Nevada's CMHS Block Grant Application

2011

Nevada Mental Health Planning Advisory Council

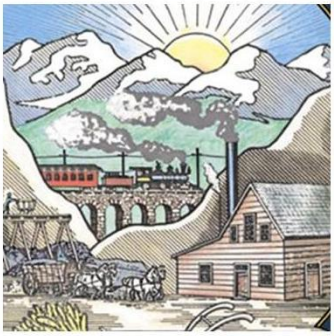


Table of Contents

FACE SHEET 4
EXECUTIVE SUMMARY 5
PART B. ADMINISTRATIVE REQUIREMENTS 10
Section I. Federal Funding Agreements, Certifications and Assurances 10
Federal Funding Agreement 10
Certifications 14
Assurances 19
Public Comment on the State Plan 21
Section II. Set-Aside for Children's Mental Health Report 22
Section III. Maintenance of Effort (MOE) Report 23
Section IV. State Mental Health Planning Council Requirements 26
State Mental Health Planning Council Membership List 26
State Mental Health Planning Council Composition 29
Planning Council Charge, Role and Activities 30
PART C. STATE PLAN 44
Section I. Description of State Service System 44
ADULT 44
Overview of Nevada's Mental Health System 44
New Developments and Issues 54
Legislative Initiatives and Changes 58
Description of the State Agency's Leadership 60
CHILD 62
Overview of Nevada's Mental Health System 62
New Developments and Issues 69
Legislative Initiatives and Changes 72
Description of the State Agency's Leadership 74
Section II. Identification & Analysis of the Service System's Strengths, Needs & Priorities . 76
ADULT 76
Service System's Strengths and Weaknesses 76
Unmet Service Needs 79
Plans to Address Unmet Needs 81
Recent Significant Achievements 84
State's Vision for the Future 89
CHILD 91
Service System's Strengths and Weaknesses 91
Unmet Service Needs 94
Plans to Address Unmet Needs 97
Recent Significant Achievements 101
State's Vision for the Future 106
Section III. Performance Goals and Action Plans to Improve the Service System 110
ADULT 110
Criterion 1: Comprehensive Community-based Mental Health Services 110
Establishment of System of Care 110
Available Services 111
Criterion 2: Mental Health System Data Epidemiology 131

Estimate of Prevalence 131
Quantitative Targets 133
Criterion 3: Not Applicable 134
Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations 135
Outreach to Homeless 135
Rural Area Services 141
Older Adults 142
Criterion 5: Management Systems 144
Resources for Providers 144
Grant Expenditure Manner 158
Table C – Description of MHBG Funding for Transformation Activities 161
Goals, Targets and Action Plans 162
CHILD 184
Criterion 1: Comprehensive Community-based Mental Health Services 184
Establishment of System of Care 184
Available Services 186
Criterion 2: Mental Health System Data Epidemiology 198
Estimate of Prevalence 198
Quantitative Targets 200
Criterion 3: Children Services 201
System of Integrated Services 201
Geographic Area Definition 204
Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations 206
Outreach to Homeless 206
Rural Area Services 207
Criterion 5: Management Systems 208
Resources for Providers 208
Emergency Service Provider Training 214
Grant Expenditure Manner 215
Goals, Targets and Action Plans 218
PLANNING COUNCIL LETTER FOR THE PLAN 235

FACE SHEET

Fiscal Years Covered by the Plan

FY 2011 ____X____ FY2010/2011

STATE NAME: Nevada
DUNS #: 21588830

I. AGENCY TO RECEIVE GRANT

AGENCY: Division of Mental Health and Developmental Services (MHDS)
ORGANIZATIONAL UNIT:
STREET ADDRESS: 4126 Technology Way, Suite 201
CITY: Carson City STATE: NV ZIP: 89706
TELEPHONE: 775.684.5943 FAX: 775.684.5966

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Harold Cook, Ph D. TITLE: Administrator
AGENCY: Division of Mental Health and Developmental Services (MHDS)
ORGANIZATIONAL UNIT:
STREET ADDRESS: 4126 Technology Way, Suite 201
CITY: Carson City STATE: NV ZIP: 89706
TELEPHONE: 775.684.5943 FAX: 775.684.5966

III. STATE FISCAL YEAR

FROM: July 1, 2010 TO: June 30, 2011

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION FOR ADULT MENTAL HEALTH

NAME: Cody L. Phinney, MPH TITLE: Director of Program Planning
AGENCY: Division of Mental Health and Developmental Services (MHDS)
ORGANIZATIONAL UNIT:
STREET ADDRESS: 4126 Technology Way, Suite 201
CITY: Carson City STATE: NV ZIP: 89706
TELEPHONE: 775.684.5984 FAX: 775.684.5964 EMAIL: cphinney@mhds.nv.gov

V. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION FOR CHILDREN'S MENTAL HEALTH

NAME: Patricia Merrifield TITLE: Deputy Administrator,
AGENCY: Division of Child and Family Services (DCFS)
ORGANIZATIONAL UNIT:
STREET ADDRESS: 6171 West Charleston Blvd. Bldg 8
CITY: Las Vegas STATE: NV ZIP: 89146
TELEPHONE: 702.486.6120 FAX: 775.684.6090 EMAIL: pmerrifi@dcfs.nv.us

EXECUTIVE SUMMARY

Overview

For almost 20 years, Nevada was one of the fastest-growing states in the nation. During the last decade, from 1990 through 2000, Nevada was the fastest-growing state with a total population growth of 66% across the decade, compared with a national average growth rate of 13%. In the early part of the current decade, the growth continued at much the same rate but has slowed since the beginning of the global economic downturn in 2008.

Nevada's economic downturn ranks as one of the worst among the 50 states. In a study in which the Henry J. Kaiser Family Foundation compiled changes in measures of state economic distress from 2009 to 2010, Nevada was ranked the most distressed state overall based on the following three indicators:

- Nevada had the highest foreclosure rate in the nation at 1 in every 88 homes. The second highest rate was Florida with 1 in every 171 homes.
- Nevada had the greatest change in monthly unemployment at 2.3% which brought it up to 14.2%. Mississippi had the second greatest change at 1.5%.
- Nevada had the third greatest percent change in monthly food stamp participation at 35.1%.[1]

Nevada faces difficult challenges in its urban, rural, and frontier areas. The state's two major population centers, Reno and Las Vegas, account for 87% of Nevada's population. In these two urban centers, the economy is highly dependent on tourism and gaming, which have recently suffered. The lingering effects of the population boom that outpaced the State's ability to provide needed community-based services coupled with the dramatic downturn in revenue has forced the State to focus on identifying and maintaining core services for its clients as a foundation for the future.

In the rural and frontier areas of the State where 13% of the population resides, local economies are more dependent on mining and ranching, and so residents tend to experience the "boom and bust" cycles characteristic of the state in a much earlier era. These fluctuating economies result in marginal infrastructure for most rural and frontier areas, creating a distinct need for community-based services, especially during fiscal and social fluctuations. Public transportation from the rural areas to the urban centers is scare and time consuming given the vast distances involved. Staff recruitment and retention has been an ongoing problem in rural and frontier counties, where it is often difficult to find and keep qualified service providers in remote areas.

Further complicating the provision of services to populations in need, Nevada faces some of the highest rates of social problems in the country. Nevada has been ranked number one nationally in the suicide rate per 100,000 population from 1996 through 1999, and remained one of the top five states each year from 2000 through 2005. Nevada currently ranks fifth highest in the nation for its suicide rate.[2]

---

[1] Retrieved from http://www.statehealthfacts.org/comparetable.jsp?cat=1&ind=649 on August 17, 2010.
[2] McIntosh, J. (2010). U.S.A. Suicide: 2007 Official Final Data. Washington, DC: American Association of Suicidology.

Taken together, the urban and rural contrast creates an acutely difficult social environment for persons with mental illness living in Nevada. Urban areas have service infrastructures that are now facing budget cuts when, just a few short years ago, they were struggling to keep up with the population boom. Rural areas have populations desperately in need of better service infrastructures but now have to do more with less.

Nevada is a small state trying to meet the challenges approaching as the details of Health Care Reform unfold while facing a substantial revenue shortfall. Increased community-based services for adults and children with mental disorders in Nevada are desperately needed in all areas of the state.

Statewide Revenue Shortfall and Budget Reductions

In Nevada's SFY 2010 grant application, it was noted that a statewide general fund revenue shortfall in Nevada was beginning to have an adverse affect on all health and human services programs. The conditions that caused the adversity have continued and the past two years have been very difficult economic times for both the United States and for the state of Nevada in particular. Many of the health and human service agencies in Nevada will be facing large budget cuts and will be grappling with the challenges of needing to serve fewer clients, reduce services, or cut programs. In addition, further workforce reductions and/or salary reductions are likely.

There are a number of estimates as to the revenue shortfall that the 2011 Nevada Legislature will have to resolve for the 2012/2013 biennium ranging from $1 billion to more than $3 billion.[3] For the second straight biennium, the State will need to reduce spending by at least 10% in contrast to previous biennia when there were increases of 15-20 percent as a growing Nevada faced steadily increasing demands for government services

Nevada's Legislature meets biennially in odd numbered years but was called into a special session in February, 2010 by the Governor to deal with a projected general fund shortfall of over $360 million in fiscal years 2010 and 2011. The Division of Child and Family Services (DCFS) cuts included the elimination of 10% of all positions to include 37 positions in children's mental health programs.

Health Care Reform

The passage of the Patient Protection and Affordable Care Act in March, 2010 will bring significant changes to mental health in Nevada. As more people become eligible for Medicaid services, the role of the State mental health system will be transformed. Currently, the Division of Mental Health and Developmental Services (MHDS) is working with the State's Medicaid agency to ensure access to mental health services for those who become eligible. The concept of the health home for people with serious and persistent mental illness is a powerful one and MHDS has made it a high priority to establish this in Nevada.

The State of Nevada's Department of Health and Human Services (DHHS) has begun planning for health care reform by creating two separate teams to review the legislation, ensure coordinated planning and implementation efforts are conducted throughout state government and

[3] Retrieved from http://www.nevadanewsbureau.com/2010/07/27/glimmer-of-hope-for-tax-revenues-looming-challenges-in-next-budget-cycle/ on August 3, 2010.

provide high-level policy advice to the Governor for him to utilize when making decisions required of him by the law.

The Health Care Reform Policy Planning Group is responsible for the development of high-level policies while the Health Care Reform Implementation Working Group will examine in significantly greater detail, the intricacies of the legislation and what affect it will have on state policies and procedures regarding Medicaid. The Administrators of MHDS and DCFS are both members of the second group

Nevada State Plan for Children's Mental Health

As a result of the passage of Senate Bill 79, the Commission on Mental Health and Developmental Services (Commission on MHDS) was tasked with developing a State Plan for Children's Mental Health. Working with representatives from the regional and statewide consortia and agency representatives from MHDS, DCFS, and the Division of Health Care Finance and Policy (DHCFP), the Commission produced a plan with initial 2-year goals to restructure state system governance. The following are the goals and objectives outlined in the first plan approved in July, 2010:

Goal One: State Governance (2-Year Plan)

- Continue to fully operate and fund the regional consortia.
- Expand the authority of the Commission on MHDS to set policies for the care and treatment of children with mental health or co-occurring disorder provided by any public or private provider or facilities.
- Review and confirm authority of the Commission on MHDS and maintain capacity to respond to this authority.
- Establish a child and adolescent behavioral health policy and accountability board to recommend policies covering public and private mental health services. The Statewide Consortium is an existing structure recommended to be reconstituted to form the board.
- Establish DCFS as the state children's mental health authority with the responsibility to set standards for practice and provider qualification; conduct quality assurance; develop and monitor contracts, provide financial oversight and performance monitoring for public and private children's mental health to include the power to adopt regulations.
- Identify any additional revisions to Nevada Revised Statues necessary to implement the intent of this plan.
- Develop capacity to provide the next two-year continuation plan (2013-14). Plan must align previous objectives and integrate findings from studies in Goal 2.

Goal Two: Determine the Impact of Federal Health Care Reform and Mental Health Parity

- Analyze federal healthcare reform and determine impacts on children's mental health services in Nevada.
- Analyze mental health parity legislation and develop an implementation plan in Nevada.
- Based on the outcomes of the above analysis, conduct a feasibility study related to implementation of the MHDS Commission's 10-year plan in the context of the Federal Patient Protection and Affordable Care Act.

The complete plan can be viewed at the following website:
http://mhds.nv.gov/dmdocuments/ChildMHStatePlanComm20100630.pdf

Transformation Plan and the Reorganization of Rural Clinics

MHDS is continuing the Transformation Plan described in the SFY 2010 Block Grant Application and, in the face of growing challenges, is focusing on identifying and maintaining core services for clients as a foundation for the future. The plan also tackles the challenge of maximizing the coordination between the Agencies within the Division responsible for the three major functions of the Division: mental health, developmental services and substance abuse programs. In these ways the Division hopes to improve the efficiency of the resources that remain. The previously separate mental health and developmental service agencies have begun combing administratively. In the coming years, the Division will seek additional social service and healthcare partners with which to collocate and collaborate.

In an effort to increase efficiencies in service delivery systems, reduce administrative costs and discover more effective models for service delivery, the Rural Clinics agency of MHDS has undertaken a significant reorganization. Historically, rural mental health clinics have been supervised by a central administrative office in Carson City resulting in problems with quality of care, staff supervision and operational efficiency. The reorganization divided the rural area into North and South, coinciding with the service areas of the Developmental Services Agencies. Further efficiencies will result from the combination of the Rural Developmental Services and Mental Health Rural Clinics in the north into one agency. This would involve combining some of the business office functions as well as the quality management functions in the two agencies.

Emergency Room Overcrowding in Southern Region

In the past 10 years, the Las Vegas Valley has struggled with a lack of psychiatric bed capacity. MHDS continues to look for solutions to this challenge. The community continues to collaborate using the regional emergency services consortium. The Division is implementing a two pronged approach to the problem. One avenue is maximizing the collaboration between Southern Nevada Adult Mental Health Services (SNAMHS), the Mobile Crisis Team (MCT) and the Emergency Departments (EDs). MCTs are available to assess individuals in the EDs and determine the need for hospitalization. When these teams find that the person is not in need of hospitalization, the EDs have the ability to contact SNAMHS for an appointment for those individuals. This allows the clients to access community based services without being unduly detained by a hospital admission.

The second front involves maximizing the efficiency of the Psychiatric Observation Unit and the Rawson-Neal Hospital. The observation unit is being reorganized to expand psychiatric coverage and reduce length of stay; the same is true of the hospital. Greater emphasis is also being place on working in collaboration with the hospital EDs to identify those patients with complex medical problems and co-occurring disorders. Close monitoring of the length of stay in the hospital is aimed at maximizing the efficient use of the hospital beds.

CMHS Block Grant Funding

Block Grant funding from the CMHS continues to be a vital and flexible funding source to improve community-based services in Nevada. The Block Grant supports a number of important programs. The Consumer Assistance Program (CAP), which was started with Block Grant

funds, has been a major step toward including consumers as service providers within the system of care and increasing consumer involvement in the planning and development of services. Programs for Assertive Community Treatment (PACT) Teams, which utilize evidence-based practices, have been active in the State since 1998 in the northern and southern regions. The Wraparound in Nevada (WIN) program, which also utilizes evidence-based practices, serves to provide increased mental health support for children in the child welfare system.

Stability in block grant funding serves to maintain community-based service improvements. These programs directly help children and adults in Nevada to achieve a higher, more functional quality of life as they work toward personal recovery from mental disorders.

