Agenda Item No: 22.C

STAFF REPORT

Report To: Board of Health **Meeting Date:** April 1, 2021

Staff Contact: Nicki Aaker, naaker@carson.org; Mary Jane Ostrander, mostrander@carson.org

Agenda Title: For Possible Action: Discussion and possible action regarding guidance or direction to staff concerning the Carson City Behavioral Health Task Force ("Task Force") relating to the gaps, needs, priorities and recommendations of the Northern Nevada Behavioral Health Policy Board ("Policy Board"), as highlighted in the draft annual report of the Policy Board. (Nicki Aaker, naaker@carson.org; Mary Jane Ostrander, mostrander@carson.org)

Staff Summary: The Policy Board oversees the northern region of Nevada, comprised of Carson City and Churchill, Lyon and Storey Counties. The Policy Board is required to present an annual report to the Commission on Behavioral Health identifying certain gaps, needs and priorities, along with recommendations for the northern region. That annual report is currently in draft form. This item is for the Board of Health to provide guidance or direction regarding recommendations of the Policy Board. Staff also welcomes any suggestions the Board of Health may have for the Task Force.

Agenda Action: Formal Action / Motion **Time Requested:** 10 minutes

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Proposed Motion
Depends on discussion.

Board's Strategic Goal
Quality of Life

Previous Action
None

Background/Issues & Analysis
The Policy Board was created during the 79th (2017) Legislative Session by the enactment of Assembly Bill 366, which required the creation of regional health policy boards for designated behavioral health regions and to advise on behavioral health issues, promote improvements in the delivery of behavioral health services and coordinate with other policy boards. The duties of these boards are established by NRS 433.4295. Each board has a coordinator who collaborates with stakeholders within the region.

The Carson City Behavioral Health Task Force has been meeting since 2016 and is comprised of a partnership of regional agencies, providers and community partners who work towards improving resources to meet behavioral health needs.

Applicable Statute, Code, Policy, Rule or Regulation
NRS 433.4295; Assembly Bill 366 (2017) and 76 (2019)

Financial Information
Is there a fiscal impact? No

If yes, account name/number: No fiscal impact.

Is it currently budgeted? No

Explanation of Fiscal Impact: Not known at this time.

Alternatives
N/A

Attachments:
Carson City Board of Health Meeting - NNBHPB - CCBHTF.pptx

2020 NRBHPB report- 3.4.21.docx

Board Action Taken:

Motion: _____	1) _____	Aye/Nay
	2) _____	_____
		_____
		_____
		_____
		_____

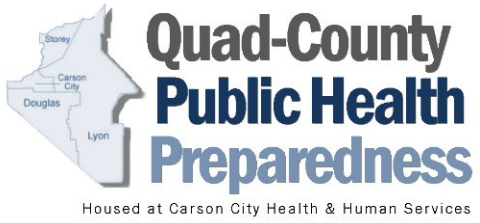
_____
(Vote Recorded By)

Carson City Board of Health

Nicki Aaker, Director

Carson City Health and Human Services

April 1, 2021



Northern Nevada Behavioral Health Policy Board (NNBHPB)

- Established by NRS
- Purpose -
- Coordinator – Jessica Flood
- Annual report required by statute
- 2020 Annual report includes:
  - Gaps and Needs
  - Priorities
  - Recommendations

NNBHPB Annual Report

- Gaps/Needs for Crisis Now Initiative
  - **24/7 Mobile Crisis Response**
  - **Crisis Call Coordination**
  - **Crisis Stabilization Unit**
  - **Rural Crisis Stabilization Access Points**

NNBHPB Annual Report – Priorities

- Priorities
  - Obtain sustainable funding for current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center
  - Increase behavioral health workforce with the capability to treat adults and youth.
  - Increase access to treatment in all levels of care.
  - Increase access to affordable and supported housing.
  - Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker).

NNBHPB Annual Report – Recommendations

- Staff Recommendations –
  - Obtain sustainable funding for MOST, and CIT
  - Affordable housing
  - Support for continued funding for Regional Behavioral Coordinator position,
  - Support development of behavioral health emergency response through regional and state collaborative efforts on initiatives such as PsyStart, Psychological First Aid, and Behavioral Health Disaster training for first responders
  - Develop increased support for older adults to maintain stability in their living environment.

2020 NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD ANNUAL REPORT

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

Update on the Northern Regional Behavioral Health Policy Board's activities and an overview of the region's identified behavioral health gaps, issues and priorities for 2020.

Jessica Flood

Please send all correspondence to Jessica Flood, Regional Behavioral Health Coordinator at Jessica@nrhp.org

EXECUTIVE SUMMARY

Overview

Members serving on the Northern Regional Behavioral Health Policy Board are community leaders, law enforcement, healthcare and treatment providers, family and peer advocates, and more. They bring diverse perspectives to the Board and are passionate about collaborating to improve the behavioral health system in the Northern Region. Collaboration facilitated by the Northern Regional Behavioral Health Policy Board and associated county behavioral health taskforces, has enabled stakeholders to develop a shared understanding of the behavioral health issues facing the region. This has allowed the Northern Board to achieve substantial progress on their goals by working with local, regional, and state partners to identify and align priorities and solutions whenever possible. Through ongoing discussion, the members of the Northern Regional Behavioral Health Policy Board, shown below, identified the Northern Region's gaps, needs, priorities and recommendations for this annual report.

- Dr. Robin Titus, Assemblywoman, Nevada Assembly
- Amy Hynes- Sutherland, Development Officer, Carson Tahoe Health Foundation
- Nicki Aaker, RN, Director, Carson City Health and Human Services
- Taylor Allison, Executive Director, Douglas County Partnership
- Erik Schoen, Executive Director, Community Chest
- Sandie Draper, Board Member, NAMI Western Nevada
- Dave Fogerson, MPA, Chief, Nevada Division of Emergency Management and Office of Homeland Security
- Ken Furlong, Sheriff, Carson City
- Lana Robards, Director, New Frontier Treatment Center, Fallon, Nevada
- Dr. Dan Gunnarson, Psychologist, Aging and Disability Services Rural Regional Center
- Matt Law, Insurer, Health Benefits Associates
- Dr. Ali Banister, PhD, Juvenile Probation Chief – Second Judicial District
- Shayla Holmes, Executive Director of Lyon County Health and Human Services

Data highlights

The data and trends shown below reflect the fact that a portion of the population continues to experience crisis or is at risk of crisis due to behavioral health issues. This aligns with the region's prioritization for continued funding of programs such as the Carson Tahoe Mallory Crisis Center, Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), and Crisis Intervention Training (CIT), that work to support individuals in behavioral health crisis and prevent crisis in the future. [1] Data in the 2020 Northern Behavioral Health Profile, developed by the Office of Analytics at Division of Health and Human Services, shows:

[1] Please see Appendix A for program status and Appendix B for program definitions

- A significant increase in the percentage of Northern Region residents who reported 10 or more days of poor mental health, a significant increase from 16.4% in 2018 to 26.9% in 2019.
- Anxiety has been the leading mental health-related diagnosis since 2010 in emergency department (ED) encounters. Anxiety-related encounters increased significantly from 2010 to 2019 in both counts and rates. However, ED encounters for depression have decreased from 2016.
- Depression is the leading diagnosis for inpatient admissions.
- The age-adjusted suicide rate for 2019 in Northern Region was 29.6 per 100,000 population, and there were 59 suicides in the region 2019.
- ED visits for marijuana, opioids, and heroin, increased from 2018 to 2019.
- There was an increase in drug related deaths in the region from 2018 to 2019.

Trends identified by local stakeholders

While the Northern Region does not have the data to quantify the issues below, stakeholders throughout the region have identified the following trends from various perspectives in the community:

- Increased crisis in older adults leading to increased need for crisis response and hospitalizations
- An increase of youth experiencing suicidal thoughts and behaviors
- Problems for youth and family accessing outpatient treatment
- An increase of adults attempting to access treatment
- Increased need for food assistance
- Behavioral health needs caused by COVID induced risk factors

Legislative efforts

In the 2019 legislative session, the Northern Board passed its first legislative bill, AB 85. AB 85, developed with input from diverse stakeholders across the state through the Statewide Mental Health Crisis Hold Workgroup, was focused on updating and clarifying NRS 433A so that the mental health crisis hold process could be standardized and understood throughout Nevada. AB 85 also mandated that regulations be developed for various topics of the mental health crisis hold and involuntary treatment process, including mandated hospital reporting of holds, behavioral health transport, defining the medical clearance process, and involuntary administration of medication. These regulations are now in Nevada Administrative Code (NAC), and efforts are being made to educate stakeholders and develop processes to align with those regulations. In addition, the Statewide Mental Health Crisis Hold Workgroup also developed a mental health crisis hold brochure which distributed to all hospitals in Nevada. This brochure can be found in Appendix C.

Through writing AB 85, stakeholders, developed a deeper understanding of NRS 433A, and identified key changes that would further modernize the law. In fall of 2020, the Northern Regional Behavioral Health Policy Board chose to use its allotted Bill Draft Request (BDR) for

2020 to focus on continuing to update and modernize the mental health crisis law in NRS 433A. The Northern Board's BDR, SB70, is currently being heard in the 2021 legislative session.

Improving the mental health system in the Northern Region new services and levels of care

In 2019, the Northern Region along with the other regions, engaged in a planning process to develop Crisis Now, a cohesive behavioral health response system that acts an alternative to traditional emergency response such as law enforcement, emergency services, and 911. This initiative aligns with the region's valued programs, including Mallory Crisis Center, Mobile Outreach Safety Teams, and Crisis Intervention Training.

In additional over the past several years, the region has seen new services and levels of care added to its behavioral health system that Northern Regional Behavioral Health Policy Board advocated for in the past and align with Crisis Now. These initiatives include:

- Four Certified Community Behavioral Health Clinics (CCBHCs) in the region including New Frontier (Fallon), Community Counseling Center and Vitality Unlimited (Carson City), and Rural Nevada Counseling (Silver Springs and Yerington, Lyon County).
- Carson Tahoe Behavioral Health Services (BHS) successfully partnering with DPBH to develop a First Episode Psychosis Program using the evidence based NAVIGATE model
- Carson Tahoe BHS also successfully partnering with DPBH to develop Assertive Community Treatment for the Northern Region.
- Carson Tahoe BHS also partnering with DPBH who submitted a SAMHSA grant on behalf of Carson Tahoe BHS to develop another ACT team focused solely on early diversion from the criminal justice system in partnership with the region's MOST teams.

These new services, along with Carson Tahoe's Mallory Crisis Center, are demonstrating significant success in supporting individuals in acute and chronic crisis due to behavioral health issues. We believe that continuing collaboration between these programs and community providers is key to the system and anticipate developing increased effectiveness moving forward. This success in the Northern Region shows signs of hope for developing an effective mental health system in rural Nevada.

Diversion from the Criminal Justice System and other inappropriate levels of care:

All five counties have initiated or are continuing efforts in developing and sustaining programs such as Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), and Crisis Intervention Training (CIT), which have been identified as core interventions in local Sequential Intercept Model (SIM) mapping efforts, and are aligned with the Stepping Up Initiative[2]. The Northern Region's top priority continues to be increased and sustainable funding for MOST, FASTT, and CIT training as the region has experienced great success with these pilot

[2] The Stepping up Initiative is a national county initiative spearheaded by the National Association of Counties with the American Psychiatric Association, and Council of State Governments as partners. The initiative, focused on diverting individuals with mental illness and substance use disorders from the criminal justice system, has been endorsed by County Commissioners in Carson City, Churchill, Douglas, and Lyon Counties

programs and would like to see their continuation and expansion to adequately serve the region's population of nearly 200,000.

