



STATE OF NEVADA
COMMISSION ON
MENTAL HEALTH AND DEVELOPMENTAL SERVICES
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BRIAN SANDOVAL
Governor

KEVIN QUINT
Chair

February 14, 2014

Governor Brian Sandoval
Office of the Governor
101 North Carson Street, Suite 1
Carson City, Nevada 89701

Dear Governor Sandoval:

The State of Nevada Commission on Behavioral Health and Developmental Services is a 10-member, legislatively created body designed to provide policy guidance and oversight on behalf of Nevada's public system of integrated care and treatment of adults and children with mental health, substance abuse, and developmental disabilities and related conditions.

The Commission establishes policies to ensure adequate development and administration of services for persons with mental illnesses,¹ reports to the Governor and Legislature on the quality of care and treatment provided for persons with mental illness, intellectual disabilities or co-occurring disorders and persons with related conditions in this State, and reports on any progress made toward improving the quality of that care and treatment.²

The Commission is charged with sending you a report in January of each year. This letter is intended to fulfill that obligation. Our last report in January of 2013 resulted in dialogue with your office and with several legislators. It is our hope that this year's report will have a similar response.

This year has been one with many ups and downs for Nevada's Behavioral Health system, from the publicized controversies of alleged improper discharge practices, excessively long wait times for clients at the state operated forensic facility, and alleged infractions within state psychiatric facilities, to the quiet successes and workings of dedicated professionals within the Division and the mental health community striving to strengthen the system on a daily basis.

¹ Nevada Revised Statutes (NRS) Chapter 433.314 Sec. 1.

² NRS 433.314 Sec. 5.

Thus, this 2014 report is constructed with the following sections. First, we would like to highlight some of the successes of the behavioral health system in Nevada so that our system and its partners can build from our strengths in order to improve at a faster pace. Second, this report will lay out items of concern that we'd like to discuss with your office. Finally, each item we mention will have recommendations for improvement from the Commission.

Successes in the Behavioral Health and Developmental Services System

1. Northern Nevada Adult Mental Health Services (NNAMHS) in Sparks has received awards for their standards on and reduced numbers of Seclusion and Restraint episodes. Low Seclusion and Restraint numbers are a gold standard of good treatment and care in the mental health system. The administration and staff of NNAMHS should be commended for attaining this high standard of care.
2. Progress has been made in Children's Mental Health. According to Nevada's Uniform Reporting System, our Nevada children and their families have a higher rate of satisfaction with care (NV rate 89%, US rate 86%) and experienced a higher rate of improved outcome from services (NV rate 72%, US rate 66.3%) than the national average. These successes are due to the work performed by personnel in the system and parents working daily with children. Every effort should be made to include families' wisdom and experience into our future planning.

Also progress has been made in securing more funds that focus on promoting good mental health in children through a significant project funded by the Safe Schools, Healthy Students grant (federal grant) that the Division received. This grant will fund facilitation of behavioral health promotion and intervention strategies in three pilot school districts in Washoe, Nye, and Lyon.

3. Across the state, there are examples of creative and collaborative improvements in our Behavioral Health System. One such example is the Forensic Assessment Services and Triage Team (FASTT) Program being piloted in Carson City by a partnership of the State of Nevada Public and Behavioral Health, Carson City Sheriff, local providers, and the coordinating effort of the coalition, Partnership Carson City. FASTT takes a person centered approach to community members who struggle with mental health and are in and out of our jail systems. Instead of only focusing on getting these clients appropriate medications, they also:
 - help consumers access stabilizing community services,
 - assess what behaviors are contributing to their re-entry into the system,
 - provide a life coach to assist consumers with strengthening their functional assets,
 - focus and practice on utilizing productive coping skills, and
 - get participants connected to a positive peer network.
4. The Mobile Crisis Team (MCT) at the Southern Nevada Adult Mental Health Services (SNAMHS) works with Las Vegas area hospital emergency departments.

The Team is comprised of Licensed Clinical Social Workers (LCSW) who travel to local emergency rooms 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.

