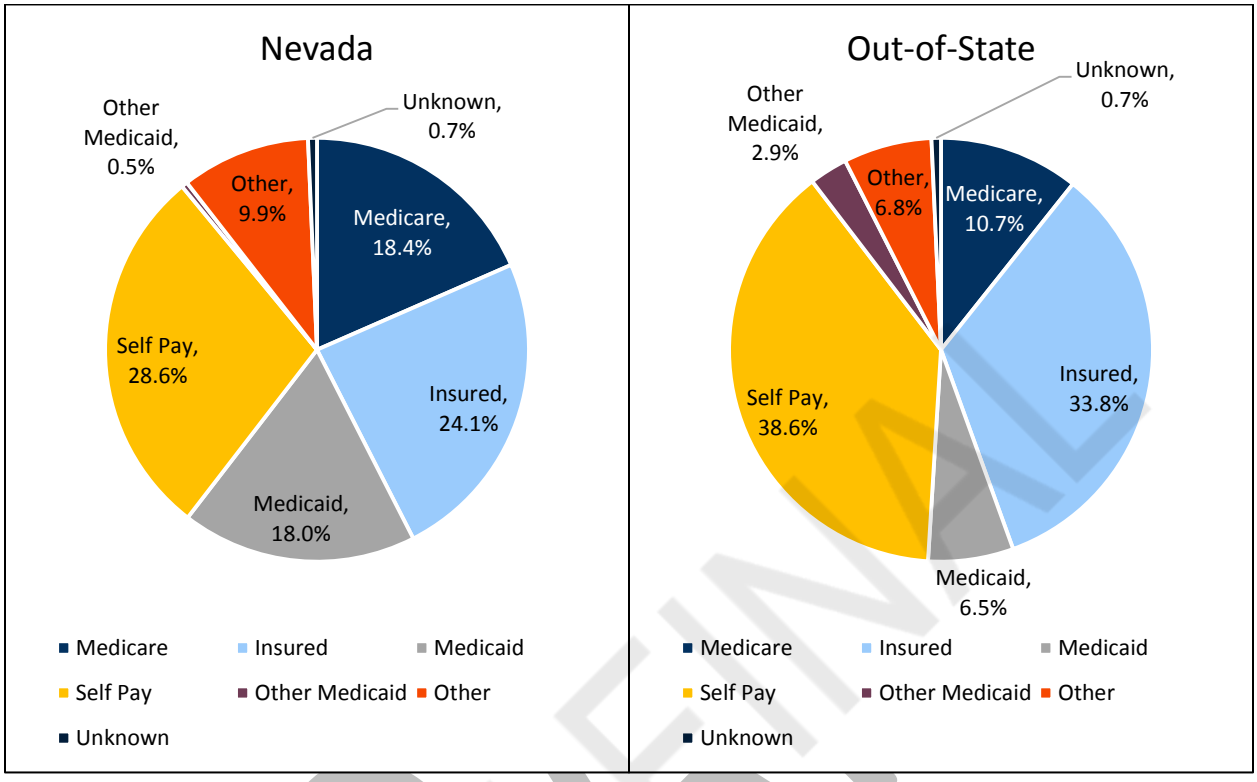
Overall number of visits to the ER for suicide among Nevada residents showed no increasing or decreasing trend from 2009 to 2014, with 3,351 visits in 2009 to 3,360 in 2014.

Suicide by solid or liquid remains the top method of suicide and suicide attempts which resulted in an ER visit in Nevada, related to 59% of all suicide-related ER visits in 2014. Suicide by solid or liquid includes all suicides where an individual entered liquid into his or her body, such as alcohols (ethanol, butanol, propanol, and methanol), fuel, oil, petroleum, pesticides, herbicides, paints, dyes, and glues; or solids such as prescription pills and illegal drugs.

The second most common suicide related cause of ER visits was for those involving cutting and piercing instruments, which was indicated on 29% of all suicide-related visits in 2014.

It is important to note that these data are reflective of suicide attempts that were not immediately successful.

Figure 11. Payer Distribution of Mental Health and Substance Use Related Emergency Room Visits by Residence Status, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Payer was consolidated into the following format:

- Medicare: Medicare, Medicare HMO
- Insured: CHAMPUS OR CHAMVA, Commercial Insurer, Negotiated Discounts e.g. PPO, HMO, All Workers Compensation
- Medicaid: Nevada Medicaid, Nevada Medicaid HMO
- Self-Pay: Self Pay
- Other Medicaid: Out of State Medicaid
- Other: Charity, Miscellaneous, County Indigent Referral
- Unknown: Unknown, Blank

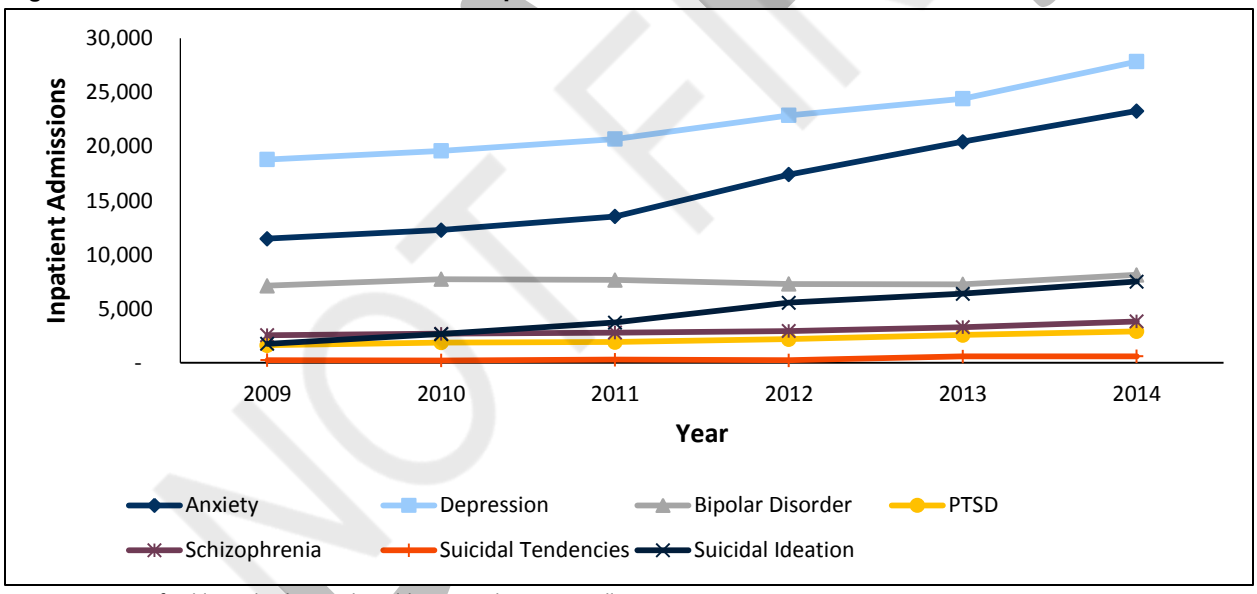
A majority of mental health and substance-related ER visits for Nevada residents was paid by Self-pay (29%), followed by "Insured" (24%), Medicare (18%), and Medicaid (18%).

Hospital Inpatient Admissions

The data provided in this section are from the hospital inpatient billing data, collected by the University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). The data are based on admissions, not patients, therefore a single person may represent multiple admissions. The inpatient data are broken into three parts: mental conditions (depression, anxiety, PTSD, suicidal ideations, etc.), suicide attempts by method (hanging, jumping, firearms, etc.) and alcohol- and drug-related admissions. The same ICD-9 codes were used for analysis as were used in hospital ER visit analysis.

There were a total of 356,538 inpatient admissions related to mental health and substance use disorders among Nevada residents between 2009 and 2014 for the reasons listed above. Since an individual can have more than one diagnosis during a single inpatient admission, the following numbers reflect the number of times a diagnosis was given and therefore the following numbers are not mutually exclusive. Diagnoses related to mental disorders occurred in 260,047 inpatient admissions, there were 90,474 inpatient admissions related to alcohol-related issues, 88,204 inpatient admissions for other drug-related issues, and 7,913 inpatient admissions with diagnoses codes related to suicide attempts.

Figure 12. Select Mental Health Related Inpatient Admissions, Nevada Residents, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

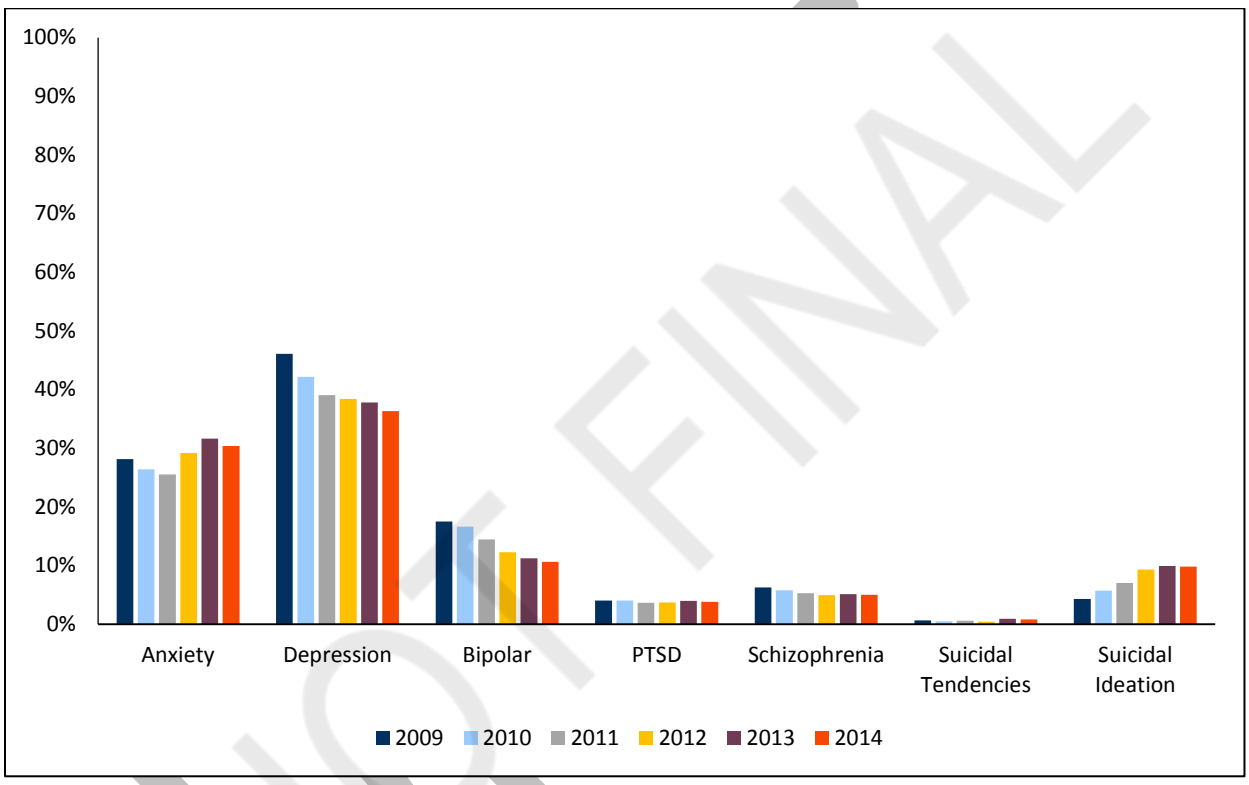
Depression was the most common mental health disorder for inpatient admissions for Nevada residents between 2009 and 2014, related to for 54% of the admissions from the disorders listed above in Figure 11. Depression inpatient admissions have increased consistently over the four year period, from 18,794 admissions in 2009 to 27,843 in 2014, a 48% increase.

Anxiety was the second most common mental health disorder seen in inpatient admissions. Inpatient admissions has increased steadily over the four year period, from 11,466 admissions in 2009 to 23,266 in 2014, a 103% increase.

Bipolar disorder is the third most common mental health disorder seen in inpatient admissions among Nevada residents, related to 16% of admissions for the mental health conditions listed in Figure 10.

Inpatient admissions for suicidal ideation experienced the greatest percent change from 2009 to 2014 with a 328% increase. The inpatient admission counts increased from 1,753 in 2009 to 7,501 in 2014.

Figure 13. Proportion of Select Mental Health Related Inpatient Admissions by Year, Nevada Residents, 2009-2014



Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

Figure 13 depicts the proportion of inpatient admissions of each mental health indicators of all mental health related inpatient admissions of that year.

Table 6. Demographics of Select Mental Health Related Inpatient Admissions, Nevada Residents, 2009-2014.

Inpatient	Depression		Anxiety		Bipolar		Suicidal Ideation	
	N	Column %	N	Column %	N	Column %	N	Column %
Sex								
Female	85,848	64.0	65,900	67.0	27,099	60.0	14,167	51.4
Male	48,329	36.0	32,438	33.0	18,084	40.0	13,389	48.6
Race								
White	97,886	73.0	73,676	74.9	30,806	68.2	14,808	53.7
Black	11,259	8.4	7,981	8.1	4,987	11.0	2,443	8.9
Native American	1,197	0.9	797	0.8	920	2.0	475	1.7
Asian/Pacific	2,653	2.0	1,930	2.0	575	1.3	400	1.5
Hispanic	8,847	6.6	6,763	6.9	2,127	4.7	1,616	5.9
Other	4,399	3.3	2,696	2.7	1,256	2.8	1,903	6.9
Unknown	7,937	5.9	4,496	4.6	4,512	10.0	5,911	21.5
Age								
0-14	2,953	2.2	795	0.8	1,450	3.2	2,098	7.6
15-24	11,290	8.4	4,662	4.7	5,352	11.8	6,014	21.8
25-34	9,310	6.9	7,976	8.1	5,352	11.8	3,395	12.3
35-44	13,084	9.8	10,970	11.2	7,299	16.2	3,960	14.4
45-54	20,814	15.5	17,309	17.6	10,320	22.8	4,943	17.9
55-64	26,089	19.4	19,424	19.8	8,924	19.8	4,006	14.5
65-74	25,257	18.8	19,368	19.7	4,664	10.3	1,992	7.2
75-84	16,802	12.5	12,237	12.4	1,477	3.3	809	2.9
85+	8,579	6.4	5,598	5.7	345	0.8	339	1.2

Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

Table 7. Demographics of Select Methods of Suicide Attempts Inpatient Admissions, Nevada Residents, 2009-2014.

Inpatient	Solid or Liquid		Cutting and Piercing Instrument		Firearms, Air Guns and Explosives	
	N	Column %	N	Column %	N	Column %
Sex						
Female	4,023	60.8	345	44.3	40	22.3
Male	2,593	39.2	434	55.7	139	77.7
Race						
White	4,783	72.3	513	65.9	139	77.7
Black	428	6.5	49	6.3	6	3.4
Native American	118	1.8	13	1.7	4	2.2
Asian/Pacific	179	2.7	20	2.6	1	0.6
Hispanic	707	10.7	102	13.1	19	10.6
Other	237	3.6	50	6.4	2	1.1
Unknown	164	2.5	32	4.1	8	4.5
Age						
0-14	136	2.1	28	3.6		-
15-24	1,277	19.3	185	23.7	23	12.8
25-34	1,277	19.3	151	19.4	33	18.4
35-44	1,303	19.7	131	16.8	31	17.3
45-54	1,303	19.7	126	16.2	28	15.6
55-64	831	12.6	91	11.7	28	15.6
65-74	316	4.8	35	4.5	17	9.5
75-84	121	1.8	22	2.8	11	6.1
85+	52	0.8	10	1.3	8	4.5

Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

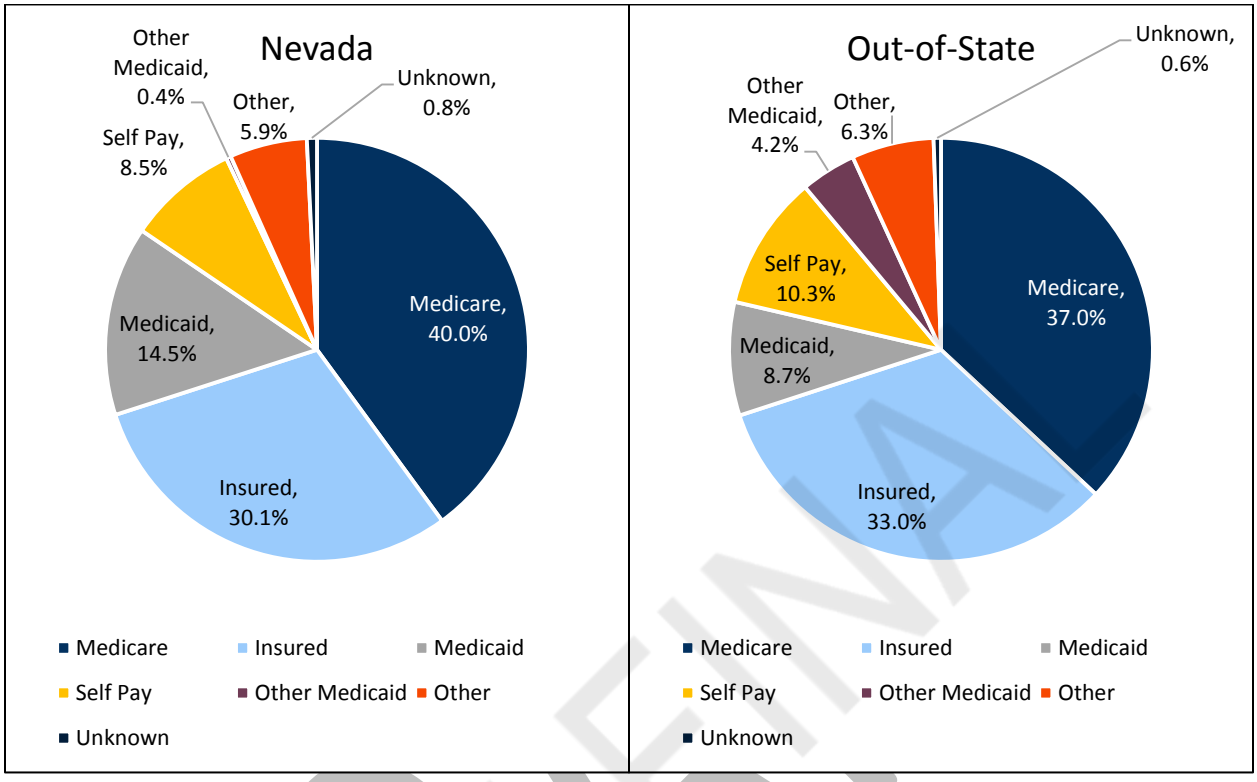
Table 8. Specific Schizophrenia Diagnoses, Inpatient Admissions by Gender, Nevada Residents, 2009-2014

Condition	Female		Male		Total
	N	Row %	N	Row %	
Unspecified schizophrenia	2,915	43.4%	3,808	56.6%	6,723
Schizoaffective disorder	3,055	45.8%	3,621	54.2%	6,676
Paranoid type schizophrenia	1,326	36.9%	2,264	63.1%	3,590
Personal history of schizophrenia	203	43.0%	269	57.0%	472
Other specified types of schizophrenia	148	35.2%	272	64.8%	420
Schizophrenic disorder, residual type	119	41.5%	168	58.5%	287
Catatonic type schizophrenia	42	42.9%	56	57.1%	98
Schizophreniform disorder	40	44.4%	50	55.6%	90
Disorganized type schizophrenia	20	40.0%	30	60.0%	50
Simple type schizophrenia	8	42.1%	11	57.9%	19
Latent schizophrenia	7	63.6%	4	36.4%	11
Total Schizophrenia	**7,749**	**42.8%**	**10,344**	**57.2%**	**18,093**

Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

**Categories are not mutually exclusive.*

Figure 14. Payer Distribution of Mental Health and Substance Use Related Inpatient Admissions by Resident Status, 2009-2014.



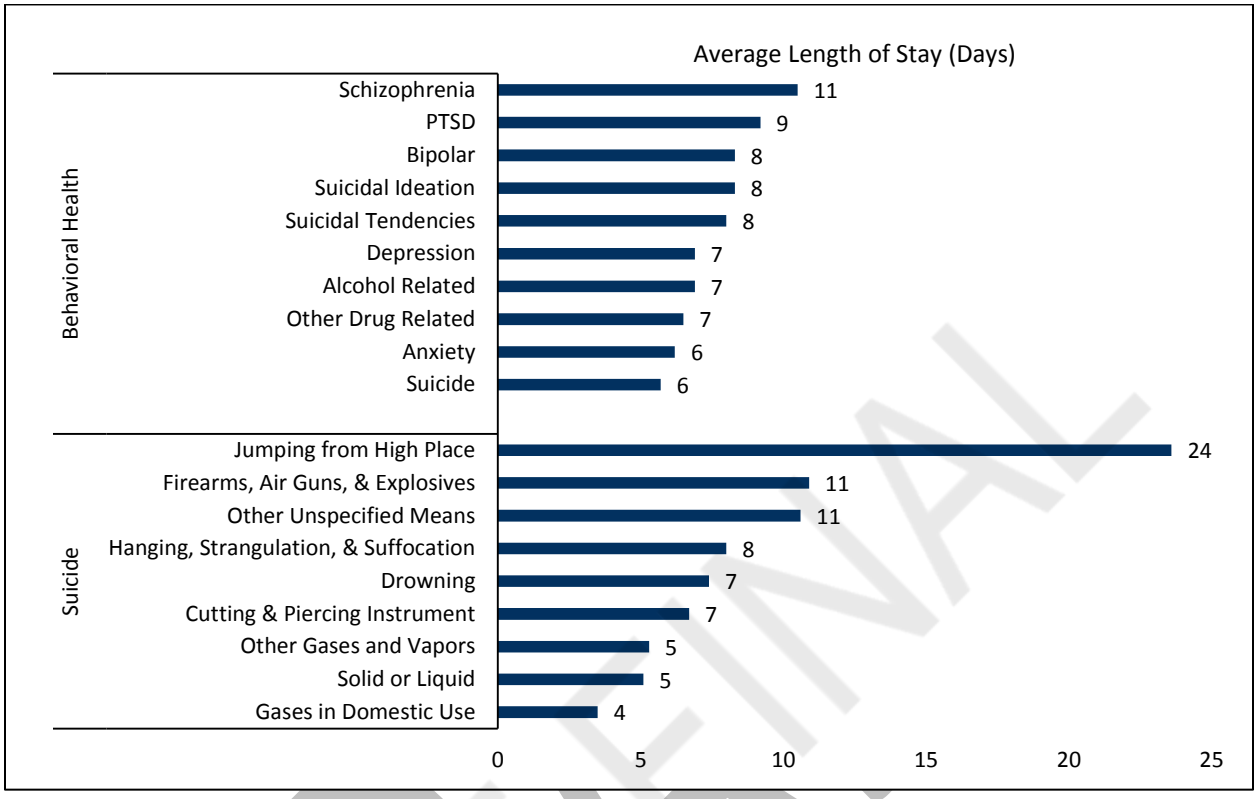
Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

Payer was consolidated into the following format:

- Medicare: Medicare, Medicare HMO
- Insured: CHAMPUS OR CHAMVA, Commercial Insurer, Negotiated Discounts e.g. PPO, HMO, All Workers Compensation
- Medicaid: Nevada Medicaid, Nevada Medicaid HMO
- Self-Pay: Self Pay
- Other Medicaid: Out of State Medicaid
- Other: Charity, Miscellaneous, County Indigent Referral
- Unknown: Unknown, Blank

A majority of mental health and substance-related inpatient admissions for Nevada residents was paid by Medicare (40%). HMOs accounted for 14% of payment types for inpatient admissions. Medicaid accounted for 15%, and Self Pay accounted for 9% of payments.

Figure 15. Average Length of Stay for Mental Health and Substance Related Disorders in Inpatient Admissions, Nevada Residents, 2009-2014.



Source: Division of Public and Behavioral Health, Hospital Inpatient Billing

Note: Since an individual can have more than one of the above diagnoses during an inpatient admission, a single hospitalization may be included in multiple categories, and would contribute to the average length of stay in each of these categories.

Inpatient admissions for suicide attempts by jumping from a high place had the longest average length of stay for the period from 2009 to 2015 at 24 days, but was not included in the previous figure due to small counts. Suicide attempts by gases in domestic use had the shortest length of stay at an average of four days.

Substance Abuse Treatment

The data in this section is reflective of services received by Nevada residents at treatment facilities funded by the DPBH's Substance Abuse Prevention and Treatment Agency (SAPTA). This is not a comprehensive accounting of all Nevada residents who receive substance use treatment. The data are based on admissions, not patients, therefore a single person may represent multiple admissions.

Table 9. Top Primary Substances of Admissions to Nevada Substance Abuse Treatment Facilities, Nevada Residents, 2014.

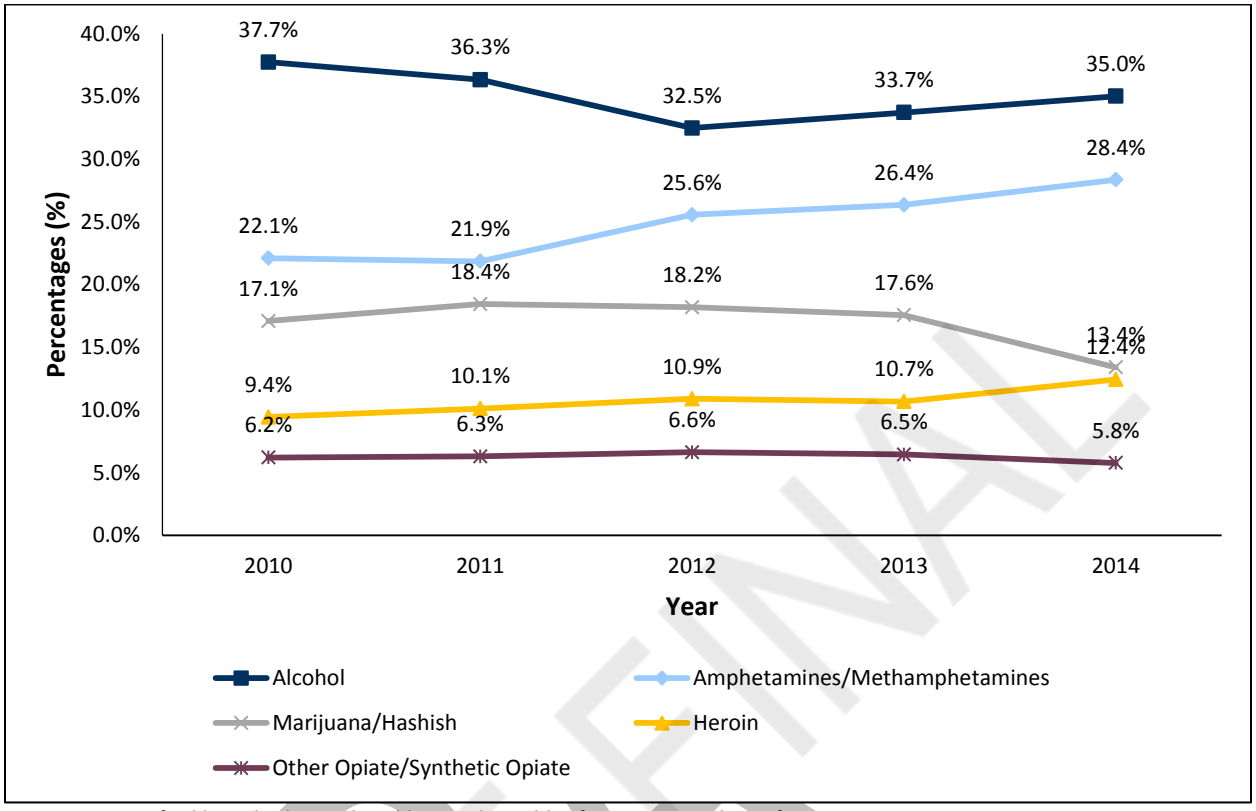
Rank	Substance	Percent
1	Alcohol	35.0
2	Amphetamines/Methamphetamines	28.4
3	Marijuana/Hashish	13.4
4	Heroin	12.4
5	Other Opiates/Synthetic Opiates	5.8

Source: Division of Public and Behavioral Health, Nevada Health Information Provider Performance System

Of the Nevada residents who received substance abuse treatment services from a SAPTA provider in 2014, alcohol was the most common substance abused (35.0%), followed by amphetamines/methamphetamines (28.4%), marijuana (13.4%), and heroin and other opiates (12.4% and 5.8% respectively).