PART B. ADMINISTRATIVE REQUIREMENTS

Section I. Federal Funding Agreements, Certifications and Assurances

Federal Funding Agreement

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2011

I hereby certify that _____NEVADA_____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

---

[1] The term State shall hereafter be understood to include Territories.

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Designee (Harold Cook, Ph.D., Administrator) Date

PART B. ADMINISTRATIVE REQUIREMENTS

Section I. Federal Funding Agreements, Certifications and Assurances

Certifications

PHS-5161-1 (7/00) Page 17

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee's policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Administrator
APPLICANT ORGANIZATION Division of Mental Health and Developmental Services (MHDS)	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: ☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. Status of Federal Action ☐ a. bid/offer/application b. initial award c. post-award	3. Report Type: ☐ a. initial filing b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime Subawardee Tier _____, *if known:* Congressional District, *if known:*	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known:*	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable:* _____	
8. Federal Action Number, *if known:*	9. Award Amount, *if known:* $	
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	b. Individuals Performing Services *(including address if different from No. 10a.)* *(last name, first name, MI):*	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in Item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

PART B. ADMINISTRATIVE REQUIREMENTS

Section I. Federal Funding Agreements, Certifications and Assurances

Assurances

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

Standard Form 424B (Rev.7-97)
Prescribed by OMB Circular A-102

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Administrator
APPLICANT ORGANIZATION Division of Mental Health and Developmental Services (MHDS)	DATE SUBMITTED

SF-424B (Rev. 7-97) Back

PART B. ADMINISTRATIVE REQUIREMENTS

Section I. Federal Funding Agreements, Certifications and Assurances

Public Comment on the State Plan

In order to obtain public input on the FY 2011 Block Grant application, the SFY 2010 application as well as the SFY 2009 Implementation Report was posted on the Mental Health Planning Advisory Council's website in October, 2009. That website is located at:

http://mhds.nv.gov/index.php?option=com_content&task=view&id=21&Itemid=22

Contact information was provided for a designated staff person who could reply to questions and comments on either document. As of the time this section of the application was updated in WebBGAS, no comments from the public had been received.

At the August 12, 2010 meeting of the Mental Health Planning Advisory Council, a presentation using a projector connected to WebBGAS was made that included details on how to sign on to WebBGAS using the "read only" Nevada Citizen log on. At that meeting, Council members provided feedback on the Block Grant application which been incorporated into the letter from the Council Chair.

PART B. ADMINISTRATIVE REQUIREMENTS

Section II. Set-Aside for Children's Mental Health Report

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY **X** Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimate/Actual FY 2010
$6,419,640	$26,445,396	$22,660,455

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

PART B. ADMINISTRATIVE REQUIREMENTS

Section III. Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY ____**X**____ Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2008	Actual FY 2009	Actual/Estimate FY 2010
$147,146,785	$174,442,441	$154,827,199

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions
A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases

by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance
If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

Footnote to the MOE Report

MHDS was unable to complete the calculation of the MOE by 9/1/2010 and will be submitting a revision to its estimate of the MOE for SY 2010 by 9/15/2010. This revision will include adjustments to the Actual FY 2008 and the Actual FY 2009 MOE. At this point in time, it cannot be determined whether or not Nevada has met the MOE requirement for FY 2010. A Waiver for Extraordinary Economic Conditions will be submitted immediately as a precautionary measure.

Revision to the MOE Report Submitted on September 24, 2010

When Nevada submitted its State Fiscal Year (SFY) 2011 Community Mental Health Services (CMHS) Block Grant application, the Division of Mental Health and Developmental Services (MHDS) added a footnote to Part B, Section III (Maintenance of Effort Report [MOE]) to the effect that it was unable to complete the MOE Report by September 1, 2010. Using the information that was available at the time, the MOE Report was submitted as follows:

Actual FY 2008	Actual FY2009	Actual/Estimate FY 2010
147,146,785	174,442,441	154,827,199
	Average of the Prior Two Years:	160,794,613
	Amount Over or (Under) the Average of the Prior Two Years:	(5,967,414)

The footnote also stated that a revision to the estimate of Nevada's MOE for SY 2010 would be submitted along with adjustments to the Actual FY 2008 and the Actual FY 2009 MOE.

Nevada has historically had to make modifications in subsequent years to its "Actual/Estimate" of the most recent year being reported. Please see the footnotes to the attached MOE Reports from the SFY 2009 and 2010 Block Grant application.

In June, 2010 the Center for Mental Health Services (CMHS) conducted a review of Nevada's administration of the Block Grant that included an analysis of the methodology of calculating the MOE. The preliminary report of that review includes the following observations:

The final MOE calculation historically has been completed by the Deputy ASO for MHDS and submitted to the State Planner for inclusion in the MHBG Application. In order to arrive at the MOE calculation, regional ASO staff for both DCFS and MHDS have completed manual calculations of financial data and submitted these data to the Deputy ASO for MHDS. At the time of the site visit, the Chief ASO and the Deputy ASO for MHDS were new to their positions with tenures of less than 6 months. They were unfamiliar with the process for calculating the MOE and had not received documentation from their predecessors about how the calculations were performed in the past.

As was stated earlier, Nevada clearly met its SFY 2009 MOE requirement; however, the method for calculating the MOE is complex and requires multiple individuals to complete manual calculations and provide financial data. As a result of staff turnover, the methodology for completing the MOE calculations may not always be communicated effectively. The State fiscal staff requested technical assistance on which expenditures can be included in the MOE and the development of a methodology for calculating the MOE with data that can be pulled from the State's robust financial data system.

The MHDS fiscal staff reviewed the calculation of the "Actual/Estimate" MOE for SFY 2010 and has determined that the methodology used when the SFY 2011 Block Grant application submitted was valid and no change to it is required. However, applying this same methodology to SFY 2008 and 2009 resulted in the changes to the "Actual" amounts in those years as detailed in the following table:

Actual FY 2008	Actual FY2009	Actual/Estimate FY 2010
146,934,495	161,136,369	154,827,199
	Average of the Prior Two Years:	154,035,432
	Amount Over or (Under) the Average of the Prior Two Years:	791,767

PART B. ADMINISTRATIVE REQUIREMENTS

Section IV. State Mental Health Planning Council Requirements

State Mental Health Planning Council Membership List

	Name	*Type of Membership*	*Agency/Organization Represented*	*Address/Phone/Fax/email*
1.	Ash, Alisha	Consumer/Youth	n/a	5616 Eugene Ave Las Vegas, NV 89108 Tel: 702.242.4850 Cell: 702.306.2764 alishanicole1991@hotmail.com
2.	Bousquet, Judy	Consumer	n/a	2611 Sunfish Drive, #B Henderson, NV 89014 Tel: 702.458.2939 Fax: none jaybousquet@aol.com
3.	Castle, Howard	State employee	State Vocational Rehabilitation Agency	DETR 2800 E. St. Louis Street Las Vegas, NV 89104 Tel: 702.486.5241 Fax: 775.486.6426 whcastle@nvdetr.org
4.	Cooley, Judge W.	Consumer	n/a	9811 W Charleston, #2-307 Las Vegas, NV 89117 Tel: 702.363.4771 Fax: 702.363.4322 judgeangel4@yahoo.com
5.	Daniels, Steve	State employee	State Criminal Justice	Department of Corrections 5500 Snyder Ave., Bldg. 17 Carson City, NV 89701 Tel: 775.882.9203 sdaniels@doc.nv.gov
6.	Ford, Lisa	State employee	State Education Agency	NDOE Education & School Improvement Programs 9890 S. Maryland Parkway, Ste 221 Las Vegas, NV 89183 Tel: 702-486-6561 Fax: 702-786-6624 lford@doe.nv.gov
7.	Herrera, Corrie (Coraline)	Family member (adult with SMI)	n/a	765 Ash Street Elko, NV 89801 Tel: 775-753-4300 Fax: 775-753-4366 Elkonncil2@citlink.net

	Name	Type of Membership	Agency/Organization Represented	Address/Phone/Fax/email
8.	Jackson, Barbara	Consumer	n/a	NNAMHS 480 Galletti Way Sparks, NV 89431 Tel: 775.688.0401 Fax: 775.688.2040 bjackson@mhds.nv.gov
9.	Lawrence, Coleen	State employee	State Medicaid Agency	DHCFP 1100 E. William St., Ste 100 Carson City, NV 89701 Tel: 775-684-3744 Fax: 775-684-3762 coleenl@dhcfp.nv.gov
10.	Norris, Rene *Chair*	Family member (child with SED)	n/a	c/o MHPAC 4126 Technology Way, #201 Carson City, NV 89706 Tel: 702.242.5918 (home) Fax: 775.684.5964 renenorris@ymail.com
11.	Parra, Debra	State employee	State Housing Agency	Housing Division 1535 Old Hot Springs Rd., #50 Carson City, NV 89701 Tel: 775.687.2041 Fax: 775.687.4040 dparra@nvhousing.state.nv.us
12.	Peterman, Patricia *Vice Chair*	Family member (child with SED)	n/a	c/o MHPAC 4126 Technology Way, #201 Carson City, NV 89706 Tel: 775.771.6173 Fax: 775.684.5964 one_sterling_rose@yahoo.com
13.	Phinney, Cody	State employee	State Mental Health Agency	MHDS 4126 Technology Way, 201 Carson City, NV 89706 Tel: 775-684-5984 Fax: 775-684-5964 cphinney@mhds.nv.gov
14.	Pinder, Denice	Family member (adult with SMI)	n/a	900 Rice Road Fallon, NV 89406 Tel: 775-423-6849 pinderpack@charter.net
15.	Polakowski, Ann	State employee	State Social Services Agency	DCFS 6171 W. Charleston Blvd., Bldg 16 Las Vegas, NV 89146 Tel: 702-486-7707 Fax: 702-486-8029 ampolako@dcfs.state.nv.us

Name	*Type of Membership*	*Agency/Organization Represented*	*Address/Phone/Fax/email*
16. Snead, Lydia	Family member (child with SED)	n/a	c/o MHPAC 4126 Technology Way, #201 Carson City, NV 89706 Tel: 775.972.9280 Fax: 775.684.5964 Lsnead73@att.net
17. Thomas, Alyce *Past Chair*	Consumer	n/a	137 Bear Court Henderson, NV 89052 Tel: 702.410.4274 Fax: 702.315.0493 alycethomaslv@yahoo.com
18. Wilhelm, Layne	State employee	Substance Abuse Prevention and Treatment Agency (SAPTA)	4126 Technology Way, Ste 200 Carson City, NV 89706 Tel: 775-684-4087 Fax: 775-684-4185 lwilhelm@sapta.nv.gov
19. Willingham, Bryce	Consumer	n/a	3761 Desert Marina Dr. #29 Laughlin, NV 89029 Tel: 702-299-1700 brwham@gmail.com

PART B. ADMINISTRATIVE REQUIREMENTS

Section IV. State Mental Health Planning Council Requirements

State Mental Health Planning Council Composition

Type of Membership	*Number*	*Percent Membership*
TOTAL MEMBERSHIP	19	
Consumers, survivors, ex-patients (C/S/X)	6	
Family members of children with SED	3	
Family members of adults with SMI	2	
Vacancies (C/S/X and family members)	0	
Others	0	
TOTAL C/S/X, family members, and others	11	57.89%
State employees	8	
Providers	0	
Vacancies	0	
TOTAL State employees and providers	8	42.11%

PART B. ADMINISTRATIVE REQUIREMENTS

Section IV. State Mental Health Planning Council Requirements

Planning Council Charge, Role and Activities

Membership Requirements

The Nevada Mental Health Planning Advisory Council (MHPAC) maintains its membership in compliance with Section 1914(c) of the Public Health Service Act. The Council is in compliance with requirements for representation from State agencies, consumers, family members of consumers, and parents of children with SED as demonstrated in Table 1 (Council Membership List) and Table 2 (Council Membership Composition).

In addition, the Council has incorporated a non-discrimination policy into its bylaws regarding the recruitment of new members as follows:

> *The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.*

A copy of the Council's bylaws is included at the end of this section. These bylaws specify the policies and procedures for the selection of Council members, their terms, and the conduct of meetings.

Planning Council Charge, Role and Activities

The Mental Health Planning Advisory Council (MHPAC) for the State of Nevada performs the following functions:

- Reviews the CMHS Block Grant application relative to the state mental health plan and makes recommendations to MHDS and DCFS.
- Serves as an advocate for adults with SMI, children with SED, and other individuals with mental illnesses.
- Monitors, reviews, and evaluates the allocation and adequacy of mental health services within the State.
- Addresses issues such as the transition of clients between child and adult systems of care, and the integration of mental health services within criminal justice systems.
- Holds regular Council meetings.
- Assists consumers and family members in attending Council meetings.
- Develops education and training opportunities for Council members, including consumers and family members.
- Recruits a diverse and culturally competent Council membership.
- Collaborates with various public and private mental health regulatory and advocacy organizations in the interest of

Monitoring of mental health services within the state is done primarily through presentations at Council meetings. During state fiscal year 2010, the Council received information and updates on the following topics and issues:

- A summary of the 2009 Nevada Legislative session and a summary of the 2010 special session regarding adult and children's mental health issues that were addressed during both sessions.
- Review and approval of Nevada's 2010 CMHS Block Grant Applications and the 2009 Implementation Report.
- Changes to the Council bylaws that included the clarification of the length of terms of Council members, the appointment of proxies, expectations for attendance at Council meetings, and a reduction in the number of members on the Council from twenty one to nineteen.
- Opportunities to collaborate with Nevada's chapter of the National Alliance on Mental Illness and the Commission on Mental Health and Developmental Services.
- Activities of the Council's committee in support of Mental Health Month in May of each year.
- Mental health professional shortage area designations in Nevada.
- Overview of the Las Vegas Metro Police Departments Crisis Intervention Team.
- A summary of the federal review of Nevada's 2010 CMHS Block Grant Application.
- The impact of Nevada's statewide general fund revenue shortfall on health and human services programs, particularly mental health.
- Nevada's efforts to secure a Transformation Transfer Initiative grant.
- The Council's rural monitoring visit to the Fallon and Silver Springs Clinics and responses to recommendations generated by the visit.
- Participation by Council members in the National Association of Mental Health Planning and Advisory Councils Regional Conference in Salt Lake City as well as in the First Annual Nevada State Recovery Conference.
- Election of new Council officers for calendar years 2010 and 2011.
- An overview of the National Outcome Measures reported by Nevada.
- Efforts by MHDS staff and collaborative partners in Southern Nevada to establish a Club House.
- Suicide prevention efforts in Nevada.
- Strategic planning of Council Goals and Objectives (see subsection below).

STRATEGIC PLANNING

After receiving training from the National Association of Mental Health Planning & Advisory Councils (NAMHPAC), Nevada's Council used strategic planning and group collaboration techniques to identify priorities and establish committees to pursue their objectives for SFY 2011. A committee to address Access to Child and Adolescent Services is tasked with determining what services are available to children and adolescents and what barriers exist to receiving services. In addition, the Council created a committee to explore the establishment of a "Club House" model in Nevada to include identifying potential funding sources and collaborative partners.

MHPAC Committees

Rural Monitoring Committee

In SFY 2007, the MHPAC developed a structured, service provision monitoring project to help better meet the federal mandate for Mental Health Planning Councils to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. The Council formed a Rural Monitoring Committee that developed a plan and format for conducting quality assurance site visits to the system of MHDS Rural Clinics, with a focus on consumer satisfaction with services.