Regional partnership with Nevada Division of Public and Behavioral Health

The Northern Region's stakeholders continue to appreciate the DPBH funding and DPBH Rural Clinics staff support that allowed for the initiation and continued sustainment of the MOST, FASTT, and CIT programs. The region is equally gratified to recently see our treatment providers receive funding to develop the Certified Community Behavioral Health Centers (CCBHCs), funding to develop a regional First Episode Psychosis Team aligned with the national best practice, and funding to develop an Assertive Community Treatment program. Our region would not have experienced this success in addressing gaps without active participation from our community leaders and strong support from Nevada DPBH.

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"The Northern Region's top priority continues to be to appropriately fund the resources we feel are needed within our region, which include our MOST co-responder teams, the FASTT jail reentry teams, Crisis Intervention Training, and Carson Tahoe's Mallory Crisis Center. We are hopeful that providing sufficient, sustainable funding for the following efforts in each of our communities will allow for the significant progress we have achieved in our communities to be continued." (From Regional Priorities, page 7)

Introduction

In 2017, the Nevada Legislature created four Regional Behavioral Health Policy Boards through the passage of AB 366. In the 2019 legislative session, AB 76 passed, changing existing Nevada law defining the behavioral health policy board regions, membership, and mandates. Upon the passage of AB 76, NRS 433.4295 directs the now five Regional Behavioral Health Policy Boards to conduct the following activities:

1) Promote improvements in the delivery of behavioral health services in the region.
2) Coordinate and exchange information with the other policy boards in the state to provide coordinated and unified recommendations to the Department, Division, and Commission regarding behavioral health services in the behavioral health region.
3) Review the collection and reporting standards of behavioral health data to determine standards for such data collection and reporting processes.
4) To the extent feasible, establish an internet website that contains an accurate electronic repository of data and information concerning behavioral health and behavioral health services in the region that is accessible to the public.
5) To the extent feasible, track data regarding individuals admitted to mental health facilities and hospitals pursuant to NRS 433A.145 to NRS 433A.197 and to mental health facilities and programs of community-based or outpatient services pursuant to NRS 433A.200 to NRS 433A.330, including treatment outcomes and measures taken upon and after the release of individuals to address behavioral health issues and prevent future admissions.
6) Identify and coordinate with other entities in the behavioral health region and this State that address issues relating to behavioral health to increase awareness of such issues and avoid duplication of efforts.
7) Advise the Commission on Behavioral Health, the Department of Health and Human Services, and the Department of Public and Behavioral Health regarding:

- Behavioral health needs of adults and youth in the region.
- Progress, problems and proposed plans regarding the provision of behavioral health services, and strategies to improve the provision of such services in the region.
- Identified gaps in behavioral health services in the region, and recommendations to address those gaps.
- Any federal, state or local law or regulation that relates to behavioral health which it determines is redundant, conflicts with other laws or is obsolete and any recommendation to address any such redundant, conflicting or obsolete law or regulation.
- Priorities for allocating money to support and further develop behavioral health services in the region.

8) Submit an annual report (which can be submitted more often if needed) to the Commission which includes:

- The specific behavioral health needs of the behavioral health region.
- A description of the methods used by the policy board to collect and analyze data concerning the behavioral health need and problems and gaps in behavioral health region including a list of all data sources used by the board.
- A description of how the policy board has carried out its mandated duties.

- A summary of data regarding emergency admissions (mental health crisis holds) to mental health facilities, hospitals, and to programs of community- based and outpatient treatment and conclusions the policy board has derived from the data.

The Northern Regional Behavioral Health Policy Board oversees the Northern Region composed of Carson City, Churchill, Douglas, Lyon, and Storey Counties. This annual report provides an update for the Northern Region, including mandated activities, continuing regional gaps and needs, identified solutions to address those needs, and plans for moving forward.

Overview of Northern Regional Behavioral Health Policy Board 2020 Gaps, Needs, Priorities and Recommendations

The Northern Board has historically been focused on crisis stabilization and diversion from unnecessary hospitalizations and interactions with the criminal justice system, with the larger goal of allowing individuals to live satisfying and meaningful lives in our communities in the least restrictive setting. This goal can be identified through the two lenses of crisis intervention and continuing support and stabilization:

1. **Crisis intervention:** Over the past five years, we have made substantial progress on crisis stabilization and diversion with the development of Mobile Outreach Safety Teams, Forensic Assessment Services Triage Teams, Crisis Intervention Training, and the Mallory Crisis Center.
2. **Continuing support and stabilization:** The Northern Region has also been working on developing solutions to support individuals with Serious Mental Illness (SMI) and co-occurring disorders to live in our communities. Community stakeholders have seen significant progress in this as well, through the development of four Certified Community Behavioral Health Centers, Assertive Community Treatment (ACT), and First Episode Psychosis Programs.

Together, these community-based programs and initiatives are showing real promise in developing a mental health system that supports individuals with behavioral health issues. However there remain gaps in behavioral health workforce, access to treatment, and supported housing to prevent many individuals in our communities from obtaining the appropriate treatment and housing support they need, in a timely manner, to live in the community and stay out of crisis. [3] In addition, while the Region is now rich in crisis hotlines, including the statewide Crisis Support Services of Nevada, Nevada CARES team, Children's Mobile Crisis Response, and others, stakeholders continue to see the need for in person response.

[3] For more information on our region's programs including definitions and scope of operations, please see Appendices A and B in this document.

Through this perspective, the Northern Board has identified the following priorities that it will be addressing in 2021 which are discussed in further detail below:

Northern Regional Behavioral Health Policy Board 2021 priorities:

1. Obtain sustainable funding for current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)
2. Increase behavioral health workforce with the capability to treat adults and youth
3. Increase access to treatment in all levels of care
4. Increase access to affordable and supported housing
5. Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker)

Northern Region Priorities

1. Obtain sustainable funding for current crisis stabilization and jail diversion programs (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)

The Northern Region's top priority continues to be to appropriately fund the resources we feel are needed within our region, which include our MOST co-responder teams, the FASTT jail reentry teams, Crisis Intervention Training, and Carson Tahoe's Mallory Crisis Center. We are hopeful that providing sufficient, sustainable funding for the following efforts in each of our communities will allow for the significant progress we have achieved in our communities to be continued:

- County level Mobile Outreach Safety Teams (MOST) - Co-responder teams that involve the response of a licensed clinician and law enforcement officer that respond to individuals experiencing behavioral health crisis.
- Crisis Intervention Team (CIT) Training - A 40-hour behavioral health training for law enforcement, fire first responders, emergency medical services (EMS), 9-1-1 dispatchers and other associated professionals. This training is essential to assist first responders in responding skillfully to individuals in behavioral health crisis.
- Forensic Assessment Services Treatment Team (FASTT) - Multidisciplinary reentry teams in each of our county jails consisting of case managers from social services and behavioral health treatment agencies working to break the cycle of recidivism through assessing client risk and needs and supporting inmates in connecting to community services upon release.
- Carson Tahoe Mallory Crisis Center - A 24/7 psychiatric emergency room accepting law enforcement and EMS drop off and walk in clients. Carson Tahoe is the only crisis stabilization unit in the state that accepts mental health crisis holds along with individuals experiencing other behavioral health crisis and plays a large role in connecting individuals in need to treatment.

The Northern Regional Policy Board sees all of these elements supporting the region's efforts in developing the Crisis Now initiative. This initiative aligns with the region's larger vision of developing a cohesive behavioral health crisis response system as an alternative to

traditional crisis response services such as law enforcement, jails, and hospital emergency rooms.

2. Increase behavioral health workforce with the capability to treat adults and youth

Like most of the state, the region is facing a behavioral health workforce shortage that impacts access to treatment and the development of behavioral health programs. Also, stakeholders are seeing that lack of a robust and experienced workforce is impacting quality of treatment and the cost of care.

3. Increase access to treatment in all levels of care

The region sees an increase in treatment for all levels of care for both youth and adults, with the exception of hotline crisis services. Adults who are experiencing behavioral health issues are often unable to schedule outpatient and residential treatment in a timely manner, obtain the ideal amount of treatment needed and have wrap around services to remain stable.
For youth, stakeholders have identified multiple issues in the system:

- Multiagency response to youth in crisis appears to be disjointed with repetitive assessments occurring between school, mobile crisis, and treatment agencies, who do not accept each other's assessment. This makes parent's and youth have to answer the same questions repeatedly.
- There are reports from parents who have insurance, which after calling multiple providers cannot schedule a therapy appointment for their children who have recently been discharged from inpatient treatment.
- There are also reports of unsafe discharges occurring before the youth are stabilized, and stories of little to no discharge planning support upon release from youth inpatient and residential treatment facilities.

These are urgent issues as data shows increasing numbers of youth with suicidal ideation and behavior in our region.

4. Increase access to affordable and supported housing

Lack of housing is possibly the largest barrier to supporting individuals living in our communities. There are many cases of individuals who are unable to discharge from inpatient psychiatric hospitals and medical hospitals for months beyond their need for treatment because our communities have very few group homes with little training in mental health, and no group homes with 24-hour supervision. In addition, many referrals have been made to our ACT teams, but the individuals receive ACT services while homeless and there are no options for housing. In addition, the region is seeing an increase in homelessness that is impacting our safety net providers and emergency services.

5. Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker)

Finally, our region has prioritized the development of services, such as community health workers, to support the continuity of care for individuals. Too often, treatment is provided in silos and individuals do not receive the support in connecting with the continuing care needed. Several members of our regional behavioral health policy board are interested in exploring mechanisms that support community health workers, as it is believed that these workers can provide community-based support and fill some of the gaps created by the lack of clinical workforce.

Recommendations:

We respectfully present the following list of recommendations for the Northern Regional Behavioral Health Policy Board. These recommendations are listed in order of board member ranking:

1. Obtain sustainable funding for crisis stabilization and criminal justice diversion initiatives and programs including: MOST, FASTT, CIT and Mallory Crisis Center.

   As noted above, these crisis stabilization programs have significantly assisted the region in responding to individuals in behavioral health crisis. The Board recommends obtaining long term funding for these programs to ensure that the progress gained in the region would not be lost.

2. Support continued funding for Regional Behavioral Health Coordinator position.

   Our region continues to advocate for a sustainable funding stream to maintain the regional behavioral health coordinator position. We deeply value our coordinator with her longstanding commitment to the position and experience. The board recommends that the state sustain current funding levels to maintain attract qualified candidates for this essential position. In addition, the coordinator position is taxed with coordinating the region's initiatives, providing technical assistance, and administrative support to the board. Ideally, the board could use more staff to support administrative activities, development of data reporting, and initiatives moving forward. This neutral position, funded by the state, but housed in a community organization, facilitates collaboration between local, regional, and state stakeholders that reduces silos, fosters honest discussion about gaps and needs, and develops innovative solutions to shared problems.

3. Support the regional implementation of the Crisis Now model, supporting efforts that respect community informed solutions in addressing local and regional gaps, challenges, and existing resources.