It is highly important to ensure that appropriate detoxification services are provided to persons who are under the influence of a substance. Many of the substances will cause withdrawal that can range from anxiety, hallucinations, seizures or even death.

Figure 16. Top Primary Substances of Admission to Nevada Substance Abuse Treatment Facilities, Nevada Residents, 2010-2014.



Source: Division of Public and Behavioral Health, Nevada Health Information Provider Performance System

Figure 13 shows trends for the top five most common primary substances, and the percentages of patients admitted into a treatment facility for that substance. Alcohol is the dominant substance seen in treatment facilities and represents a 37.7% of patients seeking treatment at a SAPTA-funded treatment facility in 2010 and 35.0% of patients in 2014.

Methamphetamines (Meth-/Amphetamines) is the next common substance abused by Nevada residents who underwent treatment between 2010 and 2014. The percentage of patients seeking treatment for Meth-/Amphetamines abuse peaked in 2014 (28.4%).

Marijuana is the third most common drug among Nevada residents seen in substance abuse treatment facilities, at 13.4% in 2014.

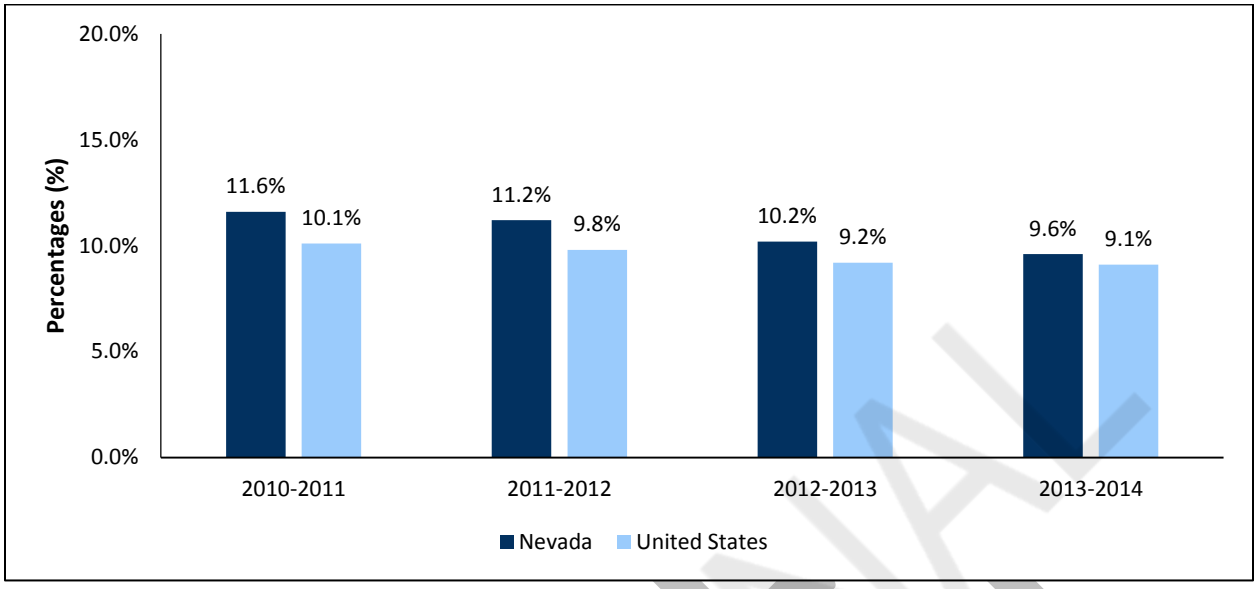
Heroin is the fourth most common drug among Nevada residents seen in substance abuse treatment facilities, at 12.4 in 2014.

Table 10. Demographics of Unduplicated Persons in Nevada State Funded Substance Abuse Treatment Facilities, SFY 2011-2015.

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Sex					
Male	5,659	6,688	6,662	4,660	5,677
Female	2,912	3,834	3,974	2,853	3,788
Pregnant Woman	133	190	192	139	190
Age					
0-17	928	1,060	1,038	574	605
18-24	1,788	2,189	2,176	1,384	1,632
25-44	3,845	4,832	5,100	3,787	5,048
45-64	1,950	2,366	2,236	1,705	2,119
65+	60	75	86	63	61
Race/Ethnicity					
White	5,790	7,074	7,208	5,064	6,625
Black or African American	1,021	1,191	1,135	845	1,005
Native Hawaiian/Other Pacific Islander	66	75	99	63	91
Asian	64	111	107	56	68
American Indian/Alaska Native	222	280	274	221	272
Multiple	383	481	521	347	391
Unknown	1,025	1,310	1,292	917	1,013
Total	**8,571**	**10,522**	**10,636**	**7,513**	**9,465**

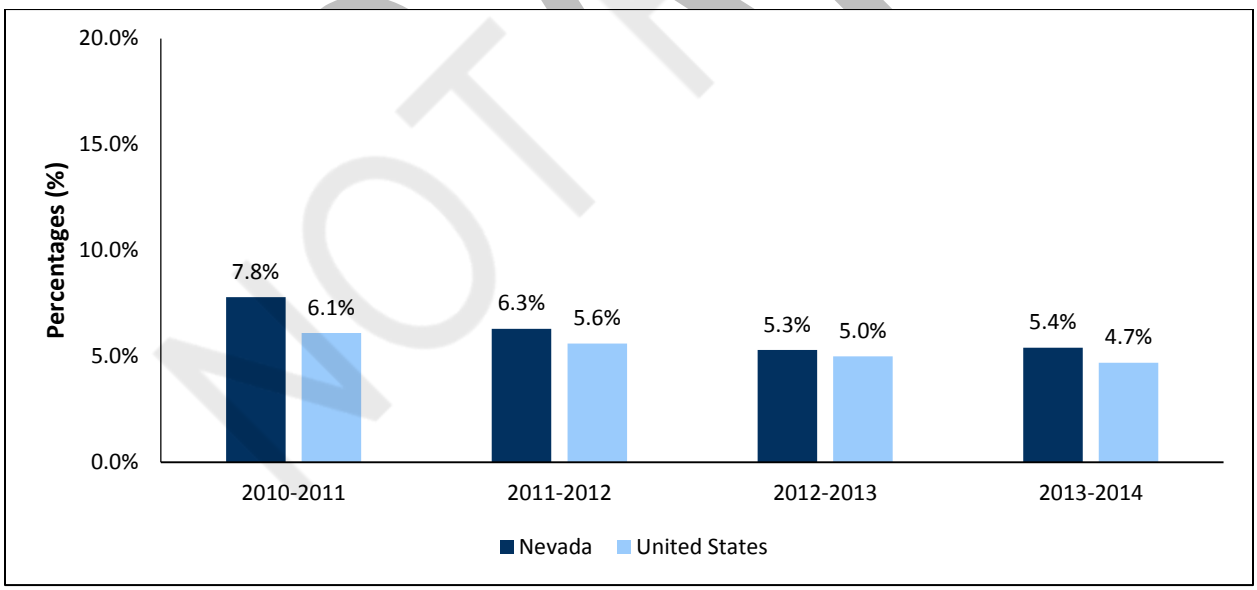
Source: SAMHSA Block Grants, WebBGAS

Figure 17. Past Month Illicit Drug Use Among Adolescents Aged 12-17 in Nevada and the United States, 2010-2011 to 2013-2014.



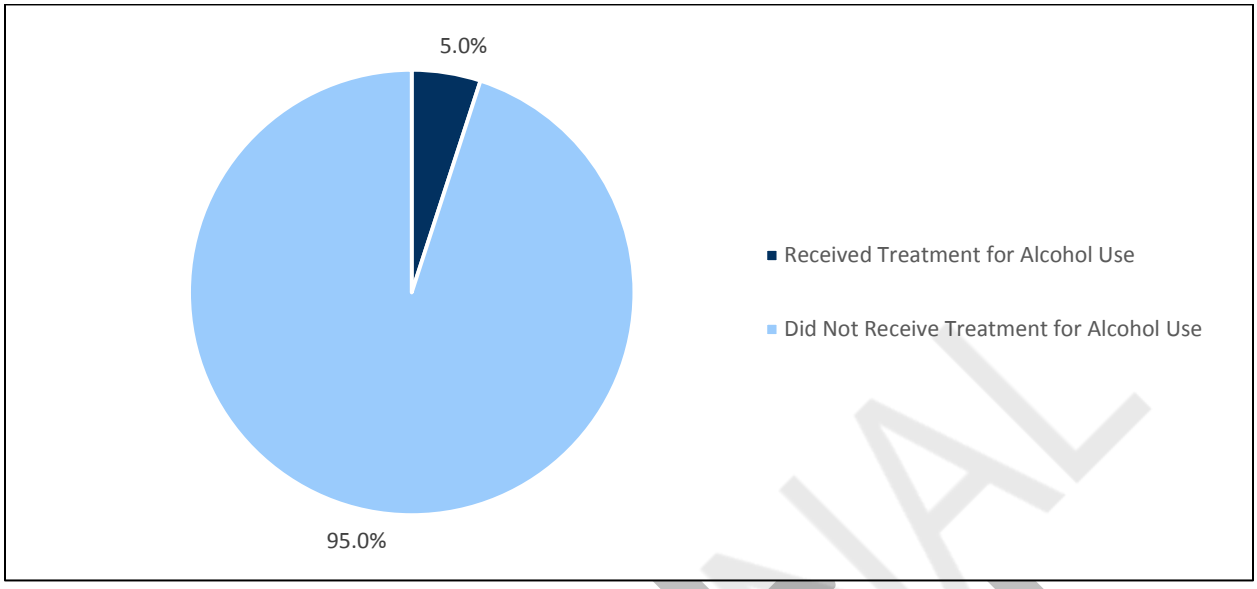
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

Figure 18. Past Year Nonmedical Use of Pain Relievers Among Adolescents Aged 12-17 in Nevada and the United States 2010-2011 to 2013-2014.



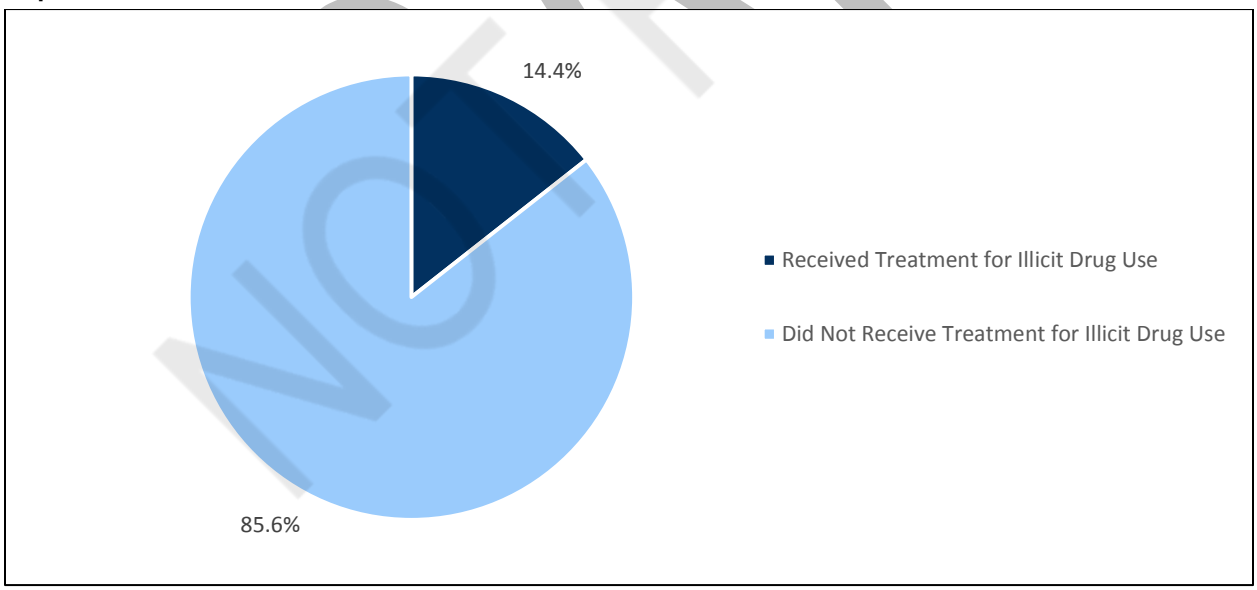
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

Figure 19. Past Year Treatment for Alcohol Use Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Nevada, 2010-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Figure 20. Past Year Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Nevada, 2010-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Table 11. Health Disparities-Related Activities by Coalition, October 2016 – March 2017

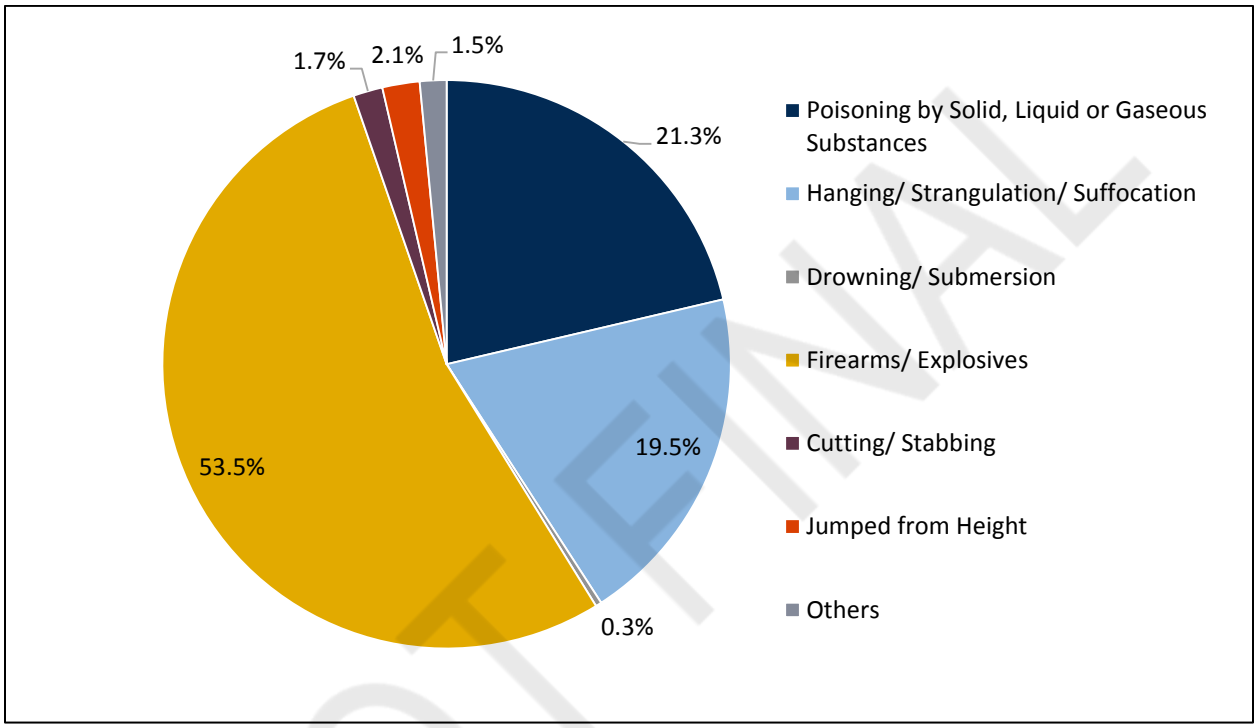
	CARE Coalition	Churchill Community Coalition	Frontier Community Coalition	Healthy Communities Coalition	Join Together Northern Nevada	Nevada Community Prevention Coalition	Nevada Statewide Coalition Partnership	Nye Communities Coalition	PACT Coalition	Partners Allied for Community Excellence	Partnership Carson City	Partnership of Community Resources
Defined specific health disparities subpopulations	X				X				X	X		
Identified specific substance use-related health disparities faced by your selected subpopulations	X				X				X			
Obtained substance use-related data specific to the high-needs subpopulations		X	X		X				X			
Considered health disparities in your PFS planning process		X	X		X			X	X			
Involved subpopulations experiencing health disparities in your PFS activities	X	X	X				X		X		X	
Received training to increase your capacity related to substance use health disparities	X		X	X	X		X	X			X	
Developed partnerships with agencies, organizations, or key stakeholders to address the health disparities	X	X	X	X	X	X	X	X	X	X	X	
Implemented interventions specifically for health disparities subpopulations	X	X	X		X	X		X	X		X	
Adapted interventions to make them apply to specific health disparities subpopulations								X			X	
Increased the availability of substance use prevention services to health disparities subpopulations	X		X			X		X			X	
Increased access to substance use prevention services for health disparities subpopulations	X	X				X	X	X		X	X	
Evaluated outcomes by subpopulations that face substance use health disparities												
Evaluated changes in the number of individuals served or reached by subpopulations that face substance use health disparities												
Developed a plan to sustain progress made in addressing substance use-related health disparities beyond the Partnerships for Success Initiative	X	X	X						X		X	
Other												
None of the Above												

Health disparities subpopulations refer to specific demographic, language, age, socioeconomic status, sexual identity, or literacy groups that experience limited availability of or access to substance use prevention services or who experience worse substance use prevention outcomes. Table 11 indicates the health disparities-related activities each subrecipient organization conducted from October 2016 – March 2017.

Mental and Substance Abuse Deaths

The data in this section are from the electronic death registry at DPBH. The Substance Abuse and Mental Health Service Administration (SAMHSA) reports suicide and mental illness are highly correlated with as many as 90% of those persons who die of suicide completion having a diagnosable mental illness.

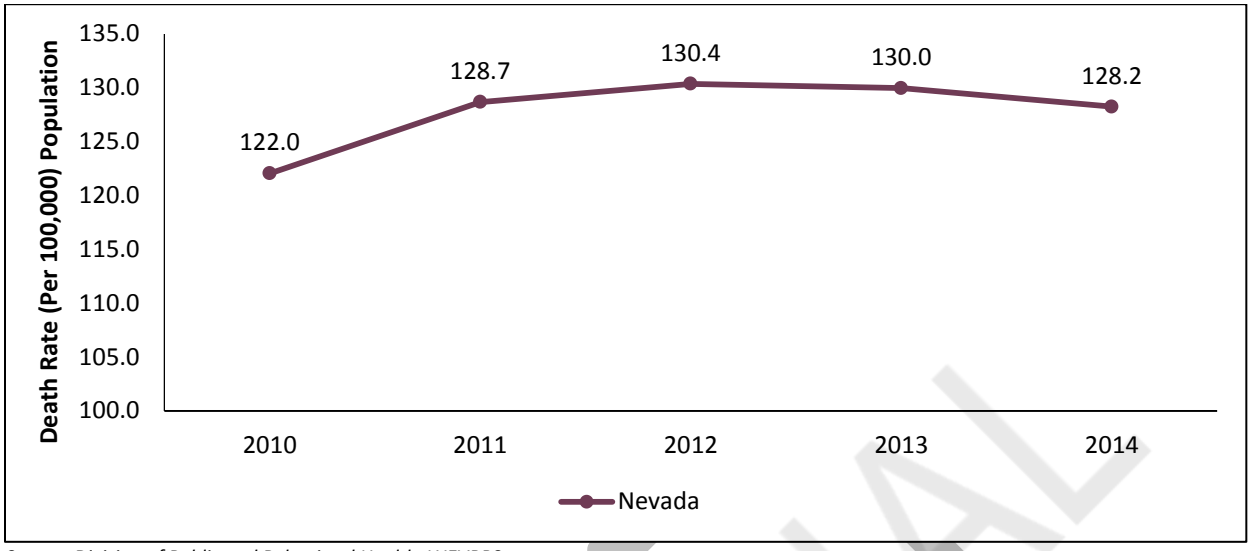
Figure 21. Percent of Suicides (Immediate Cause) by Method, Nevada, 2010-2014 (n=2,639).



Source: Division of Public and Behavioral Health, WEVRRS

Among Nevada residents who died of a suicide between 2010 and 2014, the most common method of suicide was firearms/explosives (53.5%), followed by poisonings from solid, liquid, or gaseous substances (21.3%) and hanging, strangulation and suffocation (19.5%).

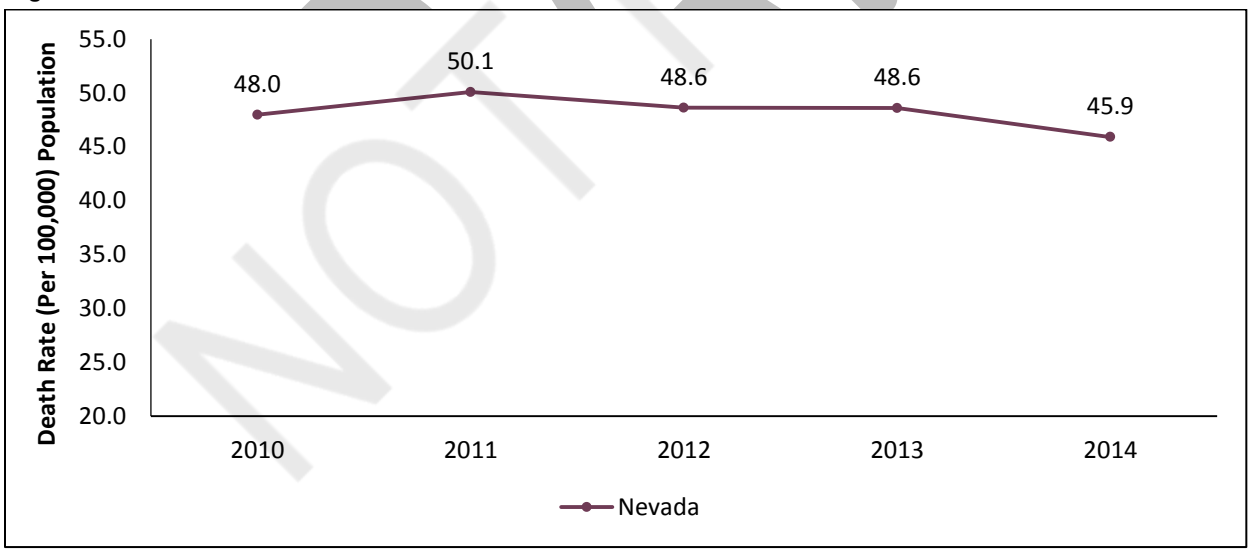
Figure 22. Mental Health and Substance-Related Deaths, Nevada, 2010-2014



Source: Division of Public and Behavioral Health, WEVRRS

There were 17,675 deaths related to mental health and substance-related disorders in Nevada between 2010 and 2014. Nevada's death rate for behavioral related deaths (defined by ICD10 codes F00-F99) 122.0 per 100,000 in 2010. There was an overall 5.1% increase between 2010 and 2014 when the rate had increased to 128.2 per 100,000.

Figure 23. Substance-Related Deaths, Nevada, 2010-2014



Source: Division of Public and Behavioral Health, WEVRRS

There were 6,664 substance-related deaths in Nevada between 2010 and 2014. During that timeframe the death rate varied between from 45.9 deaths per 100,000 and 50.1 deaths per 100,000.

Note: the following codes were used to define substance-related deaths: ICD10 codes G312, G621, I426, G721, K292, K70, K860, R78, Y90, Y91, X40-X49, T36-T60, T65, F10, X60-X69, E244, K852, O354, Y10-Y19, P043, Q860, Z721, R781-R786, F11-F16, F18, X85-X90, O355, D521, P961, T96-T97, Y40-Y59, K711, N141, P044.

Table 12. Demographics of Substance Related Deaths, Nevada 2010-2014

	N	Column %
Sex		
Female	2,384	35.8
Male	4,280	64.2
Race		
White	5,317	79.8
Black	423	6.3
Native American	118	1.8
Hispanic	588	8.8
Asian/Pacific	114	1.7
Other	6	0.1
Unknown	98	1.5
Age		
<1	15	0.2
1-4	12	0.2
5-14	12	0.2
15-24	293	4.4
25-34	660	9.9
35-44	974	14.6
45-54	1,899	28.5
55-64	1,700	25.5
65-74	767	11.5
75-84	254	3.8
85+	77	1.2

Source: Division of Public and Behavioral Health, WEVRRS

In Nevada, the most common demographic groups to die of a substance-related death included: males (64.2%), White non-Hispanics (79.8%), and those aged 45 to 64 years of age (54.0%).

Syndromic Surveillance

The data contained in this section came from DPBH's BioSense, a syndromic surveillance system that tracks chief complaints in emergency departments. Currently, syndromic surveillance does not cover the following counties: Eureka, Storey, Mineral, and Esmeralda.

Table 13. Behavioral Health Related Chief Complaints Demographics, Nevada Facilities, 2015.

	N	Percent
Sex		
Female	12,775	47.5%
Male	14,093	52.4%
Unknown	39	0.1%
Age		
0-5	104	0.4%
6-12	111	0.4%
13-19	1,429	5.3%
20-39	12,926	48.0%
40-59	7,871	29.3%
60-79	2,796	10.4%
80+	421	1.6%
Unknown	1,249	4.7%
Total	**26,907**	**100.0%**

Source: Division of Public and Behavioral Health, BioSense

Table 14. Behavioral Health Related Chief Complaints, Nevada Facilities, 2015.

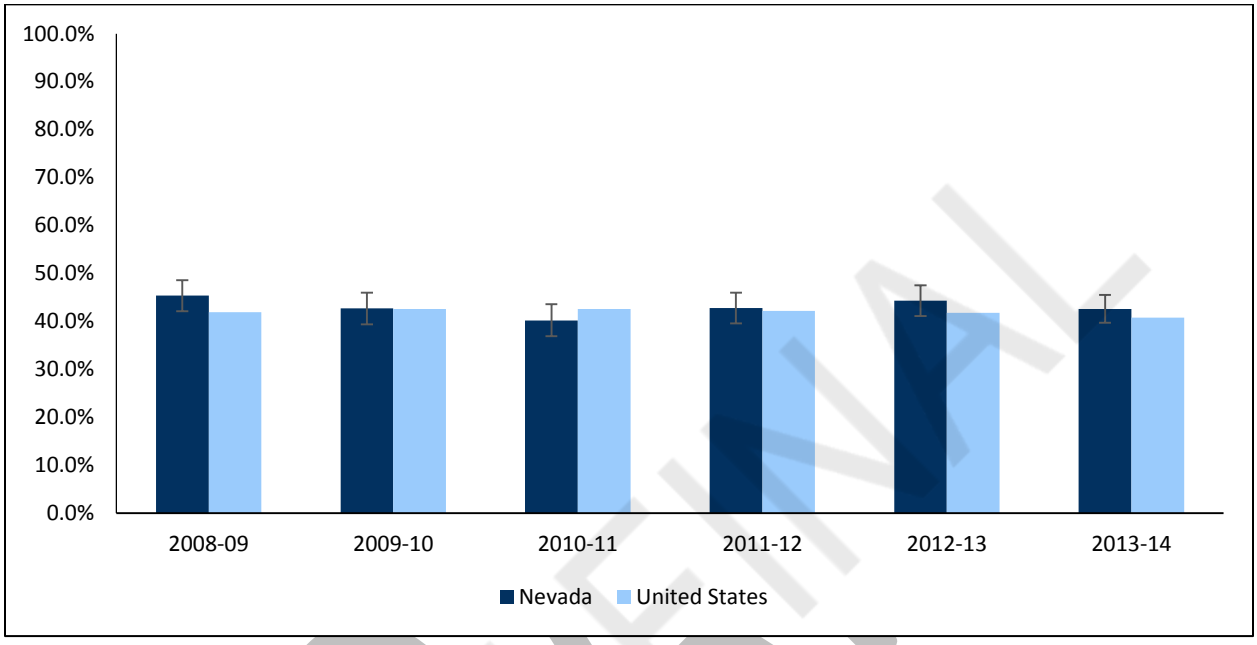
	N
Chief Complaint	
Alcohol Use*	11,325
Depression Disorder**	3,591
Suicidal Ideation	2,636
Overdose* **	2,287
Anxiety	7,150
Alcohol Withdrawal	251

*Includes: alcohol abuse, intoxication, alcoholic, ETOH, acute alcohol intoxication, alcohol dependence
**Includes: depression, major depression, mental disorder
***Includes: overdose, drugs

There were slightly more male patients (52%) among mental health and substance-related chief complaints in Nevada. The largest age group among patients were those aged 20-39 (48%). Not enough information was available to provide race/ethnicity patient demographics.