5. The Rural Hospital Association is writing a proposal that will coordinate Behavioral Health Services into our rural hospitals so that people's needs may be met in the community at all hours. Currently in our rural communities, Behavioral Health Services are not typically offered outside of business hours. During these off times, locals must be transported to our urban areas of Las Vegas or Reno. For some, this can be a 6-8 hour drive that strains local resources and creates a serious barrier to accessing care. This project will address these gaps.
6. The Division of Public and Behavioral Health has undertaken more community-based, mental health promotion, awareness and prevention activities in the past year, and will be doing more in the upcoming biennium. This includes, but is not limited to, providing Mental Health First Aid Trainings across the state, running public service announcements (PSAs) on radio stations through Nevada, and providing Whole Health Action Management (WHAM) training to both state and community partners.
7. The Division of Public and Behavioral Health in the past six months obtained two grants to assist persons in Nevada with mental illness and co-occurring disorders to access housing through education and outreach.
8. The Division is currently working to strengthen its Service Delivery Model throughout its behavioral health agencies, by establishing statewide and standardized policies, auditing protocols/processes and data collection, reporting, and analysis.

State of Nevada Commission on Behavioral Health and Developmental Services' List of Items to Discuss with the Governor's Office

✓ ITEM #1: Children's Mental Health

The Division of Children and Family Services (DCFS) is responsible for providing behavioral health services to children and adolescents in Washoe and Clark County, while the Division of Public and Behavioral Health (DPBH) is responsible for providing services in the rural areas of the state, which is comprised of the other 15 counties in Nevada. Although access to needed services is slowly improving in rural Nevada, data shows a significant gap in the urban areas of Clark and Washoe County.

According to the Nevada Gap Analysis 2013, in the last fiscal year, the Division of Child and Family Services' (DCFS) service population is estimated at 10,991, of which 2,927 were served, representing approximately 27% of the need actually served. The need is

most acute in Clark County where the total service population is estimated to be 9,138. Of that, DCFS provided services to 2,265 in FY 2011-12, representing 25% of children estimated to be in need.

For all counties except Washoe and Clark, the total service population is estimated to be 1,408. Of that, DPBH provided services to 931 children in FY 2011-12 or 66% of children estimated to be in need.

The Commission in collaboration with the Statewide Children's Mental Health Consortia recommends that the State move forward in the following areas:

1. Leverage the Affordable Care Act as it pertains to Children's Mental Health for more services: In order for expanded services to be available and offered in an efficient way under the Affordable Care Act, the state must develop mechanisms that provide outreach to the communities served, improve communication to consumers and providers, and develop improved linkages between providers, consumers, third party payers, government entities, and communities. Rural Nevada has seen successes in access to care because they are: 1) creatively linking state and county resources, 2) utilizing technology like tele-medicine, and 3) utilizing the school infrastructure to meet the varied needs of children. Some of these linkages should include
 - Developing braided/blended funding strategies to strengthen Nevada's financial ability to provide services utilizing Federal funding opportunities.
 - Creating strong oversight/utilization management for Medicaid programs to insure the service is provided by appropriately skilled providers, through a System of Care approach.
 - Insuring that reimbursement rates will allow for appropriate compensation to providers so that the providers are able to make a stable living.
 - Increasing focus on prevention services, such as parent education and school based screenings, and mental health services.
 - Expanding our current mobile crisis pilot to a statewide service.
 - Addressing the increasing number of youth with critical mental health problems treated in Clark County hospital emergency rooms by expanding the children's mobile crisis intervention program operated by DCFS.
 - Providing aftercare for some of the 200 Clark County youths with mental illness discharged from local psychiatric hospital each month by expanding family-to-family support services.
 - Developing community based and community wide best practices, with an emphasis on Trauma Informed Care.
 - Developing a continuity of care across the state in all sectors.
 - Increasing low cost trainings for Nevada's providers to ensure that they are able to maintain their licensure and improve standards of care.

- Reviewing and improving the process of licensure in the state while maintaining full protections of the consumer.
 - Increasing and improving mechanisms to connect DCFS with institutions of higher learning in the state that will lead to an improved workforce.
2. Redesign the mechanisms of service delivery for children: Although some successes have been achieved, currently Nevada has an “upside down triangle” of services, where more money is spent at the top on fewer children with severe needs not then allowing for enough to be spent on prevention, early intervention and access to other mental health services.

“Intervening at the first sign of symptoms offers the best opportunity to make a significant, positive difference in both immediate and long-term outcomes for people affected by mental health issues. As such, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has designated prevention as their first strategic priority.” --Steve Vetzner, SAMHSA 2013

However, the other side of the problem is that we are also lacking the services for the most in-depth mental health treatment needs in our state. Many of our youth are being sent out of state for residential treatment. This not only increases the cost to the State, but diminishes potential treatment effectiveness for youth in need.