   Like the other behavioral health regions in the state, stakeholders in the Northern Region see real value in developing an alternative behavioral health crisis response system through the Crisis Now Model. As discussed above, our region has made significant progress in developing that model through our MOST co-responder teams and the Mallory Crisis Center. The board recommends that the state support the region in

developing the Crisis Now model with adaptations that meet the unique needs of our region which include:

- Development of Crisis Now using locally based providers and solutions when possible.
- Access to both in-person mobile crisis response and county-based co-responder teams. Both programs respond to different populations. The mobile crisis teams respond to individuals who are voluntarily connecting with services, while the co-responder teams are able to use wellness checks to build rapport with individuals who lack insight into their illness or may not be motivated by treatment.
- Development of scaled down "living room" model crisis access points to support individuals in crisis and assess their needed level of care.
- Establish a strong coordinated relationship between state run services such as Crisis Support Services of Nevada and community owned crisis response programs and providers.

4. **Increase workforce: Increasing retention and recruitment of psychiatrists, behavioral health clinicians, substance use treatment professionals, and/or behavioral health professionals with the capability to treat youth.**
   As discussed above, the Northern Region struggles to attract and retain skilled workforce to provide quality behavioral health services. In addition, there is a dearth of mental health professionals who can treat youth. While the board does not have an identified solution, the board recommends the state explore mechanisms for recruitment and retention of workforce including licensing, reimbursement, and education.

5. **Increase access to residential treatment and housing: In particular, inpatient/ residential treatment and housing, and transition support to reenter community.**
   Stakeholders in the region continually report that there are not enough inpatient and residential behavioral health beds to care for the population. In addition, they see a gap in transitional housing and support for those reentering the community after treatment. The board recommends the state prioritize this critical issue in its policy development and planning.

6. **Increase options for supportive housing:** As noted above, stakeholders in the Northern Region have reported a lack of group homes and long-term care to support individuals in chronic sub-acute crisis. Due to lack of housing, these individuals are unable to be discharged from hospitals for long periods of time or live homeless in the streets interacting with law enforcement and impacting our emergency services system. The Northern Board does not know enough about this complex issue to provide specific solutions but seeks the state's support in identifying resources and technical assistance to progress on this issue.

7. **Develop services to support continuity of care (i.e. continuation of medication/ service connection with community health worker).** As noted above, providing funding for services to support continuity of care could address the clinical workforce gaps and allow

for community-based services. Several members of our Regional Behavioral Health Policy Board are interested in exploring mechanisms that support community health workers, as it is believed that these can provide community-based support and fill some of the gaps created by the lack of clinical workforce.

8. **Support efforts to increase use of telehealth for behavioral health services to reach isolated populations such as rural communities and older adults.** In response to the ongoing issues with lack of behavioral health workforce, timely access to various levels of care, and the increased risk of isolation in rural communities, the Board is motivated to explore opportunities and solutions to implement and expand the use of telehealth for behavioral health services where appropriate. The Board recommends the state sustain the expanded use of telehealth that was initiated by the COVID- 19 response. This includes the use of telephones for behavioral health where videoconferencing capabilities are inaccessible. This is important as many rural counties struggle with connectivity issues and the board has heard stories of individuals experiencing challenges in affording or operating smart phones or other videoconferencing technology.

9. **Develop initiatives to support regional behavioral health authorities for formalizing behavioral health infrastructure in the region, improve advocacy and collaboration with the state, and develop cost sharing among counties for behavioral health resource use.** Since the Northern Region started meeting as a coalition in 2013, stakeholders have experienced issues in applying for grants and receiving funding without a central regional authority. In addition, other states have used regional authorities to manage data and funding to respond to the unique needs of the region. The Board recommends that the State provide technical assistance in conducting a feasibility assessment.

10. **Support development of behavioral health emergency response through regional and state collaborative efforts on initiatives such as PsyStart, Psychological First Aid, and Behavioral Health Disaster training for first responders.** Through multiple stakeholder workgroups and input from the Northern Regional Behavioral Health Policy Board, the Northern Region has developed a draft Northern Regional Behavioral Health Emergency Operations Plan. This plan will assist stakeholders in responding to the behavioral health needs of the community and first responders during a disaster. The Board recommends that the state provide resources and training to make this plan operational.

11. **Develop increased support for older adults to maintain stability in their living environment.** Older adults in the Northern Region have experienced increased stress and isolation during COVID-19. Many of the supports and services they received in-person prior, such as Senior Services lunches and activities, and in-person support services were scaled down or temporarily closed leading seniors to experience increased loneliness and less support. Community stakeholders are seeing increasing numbers of older adults experiencing crisis and need for hospitalization. The Board recommends that the state explore additional community level services be put in place to support seniors in their environments.

12. **Support initiatives to increase cultural awareness and providing behavioral health services to minority populations including LGBTQ.**
    The Board seeks to advance health equity in behavioral health care in our region where everyone has a fair and just opportunity to be as healthy as possible. This includes advocating for funding education on culturally competent care, which can be defined as the ability of providers and organizations to effectively deliver and promote health care services that meet the social, cultural, and linguistic needs of patients. Some examples include: educating medical professionals about healthcare challenges specific to LGBTQA+ individuals, advocating for workforce development policies that increase the number of bilingual providers in our state, working with healthcare providers and organizations to deliver unconscious bias training into the workplace, advocating for robust data collection that will help us to identify gaps in services that disproportionately impact minority populations, and developing best-practice guidelines that help behavioral healthcare providers and organizations develop a provider community that reflects the community it serves.

    Advancing health equity also requires collaboration with, and support of, community partners who are removing barriers to care including food insecurity, discrimination of all kinds, and housing insecurity, to name a few. Additionally, we seek to foster collaboration and partnership with community organizations and entities that serve minority populations to learn how best to support their work, better understand the needs of the diverse populations in our region, and recruit individuals with diverse experiences and perspectives to boards such as this one.

2020 Northern Regional Behavioral Health Board Activities

The Northern Regional Behavioral Health Policy Board met eight times in 2020, hearing a variety of presentations from local, regional, and state organizations on ongoing activities and priorities. The board obtained regular updates from the Northern Regional Behavioral Health Coordinator regarding initiatives, programs, and legislation relevant to the board's purpose and mandates, and engaged on ongoing discussion regarding ideas for the Board's legislative bill draft request and other priorities. The Northern Board also received regular updates regarding the county behavioral health task forces in the region, ensuring ongoing coordination between local stakeholders and the region. The board also identified programs, initiatives, and legislation that aligned with the board's identified priorities, and developed letters of support to advocate for support of legislation and continuation or expansion of activities.

Northern Regional Behavioral Health Policy Board Meetings and Presentations

All presentations, materials, and minutes provided to the Northern Regional Behavioral Health Policy Board can be found on the Board's website at: http://dpbh.nv.gov/Boards/RBHPB/Board_Meetings/2018/Northern_Regional/ The table below provides an overview of presentations provided to the Board in 2020.

Date	Topic	Presenter(s)
2/26/2020	Presentation on Open Meeting Law	Julie Slabaugh, Senior Deputy Attorney General
	Division of Public and Behavioral Health (DPBH) Update on COVID's Effect on Behavioral Health at Local, State, and National Levels	Staff from DPBH
6/30/2020	Presentation and Review of Nevada Crisis Now Statewide Report	Jessica Flood, Regional Behavioral Health Coordinator
	Presentation of ideas for potential legislation focused on behavioral health and prevention	Jennifer Delett- Snyder, Executive Director of JOIN Together Northern Nevada
	Presentation, Discussion, and Prioritization of Ideas for Potential Legislation for the Northern Regional Behavioral Health Policy Board's Bill Draft Request for Nevada's 2021 Legislative Session	Jessica Flood, Regional Behavioral Health Coordinator
7.31.2020	Review of current gaps and needs analysis and discussion and update of identified gaps and needs in the Northern Behavioral Health Region in 2020. Public comment will be taken on this agenda item.	Jessica Flood, Northern Regional Behavioral Health Coordinator
	Legislative update on AB 85, AB 76, AB 47, AB 66, AB 191, and AB 37	Jessica Flood, Northern Regional Behavioral Health Coordinator

	Presentation, discussion, and decisions regarding ideas for potential legislation for the Northern Regional Behavioral Health Policy Board's bill draft request for Nevada's 2021 Legislative Session.	Jessica Flood, Northern Regional Behavioral Health Coordinator
8.20.2020	Update on Northern Region's Certified Community Behavioral Health Centers (CCBHCs)	Lana Robards, New Frontier CCBHC; Tenea Smith, Rural Nevada Counseling CCBHC; Carol Basagoitia, Carson Community Counseling CCBHC, Esther Quilici, Vitality CCBHC
	Division of Public and Behavioral Health (DPBH) and Division of Child and Family Services (DCFS) update on coronavirus effects and response	DPBH and DCFS staff
	Discussion of behavioral health and other effects of COVID on various sectors of the Northern Region, including community agencies, school, hospitals, and community members.	Board members and Jessica Flood, Regional Behavioral Health Coordinator
	Update on Northern Regional Behavioral Health Policy Board Bill Draft Request Focused on updating and clarifying the mental health crisis hold process in NRS 433.	Jessica Flood, Northern Regional Behavioral Health Coordinator
	Medicare: Affordable Care and Improved Access for Nevada	Matt Law, Health Benefits and Northern Board member
9.29.2020	Division of Healthcare and Finance Policy (DHCFP) and Division of Child and Family Services (DCFS) update on budget changes due COVID epidemic.	DHCFP staff and Jessica Flood, coordinator
	Presentation of Washoe County's Crossroads project focused on tiered housing for individuals with complex behavioral health needs.	Frankie Lemus, Washoe County Social Services

Update on Northern Regional Behavioral Health Policy Board Bill Draft Request Focused on updating and clarifying the mental health crisis hold process in *Nevada Revised Statutes* (NRS) Chapter 433	Jessica Flood, Northern Regional Behavioral Health Coordinator
Regional Behavioral Health Coordinator update on current local, regional, and statewide efforts and initiatives including the Northern Regional Behavioral Health Emergency Operations Planning Committee, Northern Regional Behavioral Health Communications committee, and Nevada Crisis Now Initiative meetings	Jessica Flood, Northern Regional Behavioral Health Coordinator
Presentation on Nevada Resilience Project	DPBH staff

2020 Northern Board Legislation: Senate Bill SB70

Northern Regional Behavioral Health Policy Board reviewed and discussed various bill draft ideas for their 2021 BDR, eventually deciding to continue the work started in its initial bill, AB85, in the 2019 legislative session. In what became SB70, the Northern Board's 2021 bill is focused on modernizing, standardizing, and reducing stigma in Nevada's mental health crisis hold process found in NRS 433A, continuing the work initiated by AB85 in the 2019 legislative session. For background, AB85 was brought forth by the Northern Regional Behavioral Health Policy Board to clarify and standardize the mental health crisis hold process, was developed by the Statewide Mental Health Crisis Hold Work Group. During the process of developing AB85, stakeholders gained a greater understanding of the issues and gaps in the law and saw the need for continued legislative effort to update NRS 433A. Some of the major changes SB70 focuses on include:

1. Updating and modernizing processes, terms, and definitions in mental health crisis hold process to our current system.
2. Updating Assisted Outpatient Treatment process to align with national best practices.
3. Updating conditional release to make it useable given the resources and constraints of our mental health system.
4. Updating youth mental health crisis hold process developed in 2019 legislative session to conform with current practice.
5. Excluding modern FDA approved interventions for treatment from the definition of chemical restraint.