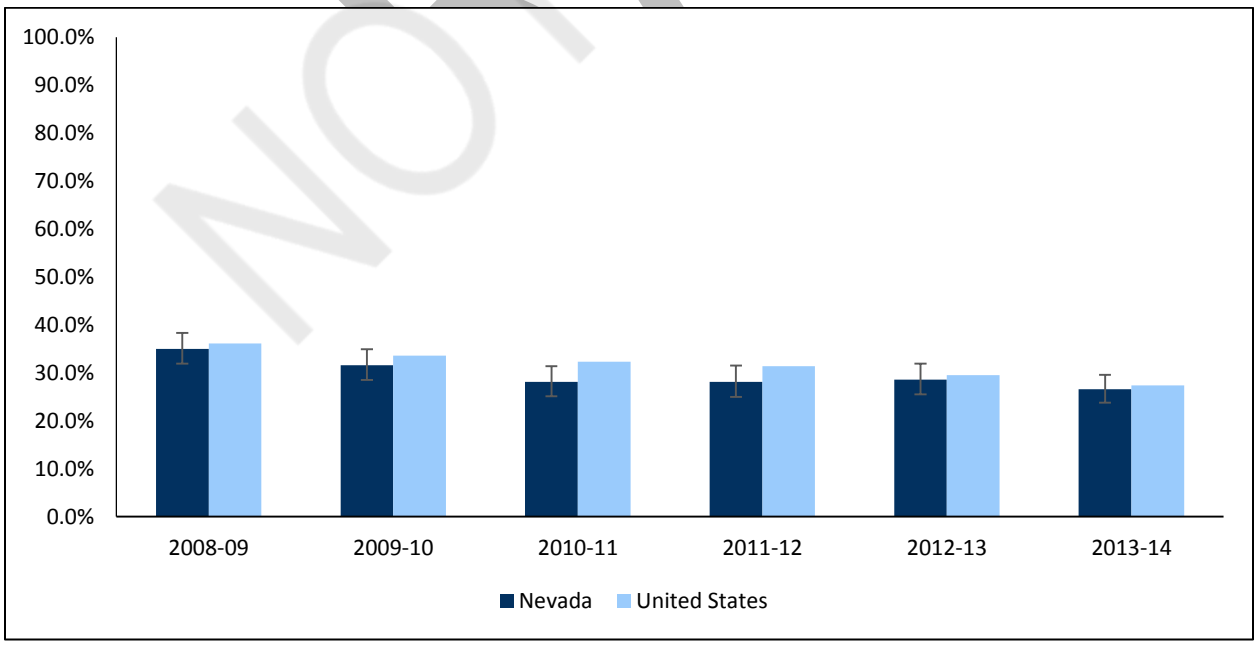
Perceived Risk

Figure 24. Percentage of Persons Aged 12 or Older Perceiving Great Risk from Five or More Drinks of an Alcoholic Beverage Once or Twice a Week: 2008-09 to 2013-14



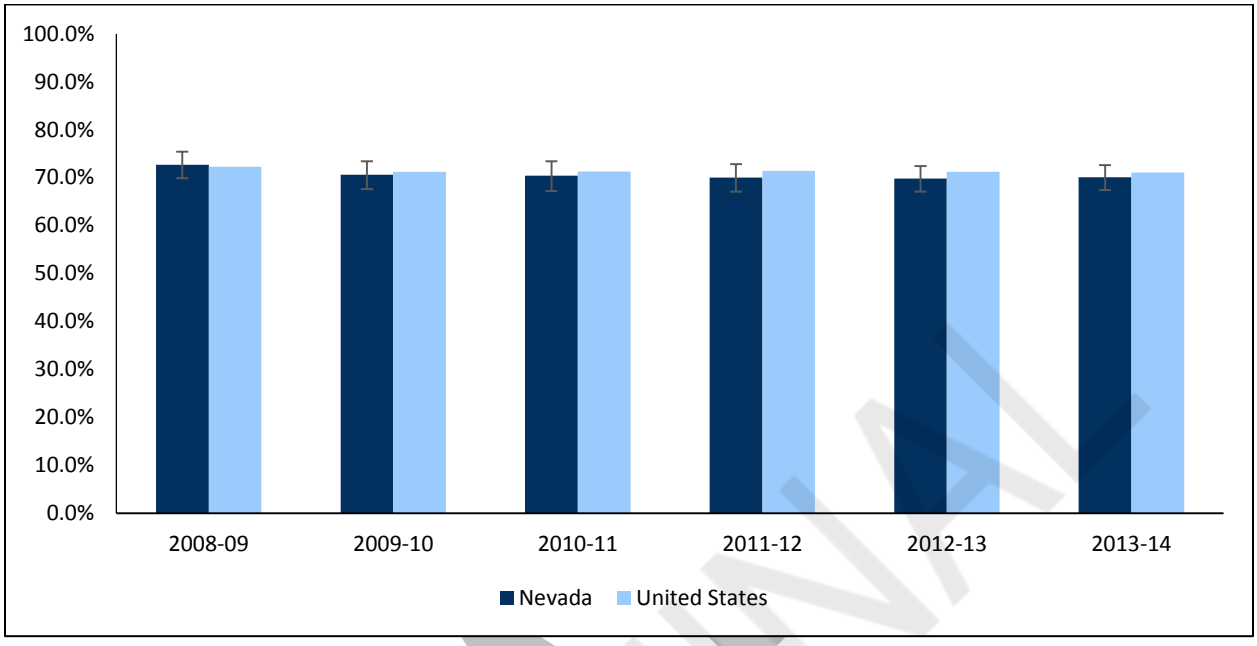
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2008--2014.

Figure 25. Percentage of Persons Aged 12 or Older Perceiving Great Risk from Smoking Marijuana Once a Month: 2008-09 to 2013-14



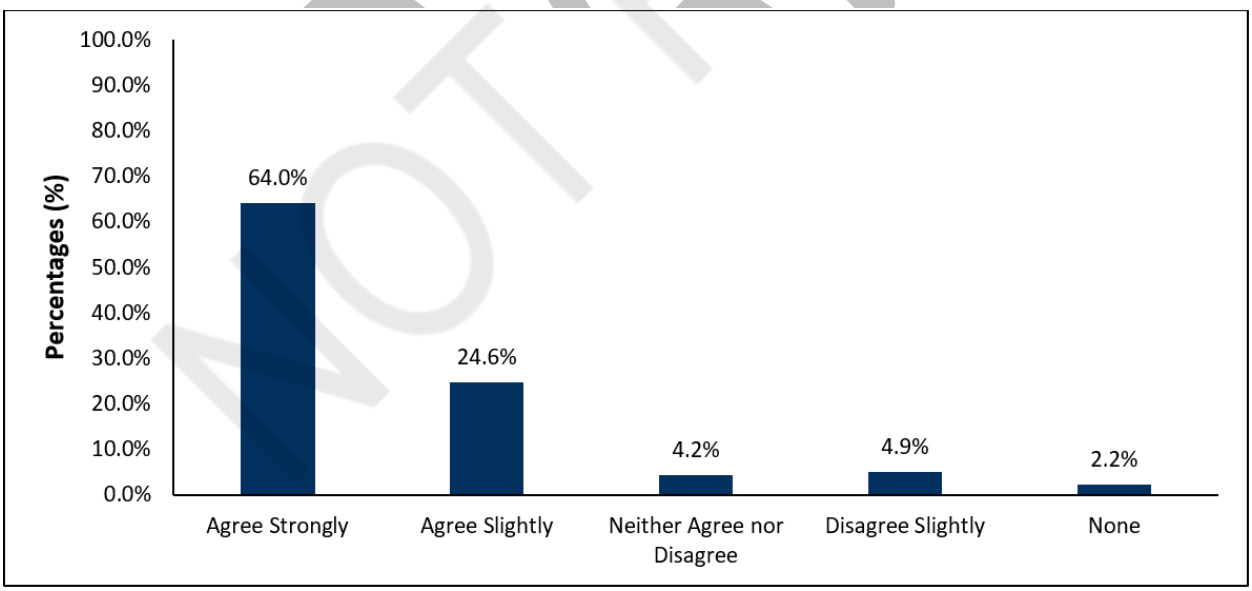
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2008--2014.

Figure 26. Percentage of Persons Aged 12 or Older Perceiving Great Risk from Smoking One or More Packs of Cigarettes Per Day: 2008-09 to 2013-14



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2008--2014.

Figure 27. Percentages of Adult Nevada Residents Who Agree that with Treatment, People with a Mental Illness Can Live Normal Lives, 2012 – 2014.



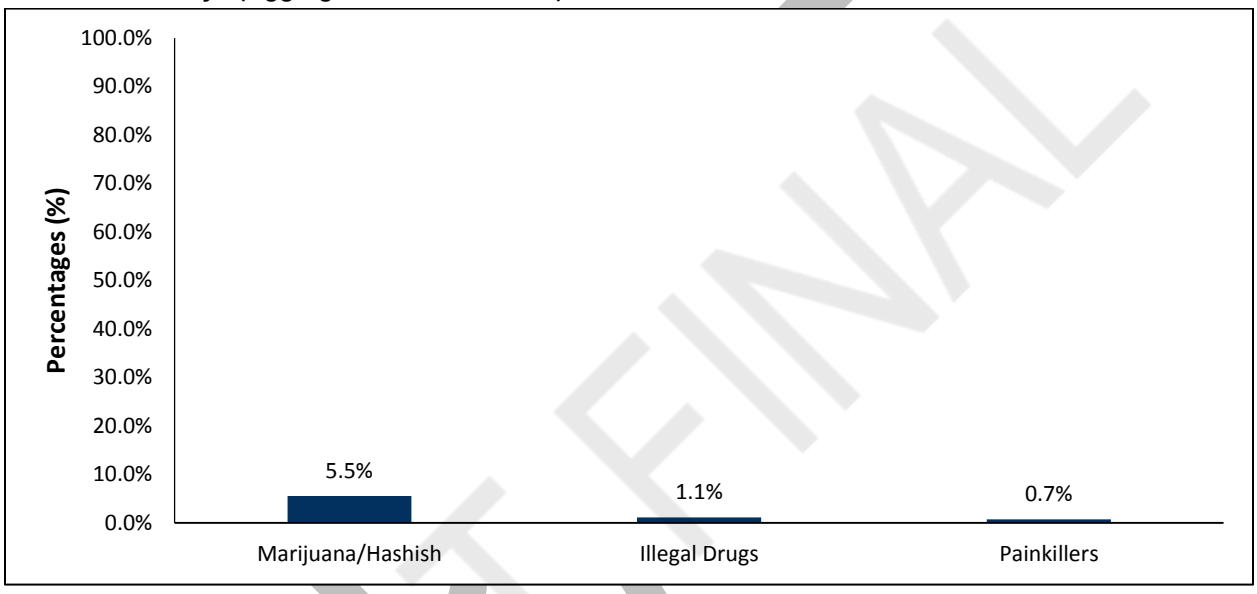
Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

From 2012 to 2014, BRFSS data was collected on perception related to the efficacy of mental health treatment. In Nevada, over 90% of adults surveyed agreed in some capacity that those with mental health disorders can live a normal life with treatment. Only 4.9% of adults disagree that those with mental disorders could live a normal life, with treatment.

Adult Behavioral Risk Factors

Data in this section are from Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data for adults aged 18 years and older.

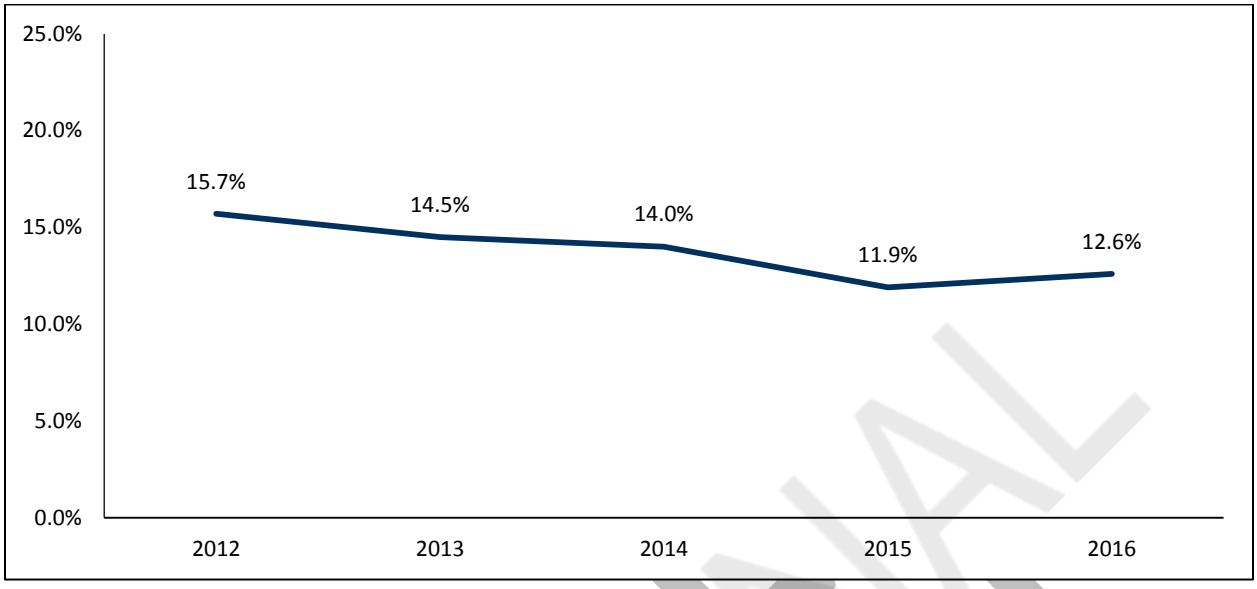
Figure 28. Percentage of Adult Nevada residents Who Used Illegal Substances or Painkillers to Get High in the Last 30 days (Aggregate 2011-2014 data).



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

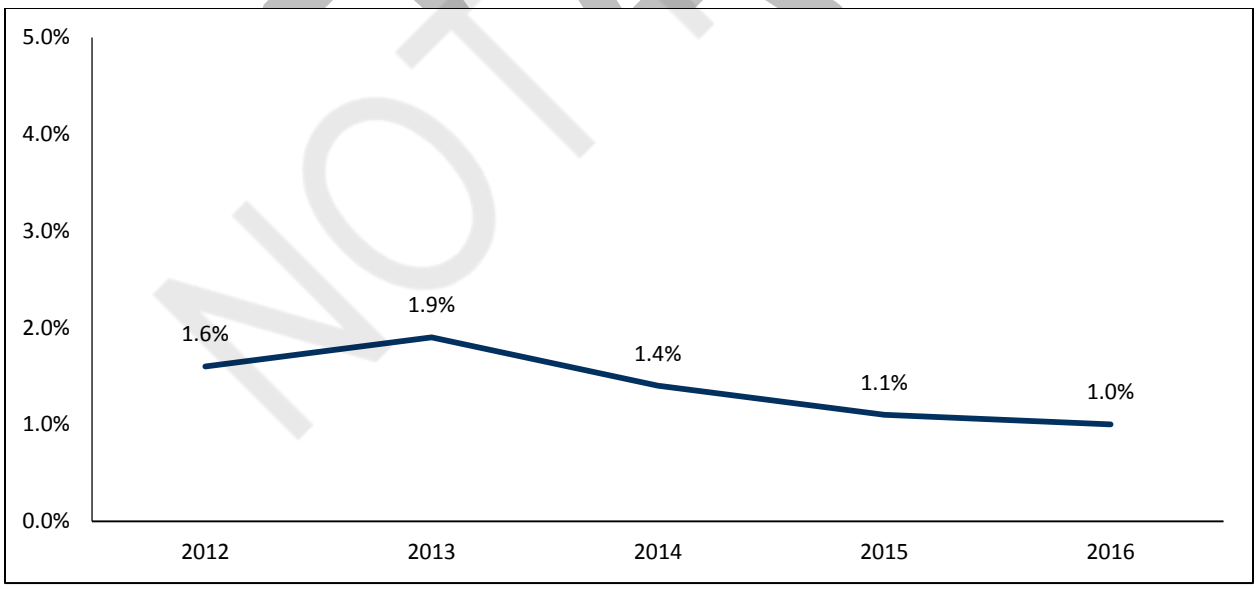
Between 2011-2014, over 5% of 17,366 Nevada adults surveyed reported through the BRFSS using marijuana or hashish in the last 30 days. By gender, 8.3% adult males reported using marijuana and 2.7% of adult females reported using marijuana. Males also reported using illegal drugs at a higher percent than females at 1.3% and .8%, respectively, and painkillers at 0.9% for males and 0.6% females.

Figure 29. Driving after Drinking Any Alcohol*, United States Undergraduate, Graduate, Professional Students, 2012-2016.



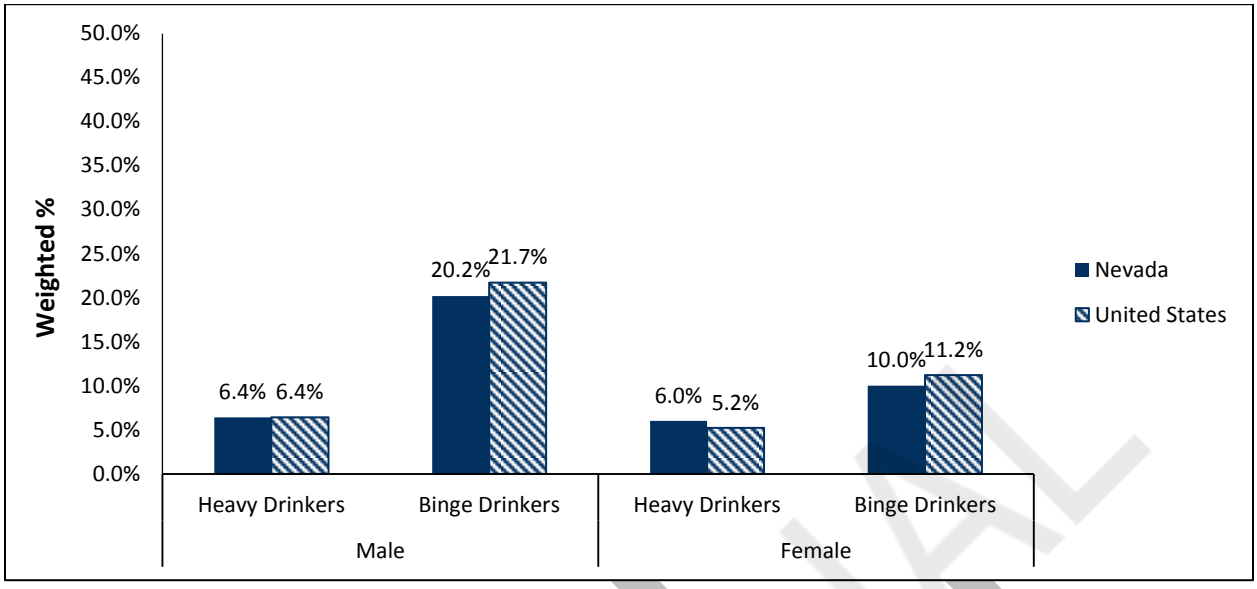
Source: American College Health Association, National College Health Assessment.
**Within the last thirty days*

Figure 30. Driving after Drinking Five or More Drinks*, United States Undergraduate, Graduate, Professional Students, 2012-2016.



Source: American College Health Association, National College Health Assessment.
**Within the last thirty days*

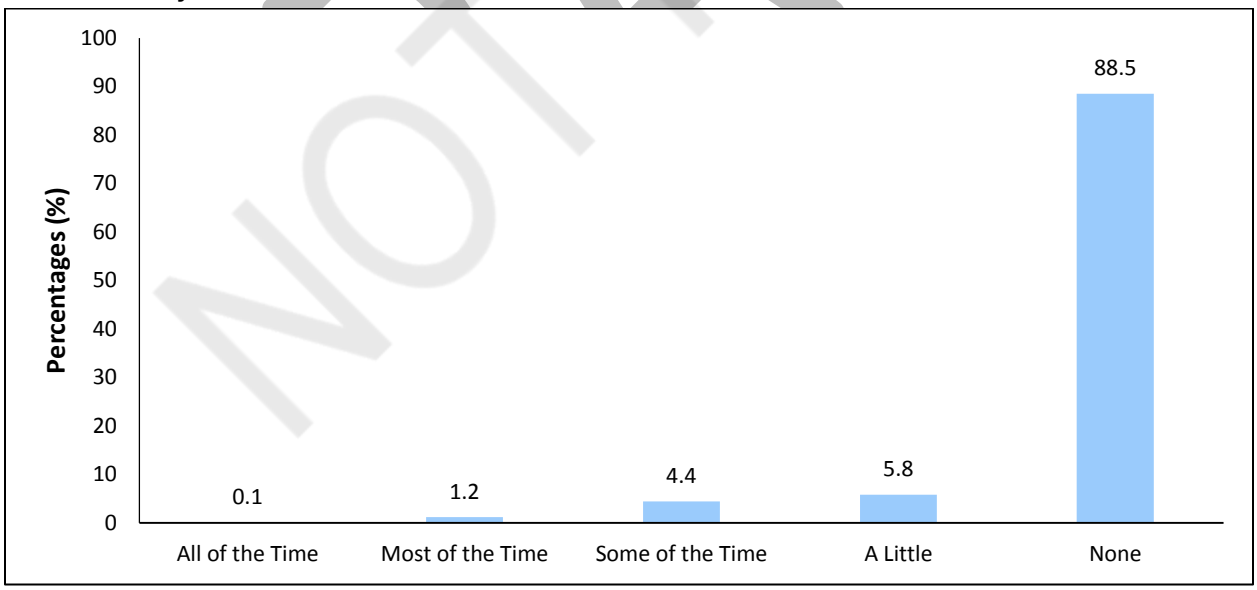
Figure 31. Percentages of Adult Residents Who are Considered Heavy/Binge Drinkers, 2015



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

Over 6% of adult Nevada males and females reported being heavy drinkers. Heavy drinking consists of males consuming more than two alcoholic beverages a day and females consuming more than one alcoholic beverage a day.

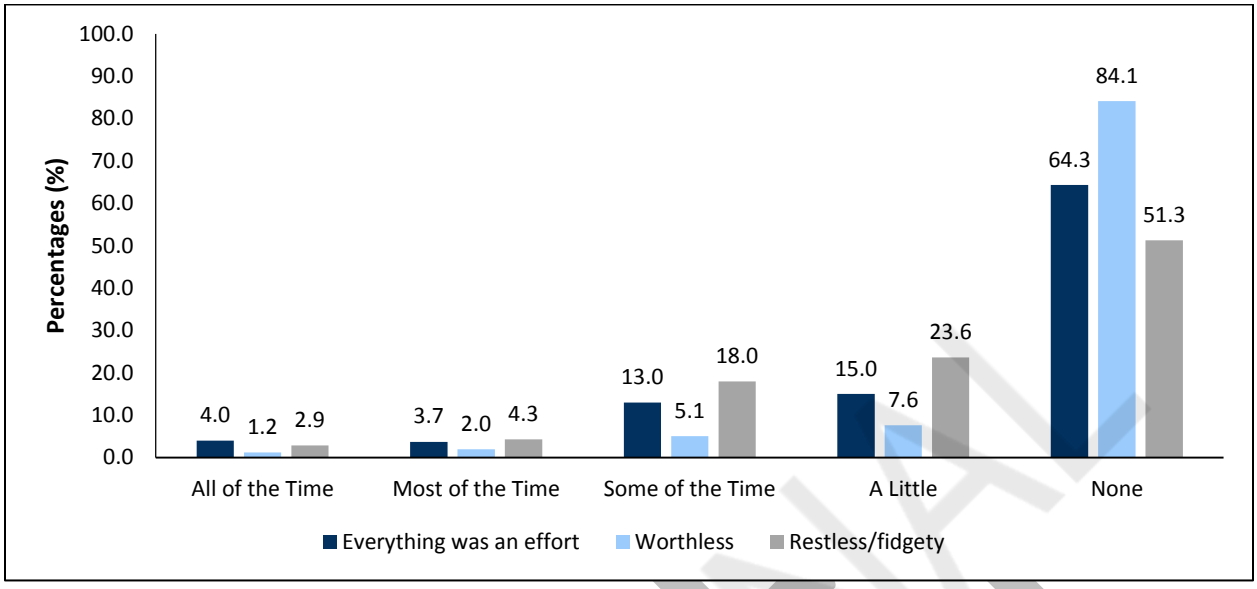
Figure 32. Percentages of How Often Adult Nevada Residents have Felt Depressed at Least One Day in the Past 30 Days, 2012-2014.



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

In 2012 to 2014, 88.5% of adult Nevada residents reported not experiencing depression at least one day in the last 30 days. The rest of the residents reported experiencing a little depression (5.8%), experiencing depression some of the time (4.4%), and most of the time (1.2%). A very small percentage (0.1%) reported experiencing depression all of the time.

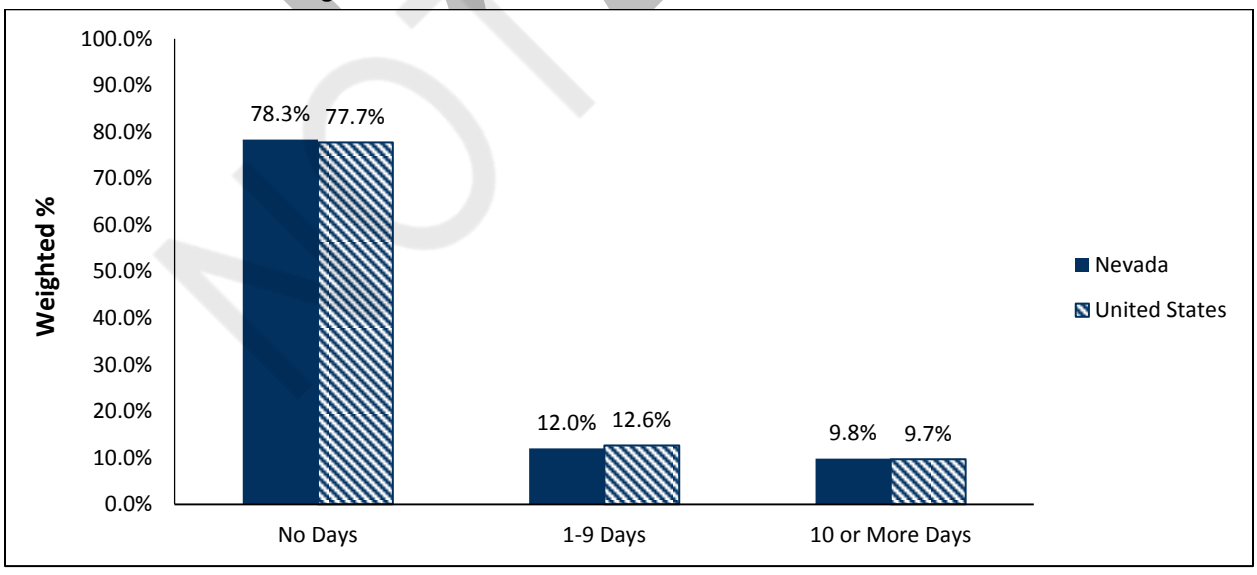
Figure 33. Percentages of Adult Nevada Residents Who Have Experienced the Following Mental Health Concerns in the Past 30 days, 2012 – 2014.