The Committee developed a set of specific questions, customized for adults, children, and their families, to serve as a uniform, statewide instrument for conducting focus groups with consumers and family members as part of the site visit. These questions were developed in conjunction with MHDS and DCFS Program Improvement staff in order to ensure that effective, consistent monitoring is done throughout the rural areas.

Pre-visit study materials were identified for review by the monitoring team members to be requested from each site prior to the monitoring visit that include the following:

- Informational materials provided at the clinic site for Rural Clinics services (State generated).
- Informational materials provided at the clinic site for related community-based services, including nonprofit and private agencies.
- Consumer survey format and outcome data from most recent survey, if available.
- Most recent performance improvement reviews, if available.
- Most recent MHDS monthly reports showing service and wait list statistics.

A typical site visit starts with a tour and environmental scan of the clinic followed by an introductory meeting with the Clinic Director to discuss the pre-visit materials. Meetings with the Clinic staff are then held to obtain direct feedback on service successes, challenges and unmet needs. Following that, separate focus group sessions are held with adult consumers and family members of child and adolescent clients to identify

The first site visit was conducted in 2007, at the Ely Mental Health Clinic. In January, 2009 the Rural Monitoring committee visited the Pahrump Mental Health Clinic to look at the services provided in the clinic, the related community-based services and consumer concerns. The Committee visited the Fallon and Silver Springs Clinics in October, 2009 and the Mesquite Clinic in May 2010.

The Rural Monitoring Project serves as an important collaboration with MHDS and DCFS in order to increase State partnership with consumers and the Council toward improving the delivery of services. Reports for all of the visits can be viewed on line at the following website:

http://mhds.nv.gov/index.php?option=com_content&task=view&id=144&Itemid=234

Child Transition Committee

After successfully completing the following action items, this committee was deactivated:

1. Monitor the Memorandum of Understanding (MOU) between MHDS and DCFS and identify opportunities for process improvement.
2. Production of regionalized fact sheets for youth and families as a tool to access resources when making the transition from children's mental health services. Three fact sheets were produced and distributed. One lists resources in Clark County (the Las Vegas area), one lists resources in Washoe County (Reno area) and one lists resources in rural Nevada.
3. Involve the State and County education systems in the transition process.

Block Grant Funding

In the interest of using block grant funds for monitoring, advocacy and innovation, the Council requested that MHDS continue to provide Block Grant funds to strengthen the operation of the Nevada Commission on Mental Health and Developmental Services and improve collaboration with the Council. MHDS agreed to continue to allocate funds as requested to provide research and data analysis services, administrative support and travel monies in support of the Commission.

After the Council's Rural Monitoring visit to Fallon and Silver Springs in October, 2009, the Council identified several unmet needs at these two clinics specifically and in most other Rural Clinics in general. At the request of the Council, MHDS agreed to allocate Block Grant funds to purchase psychological testing software as well as supplies, equipment and other interpretive resources necessary to enhance Rural Clinic staff's ability to treat children. MHDS also agreed to allocate Block Grant funds in SFY 2011 to address unmet needs identified in upcoming Rural Monitoring visits conducted by the Council.

MENTAL HEALTH PLANNING ADVISORY COUNCIL
BYLAWS

ARTICLE I
AUTHORIZATION AND PURPOSE

Section 1: Authorization

The Nevada State Mental Health Planning Advisory Council is authorized by Executive Order of the Governor. See Exhibit I.

Section 2: Purpose

1. Mission
The Nevada Mental Health Planning Advisory Council will serve as an advocate for individuals with chronic mental illness, children and youth with severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
2. Under federal statutes, the specific duties and responsibilities of the Council are:
    1) The Council shall advise the Division of Mental Health and Developmental Services and the Division of Child and Family Services on the development of the state mental health plan in accordance with Public Law 102-321. Any recommendations regarding the state plan received by the State must be submitted to the federal government along with the application, whether or not they were incorporated in the plan.
    2) Serve as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
    3) The Council shall monitor, review, and evaluate, no less than once each year, the allocation and adequacy of mental health services within the state.

ARTICLE II
MEMBERSHIP

Section 1: Appointments

The Governor shall appoint nineteen (19) members to the Nevada Mental Health Planning Advisory Council.

Section 2: Composition

1. Council membership will be composed of residents of the State, including representatives from:
    1) The principal state agencies with respect to:
    Mental Health Services for Children and Adolescents
    Mental Health Services for Adults
    Substance Abuse Prevention and Treatment

Education
Housing
Vocational Rehabilitation
Criminal Justice
Social Services
Medicaid

2) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.
3) Chronically mentally ill individuals who are receiving (or have received) mental health services.
4) The families of such individuals in (3) above.

2. Not less than 50 percent of the members of the Council will be individuals who are not state employees or providers of mental health services.

Section 3: Proxies

A member may designate another member of the Council to be their proxy to vote on a Council agenda action item for them at any meeting of the Council. A Council member may not be represented by a proxy at more than two consecutive meetings. Designation of a proxy by a Council member must be submitted in writing to the Chair in advance of the meeting.

Section 4: Term of Appointment

The term of an appointed member is 4 years. An appointed member may be reappointed for an unlimited number of 4-year terms. The 4 year term of appointment does not apply to an appointed member who was/is appointed to serve "at the pleasure of the Governor."

Section 5: Reappointment

Reappointments of Council members will be processed in the following manner:

1. The Administrative Assistant to the Council will maintain a list of members and their appointment terms and request that an Application for Boards and Commissions be completed by each member six months prior to the end of their term and submitted to the Office of the Governor of the State of Nevada.
2. Reappointment is official when the Governor of the State of Nevada or his or her designee approves a candidate and issues a Certificate of Appointment.
3. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
4. New MHPAC members must attend Council member orientation within one year of appointment, and every two years thereafter. Current members of the Council must attend a Council member orientation within two years of the date this section of the bylaws was formally amended on January 12, 2010). Failure to attend a Council member orientation within one year of appointment or within any two year period

may constitute grounds for the Council recommending to the Governor the member's removal from the Council.

Section 6: Oath of Office

In accordance with Nevada Revised Statutes (NRS) 282.020, members of the Council shall, before they enter upon the duties of members of the Council, take and subscribe to the following oath:

> I, …….., do solemnly swear (or affirm) that I will support, protect and defend the Constitution and Government of the United States, and the Constitution and government of the State of Nevada, against all enemies, whether domestic or foreign, and that I will bear true faith, allegiance and loyalty to the same, any ordinance, resolution or law of any state notwithstanding, and that I will well and faithfully perform all the duties of the office of Mental Health Planning Advisory Council member, on which I am about to enter,
> (if an oath) so help me God;
> (if an affirmation) under the pains and penalties of perjury.

ARTICLE III
VACANCIES

Section 1: Absences

Two absences from regularly scheduled meetings (which include regular MHPAC meetings and/or Executive Committee meetings) within any twelve month period without sufficient or overriding reason will be considered unexcused absences and may constitute grounds for the Council recommending the member's removal from the Council to the Governor. At each regularly scheduled meeting, absences will be noted and indications of excused or unexcused will be noted. The Chair will determine if the absences are excused or unexcused at the time of the next scheduled meeting. An excused absence includes, but is not limited to, an unexpected occurrence or emergency with health, family, or employment that would prevent the member from attending the meeting. An unexcused absence includes, but is not limited to, lack of communication (no contact) with the MHPAC Chair, Vice Chair, or Administrative Assistant. Unless an absence is the result of an emergency or unexpected occurrence, members who cannot attend a regularly scheduled meeting must give written prior notice (letter, memo, or e-mail) to the MHPAC Chair, Vice Chair, or Administrative Assistant no less than two business days prior to the meeting. Failure to do so will result in an unexcused absence.

Section 2: Removal from Membership

When a member has a second (2nd) unexcused absence within any twelve month period, the Chair will send a notification letter to the member that the Council intends to take action at the next scheduled meeting. At that meeting, the member will have an opportunity to refute the action or the Council will proceed with the removal process. The removal process shall be a simple majority vote to recommend the removal to the Governor for action.

Section 3: New Appointments of Other than State Representatives

Council vacancies for members other than State representatives are filled by the following process:

1. The Administrative Assistant to the Council shall maintain an active and secure file of interested applicants from which to draw in the event of Council vacancies.
2. Applications on file and newly received applications shall be reviewed based on Council composition requirements to establish candidates for open positions.
3. A Nominating Committee established by the Council shall nominate candidates from the pool of applicants.
4. A majority vote by the Council shall determine recommended candidates for appointment by the Governor.
5. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
6. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
7. New MHPAC members must attend Council member orientation within one year of appointment, and every two years thereafter. Failure to attend a Council member orientation within one year of appointment or within any two year period may constitute grounds for the Council recommending to the Governor the member's removal from the Council.

Section 4: New Appointments of State Representatives

Council vacancies for State Representatives are filled by the following process:

1. Upon receipt of a resignation notification, a letter to the Administrator (or their designee) of the Agency in which the vacancy occurs will be sent requesting that the name of a new prospective representative be provided to through the Council to the Governor's Office in the manner prescribed by the Governor's Office.
2. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
3. New MHPAC members must attend Council member orientation within one year of appointment, and every two years thereafter. Failure to attend a Council member orientation within one year of appointment or within any two year period may constitute grounds for the Council recommending to the Governor the member's removal from the Council.

Section 5: Resignations

When a member resigns from the Council, a resignation notification shall be submitted to the Chair of the Council, copied to Council staff, via standard mail or electronic mail. Resignations should not be submitted directly to the Governor's Office. Vacancies created by resignations will be filled as outlined in Section 3 or 4 above.

ARTICLE IV
REIMBURSEMENT

Section 1: Travel and Per Diem

Reimbursement for travel and per diem costs at State rates shall be processed by the Administrative Assistant to the Council and taken from the Community Mental Health Services Block Grant allocated to the State of Nevada.

Section 2: Stipends

Members who are not employed by the government and do not receive compensation for their participation in meetings as part of their regular employment shall be given a stipend in the amount of $80 per day for each regularly scheduled meeting of the Council. Stipends will also be provided to members of the Council who meet as part of a committee of the Council, attend conferences and other mental health related activities, or represent the Council at the direction of the Chair. Stipends for these activities shall be paid in the amount of $80 per day for full-day activities and $40 per day for half-day activities. Additionally, the MHPAC will also offer its members, who are not employed by the government and who do not receive compensation for their participation in meetings, reimbursement for respite and/or child care, to enable them to attend and participate in MHPAC meetings. The reimbursements for stipends shall be processed by the Administrative Assistant to the Council and taken from the Community Mental Health Services Block Grant allocated to the State of Nevada.

ARTICLE V
MEETINGS

Section 1: Frequency of Meetings

The Nevada Mental Health Planning Advisory Council shall meet at least four times per year. Special meetings of the Council may be called at any time by the Chair, Executive Committee, or by a quorum of Council members.

Section 2: Open Meetings

All meetings of the Council shall comply with the requirements of the State of Nevada Open Meeting Law. A Public Comment item shall be included on each agenda to allow members of the public to address the Council.

Section 3: Agenda Items

Agenda item requests for MHPAC meetings must be made using the "Request for Agenda Item" form/document, which must be sent directly to and approved by the MHPAC Executive Committee. The "Request for Agenda Item" form must be received by the Chair at least 30 days prior to the next scheduled MHPAC Meeting.

Section 4: Requesting Tapes or Transcripts of Meetings

NRS 239.052 allows a governmental entity to charge a fee for providing copies of a public record upon request. Public Record includes any MHPAC meeting or committee meetings, in the form of tape recordings, dictations, transcriptions and/or hard copy minutes before they are formally distributed at a future meeting. The fee MHDS will charge for a request of public records, including minutes being recorded on a CD, mailing and postage of the CD, and professional staff time required to process the request, will be $25.00 per request.

ARTICLE VI
OFFICERS OF THE COUNCIL

Section 1: Officers

The members of the Council shall elect a Chair and a Vice Chair. The immediate past Chair shall be considered an officer of the Council and a member of the Executive Committee.

Section 2: Terms of Office

Terms of office shall be two (2) years. Each officer shall serve until the installation of a successor.

Section 3: Officer Nominations and Elections

Elections for Council offices shall be held at the first regularly scheduled meeting falling on or after October 1 at the end of the current officers' two year term. A Nominating Committee established by the Council shall nominate candidates for open office positions, or Council members may make nominations from the floor. Each office shall be voted upon separately. If more than two nominees are selected for a single office, the lowest vote recipient shall be eliminated during each round of voting necessary until only two nominees remain. Nominees for offices who receive a majority vote for the office available shall be declared elected to that office, effective the next regularly scheduled meeting of the Council.

Section 4: Executive Committee

The Council shall have an Executive Committee comprised of the current Chair, current Vice Chair, immediate past Chair, the representative to the Council from the principal

state agencies with respect to Mental Health Services for Children and Adolescents and Mental Health Services for Adults . The Executive Committee shall be authorized by the Council to make decisions concerning the affairs of the Council in the interim between regularly called meetings. Actions taken by the Executive Committee must be reported to all members of the Council at the next regularly called meeting.

Section 5: Vacancies in Office

Any vacancies in office during an unexpired term shall be filled by an election of the Council and the elected person shall hold office for the remainder of the unexpired term of office. If the immediate past Chair is no longer able to serve on the Executive Committee, the current Chair shall appoint a successor until the next officer election which allows for a new immediate past Chair to serve on the Committee.

Section 6: Duties of the Chair

1. To preside at all meetings of the Council.
2. In consultation with the Executive Committee and Administrative Assistant to the Council, determine the agenda for Council meetings.

Section 7: Duties of the Vice Chair

The Vice Chair shall preside at Council meetings in the absence of the Chair.

Section 8: Duties of the Past Chair

The Past Chair shall preside at Council meetings in the absence of the Chair and the Vice Chair.

Section 9: Secretary

The Administrative Assistant to the Council shall act as secretary to the Council.

ARTICLE VII
COMMITTEES

Section 1: Appointments of all Permanent and Ad Hoc Committees

Except for the Nominating Committee and the Executive Committee, the Chair, in consultation with the Council, shall appoint all chairs and members of all committees established by the Council. Only members of the Council are eligible for appointment to committees. The Nominating Committee shall be appointed by the Council. The Executive Committee is established as outlined under Article VI, Section 4.

Section 2: Powers

Committees appointed by the Chair or Council shall have power and authority to make decisions only as specifically assigned by a majority of a quorum of the Council at a regularly called meeting of the Council. Committee chairs shall be responsible for keeping minutes of committee meetings and reporting on committee activities to the Council.

Section 3: Removal

The Chair or any member of a committee may be removed by a majority of a quorum of the Council at any regularly called meeting of the Council.

ARTICLE VIII
QUORUM

Section 1: Quorum

A quorum will consist of a majority of the members of the Council (more than one-half of the total membership) in attendance or represented by proxy.

ARTICLE IX
VOTING

Section 1: Quorum Present

Voting shall occur only when a quorum is present. A vote of a majority of those present or represented by proxy is required to carry a motion.

Section 2: Conflict of Interest

Members shall abstain from voting on issues that relate to a possible conflict of interest, e.g., funding to a program in which they are a salaried employee or a member of the governing or advisory board. A record of abstentions shall be part of the minutes. Agencies or programs with which Council members are directly employed or affiliated may not apply for or seek funding from the Council. Members shall not use their position on the Council to influence other members or the Council as a whole to award funding or give privileges, preferences, exemptions, or advantages to specific agencies or programs with which they are directly employed or affiliated. Members must disclose their employment or affiliation with specific agencies or programs when business related to such agencies or programs is set before the Council for deliberation.