One of the largest issues SB70 addresses is the incongruence between the law and current practice. NRS 433A, originally written in 1975, reflects a mental health crisis system that is far different than the system we have today. Back then, a law enforcement officer would respond to someone in mental health crisis and initiate an "application for emergency admission." The law enforcement officer would transport that person and the application to a state inpatient psychiatric hospital such as Northern Nevada Adult Mental Health Services (NNAMHS). The hospital would certify the person, and involuntarily admit them under "emergency admission." Since then, our system has changed significantly while the language in the law has remained the same.

Now, when an individual is experiencing a mental health crisis, they are detained by law enforcement under an "application for emergency admission" and are transported to a medical hospital or crisis center for medical evaluation and certification- not admission. While the current law anticipates that "emergency admission" occurs soon after the "application for emergency admission" is initiated, in reality patients usually remain in a medical hospital for several days where they may be stabilized and discharged or transferred when a bed in an inpatient psychiatric hospital becomes available. This incongruence between practice and the law creates confusion.

Other processes in NRS 433A, such as conditional release, have not been updated, making adherence to the law challenging and at times impossible. Other issues to be addressed came from more recent legislative changes. Assisted Outpatient Treatment (AOT), initially brought into law in 2013, was woven into the existing involuntary court ordered admission process used for inpatient treatment, making the outpatient program criteria and process confusing. In addition, the language used in NRS 433A in the youth mental health crisis hold process, developed by AB 378 in the last legislative session, has several gaps that cause continuing stakeholder confusion.

SB70 attempts to modernize our law in several areas of NRS 433A to reflect our current system with its resources and limitations. Clarifying the law and standardizing practice across Nevada will reduce confusion for patients, families and stakeholders including courts, law enforcement, mental health professionals and hospitals. These changes also support current state initiatives, such as the development of Nevada's Crisis Response system and diversion of individuals with behavioral health issues from the criminal justice system.

Ongoing Regional Behavioral Health Planning Efforts

County Behavioral Health Task Force Strategic Planning

Each county in the region has developed behavioral health task forces and community meetings to respond to the health and behavioral health needs in their communities. For some counties, this strategic planning process has taken place over multiple workshops and meetings which have focused on general strategic planning for behavioral health and on specific issues such as the Stepping Up Initiative. Priorities identified in planning efforts have been incorporated into "living" strategic planning documents that are updated as new issues arise or when progress is

made. These behavioral health task forces and strategic planning sessions receive input from diverse community stakeholder groups, including EMS/ Fire, law enforcement, county officials, social services, behavioral health treatment providers, hospitals, and peer and family advocates. These county-based strategic planning efforts provided a strong source of information for the Northern Regional Behavioral Health Policy Board strategic plan.

Regional Crisis Now Planning

In early 2020, the Northern Board initiated regional efforts to conduct a gaps and needs analysis to inform the DPBH's Crisis Now Initiative. More information on the Crisis Now initiative can be found here: https://socialent.com/2020/06/nevada-crisis-response-system-virtual-summit/. Through this process, stakeholders identified several resources already in place to support Crisis Now, including the Mobile Outreach Safety Teams, Crisis Intervention Training, and Mallory Crisis Center. In addition, the region also identified the following needs to develop a cohesive Crisis Now system in the region:

- **24/7 mobile crisis response:** The region's MOST teams are currently strained by community needs and are not 24/7. MOST is important in connecting with individuals who lack insight into their mental illness or who are at risk of violence. In addition to the MOST teams, the region hopes to develop a central 24/7 mobile crisis teams staffed by clinicians and peers to respond to voluntary and non-violent individuals. The Northern Region's stakeholders believe that having both MOST and mobile crisis teams is an adaption to the Crisis Now model that will meet the unique needs of Nevada.
- **Crisis call coordination**: While the Northern region has access to many hotlines, the region needs to be connected with a central crisis call line providing "care traffic control". Currently, Crisis Support Services of Nevada (CSSN) is intended to provide that function for the state, however MOU's and shared processes are still needed between the region's local providers and CSSN.
- **Crisis Stabilization Unit**: The region is fortunate to have Mallory Crisis Center which has successfully provided crisis stabilization for the region and rural counties for several years now. The Northern Board has prioritized the need for the state to develop a sustainable funding model for Mallory to ensure long term success.
- **Rural crisis stabilization access points:** Due to the Northern Region's geographic area, stakeholders identified the need for crisis stabilization access points in its more rural areas. The region's CCBHCs may be able to provide this function, but at this time none have a formal crisis stabilization area with 24/7 support needed for law enforcement drop off. In addition, there is an opportunity for the rural critical access hospitals to develop scale down crisis stabilization services as well.

NORTHERN REGIONAL BEHAVIORAL HEALTH COORDINATOR ACTIVITIES

The Regional Behavioral Health Coordinator position is funded through several federal grants managed by DPBH's Behavioral Health, Wellness, and Prevention. Jessica Flood, the Regional Behavioral Health Coordinator for the Northern Regional Behavioral Health Policy Board, conducted the following activities in 2020:

Coordination activities:

- Coordinated with local, regional, and state partners to decrease siloed work and possible duplication.
- Coordinated with Regional Behavioral Health Coordinators to assist in regional efforts being aligned with larger statewide vision.
- Participated as vice- president on Board of Directors for NAMI (National Alliance on Mental Illness) Western Nevada chapter.
- Participated on Board of Directors for Human Services Network, a human services advocacy organization serving Northern Nevada.
- Participated on Board of Directors for the Life Change Center to coordinate on opioid treatment response in rural region.
- Participated as a board member on Rural Children's Mental Health Consortium.
- Facilitated the regional Crisis Intervention Team (CIT) Training, Mobile Outreach Safety Team (MOST), and Forensic Assessment Services Triage Team (FASTT) Learning Collaborative.
- Worked with Carson, Lyon, and Douglas FASTT teams, in coordination with DPBH, to align the jail reentry teams with evidence-based practices.
- Served on SAMSHA/ VA Nevada Governor's Challenge team to address veteran suicides.

Policy Development and Initiative Implementation:

- Provided ongoing support of Regional Behavioral Health Policy Board through development of agendas, technical assistance, provision of knowledge and education around behavioral health theory, framework, and best practices.
- Provided ongoing support of county behavioral health task forces in Carson, Churchill, Douglas, Lyon, and Storey Counties.
- Facilitated the Statewide Mental Health Crisis Hold Workgroup and subcommittees focused on development and coordination of SB70.
- Facilitated the Statewide Youth Mental Health Crisis Hold workgroup.
- Coordinated the development of mental health crisis hold education.
- Participated in Douglas and Churchill County Committees on Health, Boards of Health, and Lyon County Public and Behavioral Health Executive Committee.
- Participated in planning and developing Rural Children's Mental Health Consortium "Community Discussion".
- Assisted DPBH in developing the DPBH Capacity Assessment of Substance Use Treatment for the Northern Region.
- Participated in the Crisis Now initiative through partnering with DPBH to develop and distribute education to region's stakeholders and behavioral health policy board.
- Participated in the Statewide and Rural Continuum of Care meetings to provide behavioral health input into HUD housing system.
- Continuing to advocate for criminal justice programs along the Sequential Intercept Model using the Stepping Up Initiative.

- Developed the Statewide Mental Health Crisis Hold Brochure to educate healthcare providers, patients, and families about the involuntary mental health crisis hold process. This brochure can be found in Appendix C.

Support of program development, implementation, and sustainability:

- Supported Carson, Lyon, Douglas, and Churchill CIT trainings through training and coordination assistance, and monthly facilitation of a Crisis Intervention Training learning community that has participation from all of Nevada's CIT coordinators excluding Washoe County.
- Coordinated the development of the Nevada Crisis Intervention Training website. The website can be found here: nvcit.org
- Partnered with Darcy Davis from DPBH in coordinating the region's FASTT jail reentry teams regarding continued funding from DPBH, development of policy and procedure, regional standardization, and alignment with evidence-based practice.
- Partnered with Darcy Davis from DPBH in coordinating the region's Mobile Outreach Safety teams regarding funding from DPBH, development of policy and procedure, regional standardization, and alignment with evidence-based practice.
- Participated in the HRSA Opioid grant funded "Resilient Eight' Counties, including Churchill, Douglas, Esmerelda, Lyon, Lincoln, Mineral, Nye, and Storey Counties.
- Successfully coordinated with DPBH in applying for a SAMHSA grant funding an early diversion Assertive Community Treatment team at Carson Tahoe, which receives referrals from the region's Mobile Outreach Safety Teams. Participated in ongoing efforts to implement the grant as well.

NORTHERN REGION BEHAVIORAL HEALTH PROFILE

The data trends highlighted in this section reflect the experience reported by community stakeholders and providers that have participated in the county behavioral health taskforces and on the Northern Regional Behavioral Health Policy Board for several years now. The region continues to see high rates of hospital emergency department (ED) encounters and admissions for anxiety and depression that have significantly increased over the past decade. This data speaks to a significant portion of the population experiencing behavioral health crisis or in risk of future crisis.

The data trends below, are highlighted from Nevada DHHS's "Substance Abuse Prevention and Treatment Agency (SAPTA) 2020 Northern Behavioral Health Profile, You can find a full version of the report on DHHS's website here.

Northern Region Demographics:

The Northern Region consists of Carson City, Churchill, Douglas, Lyon, and Storey Counties, stretching across 11,976.95 square miles in northwestern Nevada. The total population of the

Northern Region, estimated to be 192,723 in 2019, has increased 3.6% over the past 10 years. The median household income was $60,704 in 2019, an increase from $54,392 in 2017. Approximately 10.6% of the population was in poverty. 9.4% of the population under 65 had a disability in 2019, a decrease from 14.8% in 2017. In terms of ethnicity, 76.9% residents in the Northern Region are White not of Hispanic origin, 16.5% individuals are Hispanic, 3.0% of the population are Native American, 2.4%, Asian, and 1.1% of the population are Black. [4]

Data Highlights from the DPBH SAPTA 2020 Northern Region and Statewide Epidemiological Profiles

Adult mental health:

- In 2019, 26.9% of the Northern Region residents reported 10 or more days of poor mental health, a significant increase from 2018 at 16.4%. Of adults in the Northern Region, 60.7% experienced no days in which their mental health was not good.
- In the Northern Region, the percentage of adults were told they have a depressive disorder from 19.2% in 2018 to 21.9% in 2019.
- Anxiety has been the leading mental health-related diagnosis since 2010 in emergency department encounters. Anxiety-related encounters increased significantly from 2010 to 2019 in both counts and rates. However, ED encounters for depression have decreased from 2016.