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

There are a number of BRFSS questions that collect data on feelings/emotions. From 2012 to 2014, nearly 24% of Nevada adults reported feeling restless and/or fidgety, almost 15% felt that everything they did took effort, and approximately 7.6% felt worthless a little bit of the time in the past 30 days.

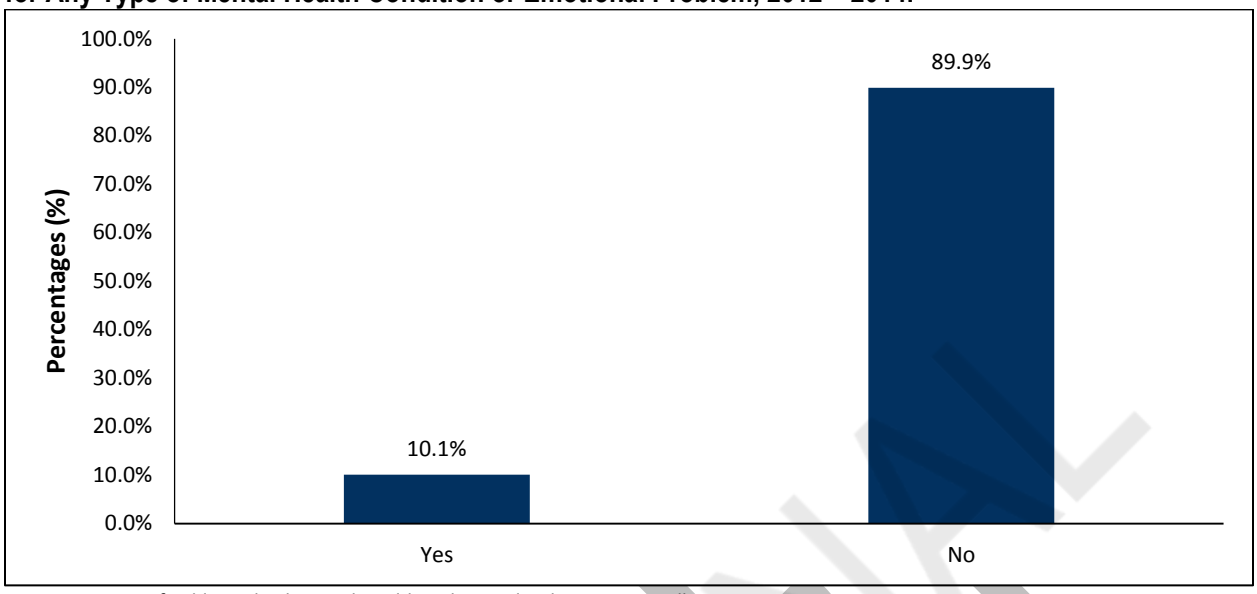
Figure 34. Percentages of Adult Residents Who Experienced Poor (Physical or Mental) Health that Prevented them from Doing Usual Activities, 2015.



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

Nevada adult residents were asked how many days, if any, did a mental health condition or emotional problem kept them from doing their work duties or other usual activities. Nearly 78% reported missing no day or work or activities, over 12% experienced missing 1 – 9 days, and over 10% missed 10 or more days of work or usual activities due to a mental health condition or emotional problem.

Figure 35. Percentages of Adult Nevada Residents Who are Taking Medication or Receiving Treatment for Any Type of Mental Health Condition or Emotional Problem, 2012 – 2014.



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

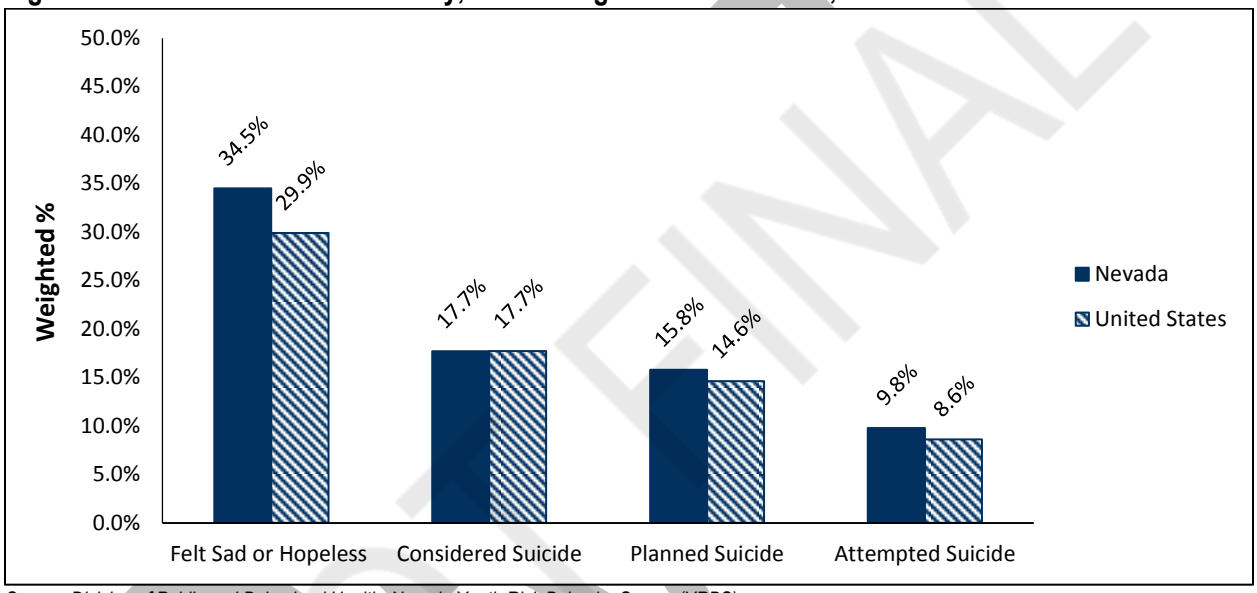
Nevada residents were asked if they were taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem. Nearly 90% reported they were not, and just over 10% reported taking medication and/or seeking treatment for a mental health condition or emotional problem.

Youth Behavior Risk Factors

The data in this section is provided through a survey from the Youth Risk Behavior Surveillance System (YRBSS) for Nevada's high school and middle school students. YRBSS is a national surveillance system that was established in 1991 by the Centers for Disease Control (CDC) and Prevention to monitor the prevalence of health risk behaviors among youth. It is an anonymous and voluntary survey of students in grades 6 through 8 (middle school survey) and 9 through 12 (high school survey).

High School Summary (Grades 9-12)

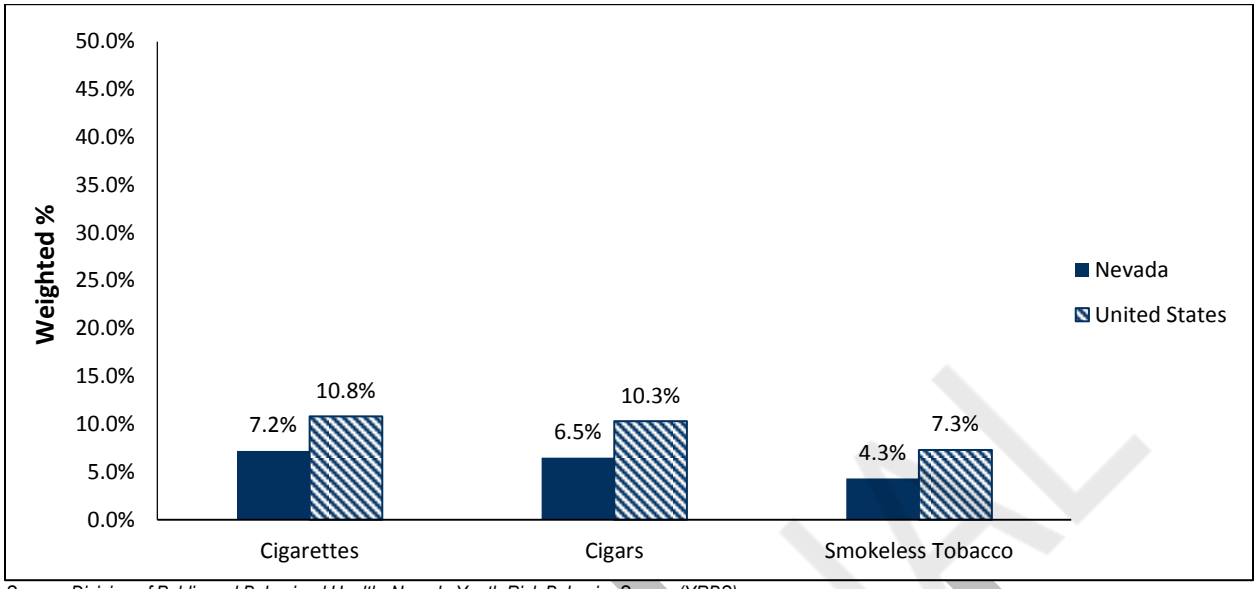
Figure 36. Emotional Health Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 34.5% of Nevada high school students have felt sad or hopeless in the last 12 months. Additionally, 21.5% of students intentionally cut or burned themselves without wanting to die in the past 12 months. About 18% of students have considered suicide, while 16% have made a plan to commit suicide in the past 12 months. Almost 10% of high school students in Nevada have actually attempted suicide in the past 12 months.

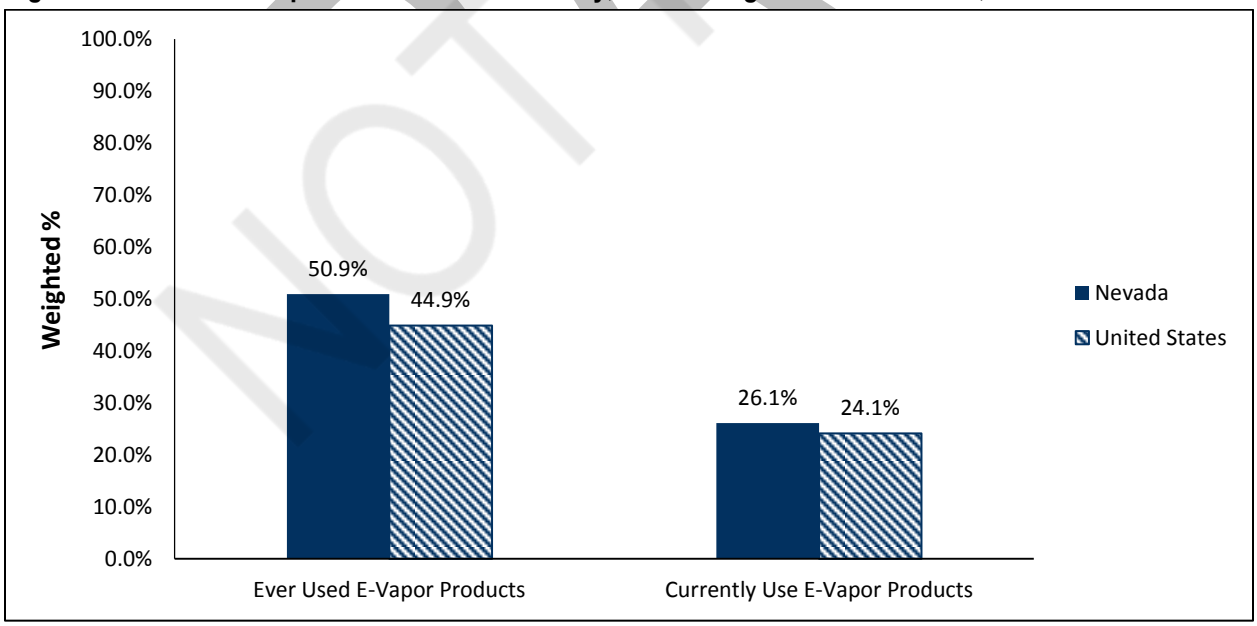
Figure 37. Current Tobacco Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Around 14% of high school students in Nevada are currently using tobacco. About 7% of these high school students smoke cigarettes, while 6% are currently smoking cigars. About 4% are using smokeless tobacco products.

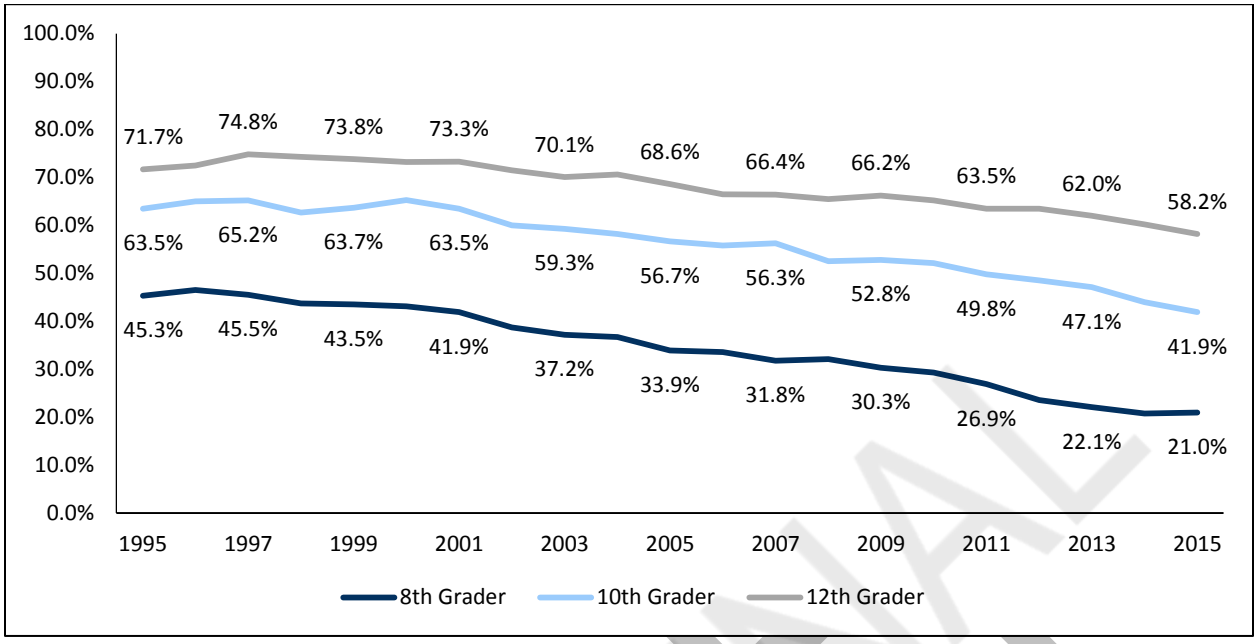
Figure 38. Electronic Vapor Product Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

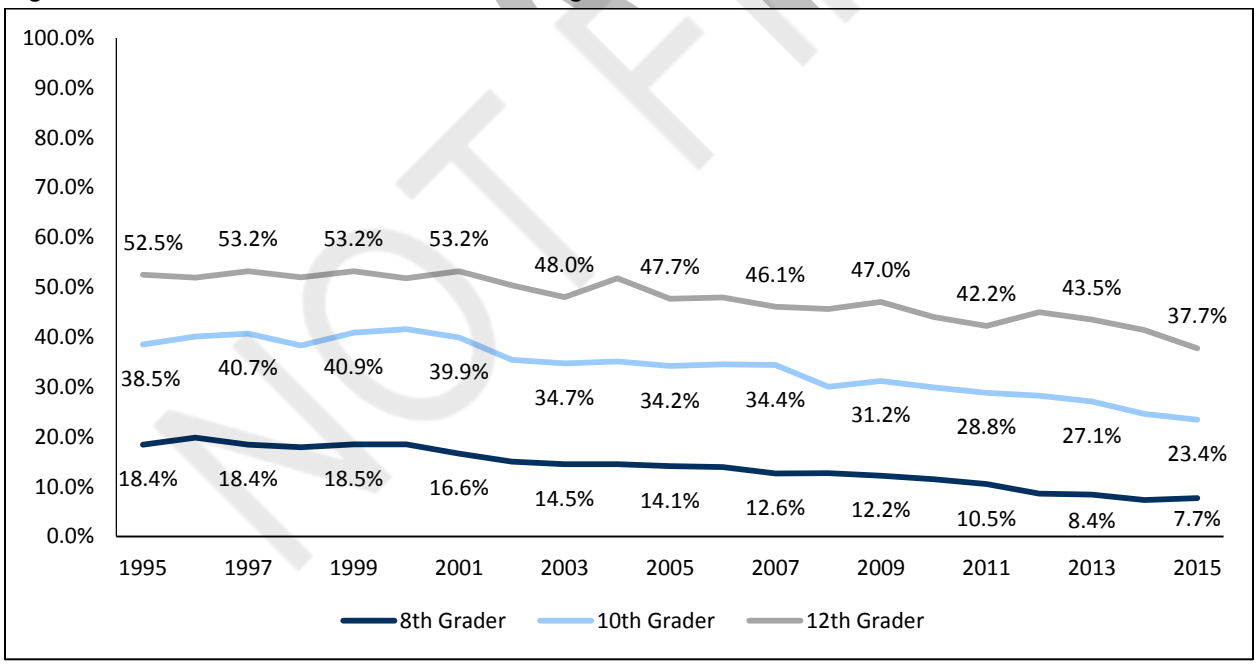
About half (50.9%) of all high school students reported ever using electronic vapor products and over one quarter (26.1%) of high school students reported using electronic vapor products in the past 30 days.

Figure 39. Trends in Annual Prevalence of Any Use of Alcohol, United States, 1995-2015.



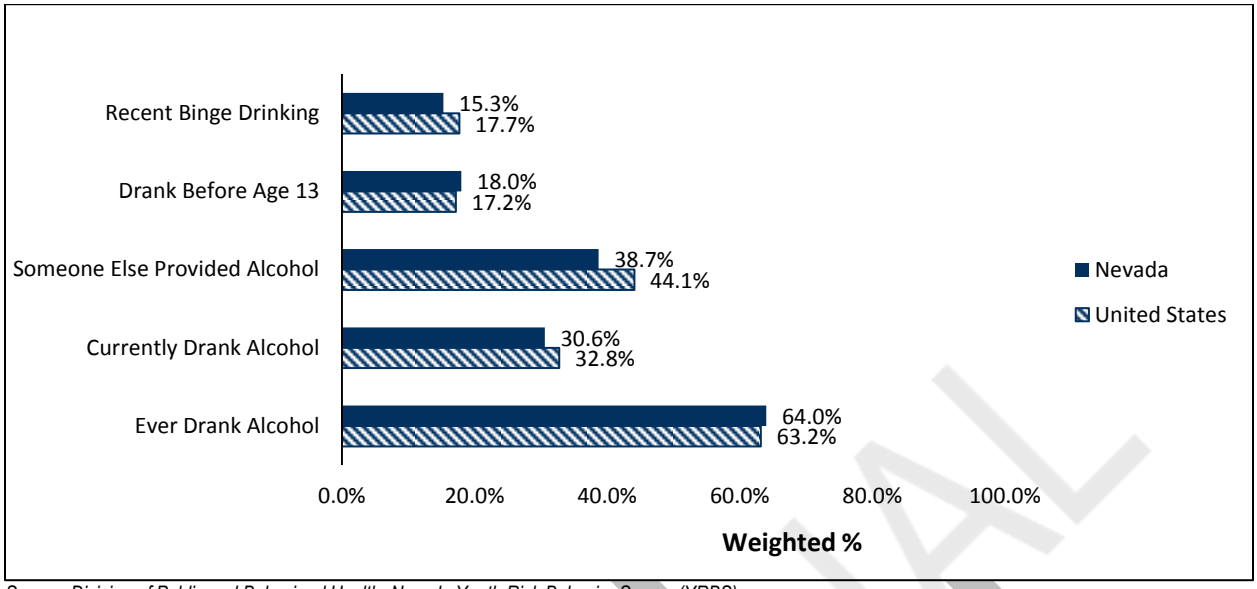
Source: Monitoring the Future Survey

Figure 40. Trends in Annual Prevalence of Being Drunk from Alcohol, United States, 1995-2015



Source: Monitoring the Future Survey

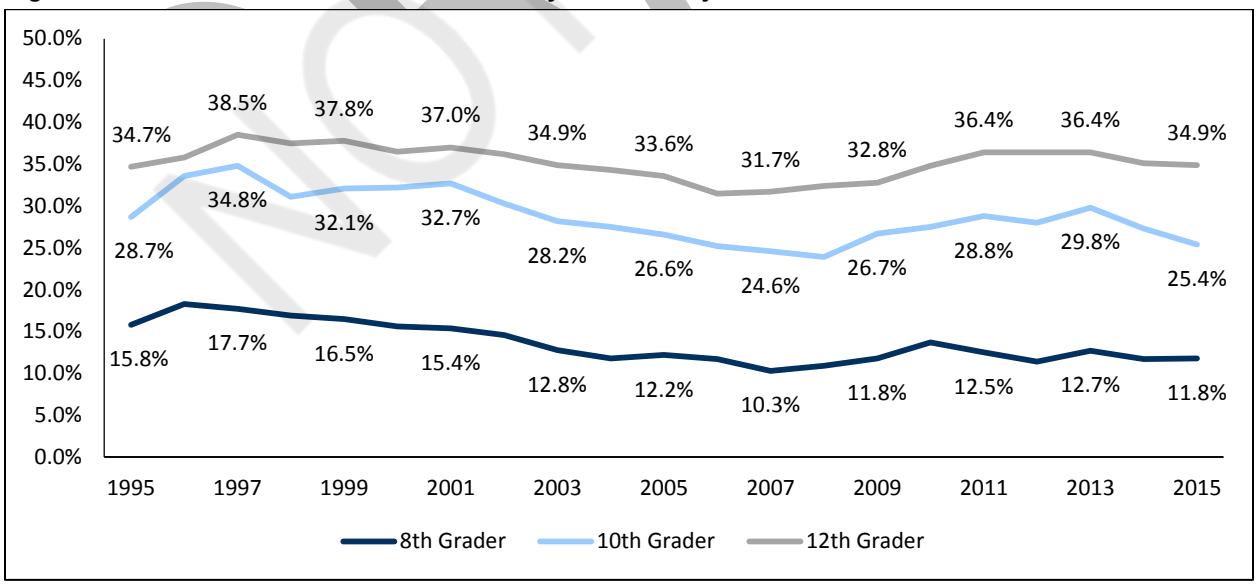
Figure 41. Alcohol Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

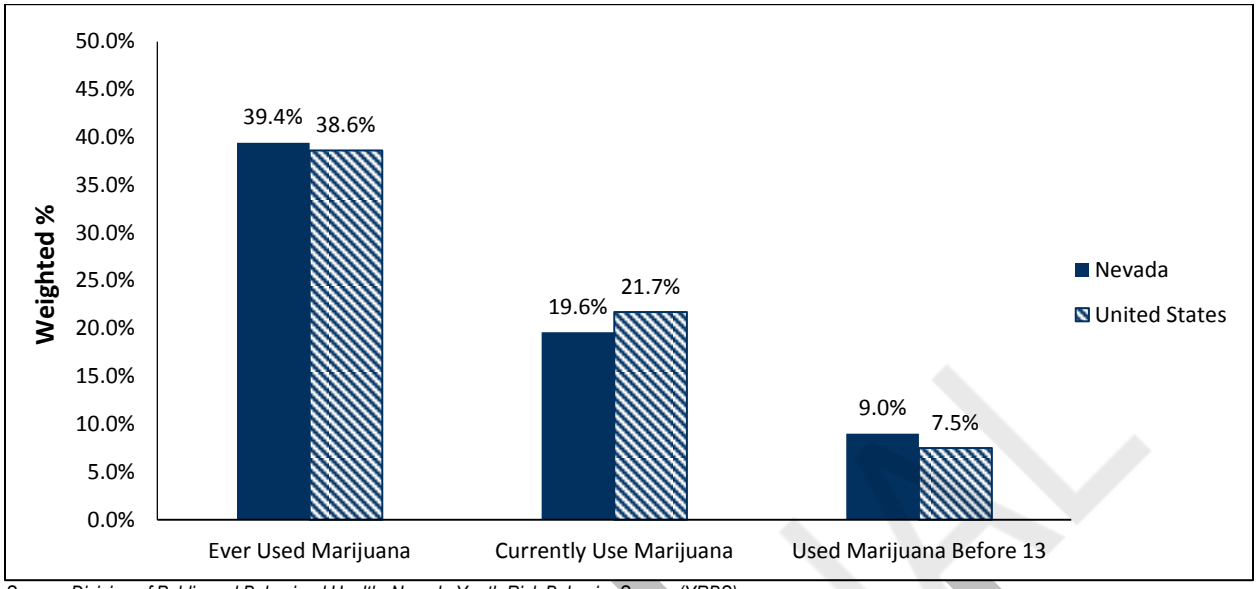
Approximately two-thirds (64%) of high school students in Nevada have had at least one drink of alcohol (more than a few sips). About 31% of high school students currently drink. Nearly 40% of high school students had alcohol provided to them by someone else. About 18% of Nevada high school students had alcohol before the age of 13 years, and over 15% of students had a recent binge drinking experience (had at least 5 drinks in a couple of hours in the past 30 days).

Figure 42. Trends in Annual Prevalence of Any Use of Marijuana/Hashish, United States, 2015.



Source: Monitoring the Future Survey

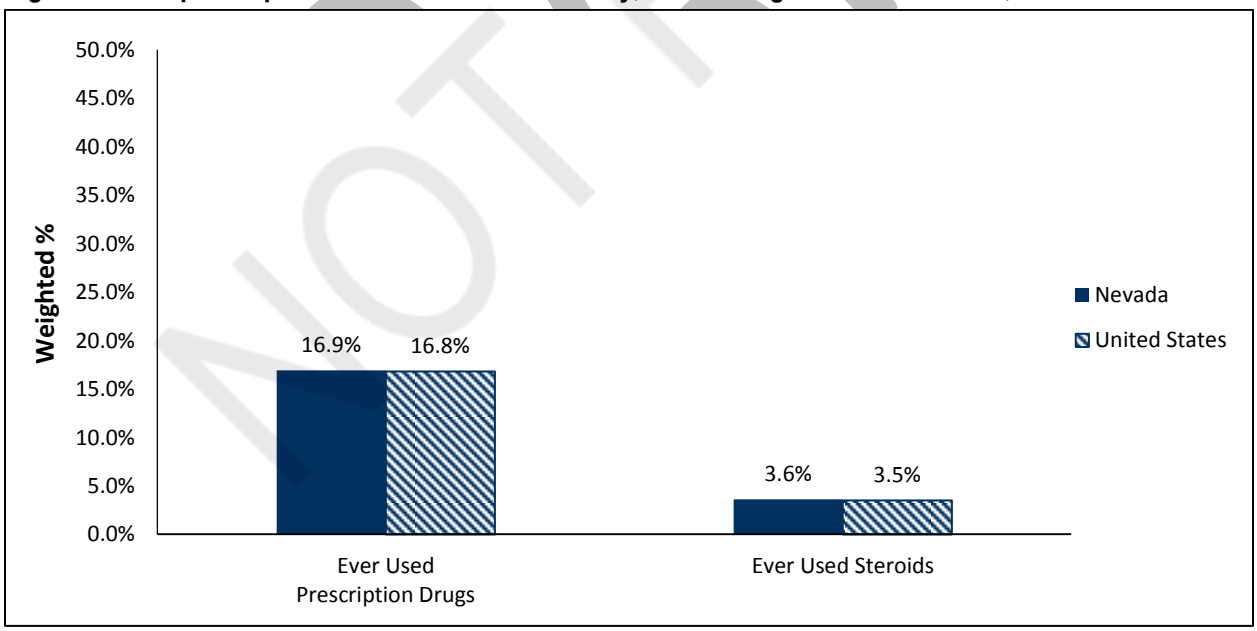
Figure 43. Marijuana Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 40% of high school students in Nevada reported trying marijuana, and 20% have used marijuana in the past 30 days. Approximately 10% of high school students have tried marijuana before the age of 13 years.

