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The Social Health of Nevada

Leading Indicators and Quality of Life in the Silver State

Behavioral and Mental Health in Nevada

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Until recently, the Nevada Division of Mental Health and Developmental Services (MHDS) was the public provider of mental health, substance abuse and developmental services. On July 1, 2013, the delivery of the mental health, substance abuse and developmental services in Nevada was restructured on several levels. With this reorganization, Developmental Services for persons with intellectual disabilities was transitioned into the Aging and Disability Services Division (ADSD), while mental health and substance abuse services were integrated to become Behavioral Health. Behavioral Health was then merged with the public health from the State Health Division to form the new Division of Public and Behavioral Health. The new system is designed to focus on whole body wellness, covering not only mental health and substance abuse but also co-occurring conditions when both mental health and substance abuse needs are present at the same time.

Chapter Highlights

- The average life expectancy of an American is 79 years; the average lifespan of a person with mental illness is 54 years of age.
- In 2010, Nevada's per capita behavioral health expenditures ranked 42nd in the nation, at \$68 per person, compared to the U.S. average of \$121 per person.
- Between 2011 and 2013, MHDS budget was cut by 12.5%, while the General Fund appropriation decreased by 13.9%, resulting in a loss of some 150 positions Division-wide.
- The deficit in the mental health services is most apparent in the Nevada southern regions where only 24% of people eligible and needing assistance are being served.

How to Cite this Report

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The following discussion is based on the 2013-2014 gap analysis conducted by Social Entrepreneurs, Inc. of Reno, Nevada, at the request of The Nevada Division of Public and Behavioral Health. A comprehensive examination of Nevada's mental health system prepared for the report is appended to this chapter.

The Nevada Division of Public and Behavioral Health (DPBH) is housed in the Department of Health and Human Services. 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). The Nevada Division of Child and Family Services (DCFS), under DHHS, delivers mental health services to children in Clark and Washoe counties. DPBH's Rural Services Agency offers behavioral health services to adults, children and adolescents in the other 15 counties in Nevada.

In addition to serving consumers directly, DPBH works with many stakeholders, including family members, advocates, service providers, legislators, law enforcement, community partners and the general public. Because of these diverse targets and interests, the issues facing DPBH require input from many different quarters. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public behavioral health services system that meets the Nevada citizens' needs.

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 services. DPBH Administration is also directly involved in decisions regarding agency structure, staffing, program administration, and budget development.

Historical Overview¹

Nevada is one of only three states in the nation that serves as the sole source provider for public behavioral health services. The other two states are Alaska and South Carolina. Historically, this had a tremendous impact on the method of service delivery and influenced how systems change efforts are addressed. Many of the current issues plaguing the system have their roots in past policies and practices.

Over the past 50 years, many states ceased to serve as the primary provider of behavioral health services for persons without insurance. Rather, they responded to the Community Mental Health Center Act of 1963 (CMHA) by shifting funding

¹ Nevada Dept. of Health and Human Services, Division of Public and Behavioral Health, "Comprehensive Gaps Analysis of Behavioral Health Services," Social Entrepreneurs, Inc., 2013, pg 19.

to local jurisdictions, supporting community-based services, and over time, closing institutions due to a lack of demand (See Nevada Gaps Analysis).²

While many states now have a community-based service delivery system, it took time to develop, with many lessons learned along the way. The Kaiser Family Foundation traces the development in its report, “Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform”:

The history of deinstitutionalization falls into several stages as policies and objectives have changed over time. The early focus was on moving individuals out of state public mental hospitals and from 1955 to 1980, the resident population in those facilities fell from 559,000 to 154,000. Only later was there a focus on improving and expanding the range of services and supports for those now in the community, in recognition that medical treatment was insufficient to ensure community tenure. In the 1990’s whole institutions began to close in significant numbers and there was a greater emphasis on rights that secured community integration – such as access to housing and jobs.

According to the Kaiser report, many systems made serious mistakes that undermined the goals driving the deinstitutionalization of mentally ill persons. Nevada was among the states that faced tough challenges:

- **Housing:** People with serious mental illness were moved to settings that were ill-equipped and poorly supported to meet their needs.
- **Essential services:** The array of supports needed for living independently in the community was unavailable.
- **Outcomes:** Mental health systems continued to measure success by effort, such as bed days, rather than by measuring the effect of services reflected in quality of life indicators.

Resources

- State funds previously used for state institutions were not reinvested in community programs.
- Federal funds for the community mental health centers program did not adequately address the persistent needs.
- Third-party health insurance policies and public programs, such as Medicare, limited coverage for the treatment of mental illness.

With leadership, vision, resources and a strategic vision, Nevada can learn from past mistakes, its own and those of other states, and seize the moment to

² Same as previous, pg. 106.

implement a public health model for community-based services through the integration of the Division of Public and Behavioral Health and the implementation of the Affordable Care Act (ADA).

Legislative History and Update

Nevada's Legislature meets biennially in odd numbered years for a statutory maximum of 120 days. The most recent Legislative session concluded in June 2013, at which time the budgets for all State agencies for State Fiscal Years (SFY) 2014 and 2015 were established. This means that the purpose and amount of funding for the portion of the Nevada's behavioral health system administered by DPBH and one of the service bureaus within DPBH, the Substance Abuse Prevention and Treatment Agency (SAPTA), as well as and the Division of Child and Family Services (DCFS) for SFYs 14 and 15, has already been established.

Chapters 433 to 436 of the Nevada Revised Statutes (NRS) set forth the provisions and responsibilities of the state mental health services and programs in the Silver State. Chapter 458 of NRS covers the abuse of alcohol and other drugs. By statute, DPBH is responsible for planning, administration, policy setting, monitoring and budget development for all state-operated public mental health and developmental services programs. DPBH administration is also directly involved in decisions regarding agency structure, staffing, program administration and budget development.

Behavioral health services of DPBH operate under the Commission of Behavioral Health, which was created with the intent to provide accountability to the taxpayers and the Nevada Legislature. NRS 232 and 433 direct the Behavioral health services to evaluate future state needs, develop a behavioral health plan for the state, upgrade the quality of care to patients, establish programs to prevent mental illness, furnish a public forum for mental health, outline through the membership needed new perspectives, increase knowledge in treatment of mental illness, be representative of mental health and improve the system in coordination of all mental health programs, and overall better the system.

The Nevada Commission on Behavioral Health is a 10-member legislatively created body providing policy guidance and oversight of Nevada's public system of integrated treatment of adults and children with mental health, substance abuse and co-occurring disorders. The service delivery system is administered by state agencies in Nevada through the Division of Public and Behavioral Health and the Division of Child and Family Services (DCFS). The Commission also promotes and assures the protection of the rights of all clients in this system.

Federal Legislation

Patient Protection and Affordable Care Act (ACA)

In March 2010, President Obama signed The Patient Protection and Affordable Care Act (ACA), otherwise known as Health Care Reform, which became effective on January 1, 2014. ACA has brought significant changes to mental health and

substance abuse services delivery in Nevada and the rest of the nation. In response to health care reform, our state has implemented the Nevada HealthLink Health Insurance Exchange. Thanks to reform, more individuals will become eligible for Medicaid services through the Medicaid expansion. This reform will bring significant changes in the Nevada mental health and substance abuse service delivery systems.