Adult Suicide:

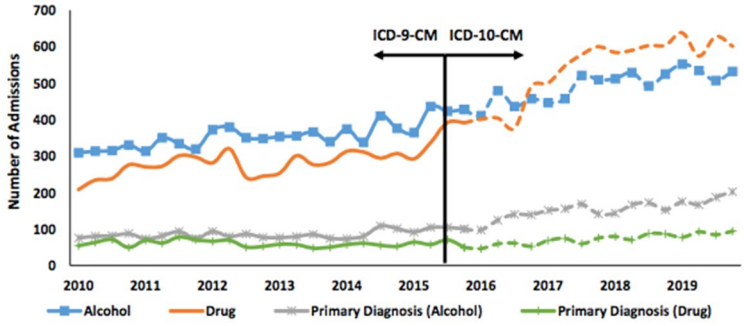
- The age-adjusted suicide rate for 2019 in Northern Region was 29.6 per 100,000 population. There were 59 suicides in 2019.
- Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have remained steady for all methods except substances/drugs from 2010 to 2019. The most common method for attempted suicide is a substance or drug overdose attempt, with 136 emergency department encounters. The substance or drug overdose attempts have been decreasing since 2016.
- When asked "have you seriously considered attempting suicide during the past 12 months," 5.4% of Northern Region residents responded "yes" in 2019. Between 2011 and 2019, the average prevalence for suicide consideration in the Northern Region is 3.8%.
- Mental health-related deaths in the Northern Region in 2019 increased from the previous year from 62.4 per 100,000 age-specific population, to 79.2 per 100,000 age-specific population.

Adult Substance Use:

[4] *Source: *Nevada State Demographer, vintage 2019 and **US Census Bureau.*

- Marijuana use has increased over six-fold since 2011. In 2019, 20.3% of Northern Region residents have used marijuana in the past 30 days, up from 3.3% in 2011. Marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Of the Northern Region residents surveyed, 1.0% (on average) used painkillers to get high in the last 30 days and 1.1% used other illegal drugs to get high in the last 30 days.
- Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Emergency department encounters for opioids, heroin, and marijuana rates increased from 2018 to 2019.
- Alcohol-related admissions were more common than drug related admissions until 2017 where drug- related admissions surpassed alcohol-related admissions and have remained higher through 2019.

Figure 40. Alcohol-Related and/or Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

- Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Opioid and cocaine inpatient admissions increased significantly from 2018 to 2019.
- Opioids were the most common drug-related hospital admission reason until 2017, when they were surpassed by marijuana. Inpatient admissions for marijuana, opioids, and methamphetamines have been increasing since 2016 while other drug-related admissions have remained steady.

Youth Mental Health:

- Due to the fact that the questions in the Youth Behavior Risk Survey relating to suicide and feelings of sadness and hopelessness were worded differently in 2019 to past years and should not be compared, there is no data to report on this topic.

Youth Tobacco Use:

- High school students for the Northern Region in 2019, had a significantly higher percent for ever having smoked cigarettes than Nevada at 27.5% and 18.0% respectively. The

middle school students in the Northern Region also, had a slightly higher percent for ever trying cigarettes at 14.6% compared to 9.9% Nevada.

- High school students in the Northern Region in 2019 have a significantly higher percent for ever having using an electronic vapor (e-vapor) product than Nevada at 59.9% and 43.5%, respectively. Similarly, middle school students in the Northern Region also have a significantly higher percent for ever using an e-vapor product at 30.6%, 22.4% for Nevada.

Youth Alcohol Use:

- High school students in the Northern Region in 2019 have a significantly higher percent for ever drinking alcohol than Nevada at 66.1% and 56.9%, respectively. The percent from previous years has decreased from 66.4% in 2017. Similarly, middle school students in the Northern Region have a slightly higher percent for ever drinking alcohol at 32.7%, compared 29.2% for Nevada.

Youth Marijuana Use:

- High school students in the Northern Region in 2019 have a significantly higher percent for ever using marijuana than Nevada at 45.4% and 35.4%, respectively. The percent from previous years has increased from 43.6% in 2017. Similarly, middle school students in the Northern Region have a slightly higher percent for ever using marijuana at 16.4%, compared 13.4% for Nevada.

Special Populations- Maternal and Child Health

- Of the self-reported substance use during pregnancy among the Northern Region mothers who gave birth between 2010 and 2019, the highest rate was with marijuana use in 2018, at 18.9 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was at 5.3 per 1,000 births in 2019. Polysubstance use (more than one substance) has decreased from 3.9 per 1,000 live births in 2015 to 2.6 per 1,000 live births in 2019.
- Over the past decade, Inpatient admissions for neonatal abstinence syndrome (NAS) in the Northern Region significantly increased from 2 newborns admitted in 2011 to 13 newborns admitted in 2018. However, there since have been a marked decrease from a high of 9.5 in 2016 to 2.1 in 2019.

Appendix A: Overview of Northern Region key crisis stabilization and criminal justice diversion programs

	Forensic Assessment Services Triage Team (FASTT) Jail Reentry Services	Crisis Intervention Team (CIT) training 40-Hour Behavioral Health Training for First Responders	Mobile Outreach Safety Team (MOST) co-responder outreach team	Carson Tahoe Mallory Crisis Center, Assertive Community Treatment (ACT) for Jail and Hospital diversion, First Episode Psychosis FEP)	Certified Community Behavioral Health Clinic (CCBHC) *All CCBHC's provide mobile crisis and ACT*
Carson City	Meets as a team weekly with staff response Monday through Friday	2 x per year (August and November)	Currently 40 hours/ week- Monday-Thursday 6am- 4pm 1 clinician from Rural Clinics & 1 Behavioral Health Peace Officer from Carson City Sheriff's Office. Expanding to two full time teams with county funding.	Crisis Services available for all rural counties 24/7, ACT and FEP services available to Northern Region	Community Counseling Center Vitality Unlimited
Douglas County	Meets as a team weekly with CHW follow up Monday-Friday	1 x per year in March	Currently 2 days/ week- Wednesday & Thursday 6am- 4pm 1 clinician from Rural Clinics and 1 private clinician funded through SAPTA & 1 BHPO from Douglas County Sheriff's Office.	" "	
Churchill County	Meets as a team weekly with Resource Liaison follow up Monday-Friday	1 x per year in March (cancelled due to COVID)	Uses "Resource Liaisons" to collaborate with law enforcement and provide community outreach Monday through Friday.	" "	New Frontier
Lyon County	Meets as a team weekly with	1 x per year in August (cancelled	Currently 2 days/ week- Wednesday & Thursday 6am- 4pm		Rural Nevada Counseling

	staff response Monday through Friday	due to COVID)	1 clinician from Rural Clinics and 1 private clinician funded through SAPTA & 1 BHPO from Douglas County Sheriff's Office	" "	Vitality Unlimited
Storey County	On-call community health worker to provide discharge planning		On-call community health worker to provide discharge planning	" "	

APPENDIX B: NORTHERN REGION BEHAVIORAL HEALTH PROGRAM AND INITIATIVE DEFINITIONS

Behavioral Health Task Force (BHTF)-

- County based policy meetings involving stakeholders that have a vested interest in behavioral health and their communities. Task forces are a place to gather, identify problems, and set goals and priorities for the communities to tackle problems, both large and small. Task forces are effective in bringing all stakeholders together as they enable different professions to understand behavioral health impacts and challenges from different perspectives.

Certified Community Behavioral Health Clinics (CCBHC)

- Outpatient behavioral health centers that provide integrated mental health and substance use treatment, primary care assessment, and medication management as needed. CCBHC's serve the 'whole person' by offering person-centered and family-centered care. Populations that CCBHCs provide services to include:
    - Adults with serious mental illness
    - Children with serious emotional disturbance (SED)
    - Individuals with severe substance use disorders
    - Individuals with mild or moderate mental illness and substance abuse disorders
- Services provided:
    - Community-based mental health and substance use treatment services
    - Combined behavioral health and physical health care with no wrong door entry to services
    - Evidenced based practices
    - Improved access to high-quality care
    - Care coordination and case management to address all needs of the individual

Crisis Intervention Team Training (CIT)

- A 40-hour behavioral health training model, focused on first responders, that brings together law enforcement, mental health providers, hospital staff, and individuals with mental illness, and their families to improve responses to people in crisis. CIT trainings enhance communication between providers, identify community mental health resources, and develop participant skills in responding to those in behavioral health crisis. CIT trainings are unique to each community region so that resources and information are tailored to the local needs of the participants in the training.

Forensic Assessment Service Triage Team (FASTT)

- The FASTT team is comprised of social services, mental health, and substance use treatment agencies who conduct community in-reach into county jails to provide inmates with screening, assessment, treatment, and other services during incarceration and upon reentry into the community to reduce risk of rearrest.

Mobile Outreach Safety Team (MOST)

- A team composed of a mental health clinician and/ or case manager, and a law enforcement deputy, and may also include an emergency services paramedic and/ or social services case

manager. The team responds to law enforcement calls and other community referrals that involve behavioral health crisis. Depending on the county, MOST teams may respond to psychiatric emergencies, provide community outreach, and provide maintenance check-ups on previous contacts. MOST's purpose is to reduce the risk of arrest and hospitalization for individuals experiencing behavioral health issues, thereby increasing the safety of the general public.

APPENDIX C: OVERVIEW OF SENATE BILL 70

Overview of Bill Draft Request SB 70

<table>
<tr><th colspan="6">SB 70 changes across the mental health crisis hold process</th></tr>
<tr><th>Elements of Mental Health Crisis System</th><th>Mental Health Crises</th><th>Detainment, evaluation, and treatment at a hospital or crisis center</th><th>Emergency admission to Inpatient Psychiatric Hospital</th><th>Involuntary court ordered admission</th><th>Discharge from inpatient psychiatric facility</th></tr>
<tr><td rowspan="4">Changes with SB70</td><td rowspan="4">Updates terms, definitions, and criteria for mental health crisis hold process</td><td>Updates chemical restraint definition to align with current national and federal standards of patient care</td><td rowspan="4">Clarifies emergency admission</td><td rowspan="3">Updates involuntary court-ordered admission to inpatient psychiatric hospitals</td><td>Updates process and reporting timelines for conditional release</td></tr>
<tr><td>Updates family court petition process for law enforcement pick- up and evaluation.</td><td>Updates reporting timelines for unconditional release</td></tr>
<tr><td rowspan="2">Deletes family petition for court ordered admission to an inpatient psychiatric hospital</td></tr>
<tr><td colspan="2">Clarifies and standardizes Assisted Outpatient Treatment- involuntary court ordered outpatient treatment for use in all Nevada counties</td></tr>
</table>

Summary:

SB70 is focused on modernizing, standardizing, and reducing stigma in Nevada's mental health crisis hold process found in NRS 433A, continuing the work initiated by AB85 in the 2019 legislative session. For background, AB85 was brought forth by the Northern Regional Behavioral Health Policy Board and developed by the Statewide Mental Health Crisis Hold Work Group. During the process of developing AB85, stakeholders gained a greater understanding of the issues and gaps in the law and saw the need for continued legislative effort to update NRS 433A. Some of the major changes SB70 focuses on include:

- Updating and modernizing processes, terms, and definitions in mental health crisis hold process to our current system.
- Updating Assisted Outpatient Treatment process to align with national best practices.
- Updating conditional release to make it useable given the resources and constraints of our mental health system.
- Updating youth mental health crisis hold process developed in 2019 legislative session to conform with current practice.
- Excluding modern FDA approved interventions for treatment from the definition of chemical restraint.

Background:

One of the largest issues SB70 addresses is the incongruence between the law and current practice. NRS 433A, originally written in 1975, reflects a mental health crisis system that is far different than the system we have today. Back then, a law enforcement officer would respond to someone in mental health crisis and initiate an "application for emergency admission." The law enforcement officer would transport that person and the application to a state inpatient psychiatric hospital such as Northern Nevada Adult Mental Health Services (NNAMHS). The hospital would certify the person, and involuntarily admit them under "emergency admission." Since then, our system has changed significantly while the language in the law has remained the same.