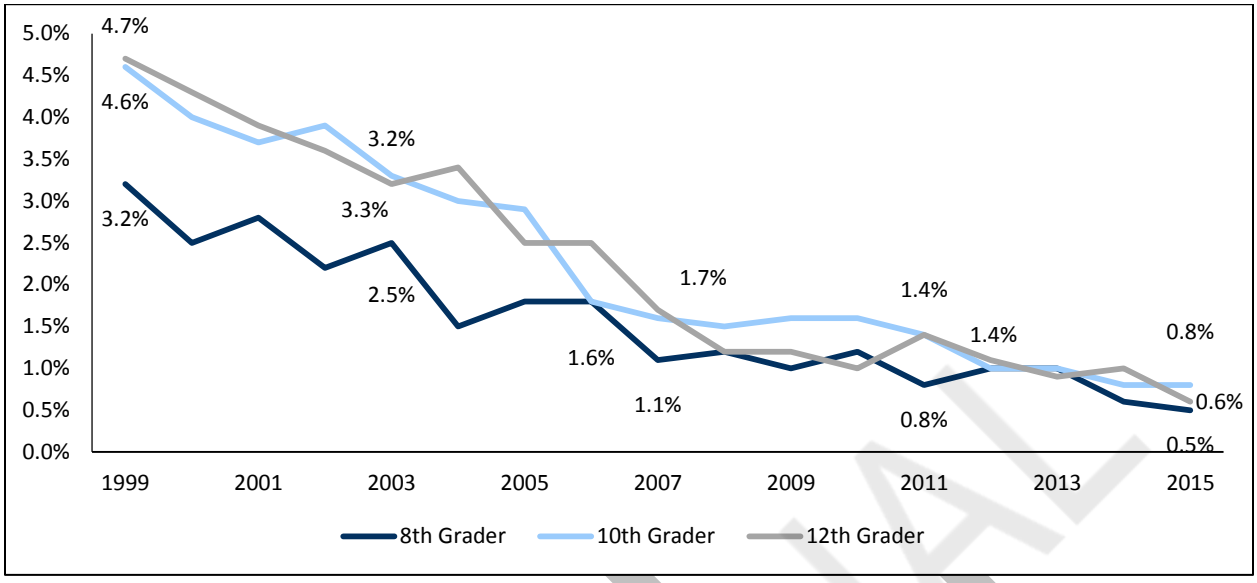
Figure 44. Nonprescription Substance Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

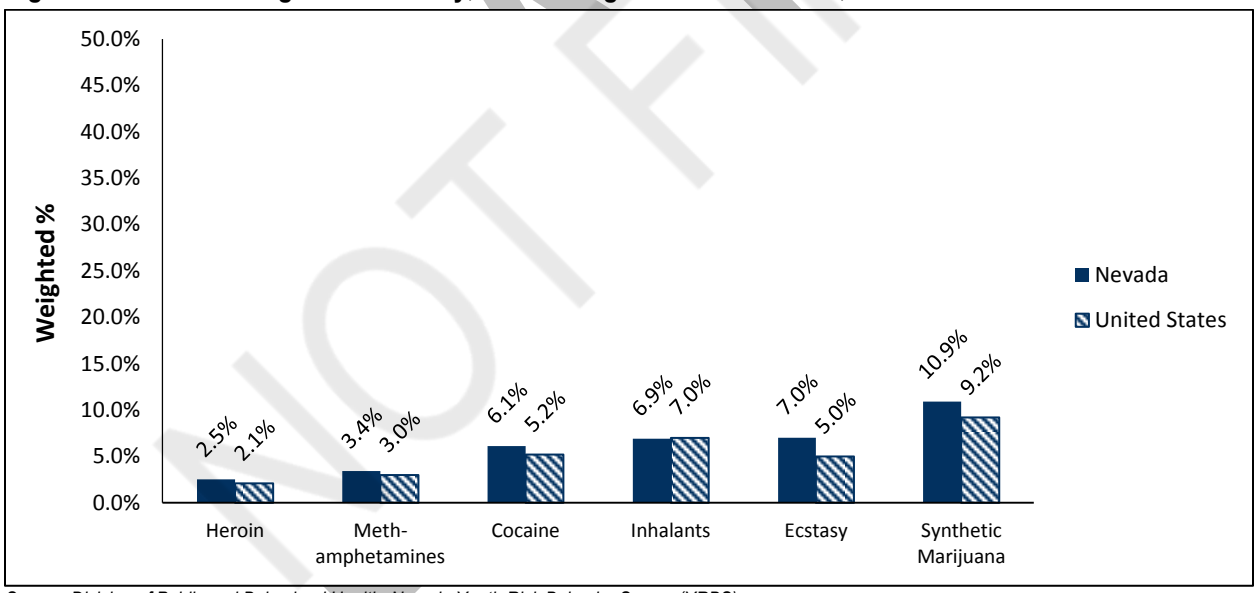
Approximately 17% of high school students in Nevada have already tried prescription drugs that were not prescribed to them in their lifetime, while about 10% of students have used them in the past 30 days. About 4% have tried non-prescribed steroids.

Figure 45. Trends in Annual Prevalence of Any Use of Methamphetamines, United States, 1999-2015.



Source: Monitoring the Future Survey

Figure 46. Lifetime Drug Use Summary, Nevada High School Students, 2015

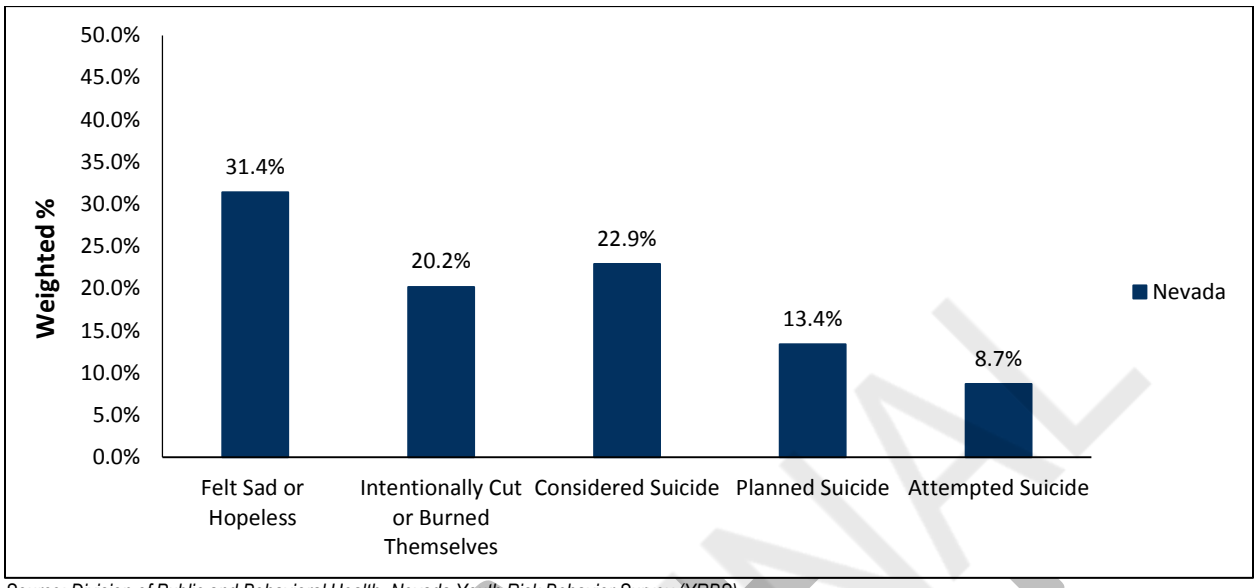


Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

In terms of substance abuse among high school students in Nevada, nearly 11% have used synthetic marijuana, the highest percentage of the select substances. About 7% have taken ecstasy, and 7% of students have tried inhalants. About 6% of students have used cocaine, 3% have used methamphetamines, and almost 3% have used heroin.

Middle School Summary (Grades 6-8)

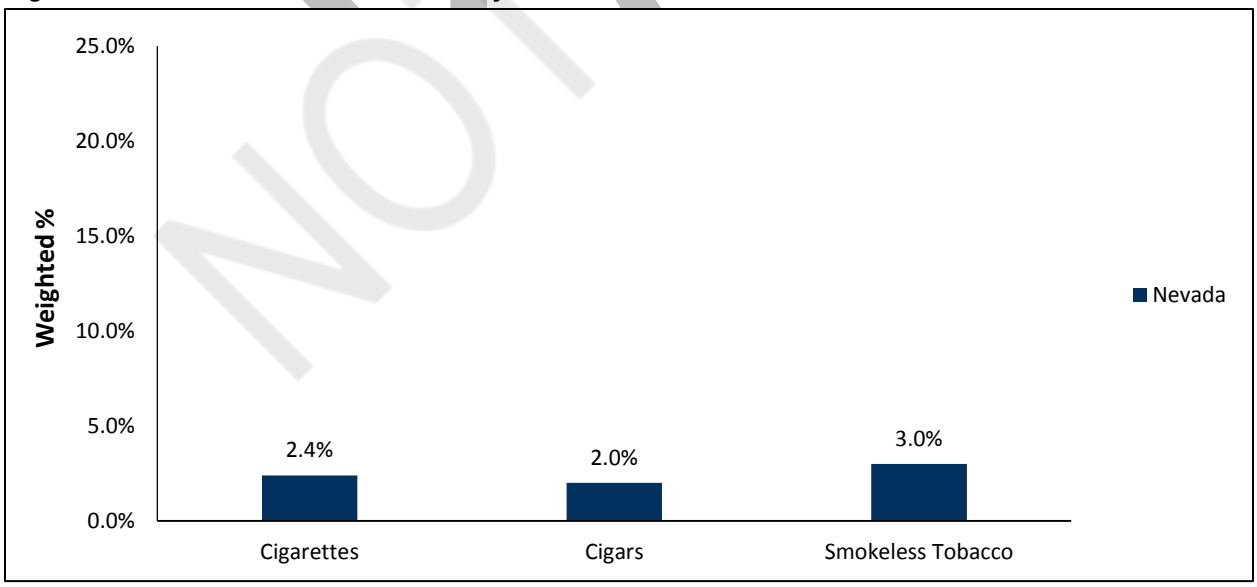
Figure 47. Emotional Health Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 32% of Nevada middle school students have felt sad or hopeless in the last 12 months. Additionally, 21% of students ever intentionally cut or burned themselves without wanting to die. About 23% of students have considered killing themselves, while 13% have made a plan to kill themselves. Almost 9% of middle school students in Nevada have ever tried to kill themselves.

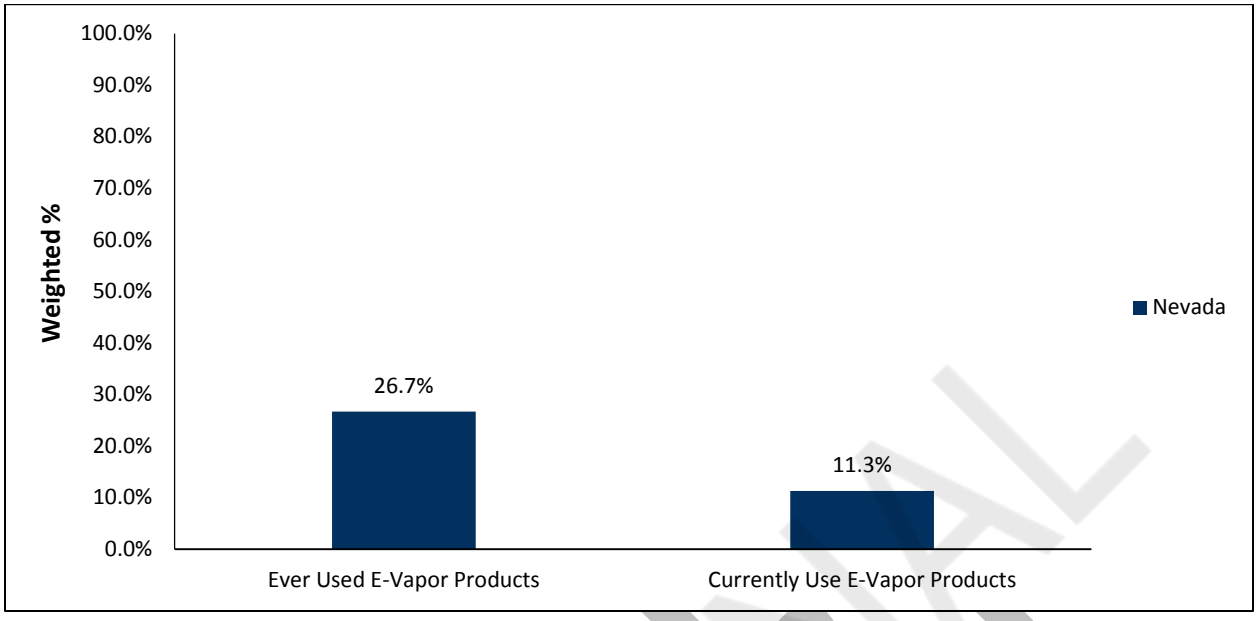
Figure 48. Current Tobacco Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Around 4% of middle school students in Nevada are currently using tobacco. About 2% of these middle school students smoke cigarettes, while 3% are currently smoking cigars. About 2% are using smokeless tobacco products.

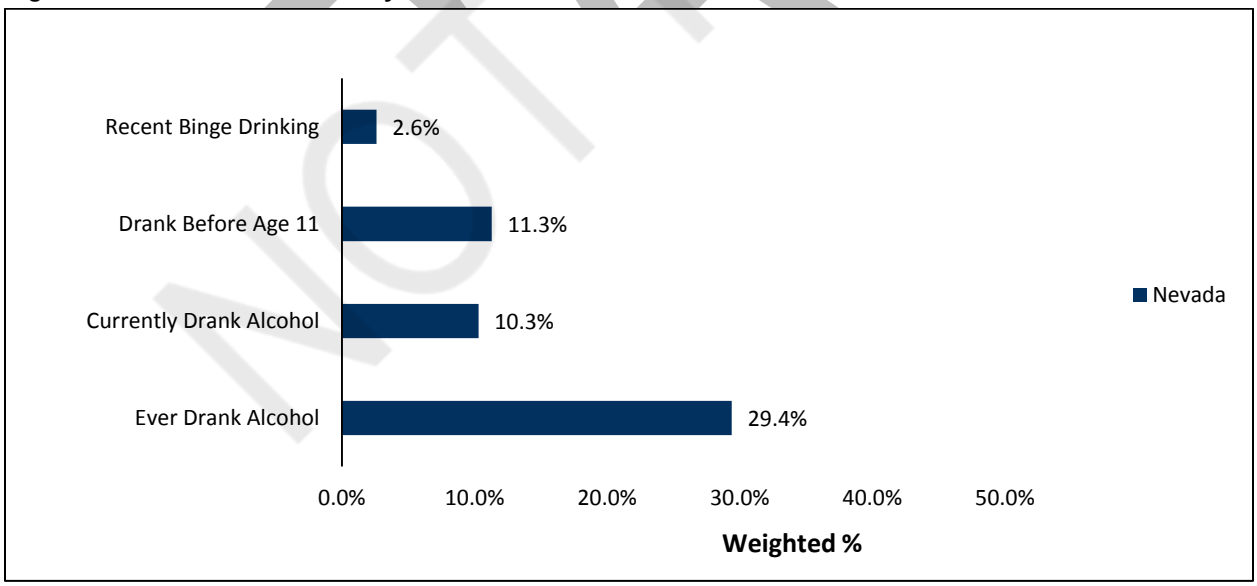
Figure 49. Electronic Vapor Product Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

About one quarter (26.7%) of all middle school students reported ever using electronic vapor products and more than one-tenth (11.3%) of middle school students reported using electronic vapor products in the past 30 days.

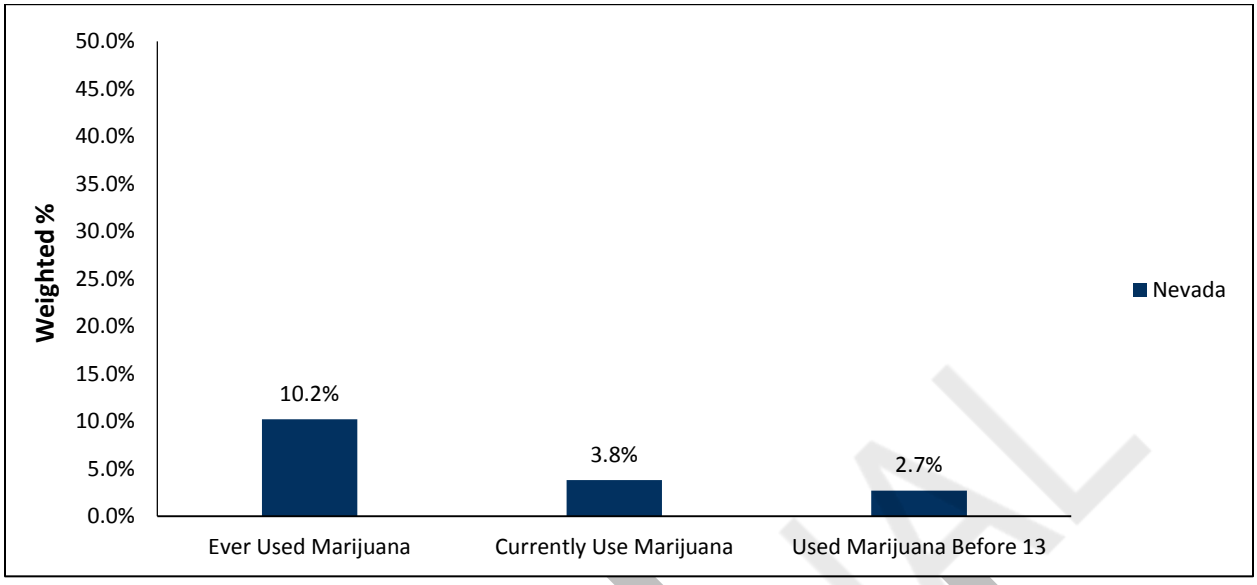
Figure 50. Alcohol Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately one third (29.4%) of middle school students in Nevada have had at least one drink of alcohol (more than a few sips). About 10% of middle school students currently drink. About 11% of Nevada middle school students had alcohol before the age of 11 years, and over 2% of students had a recent binge drinking experience (had at least 5 drinks in a couple of hours in the past 30 days).

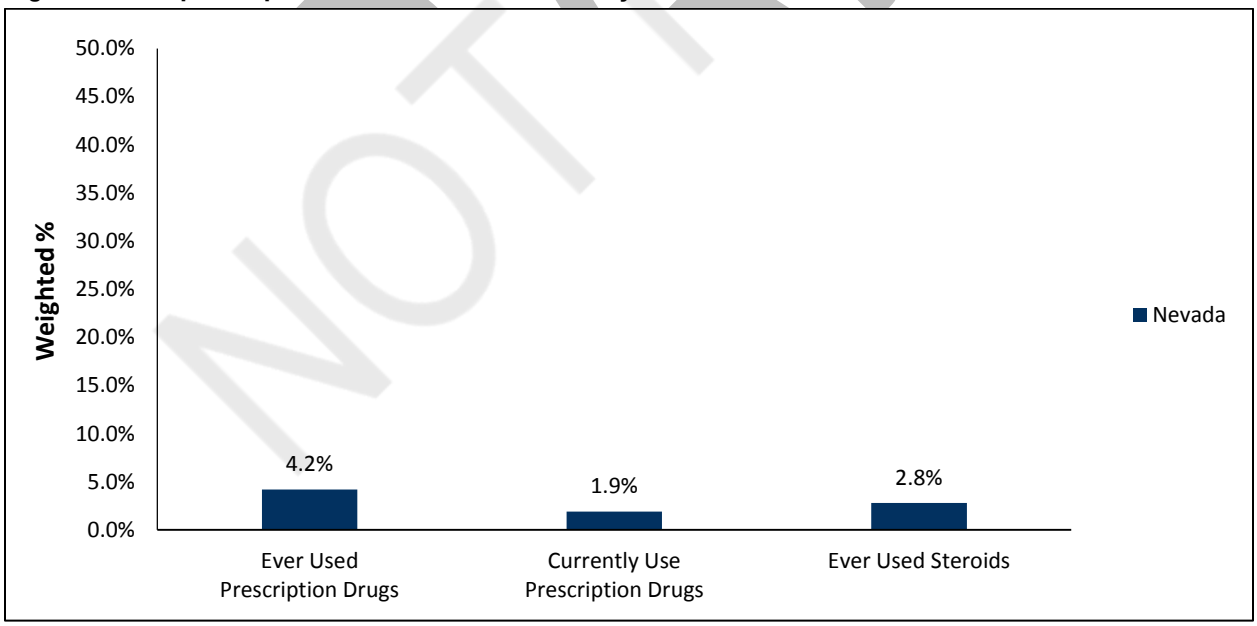
Figure 51. Marijuana Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 10% of middle school students in Nevada reported trying marijuana, and 4% have used marijuana in the past 30 days. Approximately 3% of middle school students have tried marijuana before the age of 11 years.

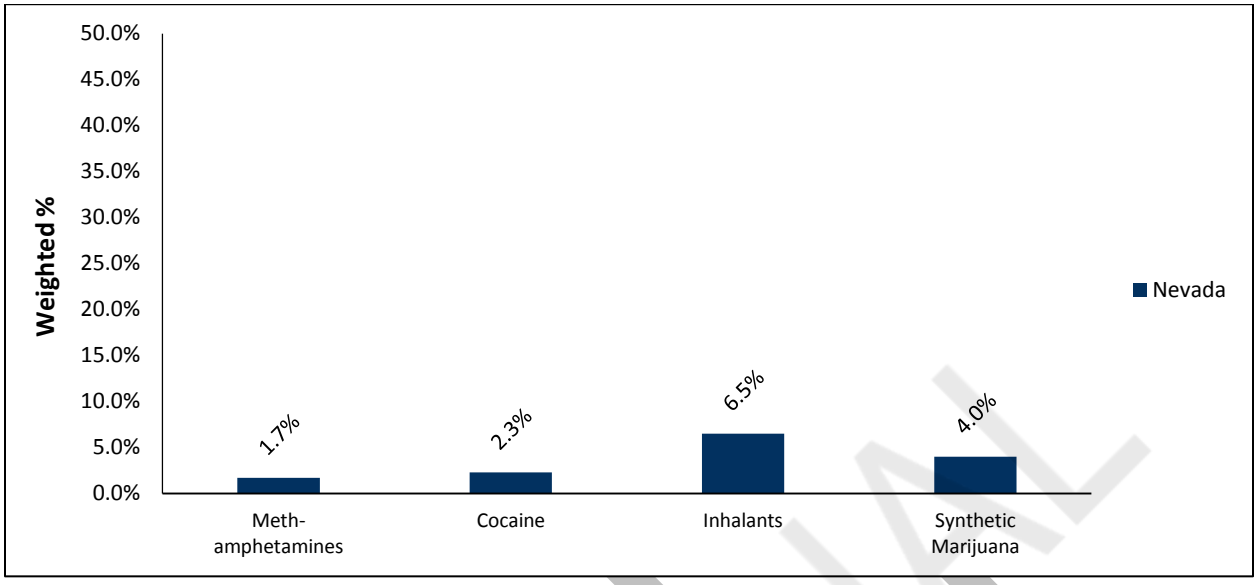
Figure 52. Nonprescription Substance Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 4% of middle school students in Nevada have already tried prescription drugs that were not prescribed to them in their lifetime, while about 2% of students have used them in the past 30 days. About 3% have tried non-prescribed steroids.

Figure 53. Lifetime Drug Use Summary, Nevada Middle School Students, 2015



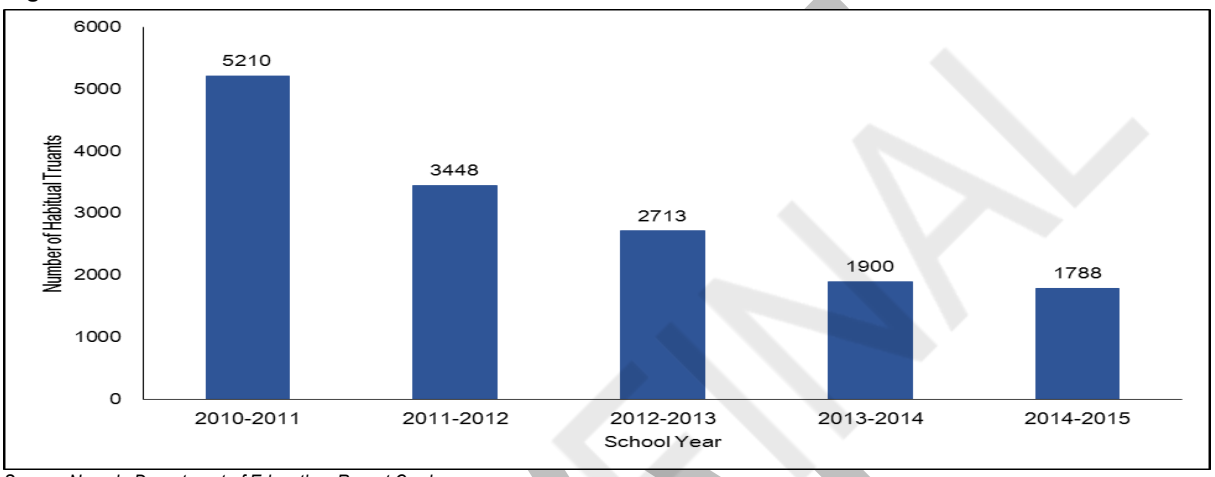
Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

In terms of substance abuse among middle school students in Nevada, nearly 7% have used inhalants, the highest percentage of the select substances. About 2% of students have used cocaine, 2% have used methamphetamines, and 4% have used synthetic marijuana.

School Success

When students' behavioral health needs are not identified, they are more likely to experience difficulties in school, including higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades. Nationally, 50% of students age 14 and older who are living with a mental illness drop out of high school. This is the highest dropout rate of any disability group.

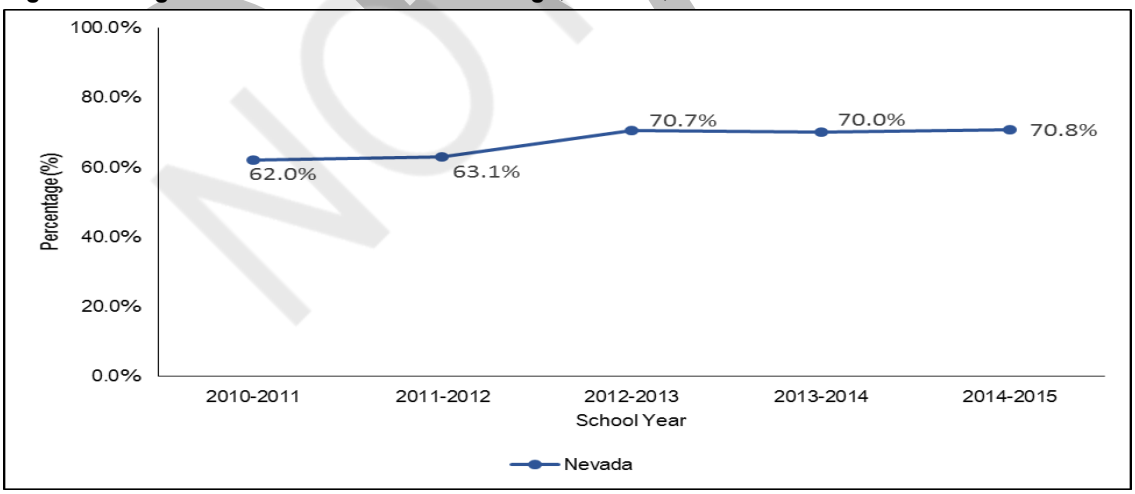
Figure 54. Number of Habitual Truants, Nevada, Class Cohorts 2010 - 2014



Source: Nevada Department of Education, Report Card

Nevada's numbers of habitual truant students has consistently been decreasing since the peak of 5,210 truant students during the 2010 – 2011 school year.