The Commission’s Children’s’ Mental Health Subcommittee in conjunction with the Nevada Children’s Behavioral Health Consortium Block Grant Application and Plan workgroup has been working for several months to develop a logic model and strategic plan that will create a System of Care model for the State. This work continues to progress with focus on ensuring that all children have easy access to services available through a centralized intake, that prevention will be a primary focus in assisting children in need before they escalate, and providing appropriate care to our “deep end” need children.

To this end we believe that we can utilize and expand current pilot programs to develop the necessary data and knowledge to move forward. This joint committee will continue to work on finalizing our plans by late spring 2014.

We, along with our partners in the Consortia (State, Rural, Washoe and Clark) would be excited to talk more with your office about this important topic of the children’s mental health service delivery system.

✓ ITEM #2: Workforce Development

Despite very recent improvement in the number of licensed health professionals, Nevada’s behavioral health workforce rankings have not changed appreciably over the past two decades. Noteworthy rankings include the number of

- physicians per capita (Nevada is ranked 45th among U.S. states),

- primary care physicians (46th),
- registered nurses (50th),
- psychiatrists (50th), and
- psychologists (47th).

While these figures beg the larger question of what is the appropriate or desired number of health professionals in Nevada, it is abundantly clear that Nevada's health workforce supply falls well short of national averages for most of the key professions needed to ensure access to basic primary, preventive, and specialty services in the behavioral health system.

These deficits will be compounded by an aging health care workforce and new demands for medical services generated by demographic changes and the Affordable Care Act. Complicating the issue, is the fact that many of the facilities under Public and Behavioral Health and in the community at large are experiencing difficulty attracting and retaining licensed professional staff.

The Commission would like to discuss with you the possibilities surrounding competitive salary and benefit packages, Medicaid reimbursement rates, and streamlining the hiring process for psychiatrists, psychologists, nurses, and therapists.

One relatively simple, straightforward way to address the behavioral workforce shortage would be to amend the Medicaid Chapter 400 to include appropriately supervised pre-doctoral psychology interns as Qualified Mental Health Professionals (QMHP's). A designation of QMHP is required to bill for therapy and assessment services. Currently, master's level social work (SW) interns and marriage and family therapy (MFT) interns are included as QMHP's but psychology interns are not.

By the time psychology interns have reached their intern year, their training and experience far exceeds that of master's level professionals. In fact, by that point in their training they have typically completed 4-5 years of coursework and research activities, roughly 1,200 direct clinical service hours through supervised practicum experience, and earned a Master's degree or equivalent along the way. Internship is the capstone of the doctoral training and internship completion and is required to fulfill the doctoral degree and licensure requirements.

Unfortunately, the Sierra Nevada Veterans Administration is the only internship site in the state approved by the American Psychological Association (APA). Therefore, well qualified, highly trained doctoral students in APA approved clinical psychology programs such as UNLV and UNR are generally forced to leave the state to complete their training. Clearly, with less than 400 psychologists in the state, most of these students do not return to Nevada, nor are we attracting interns (prospective licensed psychologists) from other states.

For every supervising psychologist, one psychology intern could double the number of Nevada's children, adults, and families served. The Nevada Psychological Association has been working on this issue with both the Board of Psychological Examiners and

Laurie Squartzoff's office. **The commission would like to see this change obtain full support from your office and the legislature and that the change would occur in a timely manner to meet the need of our growing Medicaid population.**

In addition, we would like to see a strong local pipeline of students coming from Nevada's high schools into Nevada universities and colleges and straight into our behavioral healthcare workforce.

The Division will be convening meetings with respect to a Workforce Development Mapping Project to determine how we can help to build up and sustain a viable workforce going forward.

✓ **ITEM #3: Lakes Crossing Center**

Lakes Crossing Center (LCC) is opening a new wing that will help meet the forensic needs of the state. LCC is a facility that 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 they are treated to restore competency. Located on the Behavioral Health 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 as 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.

Currently one of the primary concerns for LCC, is decreasing funding sources or alternatives for the offenders who come with acute medical needs as well as behavioral health needs. For example, people with dementia who cannot be restored have few options in the state for ongoing care. Some of these patients spend years in the Lakes Crossing facility when this facility was created for temporary care not long term care. LCC is not the best placement for this group of people causing worry and stress to staff, families, and patients alike. **The Commission recommends that this issue be added this year to the State Behavioral Health Planning agenda to be solved, so that those needing services at LCC have appropriate and safe care.**

✓ **ITEM #4: Adult Mental Health Services**

Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Counseling and Supportive Services (RCSS) provide public behavioral health services to adults, age 18 and over. Again the main concern is the unmet need in service AND the re-admission rates.