ARTICLE X
GRIEVANCES

Section 1: Grievance Rights

Grievances are limited to deviations from or violations of the bylaws established by the Mental Health Planning Advisory Council.

Section 2: Grievance Procedure

1. The grievance process will be fair, impartial, and responsive to all parties.
2. A grievant shall not be discriminated against, nor suffer any retaliation, as a result of filing or participating in the grievance process.
3. A complaint or grievance must be submitted to the Executive Committee, which will serve as the Grievance Committee, within 30 days of the date of the alleged episode causing the grievance became known.
4. The Executive Committee shall address grievances for the Council, including making a formal recommendation regarding the grievance. In the event the grievant does not agree with the Executive Committee's final decision, the grievant may appeal to the Council as a whole within 30 days of the constructive receipt of the Executive Committee's decision. In such cases, the Executive Committee will bring the formal recommendation before the Council at the next regularly scheduled Council meeting, which will be presented as an agenda item. The Council will then, by majority vote, agree or disagree with the Executive Committee's formal recommendation in determining the final action regarding the grievance. The grievant may attend in person, or if not in person, elect to submit a letter on his or her behalf.
5. In lieu of the Executive Committee, the Council shall appoint an ad hoc Grievance Committee only if and when a grievance is filed against:
    a. The Executive Committee as a whole, or
    b. An individual member of the Executive Committee.

   This ad hoc Grievance Committee will serve in the place of and handle all above-mentioned grievance-related duties otherwise to have been performed by the Executive Committee if the MHPAC determines that the Executive Committee cannot serve as a fair and impartial committee and if item a. or b. is met.

ARTICLE XI
AMENDMENTS

Section 1: Amendment or Repeal

The Bylaws may be amended or repealed at any regular meeting of the Council by a majority vote of the quorum, provided that a written notice of proposed change(s) has been submitted to each member at least seven (7) days before said meeting and public notice has been provided at least three (3) days before said meeting.

Proposed amendments shall be received by the Administrative Assistant to the Council and circulated to the members of the Council.

ARTICLE XII
FUNCTIONS NOT SPECIFICALLY COVERED BY THESE BYLAWS

Section 1: Rules of Order

Any necessary functions not specifically covered by these bylaws will be covered by Robert's Rules of Order, Revised.

THESE BYLAWS WERE LAST AMENDED AUGUST 12, 2010 AND REMAIN IN EFFECT UNTIL AMENDED OR REPEALED AS PROVIDED IN ARTICLE XI.

PART C. STATE PLAN

Section I. Description of State Service System

ADULT

Overview of Nevada's Mental Health System

NORTHERN: Washoe County (Reno)
SOUTHERN: Clark County (Las Vegas)
RURAL: All other counties

Key Staff

Position	*Name*
Administrator	Harold Cook, Ph.D.
Deputy Administrator	Dee McClellan, MPC, LCPC, LAC, NCP
Director of Planning and Performance Improvement	Barbara Qualls, LASW
Director of Program Planning	Cody L. Phinney, MPH
NNAMHS Director	Rosalyne Reynolds, MN, MBA
Lake's Crossing Center Director	Elizabeth Neighbors, Ph.D.
SNAMHS Director	Stuart Ghertner, Ph.D.
Rural Services Director	Barbara Legier
Substance Abuse, Prevention and Treatment Agency (SAPTA)	Deborah McBride

The Division of Mental Health and Developmental Services (MHDS) is projected to provide services to 28,000 Nevadans in State fiscal year (SFY) 2011. This projection is based on the year over year change in clients served in SFY 2008 through 2010. By comparison, approximately 105,368 adults in Nevada are projected to have a serious mental illness (SMI). This projection is based on a national SMI prevalence rate of 5.4% determined by CMHS/SAMHSA, and is addressed in greater detail in Section III, Criterion 2.

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

MHDS is responsible for the operation of State-funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services, substance abuse prevention and treatment, and all developmental services programs and facilities. By statute, the Division is responsible for planning, administration, policy setting, monitoring, and budget development of all State-operated adult mental health and developmental services programs. MHDS Administration is also directly involved in decisions regarding agency structure, staffing, program administration, and budget development.

The mission of the Division is as follows:

> *Working in partnerships with consumers, families, advocacy groups, agencies, and diverse communities to provide responsive services and informed leadership to ensure quality outcomes. This mission includes person-centered services in the least restrictive, most inclusive (normative) environment. This includes prevention, education, habilitation, rehabilitation, and recovery for Nevadans challenged with mental illness or developmental disabilities. These services attempt to maximize each individual's degree of independence, functioning, satisfaction, and self-sufficiency while ensuring the exercise of individual rights.*

The Division Administrator, appointed by the Director of the Department of Health and Human Services (DHHS), relies on the oversight and direction of stakeholders as represented in several advisory groups:

- Commission on Mental Health and Developmental Services (MHDS Commission): The MHDS Commission is a ten member board legislatively created body under Nevada Revised Statutes (NRS) Chapter 433, and appointed by the Governor. The MHDS Commission provides policy guidance and oversight of Nevada's public system of integrated care and treatment of adults and children with mental health, substance abuse and developmental disabilities/related conditions. The Commission also promotes and assures the protection of the rights of all clients in this system. The Commission has oversight and accountability function for both MHDS and the Division of Child and Family Services (DCFS).
- Local Advisory Boards: The MHDS Commission has created advisory boards in Washoe and Clark Counties and makes appointments to these boards from stakeholders in the community. The boards serve to provide information to the Commission regarding service needs, public input, and other issues pertaining to mental health.
- Mental Health Planning Advisory Council (MHPAC): Public Law 102-321 (1989) mandates that stakeholders, including adults with serious mental illness (SMI), their family members, and parents of children with severe emotional disturbance (SED) must be involved in mental health planning efforts related to the block grant through membership in planning advisory councils. The Nevada MHPAC has three federally mandated duties:
  1. To review the Mental Health Block Grant Plan and to make recommendations;
  2. To serve as an advocate for adults with SMI, children with SED, and other individuals with mental illnesses or emotional problems; and
  3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Administration and services are organized into three regions: North, South, and Rural. Five agencies deliver mental health care in the state:

1. NORTH: Northern Nevada Adult Mental Health Services (NNAMHS): An inpatient psychiatric hospital that also provides a variety of outpatient, community-based services.

In 2008, an additional outpatient clinic opened in Reno but will be closed in 2011 due to budget cuts.

2. SOUTH: Southern Nevada Adult Mental Health Services (SNAMHS): Provides a variety of outpatient services through four community mental health centers in the Las Vegas metropolitan area and an inpatient psychiatric hospital. As a result of a recent reorganization of Rural Clinics, supervision of five clinics in Southern Nevada outside the Las Vegas Valley was transferred from Rural Clinics to SNAMHS.
3. RURAL & STATEWIDE:
   - Lake's Crossing Center: Co-located with NNAMHS, this is the State's only facility for criminal offenders with mental illness.
   - Rural Clinics: Responsible for operating a network of community mental health centers in the rural counties of the state. As mentioned above, as a result of the recent reorganization of Rural Clinics, supervision of five clinics in Southern Nevada outside the Las Vegas Valley was transferred from Rural Clinics to SNAMHS. In addition to providing services to adults with SMI, Rural Clinics provides services to children with SED in the rural areas in cooperation with DCFS.
   - Substance Abuse Prevention and Treatment Agency (SAPTA): Nevada's Substance Abuse Prevention and Treatment Agency was merged into the adult mental health system in SFY08. SAPTA provides oversight to approximately 91 providers of substance abuse prevention services statewide.

Regional Programs and Resources for the Provision of Mental Health Services

MHDS programs have negotiated interagency agreements with local organizations to provide expanded mental health services within the community. The following summarizes the interagency agreements currently in place that help provide for an integrated system of care.

Northern Region: Northern Nevada Adult Mental Health Services (NNAMHS)

Organization: Human Potential Development, Inc. (HPD)
Purpose: HPD is a nonprofit agency that advocates and provides educational opportunities relating to issues surrounding people with co-occurring disorders. HPD presents human service solutions and programs which have resulted in the establishment of the first Mental Health Court, the Program for Assertive Community Treatment, the new Dini-Townsend hospital at NNAMHS, and the Committee on Co-Occurring Disorders.

Organization: Bristlecone
Purpose: NNAMHS continues a cooperative effort with Bristlecone to address the needs of clients with co-occurring mental health and substance abuse disorders. Bristlecone provides consultation regarding substance abuse issues for selected clients and in return, NNAMHS provides mental health evaluations and support for Bristlecone clients with mental health issues. This partnership provides greater continuity of care between the two programs.

Organization: Emergency Department Consortium
Purpose: This is a consortium of staff from all area hospital emergency departments, which meets bi-monthly. The purpose of the consortium is to improve communication and continuity of care between hospital facilities including NNAMHS Patient Observation Unit.

Organization: Mental Health Court
Purpose: NNAMHS has established a Memorandum of Understanding (MOU) with Washoe County district court in which NNAMHS provides the services of 8 service coordinators and 60 housing slots while the District Court provides two court services workers and the authority and involvement of District Court Judges to establish treatment plans and monitor compliance for individuals with mental illness who have come to the attention of the justice system. The service array includes medication clinic, counseling, residential support, and psychosocial rehabilitation. Staff work onsite with clients in the jail as well, providing direct services within the criminal justice setting. Individuals are typically treated in this model for a year. Outcome studies have revealed an 80% reduction in use of emergency rooms, jail days and police involvement after graduation from this program. The mental health court is also one of five Justice Department learning sites for this model of treatment in the country.

Organization: Reno Area Alliance for the Homeless (RAAH)
Purpose: Members of this organization (including NNAMHS) represent all the organizations locally who are involved with serving the homeless and preventing homelessness. Its mission is to advocate for services and prevent the root causes of homelessness. The NNAMHS agency director is a member of the Coordinating Committee of RAAH.

Organization: Reno Police Department, Crisis Intervention Team (CIT)
Purpose: CIT trained officers now exist throughout Northern Nevada. These are officers who have received a week long special training, organized by Officer Pat O'Bryan, provided by local mental health providers and coordinated through NNAMHS, to increase their ability to recognize mental illness and give them skills to more effectively approach mentally ill individuals who are in crisis. This has made the community safer not only for mentally ill individuals but for the officers and citizens as well. It has resulted in more individuals accessing treatment who would otherwise be in jail. Officers in Reno, Sparks, Washoe County Sheriffs, and surrounding county sheriff's organizations are being trained.

Organization: WestCare; Triage Center
Purpose: The Triage Center is a 12 bed detox and mental illness triage center offering a safe location where individuals can either present themselves or be brought by the police to stabilize and be referred for treatment. RAAH was also heavily involved in the advocacy efforts which helped bring this service to fruition.

Southern Region: Southern Nevada Adult Mental Health Services (SNAMHS)

Organization: American Foundation for Suicide Prevention (AFSP)
Purpose: This group encourages and supports research aimed at understanding and preventing suicide, brings the latest advances in knowledge to professionals who work with depressed and suicidal individuals, educates the public about the nature and extent of the problem of suicide and the need for prevention, and supports programs aimed at helping survivors cope with their losses.

Organization: Aging Service Directors Organization (ASDO)
Purpose: This organization provides information on resources available to seniors, presents opportunities to network with directors of aging programs, and develops an annual Caregivers Conference.

Organization: Clark County Health Access Consortium
Purpose: This group works to develop and implement programs that increase access to primary health care for the uninsured and the underinsured.

Organization: Clark County Health District (CCHD)
Purpose: Service Coordinators work with CCHD staff to help their clients access mental health services, many of whom have HIV.

Organization: Clark County Health District Facility Advisory Board
Purpose: This group tracks intra-agency issues. Currently, a primary topic is the overcrowding of hospital emergency rooms with patients with mental illness.

Organization: Clark County Mental Health Consortium
Purpose: This is a coalition of service providers and stakeholders working to improve mental health services for children residing in Clark County. Participation by the SNAMHS agency director facilitates a smooth transition for those needing care in the adult system.

Organization: Community Counseling Center
Purpose: This group facilitates co-occurring disorders programs.

Organization: Community Emergency Review Team (CERT)
Purpose: This is a coalition of Senior Service Providers who meet to identify, discuss, and coordinate responses to potential elder abuse, neglect, and exploitation issues within the community and seniors in residential facilities such as group homes, assisted living facilities, and nursing facilities.

Organization: Emergency Room Managers Team
Purpose: This team discusses the problems facing emergency rooms in the great Las Vegas area, particularly overflow and diversion of patients with mental illness.

Organization: Facilities Advisory Board
Purpose: This team is comprised of CEOs from all the local hospitals, including SNAMHS, and discusses the emergency management system in Clark County and the impact of persons with mental illness that occupy bed in local emergency rooms.

Organization: Department of Housing and Urban Development (HUD)
Purpose: Provide shelter plus care to homeless clients.

Organization: Las Vegas Metropolitan Police Department (LVMPD)
Purpose: Key programs include the Crisis Intervention Team (CIT) training, described in criterion five, and the ability to share patient information in emergency situations.

Organization: Mental Health Court
Purpose: SNAMHS provides liaison, treatment services and residential support for clients of the Mental Health Court. Three service coordinators and a Clinical Social Worker works with the Court to ensure that Mental Health Court clients are scheduled, receive, and are monitored for appropriate treatments.

Organization: National Alliance on Mental Illness (NAMI) of Southern Nevada
Purpose: SNAMHS staff helps NAMI plan the annual Spring Fair and Holiday Party held at SNAMHS. They also conduct an annual NAMI walk and use the facility for weekly family and client support meetings.

Organization: Nevada Bureau of Vocational Rehabilitation (BVR)
Purpose: Representatives from BVR are co-located within SNAMHS and work closely with psychosocial rehabilitation (PSR) staff to assist clients in finding employment.

Organization: Nevada Coalition for Suicide Prevention (NCSP)
Purpose: NCSP is dedicated to the collaborative development and implementation of evidence based suicide prevention, intervention and post-intervention strategies and programs in the State of Nevada.

Organization: Nevada Council on Problem Gambling (NCPG)
Purpose: This is a nonprofit education and referral agency focused on problem gambling. It serves as a resource for information and as an advocate for persons who suffer from problem gambling.

Organization: Nevada Department of Corrections
Purpose: Referrals are received from both federal and State prisons to evaluate and provide clients with mental health services.

Organization: Nevada Department of Parole and Probation
Purpose: Referrals are received from both federal and State departments to evaluate and provide clients with mental health services.

Organization: Nevada Geriatric Education Center (NGEC) – Advisory Board
Purpose: This board encourages faculty enhancement, promotes curriculum development, offers continuing education, cultivates statewide affiliations, and provides resource support.

Organization: Nevada State Welfare Division Owens Office Multidisciplinary Team
Purpose: This team consists of welfare workers who present cases to identify problems and how to treat certain individuals, including persons with mental illness.

Organization: Project Homeless Connect
Purpose: This event is the largest of its type in the U.S. and is held twice a year to provide information and assistance to the homeless.

Organization: Psychiatric Advisory Boards
Purpose: These boards set standards of medical care in the community. They are also currently dealing with the emergency room crisis, among other issues.

Organization: Ryan White Community Access Committee
Purpose: This committee assesses service needs within the Eligible Metropolitan Area (EMA) and develops a continuum of care for people living with HIV in the community.