Figure 55. High School Graduation Percentage, Nevada, Class Cohorts 2010 – 2014



Source: Nevada Department of Education, Report Card

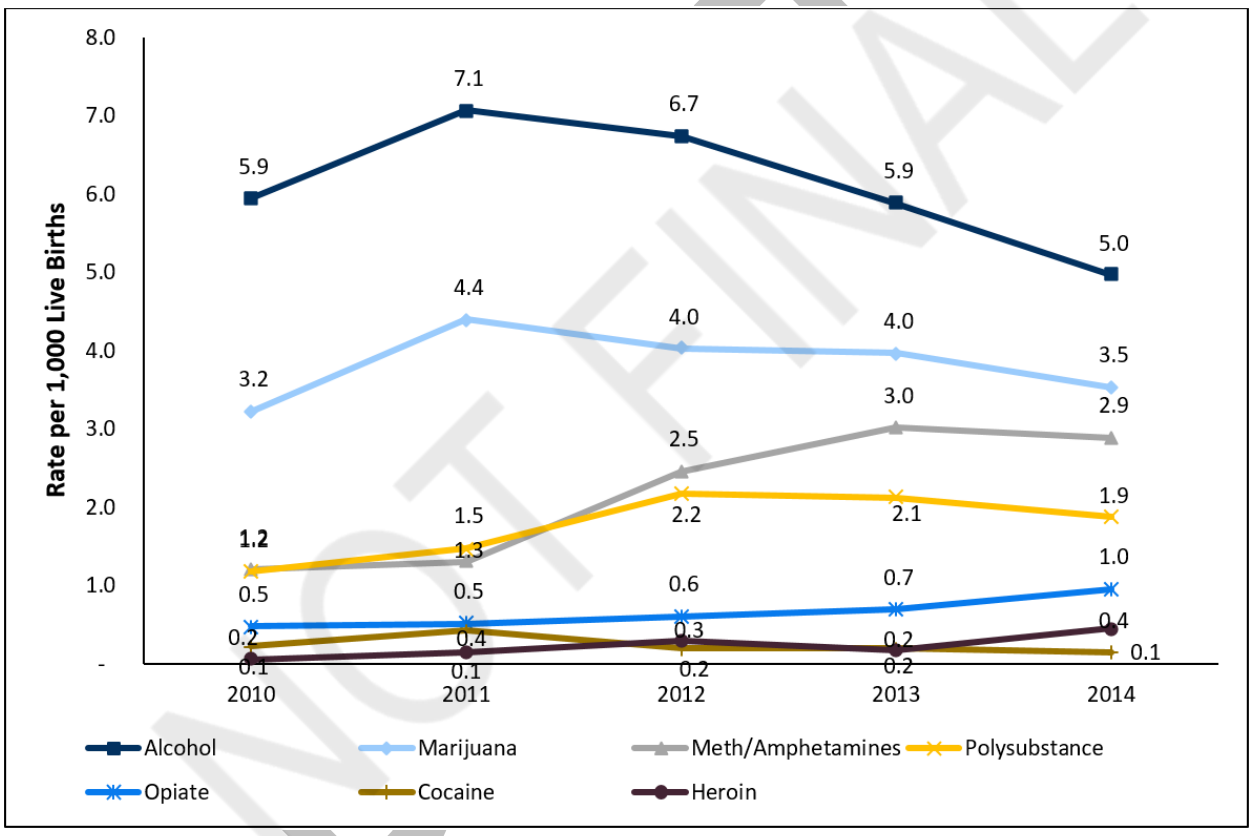
Graduation rate is defined as the rate at which 9th graders graduate by the end of the 12th grade (number of students who graduate in four years with a regular high school diploma divided by the number of students who form the adjusted cohort for the graduating class). Nevada's graduation rate has increased between the 2010 and 2014 class cohorts. In 2010, Nevada's graduation rate was 62.0% and increased to 70.8% in 2014.

Special Populations

Newborns

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average there are 35,126 live births per year to Nevada residents. From 2010 to 2014, 1,074 had alcohol use indicated on the birth certificate. 672 birth certificates indicated marijuana use, 381 indicated meth/amphetamine use, 114 indicated opiate use, and 3 indicated heroin use during pregnancy.

Figure 56. Prenatal Substance Abuse Birth Rates (self-reported) for Select Substances, Nevada 2010-2014.



Source: Division of Public and Behavioral Health, WEVRRS

Of the Nevada mothers who gave birth between 2010 and 2014 that self-reported using a substances while pregnant, alcohol has the highest prenatal substance abuse birth rate, at 5.0 per 1,000 births in 2014. A rate of 3.5 per 1,000 was reported for marijuana, 2.9 per 1,000 reported for meth/amphetamines, and 1.9 per 1,000 births reported multiple drug use. These numbers are likely significantly underestimated because data is self-reported by the mothers, and they may be reluctant to be forthcoming on the birth record for many reasons.

Table 15. Birth Defect Prevalence Rates, Nevada, 2010-2014

Category	Indicator	Prevalence Rate Per 10,000 Live Births
Cardiovascular	Aortic valve stenosis	1.31 (1.04-1.58)
	Atrioventricular septal defect (endocardial cushion defect)	1.94 (1.61-2.27)
	Coarctation of aorta	6.04 (5.45-6.63)
	Common truncus	0.46 (0.29-0.62)
	Double outlet right ventricle (DORV)	1.03 (0.78-1.27)
	Ebstein anomaly	0.40 (0.25-0.55)
	Hypoplastic left heart syndrome	1.82 (1.50-2.15)
	Interrupted aortic arch (IAA)	0.63 (0.44-0.82)
	Pulmonary valve atresia and stenosis	9.17 (8.45-9.90)
	Single ventricle	0.40 (0.25-0.55)
	Tetrology of Fallot (TOF)	2.91 (2.50-3.31)
	Total anomalous pulmonary venous connection (TAPVC)	0.57 (0.39-0.75)
	Transposition of the great arteries	0.34 (0.20-0.48)
	Tricuspid valve atresia and stenosis	0.63 (0.44-0.82)
Central Nervous System	Anacephaly	0.34 (0.20-0.48)
	Encephalocele	0.68 (0.49-0.88)
	Holoprosencephaly	4.45 (3.94-4.95)
	Spina Bifida without Anecephalus	2.11 (1.76-2.46)
Chromosomal	Trisomy 13 (Patau Syndrome)	0.85 (0.63-1.08)
	Trisomy 18 (Edwards syndrome)	1.08 (0.83-1.33)
	Trisomy 21 (Down syndrome)	12.20 (11.36-13.03)
	Turner syndrome	0.57 (0.39-0.75)
Ear	Anotia/microtia	0.51 (0.34-0.68)
Eye	Anophthalmia/microphthalmia	1.31 (1.04-1.58)
	Congenital cataract	0.80 (0.58-1.01)
Gastrointestinal	Biliary atresia	0.57 (0.39-0.75)
	Cloacal exstrophy	2.79 (2.39-3.19)
	Esophageal atresia/tracheoesophageal atresia/stenosis	1.82 (1.50-2.15)
	Rectal and large intestinal atresia/stenosis	3.31 (2.87-3.74)
	Small intestinal atresia/stenosis	3.19 (2.76-3.62)
Genitourinary	Bladder extrophy	0.28 (0.16-0.41)
	Congenital posterior urethral valves	0.46 (0.29-0.62)
	Hypospadias	18.86 (17.83-19.90)
	Renal agenesis/hypoplasia	3.48 (3.03-3.92)
Musculoskeletal	Clubfoot	11.97 (11.14-12.79)
	Craniosynostosis	7.07 (6.43-7.70)
	Diaphragmatic hernia	1.99 (1.66-2.33)
	Gastroschisis	3.93 (3.46-4.41)
	Omphalocele	1.14 (0.88-1.39)
	Reduction defects	2.74 (2.34-3.13)
Orofacial	Cleft lip only	2.45 (2.08-2.82)
	Cleft lip with cleft palate	6.38 (5.78-6.99)
	Cleft palate only	4.22 (3.73-4.71)
	Cloanal atresia	0.97 (0.73-1.20)
Substance Abuse	Anti Infectives	0.06 (0.00-0.11)
	Cocaine	0.85 (0.63-1.08)
	Fetus/Newborn affected by maternal alcohol use	0.11 (0.03-0.19)
	Narcotics	7.24 (6.60-7.88)
	Other Substances Affecting Fetus	7.69 (7.03-8.36)

Source: Division of Public and Behavioral Health, Nevada Birth Outcomes Monitoring System

Lesbian, Gay, Bisexual (LGB)

Table 16. Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation – Nevada Adults, 2014 — 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Binge drinking	22.5%	15.0%	Not significantly different
General health fair or poor	29.9%	18.0%	Significantly Higher
Limited because of physical, mental, or emotional problems	32.2%	21.1%	Not significantly different
Ever told had depressive disorder	37.6%	16.6%	Significantly Higher
Ten or more days of poor mental health	32.8%	13.5%	Significantly Higher
Ten or more days poor mental or physical health kept from usual activities	20.6%	16.3%	Not significantly different

Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System
†Statistical differences could not be determined

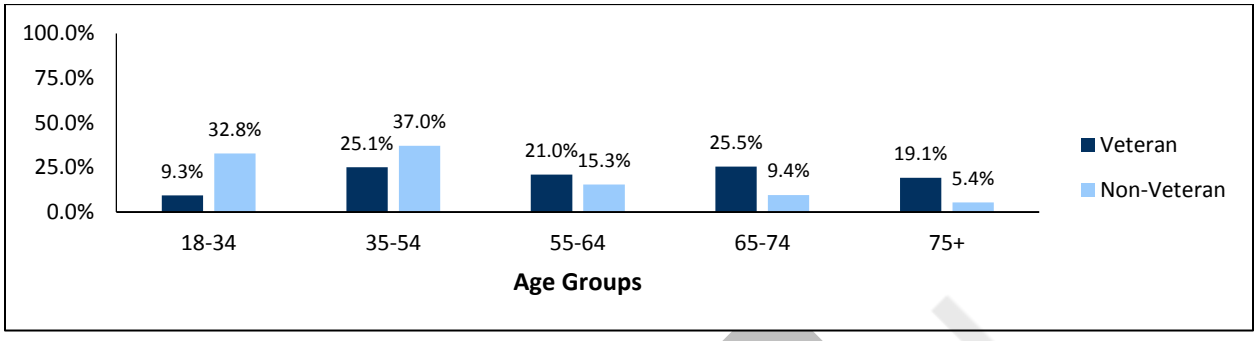
Table 17. Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation — Nevada High School Students, 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Drove when drinking alcohol.	10.6%	5.9%	Significantly Higher
Did not go to school because they felt unsafe at school or on their way to or from school.	13.1%	6.3%	Significantly Higher
Were ever physically forced to have sexual intercourse	24.4%	6.8%	Significantly Higher
Were electronically bullied	26.8%	11.9%	Significantly Higher
Felt sad or hopeless	63.5%	30.3%	Significantly Higher
Seriously considered attempting suicide	41.5%	13.9%	Significantly Higher
Made a plan about how they would attempt suicide	37.2%	12.7%	Significantly Higher
Attempted suicide	28.5%	6.8%	Significantly Higher
Ever tried cigarette smoking	51.7%	29.6%	Significantly Higher
Currently smoked cigarettes	21.3%	5.1%	Significantly Higher
Ever drank alcohol	78.1%	62.1%	Significantly Higher
Currently drank alcohol	46.8%	28.1%	Significantly Higher
Ever used marijuana	57.1%	37.0%	Significantly Higher
Currently used marijuana	34.7%	17.5%	Significantly Higher
Ever used cocaine	13.8%	4.7%	Significantly Higher
Ever used heroin	7.3%	1.5%	Significantly Higher
Ever took prescription drugs without a doctor's prescription	32.1%	14.5%	Significantly Higher
Currently use prescription drugs without a doctor's prescription	21.3%	7.1%	Significantly Higher

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

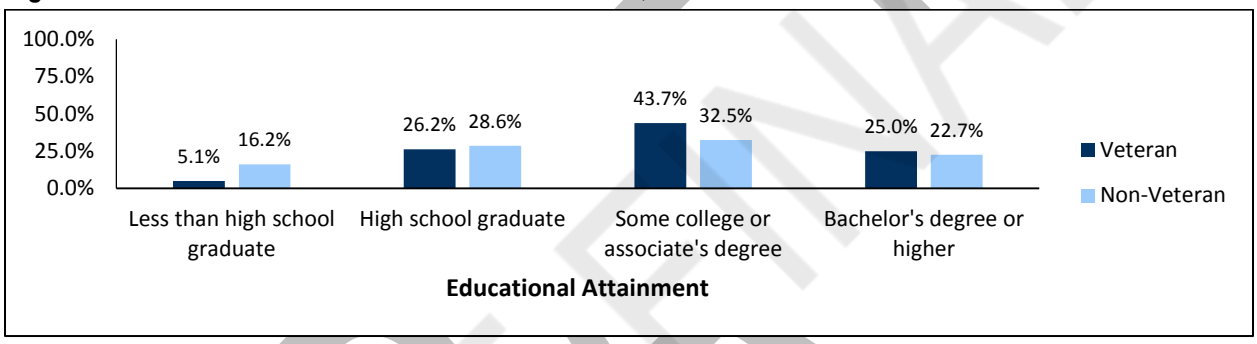
Veterans

Figure 57. Age Distribution of Nevada Veterans, 2015



Source: US Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Figure 58. Education Distribution of Nevada Veterans, 2015



Source: US Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Figure 59. Poverty Status of Nevada Veterans, 2015

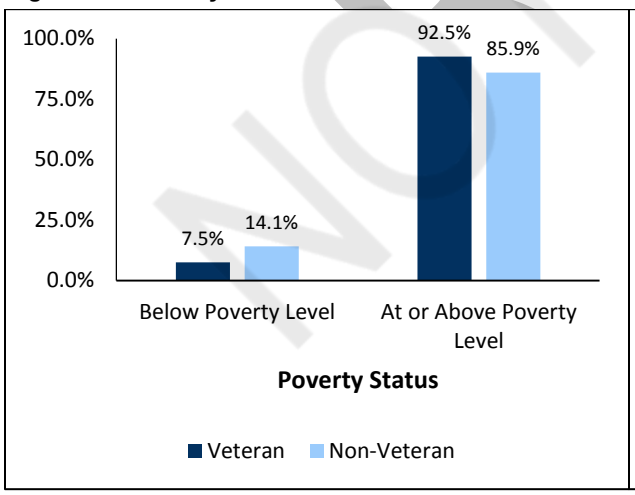
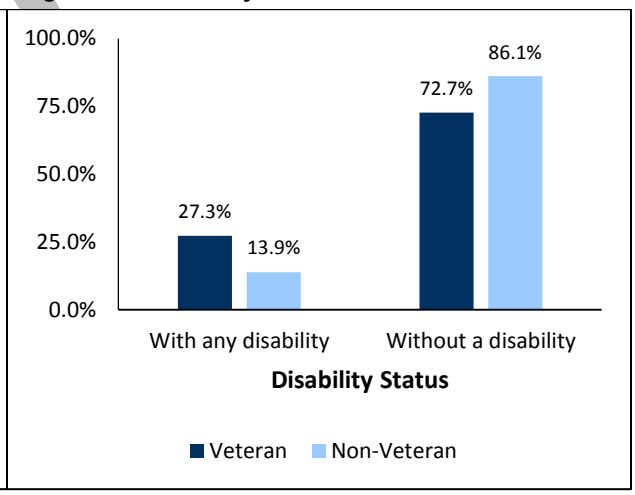


Figure 60. Disability Status of Nevada Veterans, 2015



Source: US Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

There were 851 veterans who were homeless in Nevada during a point-in-time survey* in 2016, 51.4% were sheltered and 48.6% were unsheltered.

* U.S. Dept. Housing and Urban Development (HUD). (2016) "Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations: Nevada." Accessed: https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_NV_2016.pdf

American Indian/Alaskan Native

Table 18. Prevalence Estimates of Health Risk Behaviors, by Race/Ethnicity Status — Nevada High School Students, 2015

Indicator	AI/AN (%)	Nevada (%)	Difference*
Drove when drinking alcohol.	30.5%	21.4%	Not significantly different
Did not go to school because they felt unsafe at school or on their way to or from school.	16.2%	7.6%	Not significantly different
Were ever physically forced to have sexual intercourse	12.0%	9.0%	Not significantly different
Were electronically bullied	22.3%	13.8%	Not significantly different
Felt sad or hopeless	36.4%	34.5%	Not significantly different
Seriously considered attempting suicide	21.1%	17.7%	Not significantly different
Made a plan about how they would attempt suicide	16.4%	15.8%	Not significantly different
Attempted suicide	18.0%	9.8%	Not significantly different
Ever tried cigarette smoking	53.1%	32.4%	Significantly Higher
Currently smoked cigarettes	22.4%	7.2%	Significantly Higher
Ever drank alcohol	46.6%	26.1%	Significantly Higher
Currently drank alcohol	44.3%	30.6%	Not significantly different
Ever used marijuana	59.1%	39.4%	Significantly Higher
Currently used marijuana	36.9%	19.6%	Significantly Higher
Ever used cocaine	17.9%	6.1%	Significantly Higher
Ever used heroin	9.2%	6.9%	Not significantly different
Ever took prescription drugs without a doctor's prescription	11.9%	3.6%	Not significantly different
Currently use prescription drugs without a doctor's prescription	28.5%	16.9%	Not significantly different

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

**While most of these differences are not statistically significant due to small sample size, the highlighted risk behaviors are reflective of questions related to behavioral health among Nevada high school students.*

Table 19. Opioid Related Indicators by Race/Ethnicity Status – Nevada Residents, 2015

Indicator	AI/AN Rate*	Nevada Rate*
Opioid Related Emergency Room Encounter	236.8	244.8
Opioid Related Inpatient Hospitalization	522.9	286.4
Opioid Related Overdose (Death)	21.5	16.2

Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge, Hospital Inpatient Billing, WEVRRS

**Rate per 100,000 population*

Additional Resources

- Coalition Behavioral Health Reports: http://dpbh.nv.gov/Programs/OPHIE/dta/Publications/Public_Health_Informatics_and_Epidemiology_(OPHIE)_-_Publications/
- Nevada Minority Health Report: http://dpbh.nv.gov/Programs/OPHIE/Docs/Minority_Health_Report_2015/
- Nevada Naloxone Emergency Department Encounters: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OPHIE/dta/Publications/Naloxone%20by%20Age.pdf
- Nevada Opioid Surveillance: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OPHIE/dta/Publications/Nevada%20Opioid%20Surveillance%20(2010-2015)%20(2).pdf
- YRBS: Nevada 2015: http://dhs.unr.edu/Documents/dhs/chs/yrbs/2015-YRBS-Reports/2015-Nevada-HS-YRBS-Final.pdf
- YRBS: Nevada Native American 2015: http://dhs.unr.edu/Documents/dhs/chs/yrbs/2015-YRBS-Reports/AIAN%20HS%20Final%20Report%201_13_ADA.pdf
- YRBS: Nevada Sexual Identify Analysis 2015: http://dhs.unr.edu/Documents/dhs/chs/yrbs/2015-YRBS-Reports/2015%20Nevada%20HS%20YRBS%20Sexual%20Identity%20Analysis.pdf

Nevada Rural Children's Mental Health Consortium

Annual Progress Report for Ten-Year Strategic Plan

1/31/2017

Nevada Rural Children's Mental Health Consortium
(RCMHC)
Annual Progress Report for
Ten-Year Strategic Plan

Introduction

The Rural Children's Mental Health Consortium (RCMHC) is comprised of committed professionals, agency personnel, community representatives, parents, foster parents, youth, community business representatives, representatives from the Department of Education, and advocates who come together to support children, youth and families in Rural Nevada with behavioral health needs.

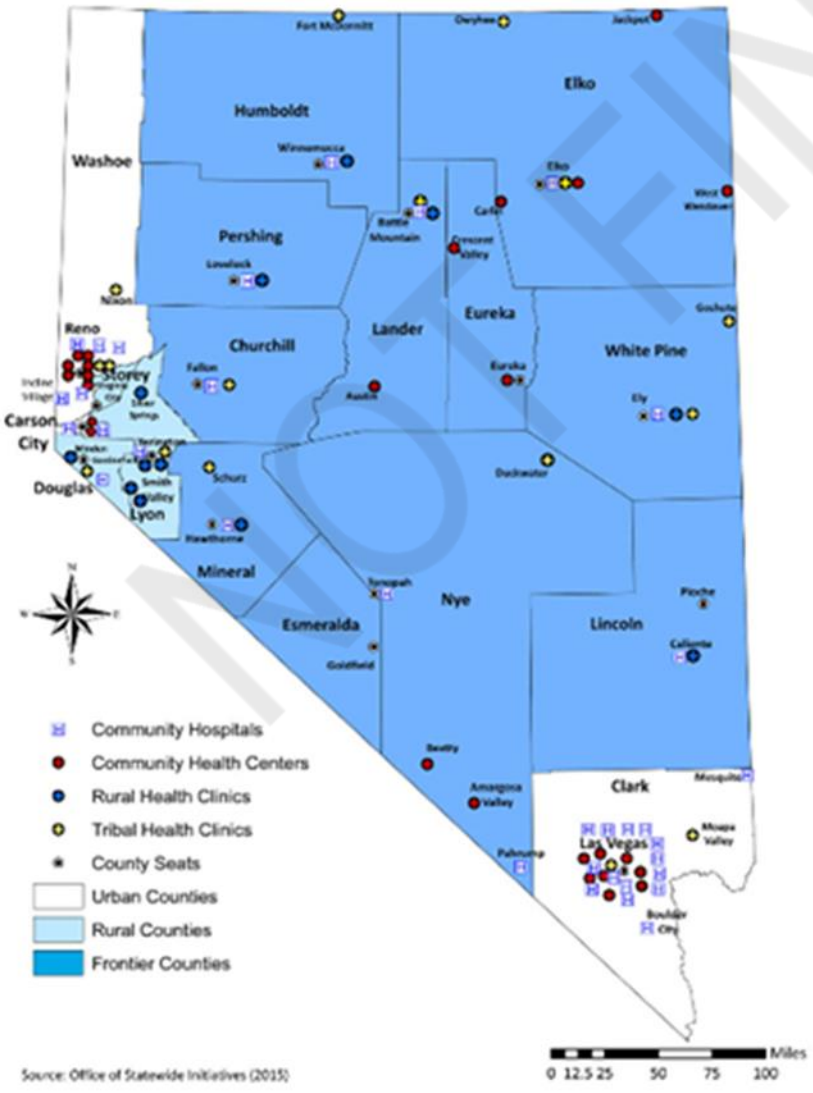
Our mission:

Advocating, Collaborating, & Connecting Children's Mental Health in Rural Nevada

The Rural Children's Mental Health Consortium is driven by a vision which includes a "System of Care" approach to serving those children and their families with an overarching focus on prevention and intervention. The intent of prevention and intervention programs is to move to a proactive system in order to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment by facilitating access to services and supports at the earliest signs of mental health concerns. These principles influence and are infused into the consortium's ideas, efforts, and work in order to develop, support and improve behavioral health throughout Rural Nevada.

Background

The Rural Children's Mental Health Consortium has been tasked with addressing children's mental health needs across fifteen large and diverse counties of Nevada. This includes the urban county of Carson; the three rural counties of Douglas, Lyon, and Storey; and the eleven frontier counties with a population density of seven or less persons per square mile of Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine Counties. Collectively, the rural and frontier counties of Nevada account for approximately 12.1% of the state's population spread across an expansive 87% of the state's land mass (Nevada Rural and Frontier Health Data Book, 2015).



The predominate issues impacting children's mental health in Rural Nevada are complex and intensified by two primary challenges: limited access to services due to geographic distance and insufficient provider availability. As of 2014, from the total of approximately 676,000 children ages 17 and under

living in Nevada, 72,000 lived in the region served by the RCMHC (Nevada State Demographer's Office, 2014).

Acknowledgement

In pursuit of advocating, collaborating, & connecting Children's Mental Health in Rural Nevada, the Rural Children's Mental Health Consortium would like to note the significant progress which has been made over the past year and extend sincere gratitude to all those who have helped and continue to passionately work to realize this purpose.

The following recommendations are respectfully submitted for consideration.

Given the unique challenges of Rural Nevada, the Consortium proposes that rather than simply replicating an "urban" children's mental health model in Rural Nevada, that efforts target the unique barriers of Rural Nevada in order to create a sustainable and accountable System of Care that fits the rural setting.

Goal #1- Address Work Force Development to Provide Appropriate Mental Health Professionals to Rural Nevada

Over the past year, large advances have been made toward the goal of "growing our own" rural providers for the development of a stable workforce that is skilled and responsive to the needs of their communities. The dedicated leadership and staff of the University of Nevada, Reno, School of Social Work have been instrumental in this effort. They have expanded the capacity of the social work program to increase professional output by admitting and thus graduating student cohorts from one time each year (Fall semester) to three times each year (Fall, Spring, and Summer semester). They began on online Masters of Social Work degree in the fall semester of 2016. Through a secured grant, they are offering a number of $10,000 stipends for students to pursue social work education. The increased enrollment and online MSW program are expected to provide additional avenues for members of rural communities to expand the number of mental health professionals at the regional and community level.

Nonetheless, in Rural Nevada, it remains that 100% of the population resides in a mental health professional shortage area (Nevada Rural and Frontier Health Data Book, 2015). The chart below provides

the detailed number of various mental health professionals in Rural Nevada and how they are dispersed by County.

County	Licensed Social Workers	Licensed Clinical Social Workers	Psychiatrists	Licensed Psychologists	Licensed Clinical Professional Counselors	Licensed Alcohol, Drug & Gambling Counselors	Licensed Marriage & Family Therapists
Churchill County	16	7	0	2	0	37	6
Douglas County	1	8	1	5	2	22	23
Elko County	29	6	0	0	2	23	3
Esmeralda County	0	0	0	0	0	0	0
Eureka County	0	0	0	0	0	0	0
Humboldt County	4	3	0	1	0	11	2
Lander County	0	2	0	0	0	5	0
Lincoln County	1	4	0	0	0	2	1
Lyon County	9	3	0	5	3	32	7
Mineral County	0	0	0	0	0	0	1
Nye County	11	6	1	3	1	16	3
Pershing County	2	0	0	0	0	4	0
Storey County	0	0	0	0	0	3	2
White Pine County	4	3	0	1	0	3	1
Carson City	70	0	3	18	0	50	22
Total	147	42	5	35	8	208	71

(Rural and Frontier Health Data Book, 2015)

Recommendations

- Support "growing our own" rural providers for the development of a stable workforce that is skilled and responsive to the needs of their communities.
- Pursue legislative changes that require reasonable and transparent state licensure reciprocity for mental health providers in order to expand the available workforce.

The mental health provider shortage in Rural Nevada could be partially relieved by utilizing licensed out of state providers. It is expected that Rural Nevadan's would benefit from mental health licensure boards that acknowledge the credentialing processes of other states, cooperate with other licensing boards, and have transparent requirements for reciprocity to facilitate potential workforce expansion.

- Work with University partners to identify workforce needs and develop novel solutions to meeting those needs through direct and internet accessible education, outreach, and training.
- Increase opportunities for rural clinical mental health internship and streamline the professional board process to allow mental health interns to learn, practice, and stay in Rural Nevada.

  By increasing the number of board approved clinical mental health internship sites in Rural Nevada, the ability of Rural Nevada to "grow our own" would be significantly impacted. Too often rural practitioners, such as psychologists, leave to pursue an internship and never return. Additionally, clinical mental health internships could benefit from streamlining the professional Board process of internship application and oversight which presently often lacks expediency and a clearly outlined process and progression.
- Adopt a standard of certification with accountability acknowledged by the State for paraprofessionals working in children's mental health.

  Youth could benefit through ensured quality and continuity of care among non-traditional support personnel whom are provided quality training and oversight.