Public health is data-driven, population-based and community-focused. Behavioral Health in Nevada is moving in this direction as well. We can see how the Behavioral Health Program is adopting the public health model by looking at the behavioral health needs of special populations, including persons with behavioral health needs who are homeless, have co-occurring disorders, are older persons or younger persons, are Native Americans and those who have interactions with Criminal Justice and Law Enforcement agencies.

Client Target Population Served

The Nevada Division of Public and Behavioral Health serves adults who have serious Mental illness (SMI), as well as children and adolescents in the 15 rural counties outside of Clark and Washoe Counties who have Severe Emotional Disturbance (SED). The Nevada Division of Child and Family Services (DCFS) addresses the needs of young SED clients residing in Clark and Washoe counties. The greatest investment in behavioral health services is made by the Division of Health Care Financing and Policy (DHCFP) through Medicaid. Those receiving services through Medicaid are not included as those served by DHCFP, although some duplication may exist.

In Nevada, the largest category of consumers accessing care from DPBH is between the ages of 25-44, representing 38% of the service population. This is followed by consumers between the ages of 45-65, representing 35% of the service population. While persons age 25-64 make up slightly more than half of the state's population, they represent almost two-thirds of the persons served by Nevada's public behavioral health services. The system serves significantly fewer very young (children up to age 12) and older adults (65+) compared to the population distribution in the state. Although DPBH is not the primary agent responsible for providing services to children and adolescents, it will ultimately bear the burden of treating these individuals in the event that early prevention and intervention services are not adequate.

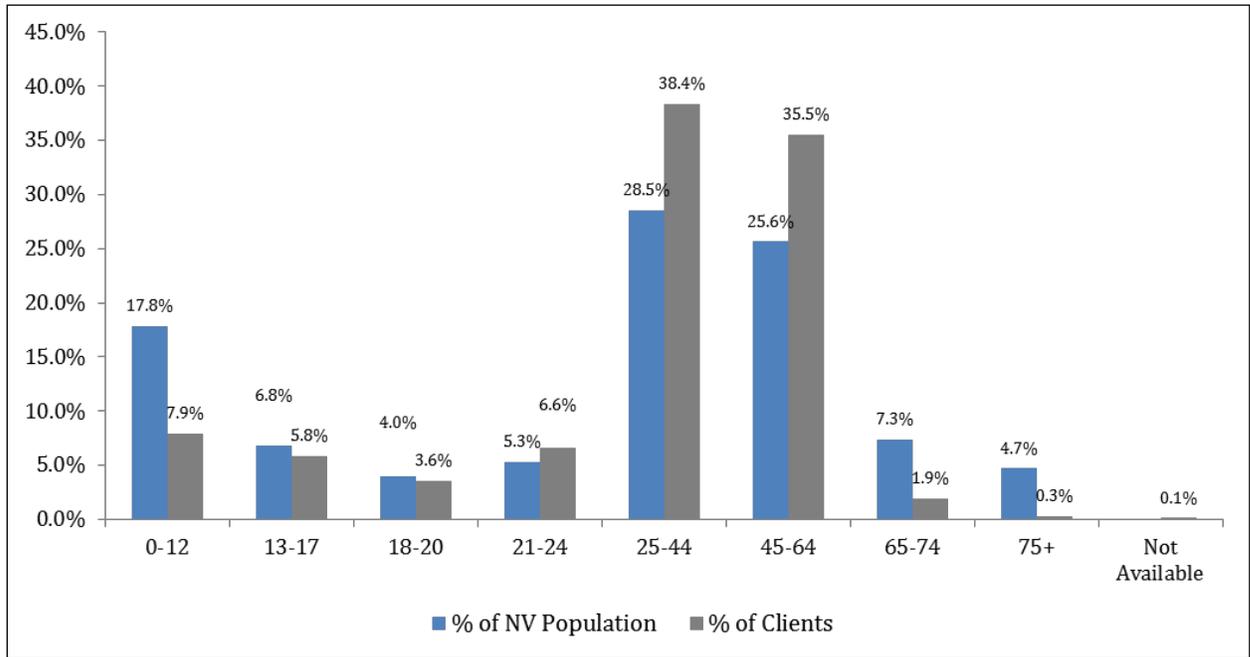


Figure 1. Individuals Receiving Services by Age.

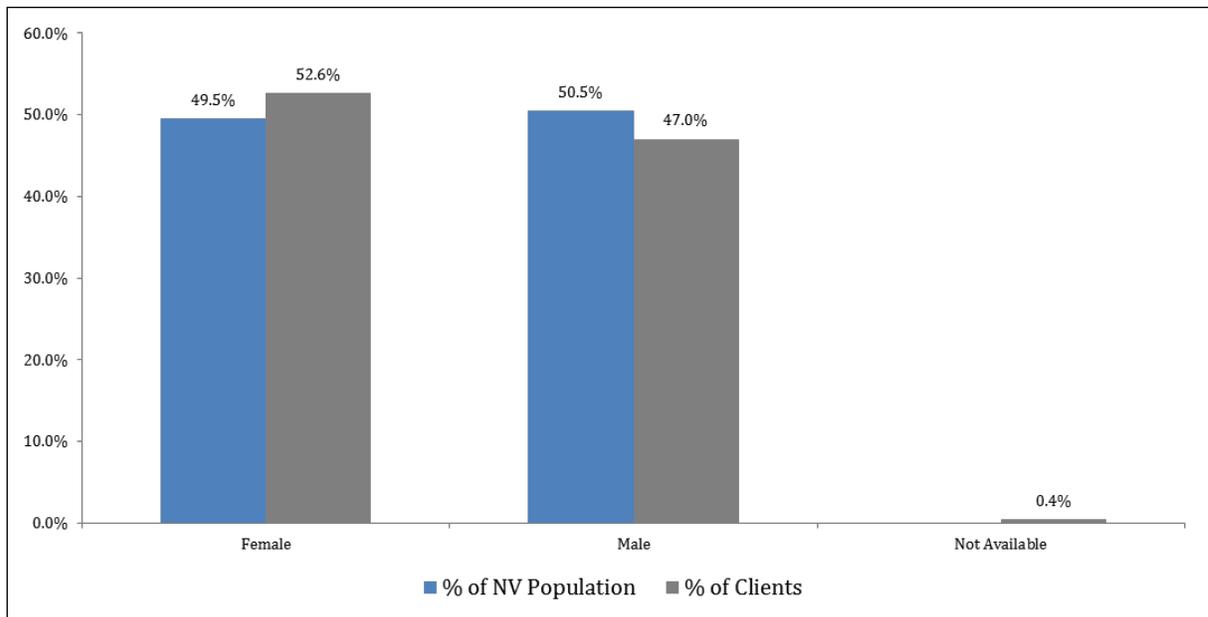


Figure 2. Individuals Receiving Services by Gender.

Structure of Behavioral Health Services in Nevada

The behavioral health system in Nevada is comprised of federal, state and local resources that operate under a variety of funding sources, priorities and mandates. Services throughout the state differ based on target population, geographic region and funding source. As a result, there are often different challenges for persons seeking behavioral health assistance based on services available and where they are sought. The system is most developed in the urban

areas of northern and southern Nevada, although more linkages exist between urban and rural areas than in the past.

Overview of the Public Behavioral Health System for Adults

The primary providers of behavioral health services in Nevada include the public behavioral health system as operated by DPBH, non-profit/community-based organizations, private practitioners and psychiatric hospitals, and federally qualified health centers.