Organization: Ryan White Planning Council
Purpose: This council sets service priorities for the allocation of Ryan White funds, develops a comprehensive care plan for the Eligible Metropolitan Area (EMA) Community, and assesses the efficiency of Clark County Health District's allocation of funds.

Organization: Seniors Integrated Response Team (SIRT)
Purpose: This is a coalition of Senior Service Providers who meet to identify, discuss and coordinate response to potential elder abuse, neglect and exploitation issues with the community at-large and seniors in residential facilities such as group homes, assisted living facilities and nursing facilities.

Organization: Southern Nevada Homeless Coalition (SNHC)
Purpose: This is part of the Continuum of Care initiative described in criterion four. This group works to address problems and develop solutions surrounding homelessness, including networking with various agencies to address homeless issues.

Organization: Stand Down for the Homeless
Purpose: This group organizes the annual Stand Down function, which is the largest in the U.S., to provide information and assistance to the homeless.

Organization: Statewide Alzheimer's Advisory Council
Purpose: This council coordinates advocacy efforts and educational activities; recommends policy changes at local, state, and national levels; integrates funded actives into the existing state service delivery system; conducts fact finding on dementia; provides assessment of the progress of the of the project; monitors progress on the Alzheimer's Disease Demonstration Grant to States focused on priorities and major objectives, including supporting program implementation.

Organization: Suicide Prevention Center
Purpose: Educate and train SNAMHS staff on suicide prevention.

Organization: Youth Homeless Counsel
Purpose: Provide collaboration for client between the ages of 18 and 24.

Rural Region: Rural Clinics

Organization: Nevada Health Centers – Integrated Approach to Health
Purpose: This program has been established in the Carson City area as a staff exchange program through which the Carson City Mental Health Clinic (which is part of the MHDS Rural Clinics system) sends a psychologist to Sierra Family Health to provide behavioral health services. This includes assessment, referral, and early intervention strategies, including a focus

on suicide risk and drug and alcohol use. In return, Sierra Family Health sends a physician's assistant to the Carson Mental Health Clinic to provide primary medical care services for mental health clients. This exchange and integration of services increases that likelihood that clients who present with both medical and psychological healthcare needs receive appropriate treatment. Rural Clinics is working with providers of primary health care and substance abuse prevention and treatment in Lyon and Churchill counties to develop a demonstration project for integrative care.

Organization: Private Therapists – Elko and Lander Counties
Purpose: Collaborative referrals are made between Elko and Battle Mountain Mental Health Centers and regional private therapists who provide individual and family therapy to isolated individuals. Individuals referred out will usually have insurance or other benefits which enable private therapists to bill for services. This leaves Rural Services free to provide services to its priority population of indigent individuals.

Organization: Vitality Center - Elko
Purpose: Provide improved, integrated referral and treatment for individuals suffering from both mental health and substance abuse disorders. Elko Mental Health Center and Vitality Center have expanded their partnership and collaboration over the last year to provide smoother, more comprehensive care to these individuals.

Organization: Douglas County, Nevada
Purpose: Douglas Mental Health Center has developed a cooperative agreement with Douglas County to provide outreach services to individuals residing in and around Topaz Ranch Estates. Approximately 2,500 individuals residing in this area lack access to mental healthcare. Through partnership with the Douglas County Parks and Recreation Department, Douglas Mental Health Center will serve individuals of this area at a much more convenient location at Topaz Ranch Community Center.

Organization: New Frontiers, Fallon
Purpose: A joint application with this chemical dependency treatment organization was submitted to SAMHSA in order to fund individuals with co-occurring psychiatric and substance use disorders. A decision on funding should occur in September, 2010.

Organization: W.B. Ririe Hospital, Ely
Purpose: This is a cooperative endeavor between the hospital serving White Pine County and Ely Mental Health Center to streamline assessment of high-risk individuals and improve continuity of care. All nurses, physicians, and physicians assistants were trained on the protocols for evaluating persons who may meet criteria for Legal 2000R.

Organization: Lyon County School District
Purpose: There is a cooperative agreement between Lyon County School District and Silver Springs Mental Health Center to provide mental health outreach services in Dayton Schools. There are currently four schools in Dayton receiving these services.

Organization: Frontier Community Collaborative
Purpose: This collaborative seeks to streamline service delivery and service referrals across Humboldt and Pershing Counties. Winnemucca Mental Health Center (WMHC) currently has collaborative agreements with the Frontier Community Action Agency, a grant funded agency that assists clients financially and in many other ways; the Winnemucca Domestic Violence Shelter refers victims of domestic violence for therapy at WMHC and, turn, the WMHC refers victims of domestic violence to the Shelter for support services. Other collaborative partners include Silver Sage, the local outpatient substance abuse treatment program; and the Family Stability Council which has been instrumental in bringing therapy services to incarcerated youth at juvenile hall through a grant and collaboration with UNLV and Great Basin Community College. In addition Army OneSource provides referrals and other needed services for military veterans.

PART C. STATE PLAN

Section I. Description of State Service System

ADULT

New Developments and Issues

Statewide Revenue Shortfall and Budget Reductions

In Nevada's SFY 2010 grant application, it was noted that a statewide general fund revenue shortfall in Nevada was beginning to have an adverse affect on all health and human services programs. The conditions that caused the adversity have continued and the past two years have been very difficult economic times for both the United States and for the state of Nevada in particular. Many of the health and human service agencies in Nevada will be facing large budget cuts and will be grappling with the challenges of needing to serve fewer clients, reduce services, or cut programs. In addition, further workforce reductions and/or salary reductions are likely.

Nevada's economic downturn continues to rank as one of the worst among the 50 states. According to the Center on Budget and Policy Priorities, Nevada's revenue gap as a percent of its General Fund was 46.8% in FY 2010 (third highest state) and is projected to be 54% in FY 2011 (highest state).[4]

Nevada's Legislature meets biennially in odd numbered years but was called into a special session in February, 2010 by the Governor to deal with a projected general fund shortfall of over $360 million in fiscal years 2010 and 2011. This issue is addressed in greater detail in the next section, Legislative Initiatives and Changes.

Health Care Reform

The passage of the Patient Protection and Affordable Care Act in March, 2010 will bring significant changes to mental health in Nevada. As more people become eligible for Medicaid services, the role of the State mental health system will be transformed. Currently, the Division of Mental Health and Developmental Services is working with the State's Medicaid agency to ensure access to mental health services for those who become eligible. The concept of the health home for people with serious and persistent mental illness is a powerful one and MHDS has made it a high priority to establish this in Nevada.

The State of Nevada's Department of Health and Human Services (DHHS) has begun planning for health care reform by creating two separate teams to review the legislation, ensure coordinated planning and implementation efforts are conducted throughout state government and provide high-level policy advice to the Governor for him to utilize when making decisions required of him by the law.

The Health Care Reform Policy Planning Group is responsible for the development of high-level policies and includes representatives from the following state agencies:

- DHHS Director's Office
- Insurance Division

[4] Retrieve from: http://www.cbpp.org/cms/index.cfm?fa=view&id=711 on July 20, 2010.

- Division of Health Care Financing and Policy (Nevada Medicaid)
- Office of the Attorney General
- State Risk Management
- Public Employees Benefits Program
- Governors' Office of Consumer Health Assistance
- Division of Welfare and Supportive Services

In addition, the Administrator of Nevada Medicaid oversees the Health Care Reform Implementation Working Group to examine in significantly greater detail, the intricacies of the legislation and what affect it will have on state policies and procedures regarding Medicaid. The Administrators of MHDS and DCFS are both members of this group. Expanding the Medicaid program is one of the primary tools for expanding health insurance coverage in the reform bill and many changes to Nevada's Medicaid program will be required in order to conform to the legislation and accommodate the new enrollees. This working group has divided itself into subcommittees to drill down into specific subject areas including:

- Benchmark Eligibility and Coverage,
- Eligibility,
- *Medical Homes,
- *Grant Options and Other Funding Opportunities,
- Medicaid/Medicare Coordination,
- *Program Integrity, and
- Reimbursement

*A representative from MHDS is included in these working groups.

Transformation Plan

Nevada has been severely impacted by the economic crisis. The state's economy is heavily dependent on the tourism industry that is generally hit hard by economic downturns and is slow to recover once the economy turns around. Under these circumstances, the State's revenue has been significantly less that forecasted and cuts have been made to most government services.

MHDS is not exempt from these reductions. All State employees have been furloughed one day per month, equivalent to a 4.6% pay reduction. This mechanism also effectively reduces available staffing for client services. Merit salary increases and longevity pay have been suspended for fiscal years 2010 and 2011. Some positions have been eliminated, primarily in the hospital services. Overall, MHDS endured a 14% budget reduction.

The Division is continuing the Transformation Plan described in the SFY 2010 Block Grant Application and, in the face of growing challenges, is focusing on identifying and maintaining core services for our clients as a foundation for the future. The plan also tackles the challenge of maximizing the coordination between the Agencies within the Division responsible for the three major functions of the Division, mental health, developmental services and substance abuse programs. In these ways we hope to improve the efficiency of the resources that remain.
The rural region has begun implementing this new vision and is the pilot. The previously separate mental health and developmental service agencies have begun combing administratively. As we move forward, we will seek additional social service and healthcare

partners with which we can collocate and collaborate. Additional information is contained in the "Reorganization of Rural Clinics" section below.

Reorganization of Rural Clinics

In an effort to increase efficiencies in service delivery systems, reduce administrative costs and discover more effective models for service delivery, the Rural Clinics agency of MHDS has undertaken a significant reorganization. Historically, rural mental health clinics have been supervised by a central administrative office in Carson City resulting in problems with quality of care, staff supervision and operational efficiency. The reorganization divided the rural area into North and South, coinciding with the service areas of the Developmental Services Agencies. The advantages of splitting the rural area and consolidating the clinics in the southern region are:

- Savings in travel costs for administrative oversight, staff training and meetings.
- Local supervision of clinics in the south out of Las Vegas allows increased monitoring of client services.
- Opportunities for increased collaboration between the southern mental health clinics.
- Improved training opportunities in Las Vegas for Rural Clinics employees.
- Efficiencies in business office functions.
- Less loss of service time due to staff travel.

Further efficiencies will result from the combination of the Rural Developmental Services and Mental Health Rural Clinics in the north into one agency. This would involve combining some of the business office functions as well as the quality management functions in the two agencies. In addition, the southern rural clinics are being consolidated into an existing administrative structure which has greater capacity to support clinic operations and provide close supervision. The consolidation of the northern clinics with rural development services will reduce duplication of support services, clinic sites and staffing.

Full implementation of this reorganization will require approval by the Nevada Legislature in its 2011 biennial session.

The following table depicts the organizational structure of the Rural Clinics prior to this reorganization.

STATEWIDE RURAL CLINICS		
Primary Clinics	**Satellite Clinics**	**Itinerant Clinics**
Carson City	Battle Mountain	Caliente
Douglas County	Hawthorne	Lake Tahoe
Elko	Lovelock	Tonopah
Ely	Moapa	
Fallon	Yerington	
Laughlin		
Mesquite		
Pahrump		
Silver Springs		
Winnemucca		

The tables below depict the proposed reorganized structure of the Rural Clinics.

NORTHERN NEVADA RURAL CLINICS		
Primary Clinics	**Satellite Clinics**	**Itinerant Clinics**
Carson City	Battle Mountain	Lake Tahoe
Douglas County	Fernley	Tonopah
Elko	Hawthorne	
Ely	Lovelock	
Fallon	Yerington	
Silver Springs		
Winnemucca		

SOUTHERN NEVADA RURAL CLINICS	
Primary Clinics	**Satellite Clinics**
Pahrump	Caliente
Mesquite	Moapa
Laughlin	

PART C. STATE PLAN

Section I. Description of State Service System

ADULT

Legislative Initiatives and Changes

Nevada's Legislature meets biennially in odd numbered years for a statutory maximum of 120 days. During each session, budgets are set on a biennial basis for each department within the State. The most recent Legislative session concluded in June, 2009. However, in February, 2010, a special session was called by the Governor to deal with a projected general fund shortfall of over $360 million in fiscal years 2010 and 2011.

The 2011 Legislative session will begin on February 7, 2011. As dire as the budget crisis appears in the current state fiscal year, the challenges facing the next session will be monumental for a number of reasons.

Budget Deficit

For the second straight biennium, the State will need to reduce spending by at least 10% in contrast to previous biennia when there were increases of 15-20 percent as a growing Nevada faced steadily increasing demands for government services. The revenue shortfall that the 2011 Nevada Legislature will have to address for the 2012/2013 biennium is estimated to range from $1 billion to more than $3.4 billion. [5]

Election of a New Governor

In November, Nevadans go to the polls to select a new governor. The new governor will be the key in determining Nevada's future policy regarding revenues and expenditures. Nevada tends to be a conservative state that attracts people who want a small government and few taxes. Nevada lacks economic diversity relying heavily on gaming and tourism for its tax base. During this nation-wide recession, Nevada has suffered because people are not visiting the state. How Nevada balances its budget in fiscal year 2012-2013 and beyond will depend upon who becomes the next governor of the silver state.

Under the provisions of the Nevada Budget Act (NRS 353), all Departments of State government must submit their "Agency Request" budget to the Governor's Budget Office by September 1 in the years preceding a Legislative session. The Budget Office compiles these "Agency Request" budgets into the "Governor Recommend" budget (also known as the Executive Budget) and must transmit it to the Legislature fourteen calendar days prior to the start of session. The next Governor will be sworn into office on January 1, 2011 giving him very little time to make his mark on the Executive Budget.

Priorities of Government (POG)

It has become clear that the current economic crisis is not a short term problem. The state government has endured multiple rounds of budget reduction. The deficits have been addressed with a combination of service reductions, temporary taxes, and one time fund transfers. These

[5] Retrieved from http://www.nevadanewsbureau.com/2010/07/27/glimmer-of-hope-for-tax-revenues-looming-challenges-in-next-budget-cycle/ on August 3, 2010.

solutions will not be sufficient as we plan for the next two years and beyond. In the face of this, the current administration has established the Priorities of Government Working Group. This group is charged with developing answers to some very difficult questions. What is the proper role of state government? What services must we provide? What is the most efficient way to provide them? What is the best way to pay for them?

Each agency in Nevada will submit a detailed list of current activities, the populations served and the cost associated with them. The working group will use this information to answer the questions listed above and prioritize the use of limited state resources. This will likely have significant impacts on the activities and organizations of State government in Nevada in the future.

Legislative Leadership Changes

Some call this the perfect storm when many elements come together at the same time to create a phenomenon of unknown proportions. One of the factors is leadership changes in the Nevada legislature. Term limits for State and local officers, including legislators, were approved by Nevada's voters by way of an amendment to the Constitution of the State of Nevada in 1996. The amendment limits a Senator or a member of the Assembly elected since 1998 to twelve years of service. The Nevada State Senate has twenty one seats, seven of which the incumbent is prohibited from serving in the 2011 Legislative Session. The Nevada Assembly has forty two seats, ten of which the incumbent is prohibited from serving in the 2011 Legislative Session. This represents a significant loss of institutional knowledge and presents a challenge for newly elected representatives who must deal with daunting and unprecedented situations. There will be a new governor to work with, a huge budget deficit to solve, and reapportionment battles to overcome. The 2011 legislative session will be challenging.

Reapportionment and Redistricting

The 2011 legislature will draw new boundaries for every legislative and congressional district. Every 10 years after release of the census data, each state reapportions its districts according to population numbers. Nevada will decide whether to add more legislators or stay at the same number. This will be only one of the challenges facing the new legislature. Nearly half of the state senate and assembly will be new comers even if incumbents win re-election.