For example, a Peer-to-Peer certification curriculum is moving forward that will provide training in both behavioral health and substance use areas. The peer to peer certification process has completed its curriculum development, has received Board approval for moving forward, and is ready to launch its online 46 hour curriculum January 2, 2017 with a cohort of between 15-20 individuals who will pilot the certification process. The curriculum was developed with resources from other states as well as Florida. Nevada's interest was to create a curriculum that provided and integrated approach in that it would provide training in both behavioral health and substance use areas. When the group was looking for curriculum that provided a blended approach to training peers, they could not find any examples of this approach--so they created their own. In addition to the core curriculum, individuals will be able to specialize in areas like Veteran or adolescent issues for continuing education credits. The Certification will be housed in Nevada's Behavioral Health Association, initially. The planning group would like to pilot the process and get feedback to determine the best way to get this information and training out to those individuals who might be interested in getting "certified." Additionally, Nevada's Chapter 400 defines the role of the "Peer specialist" in terms of their role, expectations and reimbursement rates, this has been approved for many years in Nevada making it a reimbursable service. In 2015 the Peer to Peer Agency was adopted into legislation and the Bureau of Health Care Quality and Compliance oversees this group. There is also additional work being done to expand the roles of people with lived experience in Medicaid funded services. The Department of Health Care Financing and Policy Behavioral Health Unit will be looking at "re-defining" the peer to peer qualifications to align with upcoming changes if needed.

Goal #2- Provide Appropriate Mental Health Providers to Public Schools

Significant progress has been made over the course of the past biennium in regards to the provision of appropriate mental health services in schools. In January 2015 Governor Sandoval announced the creation of the Office for a Safe and Respectful Learning Environment (OSRLE) and included in his budget requests $32 million in state block grants to put social workers and other licensed mental health workers in schools. The legislature approved the creation of the new office within the Nevada Department of Education and ultimately appropriated approximately $17 million under Senate Bill 515 for the Social Workers in Schools (SWxS) Grant.

Application for a SWxS professional required participation in the Nevada School Climate/Social Emotional Learning (NVSCSEL) survey, which was developed in partnership with the American Institutes for Research (AIR) for the purposes of determining need according to scores on school climate and social emotional learning constructs. The state's two largest school districts each utilize their own school climate survey for the purposes of application for SWxS professionals; AIR developed metrics for the comparison and alignment of the data. These surveys will continue to provide insight statewide regarding the needs of schools as well as the impact of increased supports. Implementation of the initial round of surveys for the 17-18 school year has already begun.

In January of 2016, OSRLE awarded $5.6 million in grants to hire more than 160 social workers and other licensed mental health workers in Nevada schools. The Interim Finance Committee approved continued funding of just over $11 million for fiscal year 16-17 and a staggered awards process began in July 2017. As of the end of the calendar year, 210 social workers or other licensed mental health workers had been placed in 144 schools across eleven school districts and

six charter academies. It is expected that a final round of awards will be completed by the end of February and will exhaust all funding appropriated for the SWxS grant program according to the requirements of the legislation to provide for social workers or other licensed mental health workers in schools.

Barriers to hiring school social workers that previously existed in the requirements of Nevada Administrative Code for obtaining an endorsement to serve as a school social worker were addressed in revisions that were approved by the Legislative Commission in June 2016 as well. These barriers included the requirement for a practicum in a school setting as well as the requirement for a current license from the Nevada Board of Examiners for Social Work. These requirements were expanded to include equivalent work experience providing direct services to school aged children and their families, as well as to allow the endorsement to be granted if the applicant holds a current license from another state, allowing for a one year provisionary time period in which the Nevada license could be obtained.

Finally, ongoing efforts to support and advocate for the creation of a school social work course within the Nevada System of Higher Education, and specifically the University of Nevada, Reno, School of Social Work, have resulted in a course being offered at Nevada during the Spring 2017 semester.

Recommendations

- Continue work toward expanding approved clinical internship sites to include school settings in order to both draw professionals to the field as well as to increase the qualifications of school based providers.

Previous collaborations with the Board of Examiners for Social Work produced a draft of a standardized application; it is hoped that continued work moving into the legislative session in preparation for the 17-18 school year will further advance this goal.

- Work with appropriate state agencies and stakeholders to support and advocate for the expansion of school based services that are allowable under the state's Medicaid plan, in order to increase sustainability.
- Continue to support workforce development efforts across a broad range of areas, including provision of an online school social work course such that rural school based providers have access to the increased training, as well as efforts to streamline and clarify the process for granting reciprocal licenses across all behavioral health fields in Nevada.
- In accordance with high levels of feedback from key district level stakeholders, advocate for the expansion of the SWxS grant program to allow for district level hiring as well as the provision of benefits for SWxS grant professionals.

Goal #3 Promote and Support a System of Care Designed for Nevada's Rural Region.

The System of Care is an array of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families. It is organized into a coordinated network that builds meaningful partnerships with families and youth. A System of Care includes behavioral health services that are person-centered and/or family driven, delivered in a manner that is culturally competent, community supportive, and strength based. This System of Care is designed to help youth function better at home, in school, in the community, and throughout life. We support a statewide System of Care that is flexible enough to be adapted to meet the needs of both urban and rural Nevada. Given the unique challenges of

Rural Nevada, simply replicating an "urban" model for System of Care would not be effective. Creating a model that targets the distinctive barriers of Rural Nevada in order to build a sustainable and accountable System of Care that fits rural and frontier communities is the ultimate goal.

Recommendations

- Support continued crisis services to Nevada rural and frontier youth through the Rural Mobile Crisis Response Team (MCRT) to reduce inpatient hospital admissions.

  Since November 2016, the Rural Mobile Crisis Response Team Program has been providing clinical and case management services to Rural and Frontier families experiencing behavioral crisis. The goal of the program is to serve youth in their home communities and help facilitate hospitalization when needed. The most current data, from December 2016 shows a 91% hospital diversion rate. This means that 91% of the youth served across rural Nevada where able to be stabilized in their home communities, where previously they would have been referred to the nearest emergency department for services. MCRT continues to grow, with total hotline calls statewide for the calendar year of 2016 exceeding total calls for MCRT's first year (2014) by almost 1,500.

Rural Mobile Crisis Response Team Program calls for December 2016		
ALL CALLS	**Number**	**% of all calls**
Total Calls	21	100.0%
Team Responded	12	57.1%
Team Did Not Mobilize*	4	19.0%
Information Only Calls	5	23.8%
Incomplete Response**	0	0.0%
Did Not Mobilize - No Team Available	0	0.0%

OUTCOME OF CALLS	**Number**	**% of response calls**
Hospital Diversion	11	91.7%
Hospitalization	1	8.3%
Stabilization Recommended	7	58.3%

Rural Communities that utilized the Rural Mobile Crisis Response Team Program in December

Row Labels	Count
Battle Mountain	2
Carson City	1
Crescent Valley	1
Dayton	1
Douglas	1
Elko	2
Fallon	2
Mesquite	1
Minden	1
Pioche	1
Silver Springs	4
Spring Creek	1
Winnemucca	3
Grand Total	**21**

- Identify and support entities to expand the availability of specialized youth specific training to mental health providers, parents, foster parents, and caregivers in Rural Nevada.

  Historically, many rural mental health providers report that due to no specialized training they will not serve youth. This further impacts the limited availability to services.

  Currently, this goal is striving to be addressed through organizations such as, Nevada PEP whom served 162 families in 2016. They hosted 15 workshops covering topics such as Positive Behavior Interventions, Bullying and Attention Deficit Hyperactivity Disorder. Additional efforts include the recently implemented Advanced Foster Care Program (AFCP) which is a type of foster care sponsored by the Nevada Division of Child and Family Services that helps rural foster children with serious emotional and behavioral problems. The AFCP's mission is to provide support for foster parents in

specialized foster homes in order to increase placement stability and permanency for children and youth experiencing a Serious Emotional Disturbance (SED). The Program trains, mentors, and coaches foster parents in tried and true strategies to help children in their home who also experience mental health issues. Advanced Foster Parents are trained in the evidenced based parenting program Together Facing the Challenge and in principles of Trauma Informed Care. Program coaches go into the home each week to meet with parents to help them develop their skills and abilities in fostering children with an SED designation.

- Identify and support access to internship training sites whose instruction includes child and adolescence service located within rural communities to encourage sustainable workforce development to serve youth.

  Workforce in Nevada's rural region serving youth could be increased by availability of community based internship opportunities. The expectation would be that by "growing our own" professionals they might learn, stay, and practice in their home community.

- Establish a dedicated regional entity to coordinate community resource linkage, align efforts, and leverage existing local services in order to support youth with behavioral health challenges in their home communities.

  Within Rural Nevada Communities, there is often a lack of a regional leadership authority to adequately support "grass roots" regional/community based collaborations. Supporting our rural coalitions increases the ability to find novel solutions to serving youth within their home community through leveraging existing resources and capitalizing on regionally centered assets.

- Support a trauma-informed behavioral health systems and trauma specific services.

  A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

  Individuals impacted by trauma often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services. They may carry any psychiatric diagnosis, and frequently do carry varied diagnoses over time such as Posttraumatic Stress Disorder (PTSD), borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychotic, dissociative disorder, addictive, somatoform, and sexual impairment—all diagnoses which have been related to past trauma.

- Create and utilize unified statewide assessment and data collection tools for youth.

  Nevada youth would benefit from unified statewide assessment and data collection tools that would allow for comprehensive capture of information across the entire state, regional/sample comparison, and verifiable identification of needs to support informed decision making. Unified assessment would help guide evidence based practice for youth and families.

- Promote prevention and intervention: Addressing behavioral health issues early---at a point before escalation to the level of a behavioral health diagnosis.

  Optimal mental health in childhood means reaching developmental and emotional milestones, acquiring healthy social skills, and learning how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. The Rural Children's Mental Health Consortium supports greater focus on prevention rather than crisis response alone. The consortium recognizes the need to place a primary emphasis on prevention and not simply focus on what to do after someone is in crisis; this requires addressing the mental-health concerns, bullying, trauma, substance abuse, and other risk factors that often precede mental health concerns.

  One initiative is the Resources for the Early Advancement of Child Health (REACH) program. This program will be an after school program serving the highest risk schools in Nevada that will be prioritized by the Department of Education mandated environmental scan. The implementation of these innovative preventative changes supports Nevada children in achieving a physical and emotionally safe environment. REACH Program Approval was received from the Center for Medicare and Medicaid Services on November 23, 2016 is currently going to the Board of Examiners for approval in February of 2017. Currently this will be piloted in the rural area.

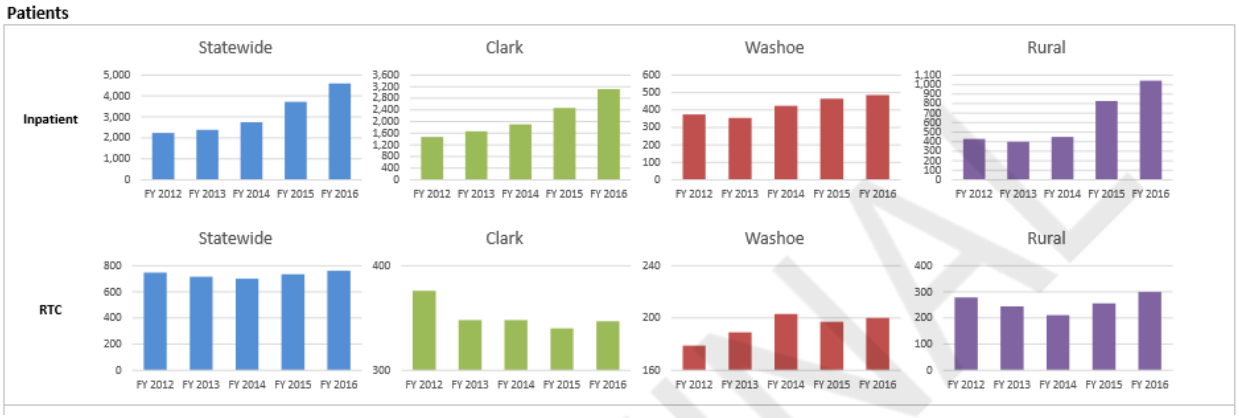
  The Division of Health Care Financing and Policy (DHCFP) is proposing the use of Health Services Initiative (HSI) funding to integrate the Resources for the Early Advancement of Child Health (REACH) program into after school programs serving the highest risk schools in Nevada that will be prioritized by the mandated environmental

scan. The implementation of these innovative changes supports Nevada children in achieving a physical and emotionally safe environment by incorporating the REACH pilot project within the targeted schools. This approach will also allow the program to be scaled up or down based on available funding and the individualized school's needs. The individualized school needs will be identified per data tracking by utilizing the newly implemented statewide longitudinal data system to track outcomes and compare cohorts within the same school as well as compare to schools across the state.

The HSI public health approach allows the services to be provided to all children in a targeted area regardless of payer source. The DHCFP will work with current after-school program(s) to determine capacity for providing the services within their current structure or coordinate with community providers who have the capacity to create a collaboration to provide these services. The DHCFP will be working to identify these groups to determine the best model for payment of these programs based on the community infrastructure and capacity. The HSI option allows the state to take a population health approach to behavioral health and early intervention for children. HSI also provides the flexibility to pilot the rising-risk concept across children ages 10 through 18 with the goal of being able to demonstrate the effectiveness of early intervention through the use of performance measures. The scope of services will target early intervention and preventive services and mental health resources to prevent the onset of a future behavioral health diagnosis. DHCFP provides assurance that the HSI program will not supplant or match the Children's Health Insurance Program (CHIP)

federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

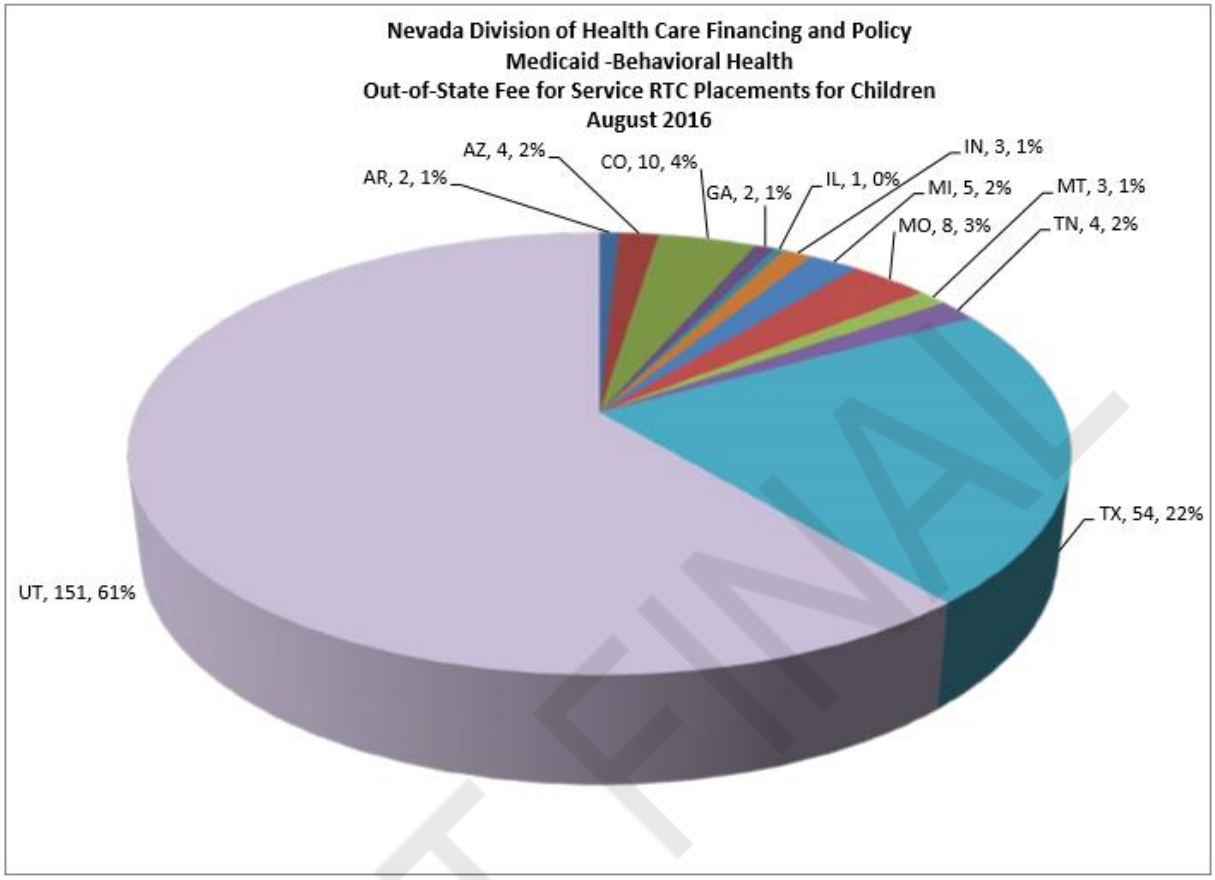
The graph below captures and compares the disproportionate number of Medicaid fee for service inpatient and residential treatment patients from Rural Nevada (approx. 12% of the state population) as compared to Clark and Washoe County for calendar years 2012 through 2016. (Nevada Department of Health Care Financing and Policy, 2016).



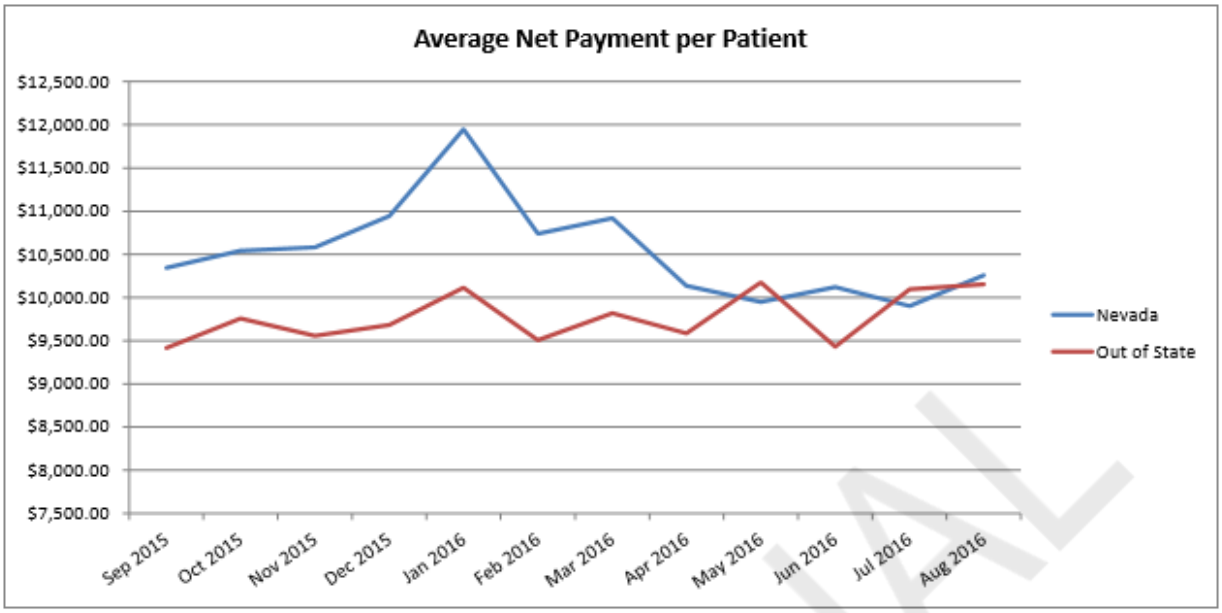
- Support changes to decrease out- of-state placement and increase transitional support to youth receiving treatment in inpatient & residential treatment centers through increased local service array

  The Rural Children's Mental Health Consortium recognizes the significant issues surrounding youth who are placed in intensive inpatient care and out of state residential treatment care. As of August 2016, a total of 245 Nevadan children were in Out-of-State placement, up from 227 in 2015 (Nevada Department of Health Care Financing and Policy, 2015 and 2016). In 2016, the top three diagnoses of these youth were Other persistent mood [affective] disorders, Unspecified mood [affective] disorder, and Bipolar disorder, unspecified (Nevada Department of Health Care Financing and Policy, 2016).

The graph below captures the location by state of the 245 children in out-of-state fee for service residential treatment center placement as of August 2016 (Nevada Department of Health Care Financing and Policy, 2016).



The graph below captures the financial discrepancy in cost between in-state residential treatment center placement vs. of out-of-state residential treatment center placement of patients from Nevada, from September 2015 to August 2016 (Nevada Department of Health Care Financing and Policy, 2016).



- Identify and provide services to tribal children and youth to support social, mental, and behavioral health needs. Provide adequate mental health providers with culturally and linguistically appropriate service (CLAS) standards to Tribal populations.

  Children who reside on the reservation are often limited in the spectrum of behavioral health care services they receive. The Consortium recognizes the unique needs and cultural considerations of each of Nevada's Tribes and seeks to build stronger partnerships with tribal leaders to support healthy outcomes for all children.

- Support the implementation and use of Peer-to-Peer Support services

  Peer-to-Peer support services are interventions designed to reduce social and behavioral impairments and restore recipients to their highest level of functioning. Peer-to-Peer supporters (e.g. peer supporters) help the recipient live, work, learn and participate fully in their communities.

- Support statewide efforts in establishment of system of care screenings and monitoring for neurodevelopmental and behavioral health issues.

- Support statewide efforts in trauma informed system approach across business and public sectors.

  Consider innovative and integrative approaches across county and statewide systems.

  A Trauma-Informed System embraces concepts: safety, trustworthiness & transparency, peer support, collaboration & mutuality, empowerment/ voice & choice, and responsiveness to cultural issues

Goal #4 Provide Adequate Bandwidth to Support the Use of Technology and Mental Health Services Provision in Nevada's Rural Region.

The expanded use of technology in the rural region offers a cost-effective opportunity to enhance services for rural families of children with mental health and behavioral disorders. It allows for access to specialized providers that are not present in Rural Nevada, maximizes the productivity of those professionals by eliminating long travel times to reach remote rural locations, and allows children and families to receive care in their home communities.

The enhancement and development of telemedicine services is a statewide goal that is identified in the Nevada System of Care Strategies. The continued struggle at Rural Mental Health Clinics as a result of inability to secure adequate bandwidth has increased to the point of impacting the quality of services for children and adults in rural and frontier communities. Currently, at several Rural Mental Health Clinic locations, days can lapse with no availability or severely interrupted access to internet services due to poor bandwidth. Proposed plans in the past, which have not been completed were to upgrade from 1.5 Mbps to at least 3 Mbps by the end of last fiscal year. At this time, even if these improvements were to be completed, they are insufficient

to meet the growing need to utilize technology. The need to increase bandwidth is imperative to providing vital services including the leveraging of existing providers to the rural regions via telehealth.

Recommendations

- Supply appropriate bandwidth to Rural Nevada locations to allow for quality service delivery and use of telehealth.

In Conclusion

The Rural Children's Mental Health Consortium thanks the many community partners that contributed to this report and looks forward to continuing these efforts to build a stronger system of care for Nevada's children with mental health needs.

Resources

Behavioral Health Planning & Advisory Council Gaps & Recommendations Prioritization Session. Nevada's Behavioral Health Gaps, Priorities and Recommendations; PRESENTATION AND PRIORITIZATION OF STRATEGIC INITIATIVES AND GOALS (July 14, 2015) Facilitated by Social Entrepreneurs, Inc. Available from:http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalBHSP/Docs/BH%20Gaps,%20Priorities,%20and%20Recommendations%20Jul2015.pdf

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Text4baby Substance Use-related Messages

text4baby: Don't start a new medicine or stop your current medicine unless your Dr. tells you to. Info on over-the-counter & prescription medicine: 866-626-6847
text4baby: No empiezes un nuevo medicamento o dejes de tomar un nuevo medicamento al menos que tu Dr. te lo diga. Info. medicinas con y sin receta: 866-626-6847

text4baby: Give baby a good start! Don't drink alcohol, smoke or use drugs. Help with smoking: 800-784-8669. Drugs & alcohol: 800-662-4357. Info: text4b.org/076
text4baby: Dale un buen comienzo al bebe! No bebas, fumes o consumas drogas. Ayuda si fumas 800-784-8669 drogas y alcohol: 800-662-4357 Info: text4b.org/076s

text4baby: Don't drink any alcohol while pregnant. Alcohol can cause baby to have behavior & learning problems, speech delays & lower IQ. Info: text4b.org/076
text4baby: No tomes alcohol durante tu embarazo. Puede causar que el bebe tenga problemas de desarrollo, aprendizaje y retrasos del habla. Info: text4b.org/076s

text4baby: Moms who smoke have a higher risk of losing their baby through miscarriage or Sudden Infant Death Syndrome (SIDS).
No matter how long you've smoked, you can quit. Get FREE help to stop smoking: 800-784-8669 or visit text4b.org/072.
text4baby: Las mamitas que fuman tienen un riesgo de perder a su bebe o que sea afectado por el Sindrome de Muerte Subita Infantil (SIDS).
No importa cuando tiempo lleves fumando, puedes parar. Obten ayuda GRATUITA para dejar de fumar. Llama al 800-784-8669 o visita text4b.org/072s

text4baby: You shouldn't drink any alcohol while pregnant. Alcohol can cause baby to have behavior/learning problems and speech delay. Info: 866-786-7327.
text4baby: Las embarazadas no deben tomar alcohol. El bebe puede tener problemas de conducta, aprendizaje y retraso al hablar. Info: 866-786-7327.

text4baby: Keep baby away from cigarette & cigar smoke. It hurts their lungs, heart, brain & nose & can raise risk of sudden infant death. Info: text4b.org/010
text4baby: Manten al bebe lejos del humo del cigarrillo y del humo del tabaco. Es malo para los pulmones, el corazon, el cerebro y la nariz.
Tambien puede elevar el riesgo de una muerte subita infantil. Mas informacion en text4b.org/010s

text4baby: Back to work? You can pump milk at work to save for later. Breastfeeding helps you & your baby re-connect at the end of each work day.
Medicine you take while breastfeeding may enter your milk. Ask Dr./midwife (CNM/CM) or lactation consultant before taking any meds. Or call 866-626-6847.
text4baby: Regresaste a trabajar? Alli podras amamantar y guardar la leche para mas tarde. Dar pecho te ayuda a ti y al bebe a reconectarse al fin del dia
Los medicamentos que tomes mientras amamantas pueden pasar a tu leche. Consulta con Dr/partera/consejera de lactancia antes de tomarlos. Llama 866-6266847

text4baby: Share with anyone caring for baby the safest way for baby to sleep is on their back, in a crib, with no stuffed animals, blankets or pillows.
Smoke raises risk of sickness or death from SIDS. Protect baby & don't let anyone smoke near baby at home or in the car. Info: text4b.org/010
text4baby: Es mas seguro que los bebes duerman boca arriba en una cuna. Sin juguetes, mantas o almohadas en la cuna.
El humo aumenta los riesgos de enfermedades y la muerte subita infantil. Protege al bebe y nadie debe fumar cerca del bebe. Info: text4b.org/010s

text4baby: Did you quit smoking during pregnancy? Congrats! Stay smoke-free to keep your family healthy. For ideas on how to stick with it: text4b.org/074
text4baby: Dejaste de fumar durante el embarazo? Felicidades! Sigue asi, para mantener a tu familia saludable. Ideas de como seguir, ve a: text4b.org/074s

text4baby: Keep baby away from tobacco smoke. It damages baby's heart, lungs, brain & increases chance of getting colds & ear infections. Info at text4b.org/010
text4baby: Manten al bebe lejos del humo del tabaco. Esto afecta el corazon, los pulmones, el cerebro & eleva los riesgos de gripe e infecciones del oido
 Obten mas info en: text4b.org/010s

text4baby: Check with your doctor before giving your baby any medicine. Follow label directions. Don't give cough & cold medicines to kids under 6 yrs.
To cancel text4baby messages Reply STOP. For info on text4baby Reply HELP.
text4baby: Consulta al Dr antes de darle medicinas al bebe. Sigue las instrucciones de la etiqueta. NO le des medicina para tos/gripe a menores de 6 anios
Para cancelar tus mensajes de Text4baby, envia la palabra ALTO. Para mas informacion sobre Text4baby envia la palabra AYUDA.

text4baby: Quitting smoking and STAYING quit is one of the best things you can do for you & baby. Want free help? Call 800-784-8669 or visit text4b.org/072.
text4baby: Dejar de fumar es una de las mejores cosas que puedes hacer por ti y tu bebe. Quieres ayuda GRATUITA? Llama al 800-784-8669 o ve a text4b.org/072s.

text4baby: Keep medicines, cleaning fluids & pesticides out of reach & locked away. If your child swallows a harmful product, call 800-222-1222 right away.
text4baby: Manten medicinas, productos de limpieza y pesticidas bajo llave. Si tu hijo se traga un producto peligroso, llama al 800-222-1222 enseguida.

text4baby: Smoking in the home raises your baby's chances of getting ear infections & can make asthma worse. For FREE help to quit, call QUIT NOW, 800-784-8669.
text4baby: Fumar en casa aumenta el riesgo que el bebe contraiga infecciones de oido y puede complicar el asma.
Recibe ayuda GRATIS para dejar de fumar. Llama al 800-784-8669.

text4baby: Keep getting regular checkups for your baby. Baby needs them even if baby is not sick. Next checkup is at 9 months.
Protect baby from poisons. Lock up medicines & cleaning products. Keep the # for Poison Control in your phone: 800-222-1222. More info at text4b.org/058.
text4baby: Lleva al bebe a sus chequeos de rutina. El los necesita, aun asi no este enfermo. Su siquiente chequeo es a los 9 meses.
Protege al bebe de venenos. Guarda bajo llave medicinas y productos de limpieza. Guarda el # de Poison Control 800-222-1222 o ve a text4b.org/058s.

text4baby: If you or someone you know has a problem with alcohol or drugs, talk to your doctor. Or call 800-662-4357 for information & resources in your area.
text4baby: Si tu u otra persona conocida tiene un problema con alcohol o drogas, habla con tu Dr. O llama al 800-662-4357 para info y recursos en tu area.

text4baby: Put all plants out of baby's reach. Visit text4b.org/059 for a list of poisonous plants and call 800-222-1222 in an emergency.
Store medicines in a high, safe place where children can't reach or see. Lock safety caps and put medicines away each time you use them.
text4baby: Pon toda planta fuera del alcance del bebe. Si el bebe se come parte de una planta, llama: 800-222-1222 cuanto antes o ve a text4b.org/059s.
Guarda los medicamento en un lugar alto y seguro donde los ninios no los alcancen, ni los vean. Tapalos bien y guardalos cada vez que los utilices.