The most significant primary provider for public behavioral health services is DPBH. Within the Division, there are four service delivery systems operated to protect, promote and improve the physical and behavioral health of the people in Nevada. These systems include Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), Rural Counseling and Supportive Services (RCSS), and Lake's Crossing Forensic Facility.

Northern Nevada Adult Mental Health Services (NNAMHS)

Located in Sparks, Nevada, NNAMHS is a comprehensive, community-based, behavioral health system for adult consumers. Inpatient services are provided through Dini-Townsend psychiatric hospital, located on the same campus as the central NNAMHS site. Numerous outpatient services are available which include the Washoe Community Mental Health Center, Outpatient Pharmacy, Program of Assertive Community Treatment (PACT), Psychosocial Rehabilitation Program (PRP), Consumer Peer Counseling, and Service Coordinator Services.

Southern Nevada Adult Mental Health Services (SNAMHS)

SNAMHS provides both inpatient and outpatient services for adults living in Clark County and in surrounding counties that may be closer geographically to this agency than to a rural behavioral health center. Inpatient services are delivered through the Rawson-Neal psychiatric hospital on the central SNAMHS campus. SNAMHS has eight behavioral health clinics serving the community and rural southern Nevada. SNAMHS feature Inpatient Services, Mobile Crisis, Outpatient Counseling, Service Coordination, Intensive Service Coordination, Medication Clinic, Residential Support Programs, Mental Health Court, and Programs for Assertive Community Treatment (PACT) Teams.

Rural Community Health Services (RCSS)

Rural Community Health Services has seven full service clinics, five partial service clinics, and one limited service clinic that provide behavioral health services to both adults and children in the rural areas of the state considered to be every county with the exception of Washoe County, Clark County, Lincoln County and parts of Nye County. Satellite Clinics provide all services offered by RCSS. Sub-satellite clinics offer many of the same services with itinerant Clinics providing services less frequently. RCSS is the only service system within DPBH to provide services to children and adolescents.

Lake's Crossing Center (LCC)

Lake's Crossing is a forensic facility whose task is to help the proper authorities to determine the legal competency of an individual to stand trial and restoration of legal competency for trial purposes. Adult forensic services include clinical assessment, forensic evaluation and short or long-term treatment for both pretrial detainees and jail/prison inmates.

Services Offered and Provided

Behavioral Health's mental health agency programs include, but are not limited to, the following facilities and services:

- Inpatient Psychiatric Hospital (NNAMHS and SNAMHS only)
- Program for Assertive Community Treatment (NNAMHS and SNAMHS)
- Mobile Crisis (SNAMHS only)
- Outpatient Psychotherapy
- Psychotropic Medications and Medication Management
- Service Coordination/Case Management
- Housing and Residential Programs
- Mental Health Court
- Co-Occurring mental and substance abuse services

Nevada Substance Abuse Prevention and Treatment Agency (SAPTA)

SAPTA currently funds private, non-profit treatment organizations and government agencies statewide that provide the substance abuse related services and treatment levels of care. In state fiscal year 2012-2013, SAPTA funded 22 treatment organizations providing services in 68 locations throughout Nevada. Together, these providers had 11,907 treatment admissions. Services consist of intervention, comprehensive evaluation, detoxification, residential, outpatient, intensive outpatient, and transitional housing services for adults and adolescents, and opioid maintenance treatment for adults

Non-Profit Community-based Organizations

Community-based organizations provide behavioral health, substance abuse and co-occurring disorder counseling and supportive services. Community-based organizations throughout the state vary in target population, approach, location, and accessibility. These services are primarily grant funded and more prevalent in urban areas. There are great differences in the sophistication and the capacity of these providers throughout the state.

Private Psychiatric Providers

Private practitioners and psychiatric hospitals are concentrated primarily in Washoe and Clark Counties. Access to these services often depends upon medical insurance. Throughout rural Nevada, there is a significant shortage of mental health professionals. One of the strategies that the DPBH is undertaking to address shortages not only in rural Nevada, but statewide, is to have instituted a Workforce Pipeline project, and a number of work groups statewide, consisting of private and public sector professions. Including but not limited to, these workgroups represent Social Work, Psychology, Marriage and Family Therapy,

Drug and Alcohol Counselors and Nursing, to explore ways how these workforce can be developed, retained and sustained over the years, to meet the growing demand of persons needing behavioral health services. To learn more about the Mental and Behavioral Health Workforce in Nevada, including deficits and needs, please consult the report completed by Dr. John Packham from the University of Nevada School of Medicine called “Mental and Behavioral Health Workforce in Nevada” dated February 21, 2014.



Federally Qualified Health Centers (FQHCs)

FQHCs serve the most medically underserved areas and/or to the most medically underserved populations. Nevada is host to a total of 31 FQHC clinics of which only two offer behavioral health services.

Financing Behavioral Health Services

Financing behavioral health services through DPBH depends on three funding streams:

- General Fund Revenues currently makes up the largest portion of funding to support public behavioral health services.
- Grants both large and small make up another source of funding to support public behavioral health services throughout the state. The largest of these grants is the Mental Health Block Grant.

Exacerbating the issue of low spending levels related to behavioral health services, was the issue of the “great recession,” which hit Nevada particularly hard. This resulted in further funding cuts to behavioral health. As noted in Nevada’s MHDS 2012 Needs Assessment, Assessment, the Silver State ranked fifth of all states with the greatest proportion of cuts to behavioral health from FY 2009 to 2012 (McKnight, 2012). These cuts were also referenced in Nevada’s 2013 Joint Block Grant Application:

MHDS suffered a total budget decrease of 12.5% for the 2011 through 2013 biennium and a 13.9% overall decrease in the General Fund appropriations. This has resulted in a loss of approximately 150 positions Division-wide. The eliminations occurred in agency programs in the north and south and in the inpatient and outpatient treatment centers. The elimination of these positions impacted services provided to Nevada’s consumers statewide and in all regions for MHDS, Division of Child and Family Services (DCFS) and the Substance Abuse Prevention and Treatment Agency (SAPTA). The cuts have raised concerns regarding meeting client needs (Block Grant Division of Mental Health and Developmental Services Substance Abuse Prevention and Treatment Agency, 2013).

Expenditures from DPBH have been on a steady decline since FY09 with a slight increase in FY13. The largest decline was in FY12 with a \$10,980,906 or 6.5% decrease.