PART C. STATE PLAN

Section I. Description of State Service System

ADULT

Description of the State Agency's Leadership

Strategic Planning

The Division of Mental Health and Developmental Services (MHDS), housed within the Department of Health and Human Services (DHHS), is the provider of adult mental health, developmental disability and substance abuse services to Nevadans who would otherwise be unable to afford these services. MHDS provides these services directly through several agencies housed within the Division and through contractual arrangements with private providers.

Mental health services for children are provided directly by MHDS in the rural region of the State and by the Division of Child and Family Services (DCFS) in the two urban regions. Facilitating coordination, both Divisions share the same governance structure in the Governor's Commission on Mental Health and Developmental Services and both are division within DHHS.

MHDS is invested in a number of collaborations with other aspects of the State government and the private mental health system. For example, MHDS leads the effort to provide mental health response personnel in the event of disaster. MHDS mans a station at the State Emergency Operations Center and collaborates with Department of Emergency Management and others to ensure a comprehensive and thorough disaster response.

The current strategic planning efforts are focused on how to change from a publicly funded and publicly provided system to a publicly funded, privately provided system and how to maintain a core of services for those who are the most ill and have the fewest available resources. Given the current economic conditions, future changes to service delivery will be exclusively private as opposed to publicly provided. Planning efforts will look to replace high cost/low outcome services with low cost/high outcomes services.

Another goal of the Division's strategic planning efforts is to diversify the funding sources to include better use of Medicaid, Vocational Rehabilitation funds and the Veterans' Administration.

Consumer Involvement

Consumers are involved at every level of Nevada's mental health agency. At the front line direct service level, there is the Consumer Assistant Program (CAP). This program created full time jobs with benefits for consumers. These positions work directly with consumers on achieving and maintaining recovery. There are Consumer Service Assistants (CSAs) in each of the three regions of the state. In each region, the CSAs run a drop-in center or club house to facilitate engagement with people needing services and provide a setting for some of the consumer run services. More information on the CAP is contained in Section III, Criterion 1, Outpatient Programs Focused on Increasing Consumer Independence.

At the governance levels of the organization, Nevada has an active Mental Health Planning and Advisory Council. This group has been successfully recruiting and sustaining consumer members on the Council. After receiving training from the National Association of Mental Health Planning & Advisory Councils (NAMHPAC), Nevada's Council identified priorities and established committees to pursue their objectives for the current year. A committee to address Access to Child and Adolescent Services has been tasked with determining what services are available and what barriers to receiving services exist. In addition, the Council created a committee to explore the establishment of a "Club House" model in Nevada to include identifying potential funding sources and collaborative partners.

Also at the governance level, the Governor's Commission on Mental Health and Developmental Services includes a consumer member. This is a ten member board, appointed by the Governor and charged with oversight of MHDS and DCFS.

MHDS regularly seeks feedback from consumers and family members at multiple levels as well. Annually, MHDS collects a survey from consumers and family members as a snap shot of consumer perception of care. On an ongoing basis, each of the mental health agencies within MHDS collects feedback, both positive and negative, from consumers as it is offered. This information is aggregated and provided to management for their use in the decision making process.

Health Care Reform

As mentioned in the New Developments and Issues portion, the State of Nevada's Department of Health and Human Services (DHHS) has begun planning for health care reform by creating two separate teams to review the legislation, ensure coordinated planning and implementation efforts are conducted throughout state government and provide high-level policy advice to the Governor for him to utilize when making decisions required of him by the law. The Administrators of MHDS and DCFS are both members of Health Care Reform Implementation Working Group.

The Healthcare Reform Act will bring significant changes to mental health in Nevada. As more people are eligible for Medicaid services, the role of the State mental health system will be transformed. MHDS staff is working closely with the State Medicaid agency to ensure access to mental health services for those who become eligible. The concept of the health home for people with serious and persistent mental illness is a powerful one and MHDS has made it a high priority to establish this in Nevada.

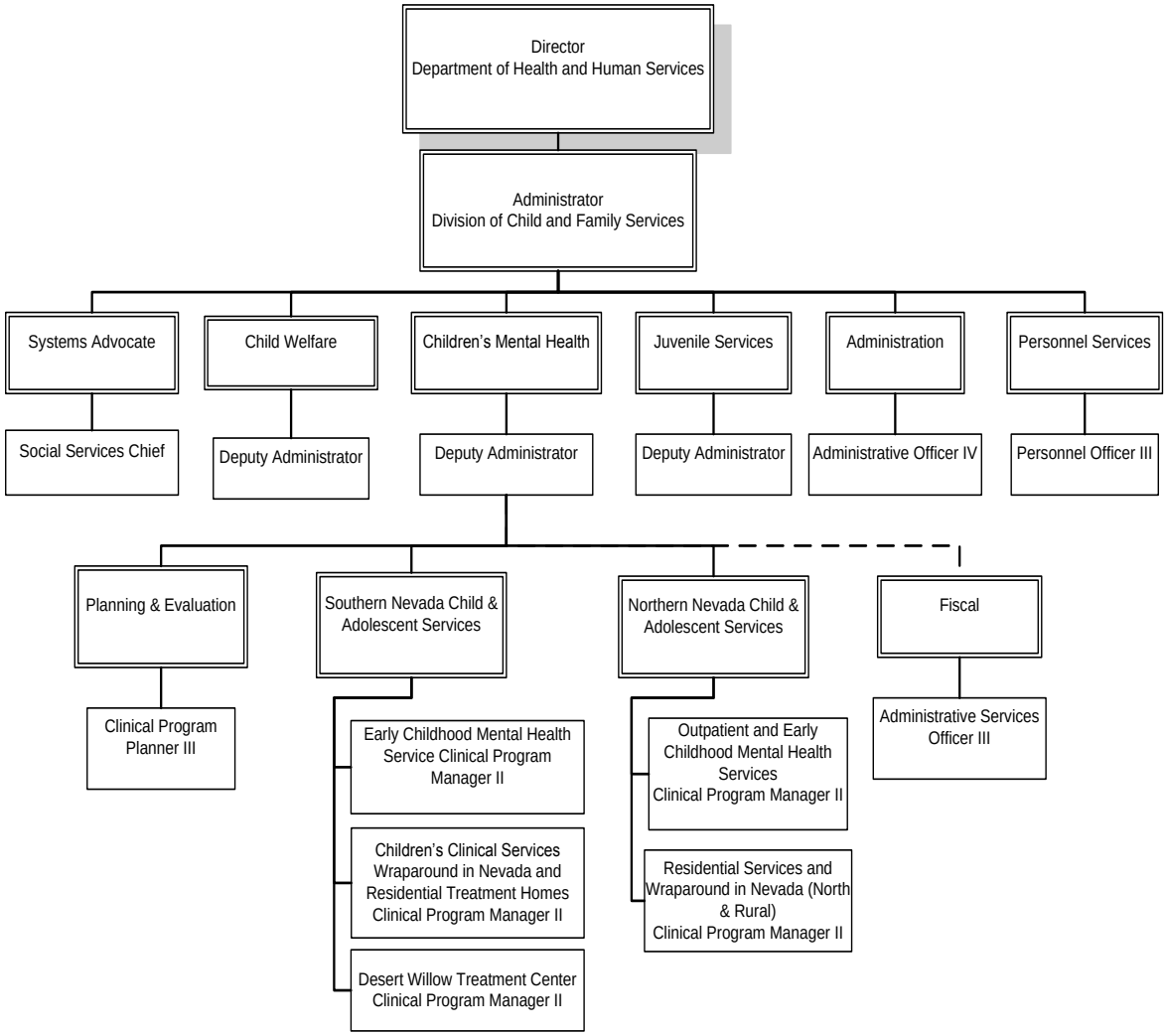
PART C. STATE PLAN

Section I. Description of State Service System

CHILD

Overview of Nevada's Mental Health System

Division of Child and Family Services



Position	***Name***
Administrator	Diane Comeaux
Children's Mental Health Services – Deputy Administrator	Patricia Merrifield
Juvenile Services – Deputy Administrator	Fernando Serrano
Child Welfare – Deputy Administrator	Amber Howell
Systems Advocate – Social Services Chief	Chrystal Main
Personnel Services – Personnel Officer III	Laura Risinger
Deputy Administrator – Fiscal	Danette Kluever
Planning and Evaluation Unit	Susan Mears, Ph.D.
Early Childhood Mental Health Services, Southern Nevada Child & Adolescent Services	Ann Polakowski
Children's Clinical Services, Wraparound in Nevada and Oasis On Campus Treatment Homes, Southern Nevada Child & Adolescent Services	Francis McClain
Desert Willow Treatment Center, Southern Nevada Child & Adolescent Treatment Services	Linda Santangelo, Ph.D.
Outpatient and Early Childhood Mental Health Services, Northern Nevada Child & Adolescent Services	Jane Griffen
Residential Services and Wraparound in Nevada (North & Rural), Northern Nevada Child & Adolescent Services	Kelly Wooldridge
Children's Mental Health Fiscal Services	Jeffrey Morrow

The Nevada Division of Child and Family Services (DCFS), in partnership with families, communities, and other governmental agencies, provides support and services to assist Nevada's children and families in reaching their full human potential. DCFS recognizes that Nevada's families are our future and children, youth, and families thrive when they:

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

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

1. **Child welfare services** including direct child protective services, foster care, adoption, independent living services, foster care licensing in fifteen rural Nevada counties, and statewide child care licensing; and oversight of the statewide Interstate Compact for the Placement of Children (ICPC). Additionally, DCFS has statewide responsibility for the oversight of all child welfare programs including the two urban county child welfare agencies, and the review and reporting of child deaths in Nevada.
2. **Funding for domestic violence programs**, children's advocacy, and legal services for victims, as well as many community-based nonprofit programs to serve victims of abuse and neglect.
3. **Juvenile services** including three residential correctional training facilities, statewide supervision of youth paroled from state-operated facilities, operation of a federally funded reentry program for violent offenders, provision of statewide interstate compact for the placement of juveniles supervision, specialized transitional aftercare program for delinquents released from state facilities, and pass-through funds to the county-operated youth camps, as well as providing grant funding to local jurisdictions that serve delinquent youth for community-based services and local coalitions addressing underage drinking issues.
4. **Community-based outpatient and inpatient mental health services** to hundreds of children and their families in the state, many of whom would enter the child welfare or juvenile justice systems without appropriate treatment and intervention. DCFS' nationally-recognized Wraparound in Nevada (WIN) program serves children in child welfare custody and their families, providing intensive care coordination delivered in a wraparound process model. Mental health programming also includes early childhood services, outpatient services, psychiatric services, community-based treatment homes, residential treatment for adolescents, and acute inpatient psychiatric care.

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

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

A program-based approach allows specialized staff to focus on policy, practice, and funding issues, while the bulk of staff and resources concentrate on direct service delivery tailored to community need.

Statewide, program-based mental health treatment provides a wide range of mental health services to children and adolescents. Children with mental health needs are identified through a strength-based, family-driven, culturally responsive assessment and service process offered through State-operated, community-based mental health centers and through community providers. These centers are organized within the following agencies:

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

Outpatient programs include:

1. Early Childhood Mental Health Services, providing a full range of direct clinical services, targeted case management and specialized day treatment for children birth through 6 years;
2. Outpatient/Children's Clinical Services, providing a full range of direct clinical services and targeted case management and;
3. WIN, providing targeted case management services for children in foster care and their families using a wraparound model.

All three programs are provided by NNCAS and SNCAS. WIN is also provided in Nevada's rural counties and managed out of NNCAS.

Residential programs include:

1. Oasis on Campus Treatment Homes in SNCAS; Family Learning Homes and Adolescent Treatment Center in NNCAS. All are highly specialized community-based treatment homes; and
2. Desert Willow Treatment Center (DWTC) in SNCAS providing both inpatient acute psychiatric care and residential treatment (PRTF).

Goals and Objectives

As a result of the passage of Senate Bill 79, the Commission on Mental Health and Developmental Services (Commission on MHDS) was tasked with developing a State Plan for Children's Mental Health. The following are the goals and objectives outlined in the first plan approved in July, 2010. Goals One and Two were identified as priorities for implementation in the first two years of the 10-year plan. The remaining three goals will build upon the results of the first two goals.

Goal One: State Governance (2-Year Plan)

- Continue to fully operate and fund the regional consortia.
- Expand the authority of the Commission on MHDS to set policies for the care and treatment of children with mental health or co-occurring disorder provided by any public or private provider or facilities.
- Review and confirm authority of the Commission on MHDS and maintain capacity to respond to this authority.
- Establish a child and adolescent behavioral health policy and accountability board to recommend policies covering public and private mental health services. The Statewide Consortium is an existing structure recommended to be reconstituted to form the board.

- Establish DCFS as the state children's mental health authority with the responsibility to set standards for practice and provider qualification; conduct quality assurance; develop and monitor contracts, provide financial oversight and performance monitoring for public and private children's mental health to include the power to adopt regulations.
- Identify any additional revisions to Nevada Revised Statues necessary to implement the intent of this plan.
- Develop capacity to provide the next two-year continuation plan (2013-14). Plan must align previous objectives and integrate findings from studies in Goal 2.

Goal Two: Determine the Impact of Federal Health Care Reform and Mental Health Parity (2-Year Plan)

- Analyze federal healthcare reform and determine impacts on children's mental health services in Nevada.
- Analyze mental health parity legislation and develop an implementation plan in Nevada.
- Based on the outcomes of the above analysis, conduct a feasibility study related to implementation of the MHDS Commission's 10-year plan in the context of the Federal Patient Protection and Affordable Care Act.

Goal Three: Workforce Development (To be added in 2013)

Goal Four: Statewide Service Delivery (To be added in 2013)

Goal Five: Quality Improvement (To be added in 2013)

Regional Programs and Resources for the Provision of Mental Health Services

DCFS programs have negotiated interagency agreements with local organizations to provide expanded mental health services within the community. The following summarizes the interagency agreements currently in place that help provide for an integrated system of care.

Statewide

Organization: Headstart
Purpose: Provides for cooperative, consultative services in the areas of child development, assessment, behavior, and curriculum for children with mental health needs served in Headstart centers.

Organization: County Juvenile Justice Services
Purpose: Provides funding to counties for outpatient sex offender specific assessment and treatment.

Organization: Local School Districts
Purpose: Provide cooperative programs of special education and day treatment to children with severe emotional disturbances in residential care and those at risk for residential care (Washoe and Clark Counties). Provide cooperative programs for children with severe emotional disturbances from birth through age five.

Organization: Nevada Parents Encouraging Parents (PEP)
Purpose: Nevada PEP is a nationally recognized parent organization that contracts with DCFS to provide family-to-family support for families served through SNCAS, NNCAS and WIN. Nevada PEP also receives a sub-grant from DCFS to support family participation in the system of care as trainers, trainees, members of or participants in boards & commissions, DCFS management teams, and as information and referral for parents. This successful collaboration began with the *Comprehensive Community Mental Health Services Program for Children and Their Families* grant from SAMHSA, and has continued with a mix of funding sources including block grant funds.

Organization: Department of Education (DOE)
Purpose: Evaluates and places children with severe emotional disturbances in need of residential care to meet educational needs. Identifies responsibilities of DOE and local education agencies in providing services to emotionally disturbed youth.

Organization: Division of Mental Health and Developmental Services (MHDS)
Purpose: Provides services to parents of DCFS consumers. MHDS provides services to children with severe emotional disturbances in rural areas. MHDS provides services to children with developmental disabilities (DD). MHDS and DCFS collaboratively serve children with dual diagnoses (SED and DD). DCFS transitions youth with severe emotional disturbances to adult services.