Now, when an individual is experiencing a mental health crisis, they are detained by law enforcement under an "application for emergency admission" and are transported to a medical hospital or crisis center for medical evaluation and certification- not admission. While the current law anticipates that "emergency admission" occurs soon after the "application for emergency admission" is initiated, in reality patients usually remain in a medical hospital for several days where they may be stabilized and discharged or transferred when a bed in an inpatient psychiatric hospital becomes available. This incongruence between practice and the law creates confusion.

Other processes in NRS 433A, such as conditional release, have not been updated, making adherence to the law challenging and at times impossible. Other issues to be addressed came from more recent legislative changes. Assisted Outpatient Treatment (AOT), initially brought into law in 2013, was woven into the existing involuntary court ordered admission process used for inpatient treatment, making the outpatient program criteria and process confusing. In addition,

the language used in NRS 433A in the youth mental health crisis hold process, developed by AB 378 in the last legislative session, has several gaps that cause continuing stakeholder confusion.

SB70 attempts to modernize our law in several areas of NRS 433A to reflect our current system with its resources and limitations. Clarifying the law and standardizing practice across Nevada will reduce confusion for patients, families and stakeholders including courts, law enforcement, mental health professionals and hospitals. These changes also support current state initiatives, such as the development of Nevada's Crisis Response system and diversion of individuals with behavioral health issues from the criminal justice system.

Stakeholders involved:
The Statewide Mental Health Crisis Hold Workgroup convened in the fall of 2018, to obtain support and input for AB85 across the state. The Statewide workgroup continued to meet monthly to develop policy solutions for the next legislative session in 2020. Multiple subcommittees were also held on a weekly basis, focused on topics including the adult and youth mental health crisis hold process, Assisted Outpatient Treatment, and conditional release.

The Statewide workgroup consists of representatives from:

- Dr. Gunnarson, representative from the Northern Regional Behavioral Health Policy Board.
- Division of Public and Behavioral Health
- Nevada Psychiatric Association
- Nevada Rural Hospital Partners
- Nevada Hospital Association
- Washoe County judicial system
    - District Attorney's office
    - Public Defender's Office
- Clark County judicial system
    - judicial staff
    - Public Defender's Office
    - Las Vegas Metro Police Department

The youth subcommittee had participation from:

- Nevada Department of Education
- Clark County School District
- Clark and Washoe County District Attorney's Office
- Clark, Washoe, and Rural Child Welfare Agencies
- Division of Child and Family Services
- DPBH
- Clark, Washoe, and Rural Children's Consortia
- Children and family advocates from Nevada PEP Statewide Family Network

Core stakeholders participating in in the adult, Assisted Outpatient Treatment, and conditional release subcommittees included:

- Judge Bita Yeager from Clark County
- Judge Cynthia Lu and staff from Washoe County
- Staff from Division of Public and Behavioral Health including, Dr. Ravin, Joanne Malay, Christina Brooks, Dr. Stephanie Woodard, Ellen Richardson Adams
- Nevada Hospital Association
- Nevada Rural Hospital Partners
- Dignity Health
- Nevada's Statewide chapter (NAMI)
- Treatment Advocacy Center

SB70 at a glance

"Modernizing and Clarifying Nevada's Involuntary Mental Health Crisis Hold and Involuntary Treatment Processes"

Sponsored by the Northern Regional Behavioral Health Policy Board

SB70 is focused on updating and clarifying the steps in the involuntary mental health crisis hold and involuntary admission and treatment processes. SB70 builds on AB85 from the 2019 legislative session in working to strengthen patient rights through creating a more transparent process. A workgroup was formed to obtain support and input from stakeholders across Nevada, and through coordination with the Policy Board, the following objectives were identified to guide the reforms below:

1. Updates and modernizes the mental health crisis hold law, originally written in 1975, to reflect the current system and provide definitions for key terms. Changes include clarifying the family petition process for court ordered pick-up and adjusting hospital discharge notification of courts and legal guardians.

2. Develops and clarifies involuntary outpatient court ordered process "assisted outpatient treatment" (AOT) for use throughout the state. Research shows that assisted outpatient treatment significantly reduces jail days and hospital readmissions for AOT participants, who are adults with mental illness and have a history of poor compliance that resulted in repeated hospitalizations and/ or arrests. This is an effective intervention for early diversion from the criminal justice system.

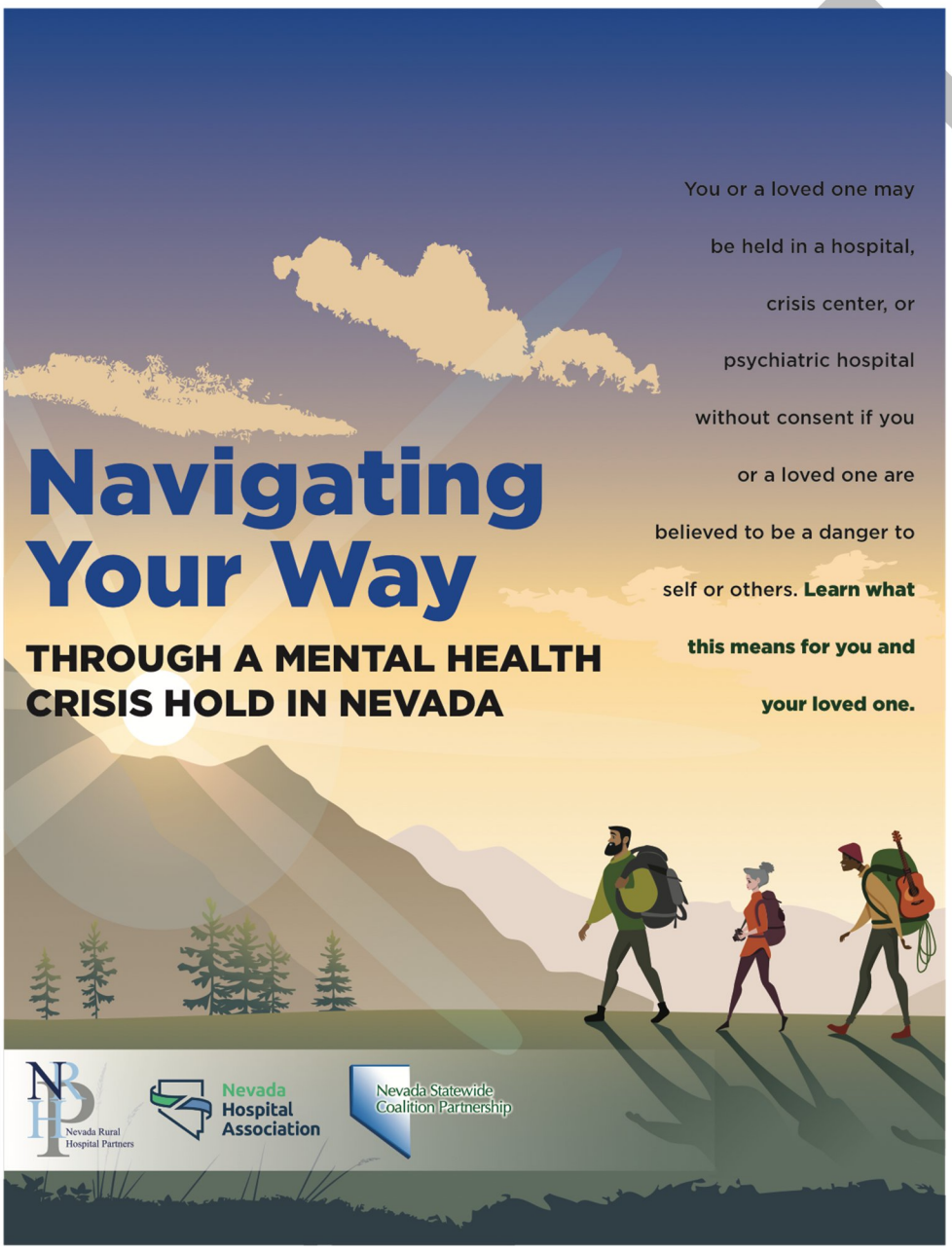
3. Strengthens continuity of care for individuals at risk of reoccurring mental health crisis by clarifying and updating conditional release process. Some individuals receiving treatment under a court ordered admission in inpatient psychiatric hospitals, once stabilized, lack the skills and resources to remain stable in the community upon discharge. These individuals are at high risk for decompensating back into mental health crisis. Conditional release provides a mechanism for more formalized discharge planning and increased community provider and court coordination to support these individuals in remaining stable in the community for the duration of the involuntary court order. Conditional release is available to those individuals who may not meet the criteria for assisted outpatient treatment or who live in communities where assisted outpatient treatment is unavailable.

4. Clarifies the youth mental health crisis hold process by updating the process so it accurately reflects our current system and without infringing on parental rights.

5. Updates chemical restraint to reflect modern federally approved processes.

Appendix E: Mental Health Crisis Hold Brochure

After the passage of AB 85, the Regional Coordinator facilitated the Statewide Mental Health Crisis Hold Workgroup and coordinated with the Northern Regional Behavioral Health Policy Board to develop the Statewide Mental Health Crisis Hold Brochure to educate families, patients, hospitals, treatment providers, and law enforcement on the involuntary hold process and associated patient rights. Partnership Douglas County provided funding to print out 10,000 of these brochures and the associated one pager overview below and distributed them to all hospitals in the state.



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1 in 5 Americans live with mental illness.

—NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

PUBLISH DATE: JUNE 2020

Getting Started...

WHERE IS ONE TAKEN ON A MENTAL HEALTH CRISIS HOLD?

If you are placed on a hold, you will be taken to a hospital or crisis center for evaluation. Once evaluated by a healthcare professional, you may either be discharged or transported to an inpatient psychiatric unit.

HOW LONG DOES A MENTAL HEALTH CRISIS HOLD LAST?

A mental health crisis hold lasts for up to 72 hours. If, at any time during the crisis hold, the healthcare provider overseeing your care believes you need additional treatment to address your mental health crisis, they may petition the court for a court ordered admission to extend the hold.

WHO CAN PLACE A MENTAL HEALTH CRISIS HOLD?

The following individuals can put someone on a mental health crisis hold:

- Authorized Law Enforcement
- Physician
- Physician Assistant
- Psychologist
- Marriage and Family Therapist
- Clinical Professional Counselor
- Social Worker
- Registered Nurse
- Advanced Practice Registered Nurse

WHY WAS I OR MY LOVED ONE PLACED ON A MENTAL HEALTH CRISIS HOLD?

A person may be held if there is a *substantial likelihood of serious harm to himself/herself or others due to mental illness*, and if, without care or treatment, is at risk of:

- Attempting suicide or having thoughts or plans of suicide
- Attempting homicide or having thoughts or plans of homicide
- Causing bodily injury to himself/herself or others
- Incurring a serious injury, illness, or death resulting from being unable to care for oneself due to mental illness with complete neglect of basic needs for food, clothing, shelter, or personal safety.