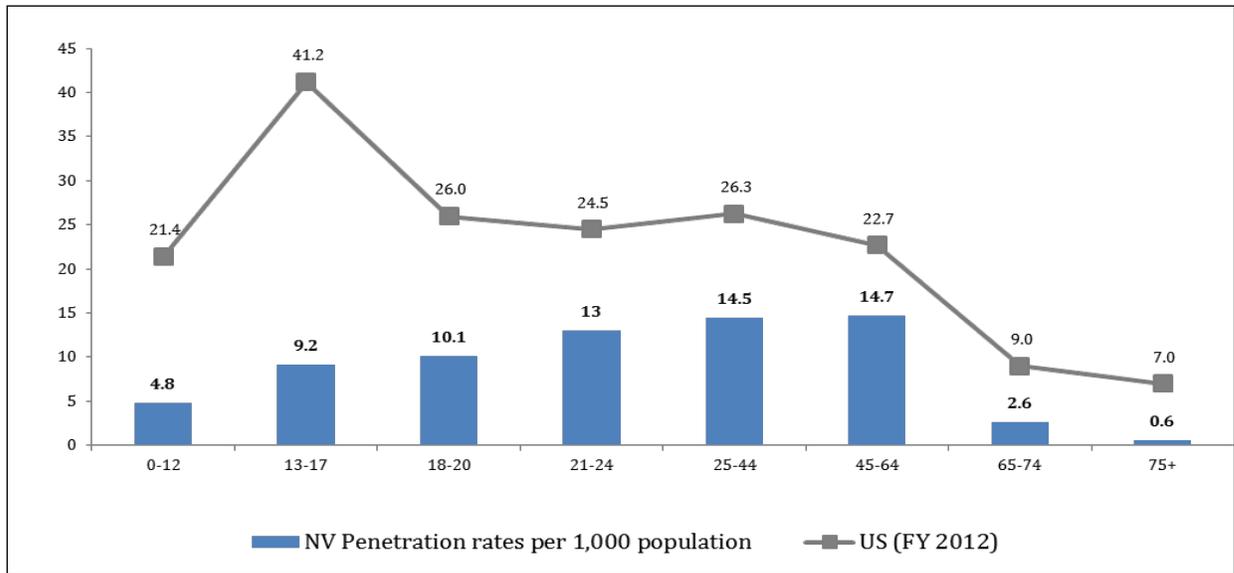
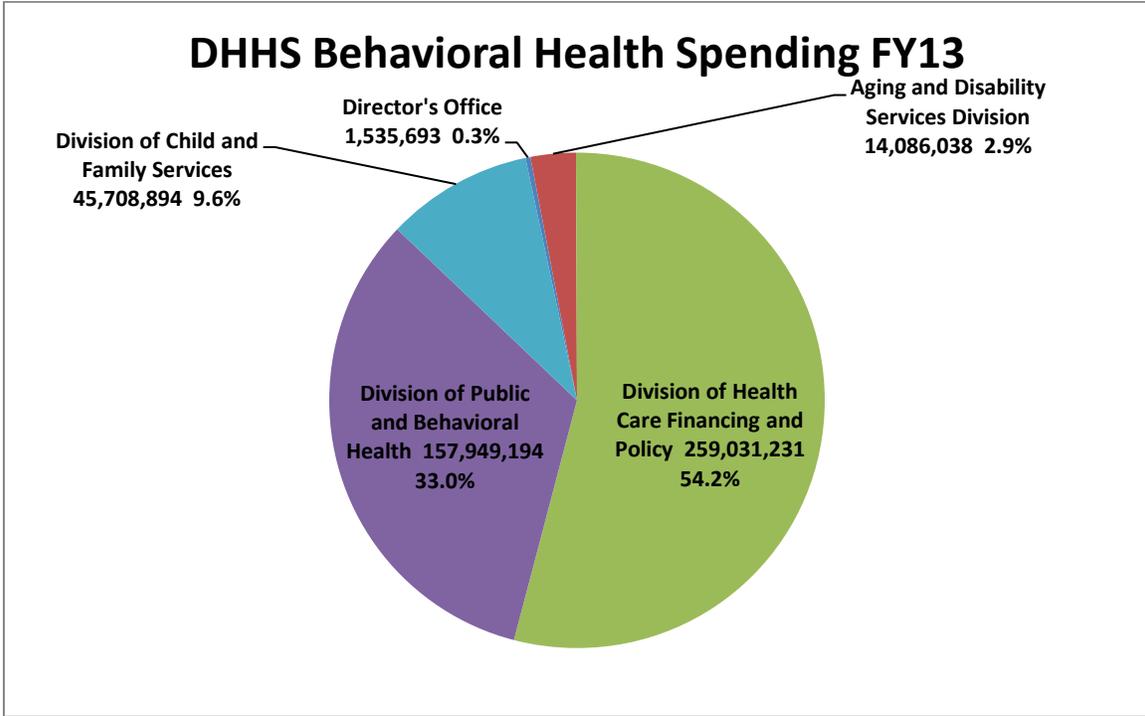


Figure 3. Service Need Penetration Rates by Age.³

During the most current legislative session, Governor Sandoval requested and the legislature approved a series of new funds to support additional staff within DPBH as well as additional services for consumers such as comfort rooms, additional civil and forensic beds, housing for Nevadans leaving jails and prisons,

³ Nevada Dept. of Health and Human Services, Division of Public and Behavioral Health, "Comprehensive Gaps Analysis of Behavioral Health Services," Social Entrepreneurs, Inc., 2013, pg 29.

and the requirement of treatment for co-occurring disorders. While these additional investments are welcome enhancements, they are not tied to a comprehensive strategic plan to confront and address some of the structural flaws within the existing service delivery model such as insufficient resources to fill position and hire professional staff, lack of community-based programming, housing shortage, and transportation barriers.

A proactive, strategic plan to implement an integrated system of care approach to behavioral health is not in place. Without this type of vision, investments will be sought on ad hoc basis to deal with the latest crises, providing short-term relief and leaving long-term problem unsolved.

Public Behavioral Health System for Children and Adolescents

The Division of Child and Family Services (DCFS) mission is to partner with families, communities and other governmental agencies in delivering support and services to Nevada's children and families and helping them achieve 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
- 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:

- 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). DCFS also 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.
- 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.
- 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.

- 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 aims to:

- Facilitate the design of service delivery matching strengths and needs
- Pair service accountability with fiscal accountability
- Involve local communities in the design and governance of services
- Taking into account the diversity of Nevada's population and regions

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. 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.
- Southern Nevada Child and Adolescent Services (SNCAS) in urban Clark County.

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 that include Trauma-Focused Cognitive Behavior Therapy and Motivational Interviewing and offer the following services:

- Individual, family, and group therapies in home, clinic and community
- Psychological assessment and evaluation
- Psychiatric evaluation and medication management
- Clinical case management
- Walk-in crisis assessments
- 24-hour on-call emergency professional coverage
- 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

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.

Early Childhood Mental Health Services

Early Childhood Mental Health Services (ECMHS) assist children between birth and six years of age when they develop emotional disturbance or show high risk of affective-behavioral disturbance associated with 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 from birth to 48 months. Staff offers multiple trainings 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 furnishes a tiered intervention framework of evidence-based interventions for promoting the social, emotional, and behavioral development of young children.

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. Both NNCAS and SNCAS offer early Childhood Mental Health Services which 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
- Clinical case management
- 24 hour on call emergency clinical coverage
- Child care, Head Start, pre-school and kindergarten mental health consultation, outreach, and training

Wraparound in Nevada for Children and Families

Wraparound in Nevada (WIN) for Children and Families is an intensive targeted case management services program for children and their families. WIN uses a nationally recognized, evidence-based model for providing wraparound – *intensive, individualized care planning and management process*. Wraparound’s philosophy of care begins from the principle of “voice and choice,” which is based on the premise 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, along with the requisite services and supports, should be individualized, family driven, culturally competent, and community based. Additionally, the wraparound process increases 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,” focused on activities helping the child and family 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:

- **Phase One: Engagement and Team Preparation.** During this phase, 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. During this phase, youth and family should feel 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 for 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 this phase, plans are made for a deliberate transition from a formal wraparound to a mix of formal and natural supports in the community (and, where 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 (Nevada PEP) for this service. The Family Specialist is a formal member of the wraparound team who serves the family by helping its members 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’s particular needs are addressed and fully met. The Family Specialist should communicate and educate agency staff on wraparound principles, the importance of family voice and choice, and other key aspects of ensuring wraparound fidelity (National Wraparound Initiative).