Organization: Regional Children's Mental Health Consortia
Purpose: As part of the passage of AB 1 in 2001, regional Children's Mental Health Consortia were established in statute in the three primary regions of the state: north, south, and rural. The Consortia are mandated to provide an annual plan regarding the mental health needs of children within their respective regions. Included under 2009 legislation in SB 131, the regional Consortia now prepare 10 year plans for submission to the Director of the Department of Health and Human Services and to the Commission on MHDS. The work of the Consortia is discussed in detail under the children's services overview.

Organization: University of Nevada, Schools of Psychology, Social Work, Nursing, and Marriage and Family Counseling.
Purpose: Provides internship sites, counseling, supervision, and training in DCFS programs.

Organization: University of Nevada, School of Social Work
Purpose: Provides in-service training for case managers and provides research projects related to children's mental health.

Organization: National University, Counseling Department
Purpose: Provides internship sites, counseling, supervision and training in DCFS programs.

Washoe County

Organization: Washoe County Department of Juvenile Services
Purpose: Facilitates the referral and evaluation of youth involved with juvenile services with severe emotional disturbances in need of mental health services.

Organization: University of Nevada, School of Medicine, Child and Adolescent Psychiatric Fellowship Program
Purpose: Provides for the training and placement of Child and Adolescent Psychiatric Fellows in DCFS treatment programs with funding from the block grant.

Organization: Washoe County Department of Social Services (WCDSS)
Purpose: Provides child welfare services and facilitates the referral of youth determined to be at risk of abuse or neglect. WCDSS provides emergency shelter and placements for children at risk of out-of-home placement.

Clark County

Organization: Clark County Department of Family Services (CCDFS)
Purpose: Provides child welfare services that includes emergency shelter and placements for children at risk of out-of-home placement due to abuse or neglect. CCDFS facilitates access to crisis services and psychiatric hospitalization for children with severe emotional disturbances.

Organization: University of Las Vegas, Pediatrics Department
Purpose: Provides healthcare to children in local residential treatment facilities in Las Vegas.

Organization: University of Nevada, School of Medicine, Psychiatric Residency Program
Purpose: Provides for the training and placement of psychiatric residents in DCFS' Desert Willow Treatment Center.

Organization: University of Washington, School of Medicine
Purpose: Is concluding a research study of the wraparound process funded in part by the National Institute of Mental Health. Provides the database and information updates for the Wraparound Fidelity Index, the fidelity instrument used for the Wraparound model.

PART C. STATE PLAN

Section I. Description of State Service System

CHILD

New Developments and Issues

Statewide Revenue Shortfall and Budget Reductions

In Nevada's SFY 2010 grant application, it was noted that a statewide general fund revenue shortfall in Nevada was beginning to have an adverse affect on all health and human services programs. The conditions that caused the adversity have continued and the past two years have been very difficult economic times for both the United States and for the state of Nevada in particular. Many of the health and human service agencies in Nevada will be facing large budget cuts and will be grappling with the challenges of needing to serve fewer clients, reduce services, or cut programs. In addition, further workforce reductions and/or salary reductions are likely.

Nevada's economic downturn continues to rank as one of the worst among the 50 states. According to the Center on Budget and Policy Priorities, Nevada's revenue gap as a percent of its General Fund was 46.8% in FY 2010 (third highest state) and is projected to be 54% in FY 2011 (highest state).[6]

Nevada's Legislature meets biennially in odd numbered years but was called into a special session in February, 2010 by the Governor to deal with a projected general fund shortfall of over $360 million in fiscal years 2010 and 2011. The cuts to DCFS included the elimination of 10% of all positions to include the following 37 positions in children's mental health programs:

- 1 quality assurance analyst position
- 6 wraparound facilitator positions in Wraparound in Nevada (WIN)
- 1 fiscal position and 1 supervisor position in WIN
- 1 administrative assistant position in WIN
- 1 psychologist position in Northern Nevada Child and Adolescent Services (NNCAS)
- 7 mental health counselor positions NNCAS (outpatient and early childhood)
- 1 clinical program manager position for Outpatient Services in NNCAS
- 3 treatment home positions closing 1 home in NNCAS
- 2 administrative assistant positions in NNCAS
- 2 fiscal positions in NNCAS
- 1 intake coordinator position in NNCAS
- 1 wraparound facilitator position in NNCAS
- 4 mental health counselor and 2 clinical social worker positions in Southern Nevada Child and Adolescent Services (SNCAS) (outpatient & early childhood)
- 1 clinical social worker supervisor position in SNCAS (outpatient)
- 2 wraparound facilitator positions in SNCAS

[6] Retrieve from: http://www.cbpp.org/cms/index.cfm?fa=view&id=711 on July 20, 2010.

Contract funding for community-based rehabilitative services for the uninsured and placement prevention funds were reduced. Out of state travel was eliminated and in-state travel was cut to include all travel reimbursement to state employees for use of personal vehicles for state business. Overtime was eliminated which has challenged 24/7 residential facilities. The cuts in the Special Session were deeper than the cuts made in the FY 2009 session.

This is a proposed drop in spending in contrast to previous biennia when there were increases of 15-20 percent as a growing Nevada faced steadily increasing demands for government services. The proposed spending is approximately $3 billion short of what state officials say is needed to maintain government services at current levels as well as deal with inflation and increased demand. This is 54% of the current budget. Budgets are currently being prepared and significant cuts in programs and funding are anticipated in the Governor recommended budget for the 2011 Legislative session. In addition to directions to state agencies to make cuts to their existing budgets, the Governor has initiated a Priorities of Government and Activities Budget (POGs). DCFS children's mental health programs are describing their services by activity types and budgets are also being built by activities. This is a new process for Nevada and means that agencies are building budget recommendations by the "traditional" method and this new activity method. A team of cabinet members and Governor's staff will review the POGs and make decisions as to which activities of state government are to be eliminated.

During the 2009 legislative session, additional budget cuts were made to the DCFS children's mental health budget that included the following:

<u>Southern Nevada Child and Adolescent Services</u>

- Eliminate 5 positions at Desert Willow Treatment Center (DWTC) in the Dual Diagnosis Unit thereby suspending the creation of a residential treatment unit to one serving youth with co-occurring mental health and substance abuse disorders.
- Eliminate the funding for a Mobile Crisis Unit.
- Mandate 8-hours per month of unpaid furlough leave for all State employees, a reduction of 4.6% in the number of hours worked and salary paid to each employee.
- Suspend Merit Salary increases for State employees for two years.
- Suspend Longevity payments to State employees for two years.

<u>Northern Nevada Child and Adolescent Services</u>

- Eliminate 2 part-time clinical positions
- Mandate 8-hours per month of unpaid furlough leave for all State employees, a reduction of 4.6% in the number of hours worked and salary paid to each employee.
- Suspend Merit Salary increases for State employees for two years.
- Suspend Longevity payments to State employees for two years.

<u>Wraparound in Nevada for Children and Families</u>

- Mandate 8-hours per month of unpaid furlough leave for all State employees, a reduction of 4.6% in the number of hours worked and salary paid to each employee.
- Suspend Merit Salary increases for State employees for two years.
- Suspend Longevity payments to State employees for two years.

Capital Improvement Project

The Center for Medicaid and Medicare Services (CMS) conducted a site visit of Desert Willow Treatment Center (DWTC) in June 2008. DWTC has acute child and adolescent psychiatric units and residential treatment center units in the same building at SNCAS in Las Vegas. Following the site visit, CMS contacted the DCFS administration to inform them that they were out of compliance with a Medicaid regulation that stipulates that an acute psychiatric hospital and a residential treatment center cannot be housed in the same building. DCFS administration quickly developed a business plan that outlined options for handling the crisis. Despite the budget cuts to all government programs, the 2009 Legislature voted to approve a Capital Improvement Project to build a 36-bed children's acute psychiatric hospital.

Specialized Foster Care

In 2008 the Nevada Division of Health Care Financing and Policy (DHCFP) changed the Medicaid reimbursement rate for children and adolescents (under 21 years of age) to match the adult rate for services. Previously children's mental health services reimbursed by Medicaid received an enhanced rate. The rate decrease went into effect March 2009.

In 2008, in response to CMS' direction, Medicaid unbundled the core services for treatment homes. Prior to unbundling, children's needs must have been for a minimum of two hours of service per day in order to qualify for treatment home services. Services are subject to prior authorization. With the unbundling of treatment home services and authorization of the separate services, providers have had difficulty navigating the utilization management process. The state is monitoring the impact of health care reform and coverage of therapeutic foster care and treatment home services.

In many states treatment home providers are paid through sources in addition to Medicaid. In late 2008, DCFS reallocated funds to pay treatment home providers a specialized room and board rate. A workgroup formed to develop the scope of work for the contracts that would be necessary to pay treatment homes for the work that they perform that is not direct mental health rehabilitative services. The specialized room and board rate covers children who are in child welfare custody, youth parole custody, tribal custody, and parental custody (includes those involved or not involved with county juvenile probation). The specialized room and board rate was increased in the state budget for fiscal years 2010 and 2011.

PART C. STATE PLAN

Section I. Description of State Service System

CHILD

Legislative Initiatives and Changes

Nevada's Legislature meets biennially in odd numbered years for a statutory maximum of 120 days. During each session, budgets are set on a biennial basis for each department within the State. The most recent Legislative session concluded in June, 2009. However, in February, 2010, a special session was called by the Governor to deal with a projected general fund shortfall of over $360 million in fiscal years 2010 and 2011. The results to DCFS were an elimination of 10% of positions. Primarily vacant positions were "swept away" which means that instead of not filling or freezing positions, the vacant positions were purged. In state government it is a difficult process to create new positions so these purged positions will not be resurrected. For DCFS Children's Mental Health 37 positions were eliminated (see New Developments section).

The next legislative session will begin in February 2011. As dire as the budget crisis appears in the current fiscal year, the challenges facing the 2011 Legislative session will be monumental for a number of reasons.

Budget Deficit

For the second straight biennium, the State will need to reduce spending by at least 10% in contrast to previous biennia when there were increases of 15-20 percent as a growing Nevada faced steadily increasing demands for government services. The revenue shortfall that the 2011 Nevada Legislature will have to address for the 2012/2013 biennium is estimated to range from $1 billion to more than $3.4 billion. [7]

Election of a New Governor

In November, Nevadans go to the polls to select a new governor. The new governor will be the key in determining Nevada's future policy regarding revenues and expenditures. Nevada tends to be a conservative state that attracts people who want a small government and few taxes. Nevada lacks economic diversity relying heavily on gaming and tourism for its tax base. During this nation-wide recession, Nevada has suffered because people are not visiting the state. How Nevada balances its budget in fiscal year 2012-2013 and beyond will depend upon who becomes the next governor of the silver state.

Under the provisions of the Nevada Budget Act (NRS 353), all Departments of State government must submit their "Agency Request" budget to the Governor's Budget Office by September 1 in the years preceding a Legislative session. The Budget Office compiles these "Agency Request" budgets into the "Governor Recommend" budget (also known as the Executive Budget) and must transmit it to the Legislature fourteen calendar days prior to the start of session. The next Governor will be sworn into office on January 1, 2011 giving him very little time to make his mark on the Executive Budget.

[7] Retrieved from http://www.nevadanewsbureau.com/2010/07/27/glimmer-of-hope-for-tax-revenues-looming-challenges-in-next-budget-cycle/ on August 3, 2010.

Priorities of Government (POG)

It has become clear that the current economic crisis is not a short term problem. The state government has endured multiple rounds of budget reduction. The deficits have been addressed with a combination of service reductions, temporary taxes, and one time fund transfers. These solutions will not be sufficient as we plan for the next two years and beyond. In the face of this, the current administration has established the Priorities of Government Working Group. This group is charged with developing answers to some very difficult questions. What is the proper role of state government? What services must we provide? What is the most efficient way to provide them? What is the best way to pay for them?

Each agency in Nevada will submit a detailed list of current activities, the populations served and the cost associated with them. The working group will use this information to answer the questions listed above and prioritize the use of limited state resources. This will likely have significant impacts on the activities and organizations of State government in Nevada in the future.

Legislative Leadership Changes

Some call this the perfect storm when many elements come together at the same time to create a phenomenon of unknown proportions. One of the factors is leadership changes in the Nevada legislature. Term limits for State and local officers, including legislators, were approved by Nevada's voters by way of an amendment to the Constitution of the State of Nevada in 1996. The amendment limits a Senator or a member of the Assembly elected since 1998 to twelve years of service. The Nevada State Senate has twenty one seats, seven of which the incumbent is prohibited from serving in the 2011 Legislative Session. The Nevada Assembly has forty two seats, ten of which the incumbent is prohibited from serving in the 2011 Legislative Session. This represents a significant loss of institutional knowledge and presents a challenge for newly elected representatives who must deal with daunting and unprecedented situations. There will be a new governor to work with, a huge budget deficit to solve, and reapportionment battles to overcome. The 2011 legislative session will be challenging.

Bill Draft to Amend Chapter 433 of the Nevada Revised Statutes

The MHDS Commission's State Plan for Children's Mental Health identified restructuring state system governance as its first goal. Implementation began with proposed statutory changes to the Nevada Revised Statutes Chapter 433 to expand the MHDS Commission's authority over public and private mental health agencies and facilities, establish a Children's Behavioral Health Policy and Accountability Board to develop policy, and establish DCFS as the children's mental health authority for Nevada. If enacted, this bill will have far reaching changes for children's mental health.

Reapportionment and Redistricting

The 2011 legislature will draw new boundaries for every legislative and congressional district. Every 10 years after release of the census data, each state reapportions its districts according to population numbers. Nevada will decide whether to add more legislators or stay at the same number. This will be only one of the challenges facing the new legislature. Nearly half of the state senate and assembly will be new comers even if incumbents win re-election.

PART C. STATE PLAN

Section I. Description of State Service System

CHILD

Description of the State Agency's Leadership

The Commission on Mental Health and Developmental Services (Commission on MHDS): The Commission on MHDS is a ten member board empowered under Nevada Revised Statutes Chapter 433, and appointed by the Governor. The Commission on MHDS establishes policies to ensure adequate development and administration of services for persons with mental illness, developmental disabilities, and related conditions. The Commission on MHDS's oversight and accountability function for both the Divisions of Mental Health and Developmental Services and Child and Family Services.

In 2009, Senate Bill 79 was passed which required the Commission on MHDS to create a subcommittee on the mental health of children to review the findings and recommendations of each regional mental health consortium submitted and to create a statewide plan for the provision of mental health services to children. The subcommittee chair convened a workgroup that included representatives from the regional and statewide consortia and agency representatives from MHDS, DCFS, and the Division of Health Care Finance and Policy (DHCFP). The workgroup produced a plan with initial 2-year goals to restructure state system governance. The goals are to:

1. Continue resources to fully operate the consortia
2. Expand the authority of the Commission on MHDS to set policies for the care and treatment of children with mental health or co-occurring disorders provided by any public or private providers or facilities. Currently the Commission on MHDS has authority only over the Division of Mental Health and Developmental Services and the Division of Child and Family Services providers and facilities.
3. Establish a Children's Behavioral Health Policy and Accountability Board which would recommend policies covering public and private providers and facilities. This is recommended to be a reconstituted Children's Behavioral Health Consortium.
4. Establish DCFS as the state children's mental health authority with the responsibilities to establish policies and performance standards for the delivery of children's mental health and co-occurring disorders services; establish qualifications for public and private providers and facilities; conduct quality assurance activities; develop and monitor contracts including fiscal oversight; develop regulations for submission to the Commission on MHDS; conduct investigations of complaints made by children and families receiving mental health services from any public or private provider or facility as directed by the Commission on MHDS; and engage in activities to support workforce development..