MENTAL HEALTH CRISIS HOLD PROCESS

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Individual is assessed to be at risk of harming self or others due to mental illness	**Mental health crisis hold is placed in community or in healthcare facility and 72- hour detainment begins**	**Individual receives a medical assessment to make sure there is no medical condition that requires immediate treatment**	**Individual receives evaluation from medical professional in order to certify that crisis is due to mental illness**	**Individual, while under detainment at any time, may be accepted and transported to inpatient psychiatric facility**	**If 72 hours is anticipated to run out, and individual is still assessed to be danger to self or others, hospital provider may petition court for court ordered admission, extending detainment until court hearing for court ordered admission. (Court must schedule hearing within six business days)**

An individual on a hold can be released at any point during the process if they are assessed to no longer be a danger to self or others due to mental illness.

Youth Mental Health Crisis Holds

What the law says...

Many of the laws in Nevada associated with adults in mental health crisis also apply to minors:

1) Under Nevada law, a mental health facility or hospital can hold a minor under emergency admission without parental consent for up to 72 hours from the time when the mental health crisis hold is initiated.

2) The person who may be placing the mental health crisis hold must attempt to contact the parent or guardian to obtain their consent prior to initiating the hold.

3) If a mental health crisis hold is necessary, the child will be transferred to a hospital for their safety.

4) The hospital or mental health facility must provide notice to the parent or guardian as soon as practicable and no later than 24 hours after admission.

5) It is important to know that a youth mental health crisis hold is not necessary or recommended if a parent or guardian is supportive of the recommended treatment.

WHAT NEVADA LAW SAYS ABOUT MENTAL HEALTH CRISIS

A person in mental health crisis: any person (1) who has a mental illness; and (2) whose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of the mental illness, to the extent that the person presents a substantial likelihood of serious harm to himself/herself or others.

WHAT IS NOT A MENTAL HEALTH CRISIS?

The following health issues are not a mental health crisis, but may occur at the same time as mental health crisis:

- Epilepsy
- Intellectual disability
- Dementia (i.e., Alzheimer's)
- Delirium
- Alcohol/drugs (either brief intoxication or dependence/addition)

(NRS 433A.0175)

WHAT DOES THIS MEAN FOR YOU OR YOUR LOVED ONE?

If a person is in danger of harming themselves or someone else, or is unable to care for themselves due to mental illness, a friend, family member or community member can call 9-1-1 to have law enforcement or a mobile crisis team assess the situation.

If law enforcement, after observation, believes the person to be in a mental health crisis, they can place the person on a mental health crisis hold and bring the person to a hospital for further evaluation.

This process is designed for the safety and well-being of the person in crisis, their family and community.

If you and your child are experiencing conflict or crisis, the Children's Mobile Crisis Response Team is available to help 24/7 at 702-486-7865. More information can also be found at knowcrisis.com.

Individual & Family Options to Support Those Experiencing Mental Illness

You may have a loved one who is struggling with mental illness. Here are some options that you can consider:

National Alliance on Mental Illness (NAMI) Family-to-Family Class

NAMI Family-to-Family is a free, 8-session educational program for family, significant others and friends of people with mental health conditions. It is a designated evidenced-based program. This means that research shows that the program significantly improves the coping and problem-solving abilities of the people closest to a person with a mental health condition. NAMI Family-to-Family is taught by NAMI-trained family members who have been there, and includes presentations, discussions and interactive exercises. More information on NAMI Nevada can be found here: **naminevada.org | 775-470-5600**

Nevada PEP (Parents Empowering Parents)

Nevada PEP services are about empowering families to be life-long advocates for their children through education and skill building. PEP recognizes that parents are experts on their children and must learn about disabilities, intervention needs, and how to develop a support system to meet those needs. More information can be found here: **nvpep.org | 702-388-8899**

Psychiatric Advance Directive (PAD)

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. Completing a PAD, along with general estate planning and health care power of attorney documentation, are all important steps that designate someone to communicate your healthcare and estate decisions for you in the event that you are unable to. More information on PADs can be found here: **nrc-pad.org/states/nevada/**

Crisis Hotline: Crisis Support Services of Nevada

The Crisis Hotline is for individuals in Nevada who are in need of an empathetic ear, a caring heart and a helping hand to anyone in need. Help is available through hotline, text line and in-person advocacy services. For more information please visit: **cssnv.org | 1-800-273-8255**

Welfare Check

A welfare check is a law enforcement contact with a person when there is a significant concern for their wellness or safety. Requests for welfare checks often originate from the person's family members, loved ones, significant others, close friends, employers or neighbors. If a citizen makes a request for a welfare check it is important that they provide information regarding the person's medical history, psychological history, substance use history, access to weapons, and any other circumstances surrounding the person that give rise to the concern for their wellbeing. If a welfare check is found to be warranted, the responding officers will use this information when determining which course of action is most appropriate. It is not unusual for a responding officer to call the requestor to obtain more information based on the unique circumstances of the call, so those requesting such checks should keep their phone nearby. Welfare checks do not give officers automatic authority to go into someone's house. If you believe a welfare check is needed, you may request one by contacting your local law enforcement.

Individual & Family Options to Support Those Experiencing Mental Illness CONTINUED

Mobile Outreach and Response

Mobile Outreach Safety Teams (MOST), Rural MOST, and Crisis Response Team (CRT)/ Mobile Crisis Response Team (for youth) are behavioral health outreach teams using mental health clinicians and, at times, law enforcement who engage individuals experiencing crisis due to mental illness and other substance use issues. Mobile Crisis Response Team (for youth) is available statewide, 24/7. MOST Teams are not yet available in all parts of Nevada. Please visit Nevada's Crisis Intervention Team training website at **nvcit.org/find-support-in-crisis/** for more specific information on where these teams are located in Nevada.

Family Petition to Courts

NRS 433A allows for families to petition district courts for a pick-up order for an individual alleged to be in mental health crisis. There are some limitations to this option:

- Courts follow the same criteria for mental health crisis, described in NRS 433A.0175, as law enforcement and hospitals. Substance use is not criteria for detaining an individual.
- If the petitioner obtains a pick-up order, it is their responsibility to provide the pick-up order to law enforcement. Law enforcement staffing is limited in many areas, and this pick-up order may take time for law enforcement to carry out.
- This pick-up order is only to provide for assessment at the hospital.

Supported Decision Making

Nevada state law, NRS 162C, provides for a supported decision making agreement between an individual and the individual's supporter. A supporter can be anyone that the individual trusts, who will look out for the them and give them advice. A supported decision- making agreement is a tool that accommodates an individual with a disability by encouraging providers to support the decision making capacity of an individual with additional guidance from a trusted supporter, instead of discriminating against them. This keeps the individual at the center of all decisions and does not give away personal autonomy. For more information, please go to: **www.nevadaddcouncil.org/supported-decision-making/**

Guardianship

Guardianship is a legal process used to protect individuals who are unable to care for their own well-being due to disability or incapacity. A court may appoint a legal guardian to care for an individual who is in need of special protection. For more information, please go to: **www.nevadaddcouncil.org/supported-decision-making/**

PSYCHIATRIC ADVANCE DIRECTIVES (PAD)

Psychiatric Advance Directives are medical-legal documents that allow individuals with mental illness to:

- Advocate for their desired care on their own behalf and uphold core principles in the provision of health care such as the preservation of patients' rights of self direction and self-determination in guiding one's care.
- Direct providers of health care on how they wish their psychiatric care to be provided in the event that they are incapable of making decisions concerning such care or are incapable of communicating such decisions.
- Designate another person to make decisions on their behalf in the event they become incapable of making such decisions.
- You can find a copy of Nevada's Psychiatric Advance Directive at **www.nrc-pad.org/states/nevada-forms/**
- You can register your Psychiatric Advance Directive with the Advance Directive Registry at the Secretary of State's Office at **www.nvsos.gov/sos/online-services/nevada-lockbox/about-advance-directive-registry**. The Secretary of State is responsible for electronically storing and making available filed documents to the registrant and/or authorized entities by request in conjunction with the registrant's medical care. This central repository allows your psychiatric advance directive to be accessed by healthcare providers when you experience crisis.

Situations in which your PAD may not be taken into consideration:

Mental health providers may decline to follow your advance directives if:

A) Compliance, in the opinion of the attending physician or other provider, is not consistent with generally accepted standards of care for the provision of psychiatric care for your benefit;
B) Compliance is not consistent with the availability of psychiatric care requested;
C) Compliance is not consistent with applicable law;
D) You are admitted to a mental health facility or hospital pursuant to certain sections of the Nevada Revised Statutes that regulate the process of involuntary commitment to inpatient psychiatric facility, and a course of treatment is required pursuant to those provisions; or
E) Compliance, in the opinion of the attending physician or other provider, is not consistent with appropriate psychiatric care in case of an emergency endangering your life or health, or the life or health of another person.

In the event that one part of the advance directive is unable to be followed, all other parts of the advance directive must still be followed.

What to Expect...

Below are some things that you can expect with a mental crisis hold.

WHAT CAN YOU EXPECT DURING THE 72 HOURS?

While at the medical facility, your healthcare team (doctors, nurses, social workers, etc.) will meet with you to determine your medical and mental health needs. They will also help you get to the appropriate treatment if you can't get it at their facility.

During your time, you will receive medical assessment based on your health needs that may include vital signs, diagnostic tests, labs, etc.

Many people will not need to go into an inpatient mental health hospital, but for those that do, the process can take anywhere from several hours to several days.

There are several factors that affect how long you stay at the hospital while waiting to get into an inpatient mental health treatment facility:

- Treatment of a critical medical condition or an infectious disease
- Injury
- Assessment of the cause of your crisis which may be due to a mental illness
- Referral to the appropriate treatment facility based on insurance and method of payment

WHAT MAY HAPPEN DURING THE CRISIS HOLD?

- You may be discharged.
- You may opt to stay as a voluntary patient.
- The hospital may ask the court for an order to extend the hold up to an additional 180 days. This is called a court-ordered admission. (For the majority of people, inpatient hospitalizations are often brief, lasting an average of 5-7 days.)

THE COURT PETITION PROCESS

What you should know about the court petition process that extends the hold after 72 hours:

- When the healthcare provider petitions the court to extend the hold, the court will schedule a hearing within six judicial days, excluding weekends and holidays, and appoint an attorney to represent you or your loved one. During that time, your attorney will meet with you and determine if you are willing to stay in the hospital or if you want to challenge the hold.
- The court may have their doctors meet with you as well, to make sure you should be on the hold.

THE COURT PROCESS AND YOUR LEGAL RIGHTS*

Nevada law states that you have the following rights while going through the court process:

1. **You have the right to a hearing and the right to be present at that hearing.**
2. **You have the right to an attorney, if you cannot afford to hire an attorney, one will be appointed for you.**
3. **The court will provide doctors, who will see if you meet criteria for inpatient mental health hospitalization, prior to your hearing.**
4. **At the hearing, the district attorney represents the state and will present evidence in support of the petition.**
5. **The court will hear and consider all relevant testimony including your perspective and the doctors' opinions.**

8

*INFORMATION OBTAINED FROM NRS 433A.270- NRS 433A.290

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*INFORMATION OBTAINED FROM NRS 433A.270- NRS 433A.290

The mental health crisis hold process is designed to keep you safe. With this in mind, your rights may be denied if your actions put the health and safety of you and those around you at risk.