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 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 is known to be associated with 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. The ART® program 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.

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 18 years. It is located in Sparks and part of NNCAS. ATC has a service capacity of 16 beds for male and female youth.

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) is a program designed to furnish intensive, highly structured mental health treatment for children and adolescents, ages six to eighteen years with severe emotional disturbances. There are five treatment homes with a total of 27 beds. Two of the homes specialize in treatment of youth with dual diagnoses of severe emotional disturbance and developmental disability. The homes are located on the main campus of SNCAS.

Here is how Residential Treatment Home Programs operate:

- 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 members 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. 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 unit that serves up to 8 children ages 6 to 12 years and another unit that serves up to 12 adolescents ages 12 to 18 years, unless the youth is still attending school past his/her 18th birthday. 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.

DWTC is located on the SNCAS campus. 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.

Rural Mental Health Service for Children and Adolescents

Rural Clinics Community Mental Health Centers are comprised of 13 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, including 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 administers medication 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.

Additional Child and Adolescent Mental Health Services

Administered by the University of Nevada School Of Medicine, Mojave Adult, Child and Family Services offer outpatient counseling for children ages 6 and older and psychiatric services for children ages 5 and older. Mojave also offers clinical assessment and case management. Mojave serves individuals with fee-for-service Medicaid coverage.

Specialized Foster Care providers work with 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.

DCFS receives oversight and direction through stakeholder and advisory groups: the Commission on Mental Health and Developmental Services, Regional Consortia; and the Children's Behavioral Health Consortium.

Commission on Mental Health Services for Children and Adolescents

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 also 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.

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.

Innovative Activities since July 1, 2012 (a year prior to integration)

The major priority of behavioral health has sub-integrating mental health with substance abuse and co-occurring disorders to form behavioral health, and the large overall integration of behavioral health with public health. Integration implies caring for the entire person, both in terms of physical or primary health care needs, and behavioral health needs, as well as including mental health and/or substance abuse. Statistics show that while the average life expectancy of a person in the United States is approximately 79 years, the average lifespan of someone with mental illness is 54 years of age – approximately 25 years less than someone without mental illness (SAMHSA – Behavioral Health is Essential to Health, 2011). People with mental illness have lower life expectancy due to health-related factors such as higher rates of suicide, untreated chronic disease (e.g., kidney, diabetes, high blood pressure, etc.), higher rates of smoking, alcohol and drug use, and lower rates of exercising.

Other factors implicated in mental health and substance abuse suggest the urgent need to integrate of Behavioral Health with Public Health.

DPBH received an Executive Order from the Governor permitting the current Mental Health Planning and Advisory Council (MHPAC) to be transformed into a Behavioral Health Planning and Advisory Council (BHPAC). MHDS is currently working on revising the bylaws to reflect the new BHPAC. This will allow the Council to include membership of persons representing alcohol and other drug services, as well as consumers, family members and providers.

DPBH submitted a Joint Mental Health and Substance Abuse Block Grant to the Substance Abuse and Mental Health Services Administration (SAMHSA) in August 2013. Historically, DPBH and SAPTA have submitted separate mental health and substance abuse block grants. By joining forces in this funding initiative, DPBH and SAPTA will assure that true behavioral health services encompassing mental health, substance abuse and co-occurring services, as well as mental health promotion and substance abuse prevention, are planned and

implemented to better serve the variety and complexity of behavioral health concerns found in Nevada.

DPBH has established a statewide Behavioral Health Quality Improvement Team, which consists of seven workgroups to study the needs and service gaps of special populations: 1) homeless; 2) veterans; military and their families; 3) older persons; 4) persons with co-occurring disorders; 5) people of race or ethnic disparities (focusing on Native Americans and Hispanic/Latino communities); 6) people involved with criminal justice/law enforcement; and 7) adolescents and young adults. DPBH will utilize the Quality Improvement team process to focus on both its internal communities (DPBH agencies) and external communities (Nevada's communities at large).

Behavioral Health joined forces with Public Health in creating the Nevada Community Health Worker (CHW) training program. Community Health Workers are frontline policy health workers who are trusted members in and among their communities. CHWs, by virtue of their community ties, serve as intermediaries or "cultural health brokers" to improve the quality and cultural competence of service delivery. They increase community knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. CHWs teach targeted populations in their communities how to live healthier and more meaningful lives, including but not limited to eating healthier, exercising, tobacco cessation, and monitoring for signs and systems of depression and anxiety, and alcohol/substance abuse issues. The Nevada CHW program will focus on the Hispanics/Latino population. This training started during the spring, 2013.

DPBH provided Whole Health Action Management (WHAM) training for Nevada statewide communities in April 2013. WHAM promotes the self-management of chronic physical health conditions and mental illness and addictions, with emphasis on peer support. The curriculum refers to the integration of physical and behavioral healthcare (mental health and substance abuse) as "whole health" to incorporate both mind and body. WHAM guides participants through a person-centered planning process to set a whole health and resiliency goal. Once the goal is set, the participant shifts to creating and self-managing a new health behavior by implementing eight-week whole health support groups that engage in a weekly action for success. Ongoing WHAM training will also be provided.

A key part of DPBH's services internally are performed by case workers known as Service Coordinators. As healthcare reform advances and as more states move to health home models, Service Coordinators' critical knowledge and skills will be needed in new ways. This new marketplace requires Service Coordinators to expand their capacity in healthcare navigation, build on their existing skills in health behavior change, and possess a better understanding of the common health problems and basic interventions for both individuals with serious mental illness and those with chronic health problems. This includes casting Service Coordinators as health navigators for people with behavioral health challenges such as diabetes and heart disease. They will apply rapid cycle change principles

to assisting people with health behavior change, goal planning, and documentation. As such, DPBH provided Case to Care Management Navigator's training to both state and community partners. This training will assist DPBH and community Care Management coordinators with monitoring and advocating for targeted groups:

- Clients with mental health and physical or primary healthcare needs. Ongoing Case to Care Management Navigators Training will also be provided.
- To promote mental health awareness, promotion and prevention, DPBH participated with the National Association of Mental Health Alliance (NAMI) during its annual NAMI Walk in Reno in May 2013, and it will continue to collaborate with NAMI each May in effort to promote community awareness.
- DPBH prepared a 12-page newspaper insert that appeared in the Las Vegas Review Journal in May 2013 and that highlighted mental health awareness and promotion and recovery, including feature articles on persons in mental health and co-occurring (mental health and substance abuse) activities, and feature articles on mental health professions dedicating their lives to serving individuals with mental health and co-occurring disorders, and statewide community resources.
- Partnering with the Department of Employment, Training and Rehabilitation (DETR), DPBH ran a Public Service Announcement (PSA) on persons with Post Traumatic Stress Disorder (PTSD) on 75 statewide Nevada radios stations during May Mental Health month in 2013.
- The Division coordinated a Mental Health First Aid "Train the Trainers" training in September 2013 for 30 statewide persons. Mental Health First Aid is an in-person training that teaches attendees how to help persons developing a mental illness or who are in a crisis. Mental Health First Aid teaches persons helping others: 1) Signs of addictions and mental illness, impact of mental and substance abuse disorders; 2) Five-step action plan to assess a situation and help; and 3) Local resources and where to turn to help. The 30 persons who receive the training across the state agreed to go back to their communities and provide at least three Mental Health First Aid trainings.