Asked multiple times:

Text4baby: Great! Here are 5 steps to lower your chances of having a baby born early: 1. Don't smoke 2. Get early & regular prenatal care
 3. Avoid drugs & alcohol 4. Ask your Dr. if you are high risk for preterm birth 5. Know the signs of preterm labor: text4b.org/117
Text4baby: Estos son los 5 pasos para disminuir tu riesgo de tener un bebe antes de tiempo. 1. No fumes. 2. Obten cuidado prenatal temprano y regularmente
 3. Evita drogas/alcohol, 4. Preguntale a tu Dr. si estas bajo un alto riesgo de tener un parto prematuro, y 5. conoce las seniales: tinyurl.com/p3gm282

1.0 POLICY

It is the policy of the Division to require its funded substance use treatment providers to report back to the Division through the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within one day when any level of service to admit individuals to the program reaches 90% capacity or greater. Although per 45 CFR [§ 96.126 (a)], the requirement to report exceeding the 90% capacity to the State is seven days for programs that receive block grant funds and treat persons who inject drugs, the Division is requiring this reporting within 1 day for all substance use services to better serve the public and expedite access to services for those in need, including pregnant women seeking substance use services per 45 CFR § 96.131 (c).

Additionally, it is the policy of the Division to require its funded treatment providers to place clients in a wait list status when services cannot be provided by the individual organization or through referral to another treatment contractor. When placing clients on a wait list, treatment providers must first obtain assistance from the BBHWP for a referral. If placement cannot be secured via a BBHWP referral, the BBHWP may authorize and place a client on a master waitlist. No person may be placed on a wait list unless authorized by the BBHWP. Clients placed in waitlist status must receive documented interim services.

The master waitlist will be generated and maintained at the BBHWP level and worked daily.

2.0 PURPOSE

The following are the primary purposes of having and maintaining a waiting list and capacity management system:

1. Wait List

    a. Ensure that documented screening and intake procedures based on concepts of aligning and triaging priority populations, high-priority, and needy cases are occurring;
    b. Documentation of the current treatment demand and unmet needs are captured to help justify capacity expansion if needed;
    c. Identify gaps in services if characteristics of individuals are identified;
    d. Facilitate appropriate referrals to another provider.
    e. Comply with federal requirements per 45 CFR [§ 96.126] and [§ 96.131].

    Only persons who cannot be admitted due to capacity limitations and are available to immediately accept treatment will be placed on the wait list after gaining BBHWP's approval. The primary factor in using the wait list is to track and monitor the current Behavioral Health system capacity needs overall. When clients are placed on the wait list, the BBHWP, in collaboration with treatment providers, shall assure that individuals waiting for admission receive interim services and that those interim services are appropriately documented and reported to the BBHWP.

2. Capacity Management

    a. Facilitate access to care as quickly as possible;
    b. Maintain access to care within prescribed timeframes;

c. Reduce risk and reduce the harm that continued substance use poses to substance-using populations, their loved ones, and their communities;

d. Document need by capturing reliable data about treatment demand versus capacity and to capture data about the unmet demand for services for specific levels of service;

e. Provide early intervention services for HIV and tuberculosis disease, and slow the spread of infectious diseases among high risk substance users, their partners, their communities, and their children and loved ones;

f. Comply with federal requirements per 45 CFR [§ 96.126] and [§ 96.131].

The target populations and required activities outlined in this policy are intended to improve health and access to care for substance using populations in Nevada. Collection of capacity related data is necessary for budgetary and treatment services planning.

The Substance Abuse and Mental Health Services Administration (SAMHSA) requires Substance Abuse Planning and Treatment Block Grant-funded States and programs to provide preference to specific priority groups for treatment as indicated in 45 CFR § 96.131 (a). In addition to the priority groups defined by 45 CFR § 96.131 (c)., this policy adds women with dependent children as a preferential group to meet State priorities. As such, it is required for all treatment programs to give preference as follows:

1. Admit priority populations within prescribed timeframes, identified later in this policy:
    a. Pregnant injecting drug users;
    b. Pregnant substance abusers;
    c. Injecting drug users;
    d. Substance using females with dependent children, including females who are attempting to regain custody of their children; and
    e. All others.

2. Coordinate with the Division and offer "interim services" as defined in [§ 96.121 (4)] to pregnant women and injection drug users if admission is not possible within the prescribed timeframes listed in section 4.0 below and the client is placed on a wait list as authorized by the Division;

3. Maintain mechanisms to effectively track, maintain contact with, and report on any of the individuals awaiting admission to treatment as described in section 4.0 Procedures.

4. Providers must at a minimum post notice within their facility that is clearly in view to the public which clearly identifies the priority populations as having admission preference and which specifies that no person will be turned away for lack of ability to pay.

3.0 SCOPE

This policy applies to all Division certified substance use programs that receive funding from the Division and to Division staff.

4.0 PROCEDURE

The rules governing the use of the wait list are critical to high-quality reporting and compliance with federal law [§96.126 (c) and (d)] and [§96.131]. Before determining whether a client should be placed in a waiting status, the following general rules must be adhered to:

- A person cannot be placed on the wait list until the Division through the Bureau of Behavioral Health Wellness and Prevention has been contacted and has granted approval for the client to be placed on a wait list.
    - The capacity management system, HAvBED, can be used in attempting to locate alternate services for the client.
- A person cannot be placed on the wait list for one level of care if they are already admitted to treatment for a different service level, even if the level of care is lower than a recommendation from a screening.
- A person cannot be placed in a lower level of care due to a capacity issue unless prior approval has been granted from the Bureau of Behavioral Health Wellness and Prevention.
- A person cannot be placed on the wait list if they belong to a managed care organization (MCO). A person who belongs to a managed care organization must be referred back to the managed care organization for further placement options with the following exceptions.
    - A waver may be granted for a person seeking services who is within a priority group, including pregnant injecting drug users, pregnant substance abusers, injecting drug users, or substance using females with dependent children, to allow for immediate access to services while working with the MCO's to coordinate care. The waiver may be obtained by contacting the Division. The initial authorization under a granted waiver for these priority populations will cover up to 10 days of care. Additional time may be granted with the submission of a written request to extend the time which must include details concerning the additional amount of time being requested, the reason for the extension, and a transition plan for the client to receive services from a provider within the MCO for which the client is a member.
    - For all other clients, a waiver of this policy may be issued if there is an undue hardship which is clearly justified and approved by the Division.
    - All waivers will be reviewed on a case by case basis.
- An incarcerated person who has been determined to need treatment but who is waiting for a release date is not eligible to be placed on the wait list.

- An incarcerated person who has been determined to need treatment but cannot be released because appropriate treatment services are not immediately available is eligible to be on the wait list.

Reporting of 90% capacity is critical to compliance with federal law, State policies, and to getting clients into needed treatment. To report capacity accurately, daily updates to the HAvBED reporting system are required for all treatment providers who offer residential services.

It is important that this data be collected so the Bureau of Behavioral Health Wellness and Prevention can assist with referrals when access to care is a problem. Furthermore, treatment providers should ensure procedures are in place and appropriate staff assignments are made so capacity reporting is routinely reported and reviewed. Technical assistance on these requirements can be obtained by contacting the Bureau of Behavioral Health Wellness and Prevention.

In accordance with 45 CFR subsection L and as further required by Division policy, all treatment providers must follow stipulations as follows:

1) Pregnant injection drug users
   a. Provide immediate services, and if unable to do so, the provider must contact the Division through the Bureau of Behavioral Health Wellness and Prevention immediately to notify the Division of the need for client placement. If available resources are known, the provider may refer the client to an alternate provider but must also call the Division as indicated above. The Bureau of Behavioral Health Wellness and Prevention will assure that appropriate referrals are made and the client obtains needed services, including interim services as defined in [§ 96.121 (4)].

   b. After being notified and if the Division determines that no treatment facility has the capacity to admit the woman, the Division may authorize the woman to be placed on a wait list and will work with appropriate providers to make available interim services, including a referral for prenatal care, available to the woman not later than 48 hours after the woman seeks the treatment services. The woman must receive priority admission as soon as capacity becomes available.

   c. If the woman is placed on a wait list, the provider must maintain a mechanism to effectively track, maintain contact with, and report on any individual awaiting admission to treatment in accord with 45 CFR § 96.126(f). The provider must report weekly to the Division on contact efforts and assurance that the woman is receiving interim services.

2) Pregnant substance abusers
   a. Provide immediate services, and if unable to do so, the provider must contact the Division through the Bureau of Behavioral Health Wellness and Prevention (BBHWP) immediately to notify the Division of the need for client placement. If available resources are known, the provider may refer the client to an alternate provider but must first call the Division as indicated

above. The BBHWP will assure that appropriate referrals are made and the client obtains needed services, including interim services as stated below and as defined in [§ 96.121(4)].

b. After being notified and if the Division determines that no treatment facility has the capacity to admit the woman, the Division may authorize the woman to be placed on a wait list and will work with appropriate providers to make available interim services, including a referral for prenatal care, available to the woman not later than 48 hours after the woman seeks the treatment services. The woman must receive priority admission as soon as capacity becomes available.

c. If the woman is placed on a wait list, the provider must maintain a mechanism to effectively track, maintain contact with, and report on any individual awaiting admission to treatment. The provider must report weekly to the Division on contact efforts and assurance that the woman is receiving interim services.

3) Injecting drug users

a. Provide comprehensive services within 14 days after initial request, or if unable to provide services within the 14 day period, the provider may refer the client to an alternate provider and contact the Division through the BBHWP to notify the Division of the client placement. If the provider is unable to refer the client to an alternate provider, they must notify the Division immediately. The Division will facilitate placement with another provider if available. If treatment services are not available, the Division may authorize the provider to place the individual on a wait list and must assure that interim services are provided in accord with [§ 96.121]. Priority admission for treatment must be made as soon as space becomes available but no longer than 45 days.

b. If the individual is placed on a wait list, the provider must maintain a mechanism to effectively track, maintain contact with, and report on any individual awaiting admission to treatment in accord with 45 CFR § 96.126(f). The provider must report weekly to the Division on contact efforts and assurance that the individual is receiving interim services.

4) Substance using females with dependent children, including females who are attempting to regain custody of their children

a. Provide services within 14 days after the initial request, or if unable to provide services within the 14-day period, the provider may refer the client to an alternate provider and contact the Division through the Bureau of Behavioral Health Wellness and Prevention to notify the Division of the client placement. If the provider is unable to refer the client to an alternate provider, they must notify the Division immediately. The Division will facilitate placement with another provider if available. If no other provider is available to deliver services, the Division may authorize the woman to be placed on a wait list.

b. If the woman is placed on a wait list, the provider must maintain a mechanism to effectively track, maintain contact with, and report on the woman awaiting admission to treatment per Division policy. The provider must report weekly to the Division on contact efforts.

5) All others

a. Provide services within 21 days after initial request, or if unable to provide services, the provider must refer client to an alternate provider and notify the Division;

b. If the provider can't provide services and is unable to locate other resources, they must contact the Division. The Division will attempt to facilitate an appropriate placement. If a placement can't be found, the Division may authorize the individual to be placed on a wait list.

c. Maintain mechanisms to effectively track, maintain contact with, and report on any of these individuals awaiting admission to treatment.

Interim Services Defined [§ 96.121]

Interim Services or Interim Substance Abuse Services means services that are provided until an individual is admitted to a substance abuse treatment program. The purposes of the services are to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include:

1. Counseling and education about HIV and tuberculosis (TB);
2. Counseling and education about the risks of needle-sharing;
3. Counseling and education about the risks of transmission to sexual partners and infants;
4. Counseling and education about steps that can be taken to ensure that HIV and TB transmission does not occur;
5. And must also include a referral for HIV or TB treatment services if necessary.

For pregnant women, interim services include the interim services listed above in 1-5 and must also include:

1. Counseling on the effects of alcohol and drug use on the fetus;
2. And must include a referral for prenatal care.

Wait list follow up activities

Division staff will follow-up daily on all waitlist clients receiving interim services until appropriate placement is secured. While the federal guideline for the wait list is 120 days, the Division requests that individuals be on the wait list for no more than 45 days. Wait list follow-up activities will include:

- Interim services for pregnant women and persons injecting drugs must be provided as listed previously in this policy;
- A minimum of weekly contact with the individual is to be documented in the provider's Electronic Health Rerecords. For higher risk individuals needing residential or detoxification service, more frequent contact is encouraged;
- Every treatment contractor must have internal written policies and procedures specifically defining any additional requirements they may have for client follow-up;
- Individuals must be updated on the wait list when they are admitted for treatment, decline treatment, or when client contact is no longer possible after making reasonable efforts to do so.
    - In the event a current phone number is not available, no contact is achieved with the client within 5 days after leaving a message, or following 2 phone call attempts, a letter must be sent via first class mail to the individual at the last known address. The letter must indicate to the client that unless they respond within 10 working days they will be dropped from the waiting list; and
- Client(s) on the wait list must be contacted and offered awaited services within 24 hours after capacity becomes available.

Furthermore, treatment providers must ensure procedures are in place and appropriate staff assignments are made so wait list and capacity reporting are routinely reviewed quarterly at a minimum. At a minimum, a program's review process must ensure:

- Priority populations are being served correctly;
- Weekly chart notes are being entered correctly in the Electronic Health Records (EHR);
- Clients are being updated on the wait list weekly; and
- Clients who have been on the wait list for 45 days or more must have their cases reviewed by a Program or Clinical Director; if after that review, a client continues to await services a second weekly chart note will be entered in the EHR stating the Director agreed with the decision. The Division must be contacted to report the decision to retain the client on the wait list.

5.0 Policy Review

This policy will be reviewed and revised if necessary on an annual basis. This review must include the Chief Medical Officer, the Chief of the Bureau of Behavioral Health Wellness and Prevention, and the Nevada Behavioral Health Commission.

RELATED DOCUMENTS

Robertson, L., & Serra, C. (2009). *Capacity Management for Substance Abuse Treatment Systems.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

CFR, Title 45, Subtitle A, Subchapter A, Part 96, Subpart L, *Substance Abuse Prevention and Treatment Block Grant*.

6.0 REFERENCES

HAvBED Training Guide Nov 2015.pdf

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION
NOTICE OF SUB-GRANT

SECTION G

PROGRAM REQUIREMENTS

In addition to the Division of Public and Behavioral Health Sub-grant Grant Assurances, the sub-grantee and all organizations or individuals to whom the sub-grantee passes through funding (subrecipients) must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State award flow down to the sub-grantee and to subrecipients unless a particular section specifically indicate otherwise.

GENERAL REQUIREMENTS

Applicability: This section is applicable to all sub-grantees who receive finding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention. The sub-grantee agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.
3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants & / or Projects for Assistance in Transition from Homelessness
4. NRS 218G - Legislative Audits
5. NRS 458 - Abuse of Alcohol & Drugs
6. NRS 616 A through D Industrial Insurance
7. GAAP - Generally Accepted Accounting Principles and/or GAGAS Generally Accepted Government Auditing Standards
8. GSA - General Services Administration for guidelines for travel
9. The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention Policies and guidelines.
10. State Licensure and certification
    a. The Sub-grantee is required to be in compliance with all State licensure and/or certification requirements.

b. The Sub-grantee's Certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Sub-grants cannot be issued unless certifications are current.

11. The Sub-grantee's commercial general or professional liability insurance shall be on an occurrence basis and shall be at least as broad as ISO 1996 form CG 00 01 (or a substitute form providing equivalent coverage); and shall cover liability arising from premises, operations, independent Sub-grantees, completed operations, personal injury, products, civil lawsuits, Title VII actions, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

12. To the fullest extent permitted by law, Sub-grantee shall indemnify, hold harmless and defend, not excluding the State's right to participate, the State from and against all liability, claims, actions, damages, losses, and expenses, including, without limitation, reasonable attorneys' fees and costs, arising out of any alleged negligent or willful acts or omissions of Sub-grantee, its officers, employees and agents.

13. The sub-grantee shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.

14. The sub-grantee agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed;

15. The sub-grantee will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).

16. The sub-grantee is required maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the sub-grantee serves minors with funds awarded through this sub-grant.

17. Application to 211
    - As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 211 system.

18. The Sub-grantee agrees to fully cooperate with all Bureau of Behavioral Health Wellness and Prevention sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.

19. The Sub-grantee must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.

20. The Sub-grantee acknowledges that to better address the needs of Nevada, funds identified in this sub-grant may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The Division may reallocate funds to other programs to ensure that gaps in service are addressed.

21. The Sub-grantee acknowledges that if the scope of work is NOT being met, the Sub-grantee will be provided a chance to develop an action plan on how the scope of work will be met and technical assistance will be provided by Division staff or specified sub-contractor. The Sub-grantee will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, the Division will provide a written notice identifying the reduction of funds and the necessary steps.

22. "The Sub-grantees will NOT expend Division funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health services Block Grant Funds for any of the following purposes:
    a. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
    b. To purchase equipment over $1,000 without approval from the Division.
    c. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
    d. To provide in-patient hospital services.
    e. To make payments to intended recipients of health services.
    f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
    g. To provide treatment services in penal or correctional institutions of the State.

23. Failure to meet any condition listed within the sub-grant award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

24. For sub-grantees of the program who expend less than $750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.

25. For sub-grantees of the program who expend $750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

Year-End Financial Report

26. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.

27. The non-federal entity financial statements may also include departments, agencies, and other organizational units.

28. Year-End Financial Report must be signed by the CEO or Chairman of the Board.

29. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.

30. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:

    a. List individual federal and State programs by agency and provide the applicable federal agency name.
    b. Include the name of the pass-through entity (State Program).
    c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
    d. Include the total amount provided to the non-federal entity from each federal and State program.

31. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at the following address.

    Behavioral Health, Prevention and Treatment
    Attn: Management Oversight Team
    4126 Technology Way, Second Floor
    Carson City, NV 89706

Limited Scope Audits

32. The auditor must:
    a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
    b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
    c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
    d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
    e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

33. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

34. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:
    a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
    b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
    c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
    d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

35. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

    Behavioral Health, Prevention and Treatment
    Attn: Management Oversight Team
    4126 Technology Way, Second Floor
    Carson City, NV 89706

Amendments

36. The Division of Public and Behavioral Health policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the Bureau of Behavioral Health Wellness and Prevention prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via e-mail.

37. For any budgetary changes that are in excess of 10% of the total award, an official amendment is required. Requests for such amendments must be made to the Bureau of Behavioral Health Wellness and Prevention in writing.

38. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.

39. Any significant changes to the Scope of Work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all Scope of Work amendments.

40. The Sub-grantee acknowledges that requests to revise the approved sub-grant must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.

41. Final changes to the approved sub-grant that will result in an amendment must be received 60 days prior to the end of the sub-grant period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60 day deadline will be denied.

Remedies for Noncompliance

42. The Division reserves the right to hold reimbursement under this sub-grant until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

SUBSTANCE USE TREATMENT SERVICES

Applicability

This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The Sub-grantee, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.

    a. The Sub-grantee must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee's organization as applicable.

    b. The client has the right to be referred to another Division funded provider that is not faith-based or that has a different religious orientation.

2. Priority Groups – The sub-grantee agrees to prioritize admission to treatment, except for Civil Protective Custody Services, for priority populations in the following order:

    a. Pregnant injecting drug users;
    b. Pregnant substance abusers;
    c. Injection drug users;
    d. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
    e. All others.

3. The sub-grantee agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90% capacity or greater in accord with the Division's Wait List and Capacity Management policy.

4. A sub-grantee who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division's Wait List and Capacity Management policy.

5. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.

6. The sub-grantee must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.

7. The sub-grantee is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.

8. The sub-grantee is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

Capacity of treatment for intravenous substance abusers

9. A sub-grantee must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the sub-grantee must contact the Bureau of Behavioral Health and Wellness according to the Division's Capacity Management and Wait List policy.

10. The sub-grantee who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The sub-grantee must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the Bureau of Behavioral Health Wellness and Prevention. All outreach activities will be reported to the Division quarterly. The model shall require that outreach efforts include the following at a minimum:

    a. Selecting, training and supervising outreach workers;
    b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
    c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
    d. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
    e. Encouraging entry into treatment.

Treatment services for pregnant women (45 CFR § 96.131)

11. All sub-grantees who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.

12. Sub-grantees who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.

13. Sub-grantees who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed in target areas, and frequent notification of availability of such treatment services distributed to the network of community based organizations, health care providers, and social services agencies.

Records

14. All sub-grantees will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.

15. The system to protect confidentiality shall include, but not be limited to, the following provisions:
    a. Employee education about the confidentiality requirements, to be provided annually;
    b. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.

Reporting

16. The sub-grantee is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The sub-grantee is also required to submit any other reporting as defined and requested by the Bureau of Behavioral Health Wellness and Prevention.

17. The sub-grantee agrees to participate in reporting all required data and information through the authorized Bureau of Behavioral Health Wellness and Prevention data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.

Fee for Service requirements

18. Sub-grantees that have been awarded a fee for service sub-grant must comply with the Division's Utilization Management policy and the following billing and eligibility rules for claims processing.

    a. The service must be delivered at a Division certified facility.
    b. The certifications must cover the service levels under which the qualified service was delivered.
    c. The service must be provided by an appropriately licensed/certified staff member.
    d. The service delivered must be a Division qualified service which is **NOT** reimbursable by Medicaid or other third party insurance carrier.
    e. The rate of reimbursement will be based on the Division approved rates (available upon request).
    f. The sub-grantee agrees to accept the Division reimbursement rate as full payment for any program eligible services provided.
    g. The Sub-grantee is responsible for ensuring that all third party liabilities are billed and collected from the third party payers and are **NOT** billed to the Division.

h. Division funds will **NOT** be used to fund the services for self-pay clients or clients who elect not to use their insurance coverages. This includes clients that elect not sign up for insurance under the Affordable Care Act or clients that have existing insurance and choose not to use their insurance for treatment services. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
i. Division funds will **NOT** be used to reimburse Medicare claims.
j. Division funds will **NOT** be used to reimburse claims for which the client is pending eligible for insurance coverage.
k. Division funds will **NOT** be used to reimburse for claims denied by Medicaid or other insurance carriers unless the claim was denied as "not a covered benefit".
    a. Claims denied as "not a covered benefit" and billed to the Division must have the accompanying denial attached in order to guarantee payment.
l. Division funds will **NOT** be used to cover any unpaid costs that Medicaid and/or other insurance carriers may not reimburse (i.e. copayments, deductibles).
m. The Sub-grantee agrees to use Division funds as the "payer of last resort" for all services provided to clients. If an undue barrier to treatment exist, a written request to the Division may be submitted for review and some services may be covered upon written permission from the Division.

19. The Sub-grantee must establish policies, procedures, and the systems for eligibility determination, billing, and collection to:
    a. Ensure that all eligible clients are insured and/or enrolled in Medicaid in accord with the Affordable Care Act.
    b. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical assistance, any grant program, any private health insurance, or any other benefit program; and secure from client's payment for services in accordance with their ability to pay.
    c. And prohibits billing the Division for a service that is covered by Medicaid or any other insurance carrier. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.

Billing the Division

Fee for Services only:

20. The sub-grantee agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Sub-grantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.

21. Upon official written notification from the Bureau of Behavioral Health Wellness and Prevention, prior authorizations will be required for all residential and transitional housing services being billed to the Division.

22. The Sub-grantee agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.

23. The Sub-grantee understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.

24. The Sub-grantee understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.

25. The Sub-grantee understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
    a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
    b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
    c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706.
    d. The invoice must show the total number of services by CPT or HCPS code, the rate being charged, the total amount charged to that CPT or HCPS code line and summarize the totals by level of care.
    e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
    f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this invoice."

PREVENTION SERVICES

Applicability

This section is only applicable to primary prevention coalitions and programs.

1. The sub-grantee will implement the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework Planning Process.

2. If the sub-grantee is a certified prevention coalition, it will solicit representatives from local substance abuse prevention programs and treatment providers to become coalition members and assist with efforts to implement the CSAP's Strategic Prevention Framework Planning Process.

3. The sub-grantee representatives are required to attend prevention training as listed below if applicable to provide prevention services:

    a. All fulltime staff must annually complete a minimum of twenty (20) hours of prevention training.
    b. All part-time staff must annually complete a minimum for ten (10) hours of prevention training.
    c. Participate in the implementation of evidence-based prevention programs, strategies, policies, and practices, and use the Prevention Program Operating and Access Standards as the basis for program, workforce, and agency development.

REQUESTS FOR REIMBURSEMENTS (All non-fee for service sub-grants):

1. A Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.

2. Reimbursement is based on actual expenditures incurred during the period being reported.

3. Requests for advance of payment will not be considered or allowed by the Division.

4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.

5. Payment will not be processed without all programmatic reporting being current.

6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.

7. The sub-grantee is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the CLOSE OF THE SUB-GRANT PERIOD. All remaining balances of a federally funded sub-grant revert back to the Division 30 days after the close of the sub-grant period.

8. The Request for reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY which occurs on June 30. All remaining balances of the State funded sub-grants revert back to the State after the close of the SFY.

9. The sub-grantee must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

The sub-grantee agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

Signature:

_____ _____

Authorized Sub-grantee's Official & Title **Date Approved**