PATIENT BILL OF RIGHTS: PART ONE

YOUR RIGHTS WHILE IN A HOSPITAL

1) Your Treatment
You have the right to be informed of the nature of your condition, proposed treatment or procedure, risks, benefits and prognosis and any continuing health care needs in terms you understand.

2) Participation in Your Treatment
You have the right to participate in the decision making process related to the plan of your care. You also have a right to participate in the discussion of ethical issues that may arise.

3) In the Least Restrictive Setting
You have the right to receive medical and psychiatric care and treatment in the least restrictive treatment setting possible, suited to meet your individual needs.

4) No Discrimination
You have the right to receive access to medical treatment or accommodations regardless of race, sex, creed, sexual orientation, gender identity, national origin, religion, disability, or sources of payment.

5) Right to Refuse Treatment
You have the right to refuse treatment as otherwise provided by law, and to be informed of the consequences of your refusal.

6) To be Informed
You have the right to be informed of the hospital's rules and regulations as they apply to your conduct.

7) Respectful Care
You have the right to receive considerate respectful care at all times and under all circumstances.

8) Communication
You have the right to effective communication with your health care team and other hospital members including being provided with an interpreter or other communication aides or services at no cost to you.

9) Patient Support and Advocacy
You have the right to know what patient support services are available, including patient advocates to assist with care coordination, quality of care concerns, and billing issues.

10) Access to Medical Records
You have the right to have access to your medical records according to hospital policy.

11) Cultural and Spiritual Practices
You have the right to have access to professionals to assist you with emotional and/or spiritual care. You also have the right to exercise your cultural values and spiritual beliefs as long as they do not interfere with others, or the planned course of medical care.

12) Grievance
You have the right to express concerns regarding any of these rights in accordance with the grievance process.

13) Advance Directive
You have the right to create a medical advance directive or a psychiatric advance directive (PAD) to appoint a surrogate to make health care decisions on your behalf to the extent permitted by law.

14) Confidentiality
You have the right to expect that all communication, and records pertaining to your care are confidential, and will not be used or disclosed except as required or permitted by law.

PATIENT BILL OF RIGHTS: PART TWO

YOUR PRIVACY RIGHTS

The exchange of information for care coordination between your providers is important, however, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) federal law protects your healthcare privacy rights as well as addresses security and privacy of health-related information.

- Your medical records, including treatment plans, are confidential and you have the right to control who is able to access your information except for special circumstances as discussed below.
- A patient must sign an authorization for the hospital to release information about your medical care to anyone including confirming or denying if someone is or was a patient.
- Listening carefully to family members may be all the staff is able to do during a phone call.

Family members are welcome to call the hospital at any time to share information with an employee. An employee will not share information and/or provide an update to the family member unless the patient has signed an authorization allowing disclosure of information to that person.

PLEASE NOTE: If you are a parent of a patient under the age of 18 or a legal guardian of a patient, you always have the right to receive information.

Patients often change their minds and sign an authorization one day and revoke it the next which means that contact with family members could change within 24 hours. Patients retain their right of choice even in cases where family disagrees. In cases where patients and families disagree or oppose, patient rights and choices override family preferences and directives.

YOUR RIGHTS REGARDING YOUR HEALTH CARE INFORMATION

You have the right to...

- Inspect and copy your medical records
- Amend the information
- Request a summary of who has been provided your health information
- Request restrictions on who can receive your health information
- Request confidential communication
- Receive a paper copy of the Notice of Privacy Practices

Patient Rights & Nevada Law

YOUR LEGAL RIGHTS IN AN INPATIENT MENTAL HEALTH FACILITY*

1) Legal
You have the right to retain and consult with an attorney at any time. Also, you have the right to request a court hearing if you think you are being wrongly held. The court will decide whether or not your mental health crisis hold should be removed.

2) Right to Be Informed
If you are in a psychiatric facility, you have the right to receive a copy of the facility's admission and discharge criteria.

3) Second Opinion
You have the right to receive a second evaluation from a psychiatrist or psychologist who does not have a contractual relationship with or financial interest in the facility.

4) Clothing and Personal Items
You have the right to wear your own clothing and keep personal items, including toilet articles, unless those articles may be used to harm yourself or others.

5) Personal Storage
You have the right to have access to storage for private use.

6) Visitors
You have the right to see visitors during regular visiting hours.

7) Telephones
You have the right to reasonable use of telephones, including making and receiving confidential calls.

8) Letters
You have the right to access materials for writing letters, including stamps, and to mail and receive unopened correspondence with some exception noted in NRS 433.482. This does not include packages.

9) Language Interpreter
You have the right to have reasonable access to an interpreter if you do not speak English or are hearing impaired.

10) Coordination with Family and Friends
If you sign a release of information form, you have the right to designate a person for the facility to share your medical and mental health information. Otherwise, your information will not be shared with others and will remain confidential (except as permitted or required by law).

11) Informed Consent
You or a parent or guardian (for minors under 18 years of age) have the right to review your treatment plan, including reasonable risks, benefits and purposes of the treatment. This includes any treatment alternatives available. You must provide a signature consenting to the agreed upon treatment plan. You can also withdraw your consent.

**Information obtained from Nevada Revised Statute 433.*

FREQUENTLY ASKED QUESTIONS

WHAT CAN I EXPECT FROM TREATMENT?

Treatment starts with the evaluation of the situation directly related to the admission, the gathering of patient history, and diagnosis evaluation. Patients work on developing the life skills and coping strategies appropriate for their illness and circumstances, which they will need to continue to use after discharge. The more a patient and their support system is engaged in treatment and embracing new ways of doing things, the more successful treatment can be.

WHAT IS A TYPICAL DAY LIKE?

Each day, patients follow a structured schedule that may include group and/or individual therapy, recreational activities, treatment plan meetings, family sessions, and private time for reflection and working on written assignments. Each patient is seen regularly by a psychiatric provider (psychiatrist and/or advanced practice psychiatric nurse and/or physician assistant).

ARE FAMILIES EXPECTED TO BE INVOLVED?

Yes! It is extremely important that family members participate in treatment. Family members are essential members of each patient's treatment team and family support assists in healing. It is also very helpful for families to understand and participate in the discharge and aftercare plans. Once discharged, if you notice any changes in behavior or the safety level of your loved one, please call the treating provider and make them aware of your concerns immediately.

HOW CAN I OBTAIN UPDATES ON MY FAMILY MEMBER'S STATUS IN TREATMENT OR IN THE HOSPITAL?

In order for you to obtain information about the status or condition of your loved one, the patient must sign a release that allows the hospital to share their information with others. Some hospitals in Nevada have attempted to make this process easier by providing patients with codes that family members can use to see if the patient is currently hospitalized. Codes may be words or a short combination of numbers that lets the provider know that your family member of loved one shared it with you and that they support you getting updates and other information about their progress.

WHAT IF I DON'T HAVE INSURANCE TO PAY FOR TREATMENT?

There are several options for those who do not have insurance but need mental health treatment. A hospital social worker or staff person will work with you to ensure you get the care you need.

The following options are available so you can get treatment:

- Many individuals are eligible for Medicaid, which after an often quick enrollment process, will allow you to access private hospitals offering inpatient mental health services.
- If you are ineligible for Medicaid and do not have insurance, the State of Nevada operates two psychiatric hospitals (Northern Nevada Adult Mental Health Services (NNAMHS) in Reno and Southern Nevada Adult Mental Health Services (SNAMHS) in Las Vegas) that provide services for individuals without insurance. However, these state hospitals are considered to be "safety net" services and could take several days before you could be admitted due to limited bed availability.

FAQ

Planning for Discharge & Advocating for Your Care

PLANNING FOR DISCHARGE

What to expect:

- A discharge planner, who could be a social worker, nurse, or other hospital staff, will meet with you within the first 24 hours of your stay to discuss your goals, preferences, and needs to begin developing a discharge plan to leave the hospital. Your provider overseeing your care will also be involved in making sure that this plan is aligned with your goals for care and treatment.
- If your plan changes during your stay, you can meet with your discharge planner to reassess and change the plan as needed.
- The following elements will be used to develop your plan and connect you to providers who can support you after discharge:
  - Your diagnosis
  - Medical issues and past medical history
  - Ongoing needs after discharge
  - Any risk for needing to be admitted again
  - Your social, family, psychological, employment, food, housing and transportation needs
  - Communication needs, language barriers, diminished eyesight or hearing, literacy
- When your discharge planner meets with you, they will help you select a provider and can give you information on the provider's quality of services.
- You and your caregiver (if you have one) will be involved in the development of your discharge plan and will be notified of your final plan so you can prepare for after discharge.

HAVE A CONCERN ABOUT YOUR CARE?

All hospitals strive to provide the best care possible, however there may be times when you are not satisfied with the care you are receiving. The following actions can help in these situations:

- If you believe your rights have not been observed, discuss your concern with any staff member in person and/or in writing.
- Request to speak to a patient advocate at the hospital, who can help you navigate the hospital's complaint and grievance process. This person serves as an advocate for those admitted to the hospital. The patient advocate is available to both you and your family, assisting in clarifying information, supporting your rights and connecting people to the right resources. The patient advocate can help with grievances and also can pass along compliments regarding your rights and the quality of care and service at the hospital.
- If you have a concern about your rights, you may discuss your concerns with your attorney.

Next Steps

IF YOU HAVE ISSUES OR EXPERIENCE CRISIS IN THE FUTURE

The following resources can help you:

STATEWIDE:

CRISIS SUPPORT SERVICES OF NEVADA
800-273-8255
Text "CARE" to 839863
cssnv.org

SUICIDE PREVENTION LIFELINE
800-273-8255
suicidepreventionlifeline.org
Crisis text line: Text HOME to 741741

CHILDREN'S MOBILE CRISIS RESPONSE TEAM
702-486-7865
knowcrisis.com
Crisis hotline: 24/7

RURAL:

RURAL CLINICS IMMEDIATE MENTAL HEALTH CARE TEAM
1-877-283-2437
Telephone triage 24/7
Care Team response 9:00 am-6:00 pm
7 days/week

COMPLAINTS AND GRIEVANCES:

NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Healthcare Quality and Compliance
775-684-1030
http://dpbh.nv.gov/Reg/HealthFacilities/dta/Complaints/HCQC-Complaint-Form/

RESOURCES

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NEVADA LAWS THAT APPLY TO MENTAL HEALTH CRISIS

To read the specific laws, please visit:
www.leg.state.nv.us/NRS/NRS-433A.html

Thank you to the Northern Regional Behavioral Health Policy Board for their leadership and support in clarifying and standardizing the mental health crisis hold process in the 2019 Nevada legislative session through AB 85. This document was prepared by the Statewide Mental Health Workgroup, a multidisciplinary group composed of law enforcement, courts, hospitals, healthcare providers, peers and family members, and treatment providers across Nevada, and was facilitated by the Northern Regional Behavioral Health Coordinator. A special thanks to the Statewide Mental Health Crisis Hold Workgroup for their work on developing and supporting language and ideas for AB85 and ongoing development of education on mental health crisis holds.

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APPENDIX F: OVERVIEW OF YOUTH MENTAL HEALTH CRISIS PROCESS

The Regional Behavioral Health Coordinator facilitated a Statewide Youth Mental Health Crisis Hold Workgroup that developed an overview of the youth mental health crisis hold process to education stakeholders, including schools, hospitals, treatment providers, and law enforcement, about the new process put into law in 2019.