Innovative Activities since July 1, 2013 (official integration)

Since July 1, 2013, when the integration of the Division of Public and Behavioral came into effect, the Division has made, or is making, progress in the following areas:

- Sponsored NAMI's 2013 Annual Nevada Conference in October 2013.

- Presented several statewide communities Gun Safety and Mental Health Awareness trainings.
- Applied for and received a federal technical assistance award to develop a 1) Peer Certification Training initiative for Nevada, 2) Statewide Peer Leadership Council and 3) Peer Policies and job enhancement opportunities. Peers are those persons who are in recovery of mental illness and/or substance abuse, who are, with the proper training and certification, able to be part of an integrated treatment team with other professionals serving clients with mental illness, substance abuse and co-occurring needs. DPBH is also working with Medicaid to assure, once these persons receive the training and become certified as Peer Specialists, that they can also become Medicaid reimbursable providers, thus enhancing their employment skills and opportunities.
- DPBH is currently redesigning much of its statewide behavioral care and services, focusing on developing or redefining clinical care, including statewide standardization of policies, integration of co-occurring disorder services and better and more consistent data collection, reporting and analysis.
- DPBH has received four grants: 1) Project to Assist Transition from Homelessness (PATH), which, through outreach, education and partnerships, assists persons with mental illness who are homeless or imminent of becoming homeless, to find and sustain housing; 2) Cooperative Agreements to Benefit Homeless individuals (CABHI), which, through outreach, education and partnerships, assists persons with co-occurring disorders who are homeless or immanent of becoming homeless; 3) Safe Schools/Health Students grants, which will help to create violence-free schools, promote mental and emotional health in children and youth, promote early childhood social and emotional learning programs, and help to reduce alcohol tobacco and other drug use; and 4) Partnership for Success, which helps to address and eliminate prescription drug abuse.

Strengths

The 2013 Nevada Behavioral Health Gaps Analysis Report prepared by Social Entrepreneurs identified several strengths of the Nevada Behavioral Health System.

Innovative Practices

Research and key informants point out a number of innovative practices across the state at various stages of development and implementation. Among the initiatives cited by key informant are “the Health Home Pilot Project, the Community Health Worker Program, Project Echo, Community Triage Centers and WHAM18 to name a few.” There is a subset of practices that have had a measurable impact on mental health services and should be understood as they

present opportunities for state-wide implementation. Each of the following was identified as system strengths by a number of key informants. Descriptions of services were obtained from public sources.

Whole Health Action Management

Whole Health Action Management (WHAM) is designed to train "peers teaching skills to better self-manage chronic physical health conditions and mental illnesses and addictions to achieve whole health and resiliency."

Mental Health Court

Mental Health Court is a collaborative effort between DPBH and the criminal justice system. This program allows people with misdemeanor and minor felony criminal charges to be diverted from the standard criminal justice system if they participate in treatment. A service coordination program with a caseload of 25 consumers per coordinator, it ensures that consumers obtain benefits, comply with court ordered treatment, medication and substance abuse recovery.

Mobile Crisis Team (MCT) 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 (LCSWs) 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.

Mobile Outreach Safety Team (MOST) at NNAMHS

This is a specialized program staffed with two Licensed Clinical Social Workers (LCSWs, in collaboration with local law enforcement agencies (Reno, Sparks, Washoe County) that offers psychiatric services to the homeless mentally ill and those with mental illness who bring themselves to the attention of law enforcement. The program helps cut the number of persons with mental illnesses going to prison and assist with enrolling them in appropriate services. Also noted was the "Crossroads Program," which provides long-term housing and support for persons considered, "frequent flyers" that are identified by the MOST team.

Project for Assistance in Transition from Homelessness (PATH)

This program targets homeless, or those at risk of becoming homeless. Individuals access mental health services, apply for housing assistance, and/or maintain current housing. This program is funded through a grant from SAMHSA. DPBH contracts with three private providers throughout the state to meet the program objectives.

Telemedicine Services

Teleconferencing therapy, psychiatric consults and medication management at RCSS have been implemented, beginning in 2011, to better serve people in frontier and rural Nevada who have limited access to services and face transportation barriers. This pilot project included purchasing and installing

equipment in remote locations and hospitals across Nevada to connect consumers to providers. One key informant described equipment placed at China Springs. “Now we don’t need to discharge children with mental health issues as they can have psychiatric care there and their families can come see them.”

Evidence-based Practices

DPBH has implemented the Program for Assertive Community Treatment (PACT) in northern and southern Nevada that 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 living in the community, adherence to their medication regime and employment rehabilitation. Key informants noted repeatedly the implementation of evidence-based practices within DPBH as strength.

DCFS currently implements the following best practice approaches in their deployment of behavioral health services to children and adolescents:

- Trauma-Focused Cognitive Behavioral Therapy
- Parent-Child Interaction Therapy
- Motivational Interviewing
- Dialectical Behavior Therapy
- Aggression Replacement Training
- Positive Behavioral Supports
- Wraparound

Resource Development

Leadership has charged the staff of DPBH with securing grants for additional resources. They have supported grant writing training for staff to better position the Division to secure new sources of funding. One state employee noted, “We have written more grants in the last 60 days than I can remember in the past 10 years.”

These efforts have financially strengthened the system. Nevada recently received notice that the state is likely to be awarded a new Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant, which will include capacity building and supports including treatment for homeless individuals. The state was awarded an expansion of the Maternal, Infant and Early Childhood Home Visiting Program grant, which provides prevention and early intervention services to at risk families. In addition, the state received a technical assistance award to implement a PEER counseling project. These projects help augment the system of care currently in place. The state is also awaiting word on other grants submitted.

Additional revenue development activities have centered on how to draw down additional federal funding for existing services rendered. Staff at SAPTA-funded programs has been trained to bill Medicaid and increase reimbursement for services.

New funding was approved during the 2013 legislative session and the Interim Finance Committee to expand or reconfigure existing services to include:

- 11 new full time positions and 12 new contract positions for SNAMHS
- SNAMHS renovation of building 3A for 21 Civil Psychiatric beds
- 5 new comfort rooms at Rawson-Neal
- SNAMHS Drop-In Center opened September 23rd
- 42 forensic beds and 16 civil beds in building 3 at SNAMHS
- 20 new full time positions at Lake's Crossing
- 10 new Forensic Psych beds at Lake's Crossing

Quality of Care

Key informants noted the following areas of strength in delivering quality services in Nevada:

- "The state formulary provides good coverage for services/medications."
- "Outpatient and group services are delivered well by qualified staff."
- "System of care principles and values are embraced by system partners that serve children."
- "Staff of DPBH are passionate, dedicated and talented." "Use of evidence-based practices," within DPBH was also acknowledged by key informants.
- The Division has, "a good training series that orients staff" to evidence-based services.
- One key informant noted that, "therapists are unbelievably good."
- "Medications are good."
- "Use of state of the art evidence-based practices, are in place."