Unmet Need: There are a total of 88,956 adults in the state of Nevada that are Medicaid eligible and are considered to have any mental illness or a severe mental illness. This is considered the service population that DPBH is responsible to serve. Of that total, DPBH provided services to 25,522 in FY 2011-12, representing 29% of the total of those estimated to be in need. Over 60,000 adults were estimated to be in need of but not receiving services in FY 2011-12. (Source: *2013 Comprehensive Gaps Analysis of Behavioral Health Services*)

Re-admission Rates:

Readmission Rates: Civil "Non-Forensic" Patients	State	U.S. Rate
State Hospital Readmissions: 30 Days	42.3%	8.9%
State Hospital Readmissions: 180 Days	89.0%	19.6%
State Hospital Readmissions: 30 Days: Adults	42.3%	9.1%
State Hospital Readmissions: 180 Days: Adults	89.0%	20.0%

Nevada 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates:

Length of Stay Rates: State Hospitals	State Rate	U.S. Rate
State Hospital LOS Discharged Adult patients (Median)	13 days	63 days
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	11 days	69 days

Nevada 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

These kinds of gaps in adult services strain our local infrastructures as they deal with people coming and going in and out of our system. Local providers are frustrated but they are very motivated to work with the state system to solve this issue. The Commission encourages this kind of state and local collaboration of resources to mend these unsafe gaps.

✓ **ITEM #5: The Affordable Care Act and its Impact on Behavioral Health**

The Affordable Care Act officially went into effect on January 1, 2014. The ACA brings with it many exciting possibilities and will provide unprecedented health care coverage to the population in need of behavioral health care. However, one of the Commission's concerns is in relation to provision of comprehensive services as well as utilizing existing funds to create a "safety net" for those that may lack access to treatment due to no health care coverage or for the fact that their coverage has been maxed out by previous utilization.

All health insurance plans, including Medicaid are not "forever" insurances in that they are not designed to provide unlimited care over a lifetime. However, many of the most chronic clients and patients in the behavioral health care system are people that need rehabilitative treatment over long periods or even over their lifetime. In addition, Systems of Care (SOC) theory encourages the development and implementation of services and supports in some way, shape, or form over a lifetime and/or as clinically necessary.

One example of the dilemma created by the needs of chronically ill patients coupled with limited resources lies within the 2013-2015 budget that was passed by the last Legislature. In that budget \$6.4 million of state funds were cut from the Substance Abuse Prevention and Treatment Agency (SAPTA) budget for treatment services. That cut was made predicated on the idea that Medicaid and other third party reimbursement will make up that loss of funding.

Put another way, as a result of the State budget passed in 2013 the SAPTA funded treatment providers were cut an average of 30% with the expectation that Medicaid and

other third party payments would make up that loss. Unfortunately, a little over half way through the first year of the biennium, one treatment program in Carson City closed its residential and adolescent outpatient doors and other agencies are finding ways to cut budgets by cutting services, staff, hours, and more. It is distinctly possible that by April or May of this year, some of the treatment organizations will have spent out their SAPTA funds, leaving no "safety net" with which to treat those who are uninsured or whose insurance will not cover the remainder of their treatment in the remaining months of the fiscal year.

The essential point in all of this is that no matter what shape or form the service delivery system takes, we want to make sure there will be a "safety net" for those who will not have insurance and/or those who have more severe problems requiring more intense and/or longer term treatment. Specifically, we need to guarantee that long term inpatient, residential, and outpatient services for the serious and persistently mentally ill as well as those with substance use disorders are available and accessible.

There also needs to be a full continuum of care for the seriously mentally ill, those who are developmentally disabled, and those with substance use disorders. Failure to retain and improve the continuum of care that now exists will result in more people falling through the proverbial "cracks" and landing unnecessarily in the criminal justice, primary health, or social services systems. Failure in the continuum of care will cause more human suffering, not to mention the cost to the taxpayer and to State government.

To summarize our concerns in this item:

- State funds need to be available to fund treatment because not every person requiring treatment may qualify or be covered by Medicaid or by insurance.
- High end users in particular quite often have other needs such as housing, vocational, and other non-medical needs that may not be covered by Medicaid.
- High end users may max out their health care benefits but still need more treatment and/or support services.