Statewide Collaboration

Parts of the system in northern and southern Nevada were described this way:

- "Working much better these days between jail, cop on the street, public defender and court."
- "There is good cooperation with the pharmacy board."
- "Parole and probation are much more collaborative now."

Major Resource Needs and Challenges

The 2013 Nevada Behavioral Health Gaps Analysis Report prepared by Social Entrepreneurs in 2013 singled out several key weaknesses, major gaps and unmet needs of the Nevada Behavioral Health System.

- Services are currently reaching people in their middle stages of life, with insufficient resources for prevention or early intervention. "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, 2013).

- Services are not sufficient to meet the needs of people later in life. Attention should be paid to identifying and engaging older Nevadans who require behavioral support services. Older adults require different treatment responses and supports such as transportation, home-based treatment options, and specialized outreach efforts (Services W. S., 2013).
- Particular attention should be paid to the over-representation of African-American males in the service system, exploring the link between this dynamic and their over-representation in the criminal justice system. As identified in the report: “Prevalence of Mental Illness in the Criminal Justice System,” “mentally ill individuals of African American origin were over-represented among the CCDC detainees with mental illness while all other racial/ethnic minorities were underrepresented. The rate of detained African Americans with mental illness was 20.8% at CCDC in 2011, which significantly exceeded their overall rate of less than 11% among the residents of Clark County.”
- Insufficient service reach is most pronounced in the southern region of the state, as indicated by statistics that reveal only 24% of people eligible and needing assistance are being served by DPBH. Identifying the differences between the regions in service populations, resources, and service deployment is critical for understanding and addressing this reality.
- A culturally competent framework to provide services to Nevada’s growing minority population is needed.
- Hispanics/Latinos are significantly underrepresented in service delivery. Attention should be paid to how to reach this population.

Recommendations and the Agenda for the Future

The 2013 Comprehensive Gaps Analysis of Behavioral Health Services in Nevada made several recommendations to improve the Behavioral Health system.

Nevada has an opportunity to implement a behavioral health system that is community-based, comprehensive and efficient. The gaps analysis is intended to assist the state in identifying unmet needs and taking steps to address them. Three areas in particular are designated as decisive for future action. The strategies listed below as the principal focus areas come from research, key informants and best practices. Each is designed to address one or more of the

gaps, unmet needs and/or the weaknesses or threats from the situational analysis.

Ensure Accountability, Credibility and High Quality Services

- Ensure that policies and procedures are clearly articulated and understood across the state. From the point of first contact, procedures for assessment, referral, admission, treatment, discharge planning and transition should be clear, coherent and consistently implemented.
- Ensure that outcome-based, measurable criteria are in place to document and later describe those receiving services, what the service delivery cycle entailed, how waiting lists and discharges were managed and the outcome of services.
- Collect and report data uniformly across services and within DPBH using one shared data system. Use data to make decisions about how future resources are allocated.
- Establish performance-based targets of penetration rates for all levels of care, by region, provided by both the state and community-based providers.
- Implement the recommendations from the consultation report on the Rawson-Neal Psychiatric Hospital system-wide, as appropriate, with a focus on the ten recommendations provided.
- Ensure that substance abuse services meet the regulations and standards that apply to them.
- Seek accreditation and certification to demonstrate credibility and quality.

Build Community and State Capacity to Implement No Wrong Door

- Educate the public about the value of identifying and seeking care for behavioral health issues before a person escalates to the point of criminal justice involvement. Work to reduce the stigma related to mental illness and confront individuals' desires to, "solve it on my own."
- Ensure that the community is aware of services and how to access them and that services are accessible, available and supportive in every community.
- Identify and engage community partners throughout the state to include county commissioners, county social service agencies, and county and city managers.

- Define with community partners' roles and responsibilities to collaborate, coordinate and care for Nevadans in need of behavioral health prevention, intervention and treatment.
- Outline a shared approach to building the capacity of community-based organizations to provide services to people in need in their communities.
- Create a plan to build the capacity for services focused on prevention and early intervention and for culturally appropriate services for special populations.
- Support the development and enhancement of behavioral health services for children ages 0-17 and those ages 65+.
- Promote a culture of shared ownership with regional, county and local partners where all staff promotes collaboration, coordination and communication with counties and community-based agencies and between public health workers and behavioral health staff.
- Develop and formalize partnerships that effectively facilitate referrals and transitions across systems so that there truly is no wrong door or point of contact within the Division and throughout Nevada.
- Provide cross-training between behavioral health and public health staff to maximize resources and advance knowledge of all services within all programs and staff of DPBH.
- Promote recruitment and retention, and publicize loan repayer programs to retain professionals who receive their education and training within Nevada.
- Use technology to provide training and promote evidence-based practices within the system of care.

Envision the Full System of Care and Secure the Needed Resources

- Define the system of care essential for Nevada, including sufficient providers, substance abuse and co-occurring disorder services, housing, transportation, wrap around support and case management (a description of the components can be found at the end of this section).
- Convene state, county and local providers to define roles and responsibilities for each component of the system of care.

- Quantify the funds needed, based on target penetration rates to meet demand and identify all funding sources at the federal, state and county level that can be accessed to support the system of care.
- Transition appropriate state services to local communities as soon as possible, appropriate and reallocate funding to support the system of care.

Work with Partners to Diversify Funding for the System of Care

- Continue to pursue new grants to support components needed to implement the system of care.
- Leverage federal dollars and matching funding programs and establish systems to obtain reimbursement for services.
- Request revisions to regulations to maximize flexibility and efficiency in how state funding can be allocated and reallocated based on demand and need for services, deploying state resources in a strategic manner.
- Evaluate feasibility of a dedicated funding stream to support behavioral health services.
- Invest additional resources in prevention and intervention as available from treatment savings.
- Evaluate the system of care based on outcomes and indicators agreed to by all parties.

Prevention/Education

Implement high-impact prevention and use scientifically proven, cost-effective, and scalable interventions targeted to the relevant populations in the right geographic areas. Include screening and assessment to identify concerns early and back it up with the appropriate level of support. Link with other formal systems to identify and address behaviors that merit close attention (e.g., school expulsions). Design an education and prevention program to confront myths about behavioral health, explain the signs of mental illness and substance abuse and inform the public on how they can help persons at risk.

Identification, Outreach and Access

Build on the MOST and MCT team concepts to develop identification mechanisms that will establish linkages with community-based entities (including group homes, churches, police, emergency rooms, inpatient facilities, pharmacists, primary care physicians, public housing facilities, senior centers, child care settings, etc.) that can refer people with specific needs to the proper services prior to law enforcement involvement. Incorporate mental health screenings in health check-ups, with referral to a behavioral health assessment for follow-up. Design effective outreach to engage individuals in their own

environments including school, work, home, or other settings including health care. Convene a planning team comprised of state, county and local health and human service providers to map an effective process for identification, outreach, and access that defines roles, responsibilities, and agreements between state and local government and that spells out local access points based on the capacity of local providers and service delivery systems.

Assessment and Evaluation

Identify resources and approved assessment processes that are appropriate to the person's culture and level of acculturation, and utilize assessment tools that are valid and reliable. Establish standards for access to assessment that promote prevention and intervention rather than delaying access until an individual reaches crisis status.

Behavioral Health Treatment

Treatment is a critical component of the continuum of care. To encourage the use of services and to minimize stigma, treatment should be available and provided within an individual's community, in the least restrictive environment possible. In addition to psychiatric management, behavioral health treatment should include counseling, medication management, and linking individuals to other wrap around services necessary for them to remain stable.

The system of care must promote community-based organizations that offer full range of inpatient, partial hospitalization, intensive outpatient, outpatient, residential, adult day treatment, and mobile therapy options. Specialized treatment facilities for youth with substance abuse disorders are needed, and should include peer-supportive counseling to prevent relapse and develop strategies for drug-free living.

Discharge planning must take into account housing, medication and other basic needs. No persons should be discharged to another level of care or from a facility without a safe, stable environment to go to with assistance in making the transition. To assure this was being done, in 2013, when media reports surfaced that DPBH's Las Vegas Inpatient Psychiatric Hospital had been discharging persons out of state on buses and without proper service connection, DPBH sprang into action, by researching the issue and looking back at consumers records showing consumers who had been discharged out of state. While the overwhelming majority of consumers had been discharged properly, DPBH worked to strengthen the process involving consumers who need to be discharged out of state (who lived or came from there). The new procedures require that such consumer discharges must be approved by the Southern Adult Mental Health Services Agency Director, that attendants accompany consumers to make sure they arrived at their destination, and that the consumer is connected to services and care once they arrived at their out-of-state destination.

Additionally, to identify and address behavioral health needs in Nevada, in December 2013, the Governor issued an executive order to establish the Council on Behavioral health and Wellness. This 18-person Council is charged with

“examining ways of improving and strengthening the systems of support and delivery of services, and shall offer key policy recommendations to help improve the quality of life, security and independence of those living with behavioral health conditions.” (Governor’s Executive Order 2013-26).

Housing

Any system of care for persons with behavioral health needs must emphasize safe and stable environments. Affordable housing must be made available for low-income individuals and families. It should also include an appropriate range of supportive housing options. Clustered apartments such as those implemented through the Crossroads program should be replicated to provide services and supports in a cost efficient manner. A variety of more structured residential settings are needed for a small number of more seriously disabled individuals who require a greater degree of attention, supervision or structure. This may include housing specific for subpopulations such as persons with dementia under the age of 60, youth with a behavioral health disorder and other disability, and adults in need of structure and support in order to remain independent.

Coordination with Health Care

Create systems and linkages to ensure a high level of integration of physical and behavioral health care, using a public health model approach to a continuum of care. Make sure individuals are connected to both medical and behavioral health services, and facilitate the coordination of care. This includes ensuring primary care practitioners are skilled in identifying behavioral health and substance abuse problems and in making referrals for treatment and ensuring that treatment is available at the time of the referral.

Care Management

Care management should be available to the most severely impacted consumers to ensure they receive the services they need. Depending on individual needs and preferences, care managers could be a single person or a team who assumes responsibility for maintaining a long-term, caring and supportive relationship with the individual. All care managers should be trained in behavioral health and be skilled in working within behavioral health, public health and human service systems.

Crisis Response Service

Ensure crisis assistance is ready to assist immediately persons in crisis and members of their support system, with the service available 24-hours a day, 7 days a week. This can be done by building upon programs that are working in both northern and southern Nevada including the MOST teams and the MCT teams. These services could be replicated in some manner in the other counties in Nevada.

Protection and Advocacy

Persons with behavioral health/substance abuse problems are particularly at-risk as victims of violence or abuse, but may be afraid or unable to report crime and abuse. They also may have difficulty caring for themselves. Law enforcement,

social service providers and emergency responders should be linked to crisis intervention teams to identify and provide protection for vulnerable populations.

Peer Support

Peers are one of the most influential groups for people with behavioral health issues and provide a "non-treatment" approach most persons prefer. Faith-based groups, community organizations, veteran groups, senior centers and other informal support systems can help identify at-risk children and adults and help them maintain their treatment.

Social Rehabilitation

Social rehabilitation services help consumers gain or regain practical skills needed to live and socialize in the community. Activities should be age and culturally appropriate and tailored to individual needs and preferences. Social rehabilitation should include assistance in developing interpersonal relationships and leisure time activities/interests that provide a sense of participation in a community. Make employment and volunteer opportunities available through community-based organizations for those who choose and are able to work or volunteer in the community.

Peer support and social rehabilitation exemplify the secondary components that are essential to the functioning of an efficient care system and that can be provided by community-based organizations on a community-by-community basis.

Summary

Nevada has an opportunity to strengthen the behavioral health system by taking a public health approach to behavioral health. Research indicates that by pursuing this approach, the Silver State will advance the field of practice, build on brain development research, and create community-based solutions to prevent crises. To achieve its long-term goals, the Nevada behavioral health system must:

- Recognize the interrelatedness of behavioral health and physical health
- Focus on prevention and promotes behavioral health across the lifespan
- Identify risks contributing to illness or disability and, where possible, prevent illness and disability or limit the severity
- Provide Nevadans with the knowledge and skills to maintain optimal health and wellbeing
- Bring together individuals, communities and the systems throughout the state to work collaboratively toward better behavioral health for all.

Such measures would strengthen the current service delivery system and promote strategies that build upon a public health approach to the prevention, intervention and treatment of behavioral health conditions. With the Division undergoing integration, the scope of the problem increasingly clear, and the ASA

progressively implemented, we can build the system of care that Nevadans need and deserve.

The Nevada Divisions of Public and Behavioral Health and Child and Family Services also plans to review several legislative initiatives that will assist the state as it continues to develop and integrate its primary, mental health and substance abuse services.

Data Sources

DPBH Website

<http://www.health.nv.gov/>

DPBH (Mental Health) website

<http://mhds.state.nv.us/>

Division of Child and Family Services Website

<http://www.dcfs.state.nv.us/>

Substance abuse Prevention and Treatment Agency (SAPTA) Website

http://mhds.state.nv.us/index.php?option=com_content&view=article&id=61&Itemid=73

2013 Comprehensive Gaps Analysis for Behavioral Health

<http://mhds.state.nv.us/>

Mental Health Resources for College Students

<http://www.onlinecolleges.net/for-students/mental-health-resources/>

Tips for Responding to a School Crisis

<http://mhds.state.nv.us/>

Charting a Path to Recovery

http://mhds.state.nv.us/images/Mental_Health_Insert_South.pdf

Governor's Council on Behavioral Health and Wellness

<http://gov.nv.gov/News-and-Media/Press/2013/Sandoval-Signs-Executive-Order-Creating-Behavioral-Health-and-Wellness-Council/>

Behavioral Health Barometer

[Behavioral Health Barometer, 2013|SAMHSA](#)

Suicide Mortality of Nevada Veterans (2008-2010)

http://www.health.nv.gov/Publications/2008-2010_Suicide_Nevada_Veterans.pdf

SAMHSA Data Portal

<http://www.samhsa.gov/data>

State and Community Resources

Northern and Rural Nevada

http://mhds.state.nv.us/images/handouts_for_northern_nevada_revised_07-26-13final.pdf

Southern Nevada

http://mhds.state.nv.us/images/handouts_for_southern_nevada_revised_07-26-13final.pdf

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APPENDIX

The full gap analysis conducted in the fall and winter of 2013-2014 by the Social Entrepreneurs, Inc. of Reno, Nevada, at the request of The Nevada Division of Public and Behavioral Health can be accessed on this page, http://cdclv.unlv.edu/healthnv_2012/nv_behavioral_health_13.pdf.