We would like to exchange thoughts with you on how the State of Nevada can achieve the delicate balance of providing "safety net" funding for those in need as well as how we can all work together to develop and implement a true System of Care that affords access, quality treatment, and needed support services.

✓ **ITEM #6: Mental Health Services for the Criminal and Juvenile Justice Populations**

The Commission would like to begin a dialogue with your office to look at options for integration and collaboration between the behavioral health system and the Nevada Department of Corrections as well as with all levels of the criminal justice system in Nevada.

Although prevalence estimates vary, there is consensus that high percentages of justice-involved men, women, and youth have experienced serious trauma throughout their lifetime. The reverberating effects of trauma experiences can challenge a person's

capacity for recovery and pose significant barriers to accessing services, often resulting in an increased risk of coming into contact with the criminal or juvenile justice systems.

Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals, and thereby increase safety for all, decrease recidivism, and promote and support recovery of justice-involved men, women, and children with serious mental illness and/or substance use disorders. Partnerships across systems can also help to link individuals to trauma-informed services and treatment for trauma (SAMSHA'S GAINS Center for Behavioral Health and Justice Transformation). In addition, these partnerships should address basic mental health and addiction treatment needs in the criminal and juvenile justice population and linking them into a system of care.

The need for integration of behavioral health services into the justice system population is illustrated by the following story:

"My nephew's poison was his mother. A teen mom with mental health and addiction issues, my nephew's chaotic family led him to the criminal justice system early in his life. At 13, with multiple arrests and a suicide attempt, he landed in Willow Springs (Reno/Sparks) where he flourished, but three months later he was back with his mother who was still not healthy. Throughout his teen years, he came and went from Juvenile Detention eight times. Each time he came out, I tried to connect him to desperately needed mental health services, but he was a teen in rural Nevada and services were very difficult to access. He had little support when he was out with his mother and he never had the chance to grow-up healthy. He now is serving prison time as an adult. The good news is, this sentence is long enough for him to get his GED, and, in his words, learn how to be a human. We don't know what to expect when he gets out in two more years."

—Rural Nevada Aunt

To initiate discussion at the Community level the Division of Public and Behavioral Health is taking part in a series of discussions/meetings called "Community Conversations," which focus on the criminal justice system and mental health. But more is needed.

The Commission highly recommends better integration between these two systems (i.e. Criminal/Juvenile Justice and Behavioral Health) and utilizing trauma informed care and judicial responses consistently throughout the state. We would like to talk with you about the possibilities and prospects of such integration.

✓ ITEM #7: Developmental Services

One of the biggest issues facing families with children or adults with disabilities is the low Medicaid reimbursement levels for providers. Essentially, low reimbursement rates create a workforce shortage. Due to economic conditions, providers have not received a rate increase since 2005. The current rate, along with additional federal regulation changes, has created a fragile support system for this vulnerable population. Thus even though families are qualifying for services, their needs are not getting met because there are too few providers.

"As the parent of child with multiple disabilities, the low reimbursement rates cause a gap in my daughter's care. Though capable and often willing, there is not a single provider in northern Nevada that can financially afford to provide us with the home nursing care my daughter needs, so most of the time her care feels overwhelming. Also, the resulting stigma surrounding Medicaid hurts – like we are malingerers and have made bad choices – when really, we are just trying to keep our daughter at home [vs. a nursing institution]. She did not choose to be born with a disability, and I did nothing to make her this way. She just is." --Stephanie Schoen, a parent

In Closing

In closing, we would like to take the liberty of following up on this letter in order to begin what we hope will be an ongoing dialogue with you on how the Behavioral Health Commission can best follow up on these items. Please let us know if you have a designated staff whom we should contact. Thank you for taking time to consider our concerns.

Sincerely,



Kevin Quint, Chair
Nevada Commission on Behavioral Health and Developmental Services

Pc: Nevada State Senate
Nevada State Assembly
Nevada Behavioral Health and Wellness Council
Mike Willden, Director, Department of Health and Human Services
Jane Gruner, Administrator, Division of Aging and Disability Services
Richard Whitley, Administrator, Division of Public and Behavioral Health
Tracey Green, M.D., State Health Officer
Amber Howell, Administrator, Division of Child and Family Services
Nevada Children's Mental Health Consortia
Nevada Behavioral Health Planning and Advisory Council (BHPAC)