With the approval of the State Plan for Children's Mental Health by the Commission on MHDS, a bill draft that outlines the restructured state system has been drafted and an implementation plan is being developed.

Nevada Children's Behavioral Health Consortium

In 2006, the Nevada Children's Behavioral Health Consortium (NCBHC) was created to provide leadership and oversight for developing Nevada System of Care for children and families. The NCBHC has four active workgroups that focus on: 1) governance, 2) family and youth involvement, 3) accountability and workforce development, and 4) policy and legislation. The NCBHC also serves to augment the work of the three regional Mental Health Consortia.

Clark County, Washoe County and Rural Regional Children's Mental Health Consortia

In 2001, the Nevada Legislature established three regional Children's Mental Health Consortia which were charged with engaging in annual planning efforts for the provision of services to children with emotional disturbance within the three primary regions of the state: north, south, and rural. In the 2009 Legislative session, Senate Bill 131 was passed. This bill changed established expectations for a ten year plan and required annual reports. It also required that the plan be submitted to the Commission on MHDS in addition to the director of the Department of Health and Human Services. In addition, each regional consortium was given the ability to submit a bill draft each legislative session.

The composition of Consortia membership is outlined in the law and includes representatives from child welfare, school district board of trustees, local juvenile probation offices, local business communities, private mental health providers, foster care providers, substance abuse providers, and parents of children with SED. The Administrator of DCFS appoints Consortia members.

The primary duties of the Consortia include the following:

- Assess the behavioral health needs of children with severe emotional disturbance residing within the respective jurisdictions.
- Characterize how well these children's needs are being met by current health care systems.
- Develop a 10-year strategic plan that addresses identified behavioral health needs.
- Report this information regularly to statewide oversight groups, Legislative Committees, the Department of Health and Human Services, and the MHDS Commission.

The regional Consortia are operational in all three state jurisdictions. Work committees have been formed and strategies devised for the Consortia to accomplish their legislative mandate.

PART C. STATE PLAN

Section II. Identification & Analysis of the Service System's Strengths, Needs & Priorities

ADULT

Service System's Strengths and Weaknesses

Strengths

Throughout Sections I and II of this application, various system strengths have been identified which are serving to improve the system of care in Nevada. These include the following:

- Reorganization of Rural Clinics to gain efficiencies: In response to the continuing budget cuts, MHDS launched a strategic initiative to improve the efficiency of services delivered by its Rural Clinics agency and to reduce administrative costs by moving the five clinics in southern Nevada under the supervision of the Director of SNAMHS. The reorganization divided the rural area into North and South, coinciding with the service areas of the Developmental Services Agencies. Further efficiencies will result from the combination of Developmental Services and Mental Health Rural Clinics in the north into one agency. This would involve combining some of the business office functions as well as the quality management functions in the two agencies. In addition, the southern rural clinics are being consolidated into an existing administrative structure which has greater capacity to support clinic operations and provide close supervision. The consolidation of the northern clinics with rural development services will reduce duplication of support services, clinic sites and staffing.
- Consumer Assistance Program (CAP): The involvement of consumers as stakeholders in the development and growth of the mental health service system continues in Nevada.
- Full implementation of new data infrastructure: Full implementation of AVATAR, Nevada's statewide data management system, is improving staff efficiency, providing reliable data, and increasing compliance with federal reporting requirements. Funding from the Data Infrastructure Grant (DIG) is being leveraged to strengthen the capacity of MHDS to harvest data from AVATAR and provide targeted staff training for system users. The Division continued to strengthen the application by implementing a cache to address problems with system response time.
- Medication only clinic pilot project: The Rural Clinics Agency implemented a pilot program in Fallon to provide "medication clinic only" services for individuals who no longer need therapy or group intervention or service coordination. It is effectively reducing barriers to service and has increased the capacity of the Fallon clinic.
- Multiple access points in Southern Nevada: At SNAMHS, psychiatric emergency services are provided at each of the four community mental health centers in the Las Vegas metropolitan area as opposed to a centralized location in the city. This has also proven to be effective in reducing barriers to service.

In its 2009 publication of State Report Cards, the National Alliance on Mental Illness (NAMI) stated "Mental health care in America is in crisis. The nation's mental health care system gets a dismal D. As the nation confronts a severe economic crisis, demand for mental health services is

increasing -- but state budget cuts are creating a vicious cycle that is leaving some of our most vulnerable citizens behind."[8] NAMI identified some strengths in Nevada's system despite giving the State a "D" again as they did in 2006[9]. NAMI said that Nevada's efforts to increase investment in the system prior to 2008 deserves some degree of praise as does the transparency of its system in identifying serious needs. They complimented Nevada's biennial needs assessment saying that it provides helpful information on the mental health care system, including spending comparisons and unmet community needs.

Other qualities that NAMI found noteworthy included Nevada's establishment of Assertive Community Treatment (ACT) teams, medication clinics, recovery-focused clubhouses and certified peer specialists. In addition, they observed that the preliminary outcomes data for mental health courts show remarkable success in reducing jail days.

Finally, NAMI acknowledged that the funding of the Rawson-Neal Psychiatric Hospital in Las Vegas, which opened in 2006, coupled with a new urgent walk-in clinic model has provided much needed relief for local emergency departments.

In the previous four Block Grant Applications, Nevada referenced the Center for Mental Health Services (CMHS) report on its Block Grant monitoring visit to Nevada conducted in February 2006. In June, 2010, CMHS conducted another monitoring visit to Nevada, the report for which has not been completed. Strengths identified in it will be included in Nevada's SFY 2012 Block Grant Application.

Weaknesses

In Nevada's SFY 2010 grant application, it was noted that a statewide general fund revenue shortfall in Nevada was beginning to have an adverse affect on all health and human services programs. This past year has been a very difficult economic year for both the United States and for the state of Nevada. Many of the health and human service agencies in Nevada will be facing large budget cuts and will be grappling with the challenges of needing to serve fewer clients, reduce services, or cut programs. All this may result in further workforce reductions and/or salary reductions.

Nevada's economic downturn continues to rank as one of the worst among the 50 states. In a study in which the Henry J. Kaiser Family Foundation compiled changes in measures of state economic distress from 2009 to 2010, Nevada was ranked the most distressed state overall based on the following three indicators:

- Nevada had the highest foreclosure rate in the nation at 1 in every 88 homes. The second highest rate was Florida with 1 in every 171 homes.
- Nevada had the greatest change in monthly unemployment at 2.3% which brought it up to 14.2%. Mississippi had the second greatest change at 1.5%.

[8] National Alliance on Mental Illness website accessed on August 17, 2010 at: http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009

[9] National Alliance on Mental Illness website accessed on August 17, 2010 at: http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=74901

- Nevada had the third greatest percent change in monthly food stamp participation at 35.1%.[10]

According to the Center on Budget and Policy Priorities, Nevada's revenue gap as a percent of its General Fund was 46.8% in FY 2010 (third highest state) and is projected to be 54% in FY 2011 (highest state).[11]

There are a number of estimates as to the revenue shortfall that the 2011 Nevada Legislature will have to resolve for the 2012/2013 biennium ranging from $1 billion to more than $3 billion.[12] For the second straight biennium, the State will need to reduce spending by at least 10% in contrast to previous biennia when there were increases of 15-20 percent as a growing Nevada faced steadily increasing demands for government services

In its 2009 State Report Card for Nevada mentioned in the "Strengths" subsection, NAMI identified several weaknesses in Nevada's mental health care system[13]. They include:

- Nevada has struggled to keep pace with population growth and demand for mental health services.
- Although the state legislature increased mental health funding in previous years, over $20 million in cuts in 2008 and an $11 million cut in 2009 have resulted in closures of clinics, reduced services, and staff cuts in state hospitals and outpatient care. Deeper cuts are anticipated. The governor's biennial budget for 2010-2011 has proposed additional cuts of 10 percent or more.
- Nevada's greatest challenge is to adequately fund mental health services, including supportive housing.
- Nevada also needs to develop culturally competent services. Nearly 40 percent of Nevada's population is ethnically or racially diverse, yet Nevada's cultural competence plan lacks evidence of implementation or progress.
- In a state with high rates of severe depression and other serious mental illnesses—as well as suicides—a strong commitment is needed to restore and expand the mental health safety net. Without one, Nevada will find its emergency rooms and criminal justice system overwhelmed—and costs being shifted to other sectors of state and local government.

As noted above, in the previous four Block Grant Applications, Nevada referenced the Center for Mental Health Services (CMHS) report on its Block Grant monitoring visit to Nevada conducted in February 2006. In June, 2010, CMHS conducted another monitoring visit to Nevada, the report for which has not been completed. Any weaknesses identified in it will be included in the SFY 2012 Block Grant Application.

---

[10] Retrieved from http://www.statehealthfacts.org/comparetable.jsp?cat=1&ind=649 on August 17, 2010.
[11] Retrieved from: http://www.cbpp.org/cms/index.cfm?fa=view&id=711 on July 20, 2010.
[12] Retrieved from http://www.nevadanewsbureau.com/2010/07/27/glimmer-of-hope-for-tax-revenues-looming-challenges-in-next-budget-cycle/ on August 3, 2010.
[13] National Alliance on Mental Illness website accessed on August 17, 2010 at: http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=74901

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

ADULT

Unmet Service Needs

Transformation of Services

Like virtually every other state agency in Nevada, MHDS is addressing the need to reduce budgets due to the state's economic crisis. The Division has chosen to take this opportunity to revisit their vision, mission, and the underlying values that govern service delivery as well as to design and develop a strategy that will enable them to improve the effectiveness and efficiency of both services and programs. Additionally, the Division will take into account and address the reduced funding that will affect the delivery of services during the next two biennia. Multiple issues have triggered the Division to redesign its services and supports. These include:

- The complex nature of the MHDS organizational structure;
- Nevada's economic woes;
- The number of Nevadans who are currently un-served;
- The urban/rural dichotomy of needs; and
- The growing and changing demographics of Nevada that continues to strain already stretched services.

MHDS had identified the following unmet needs that have become more severe and significant in light of these unprecedented circumstances.

Emergency Room Overcrowding in Southern Region

In the past 10 years, the Las Vegas Valley has struggled with a lack of psychiatric bed capacity. As a result, people have to wait extended periods of time in local emergency departments for psychiatric beds to become available. MHDS has made multiple efforts to address this problem. In 2003, a mobile crisis intervention team was initiated to increase the efficiency of assessment in emergency departments. In 2006, Rawson – Neal Hospital was opened adding to the bed capacity in the valley. While each of these efforts had some impact on the problem, none have eliminated the problem completely. As the population in the region continued to expand, the need for psychiatric beds continued to expand as well. With the onset of the economic downturn, the numbers have begun to increase again. In 2010 the number of people waiting in hospitals and emergency departments is on par with those at the height of the problem. MHDS has continued to work on methods of increasing the efficiency with which people can be moved through the service system. The issue is complicated by a variety of factors, including but not limited to the availability of transportation, reimbursement policies, legal requirements, a lack of community outpatient resources and the geographic distribution of population in Nevada. According to CMHS, the national average of publicly funded inpatient psychiatric beds is 33 per 100,000 of the general population. By contrast, the average number of publicly funded inpatient psychiatric beds in Nevada is approximately 12 per 100,000 of the general population.

Access to Services in Frontier Areas

Statewide, there is a shortage of psychiatrists in Nevada but it is particularly acute in the rural and frontier areas of the state where 26% of Nevada's mental health clients reside and have the highest rate of depression. An unmet need related to the shortage of psychiatric services is the difficulty in providing appropriate levels of medication to clients in these areas.

Further complicating the matter is the lack of consistent and reliable transportation from rural and frontier areas to services in either the Las Vegas or Reno/Carson City areas. Nevada is the seventh largest state in the union and the distance from some of the rural areas to the urban areas is hundreds of miles.

Technological Challenges

Although all of the Rural Clinics have some form of Telemedicine, the technology behind it is far from state of the art. The current system started as a pilot project using consumer grade web cams attached to basic computers. Although the pilot project has demonstrated that clients can be served remotely, there are many shortcomings throughout the Rural Clinics network. They include:

- Office space – in many locations, telemedicine equipment is located in cramped rooms that lack privacy.
- Equipment – the basic computers currently being used generally have low resolution screens and sub-standard audio components that hinder communication.
- Connectivity – the connections between locations are inconsistent and in most cases, insufficient to support real-time communication. As a result, there are often delayed video images and garbled audio transmissions.
- Staffing – the statewide hiring freeze and the one day per month mandatory furloughs have resulted in staffing shortages thus reducing the availability of telemedicine proportionally.

Health Care Reform

Although much remains to be clarified as to the impact of Health Care Reform on mental health services, it is clear that much effort will need to be made to integrate the provision of mental health services with primary care health services. There are currently only a limited number of mental health clinics coordinating services with primary care providers in Nevada. This model will allow us to provide better access to people who need services and more holistic services without large increases in personnel.

Further discussion of the plans for the transformation of services is contained in the "Plans to Address Unmet Needs" and the "State Agency's Vision for the Future" sections of the application.

PART C. STATE PLAN

ADULT

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

Plans to Address Unmet Needs

Strategic Planning for the Transformation of Services and Health Care Reform

As a result of the unprecedented challenges facing the State in general and DHHS Divisions in particular in the next biennium, MHDS will focus on the redesign of the mental health care delivery system to maintain a foundation of core services for those who are the most ill and have the fewest available resources. The Division's management team has identified a tier of core services that will ensure preservation of life, meet regulatory standards, preserve safety, preserve quality of life, and address prevention in the event services must be reduced or eliminated because of budget cuts.

MHDS is consolidating and centralizing services as illustrated by the reorganization of Rural Mental Health Clinics (RC) and Rural Developmental Services (RDC) described in previous sections. Further collaboration with other sister agencies within DHHS to create a 'one-stop' service delivery model for rural Nevadans is also being considered. Another arena of service delivery that is under consideration in the strategic plan is privatization of some MHDS services.

The MHDS Leadership Team will consider the following recommendations in the development of its strategic plan for the near future:

Organizational and Management Structure

- Transform the MHDS and SAPTA into a cohesive Division that ensures and assures quality of care for all Nevadans seeking services. This transformation will include:
    1. An integration of the vision, mission, and goals of the agencies within MHDS/SAPTA;
    2. Articulating this new integrated entity in all Division communications and through the Division website; and,
    3. Disseminate this renewed Divisional integration among the diverse stakeholders within the state.

Establishment of a Tier of Core Services

- Identify an array of core services based on the vision and mission of the Division.
- Develop a tier of core services based on specific criteria such as preservation of life, regulatory mandates, preservation of safety, quality of life, and prevention.

Delivery Systems, including access to Services and Supports for adults and children

- Develop clear Division guidelines on who is served and how they are served. The guidelines will include:
    1. Clear definition of service recipients and limits of services;
    2. Clear strategy for prioritization providing for both case severity and long-term need;

3. Effective case management strategies to ensure effectiveness and efficiency; and
4. Review of caseload requirements for service agencies.

- Create a service delivery model for the rural areas that contain components that may eventually serve as a model for the rest of Nevada. Some components may include:
  1. Co-location of mental health, developmental services and SAPTA; and
  2. Focus on Telemedicine.
- Create a guarantor of services model that will entail administering, monitoring, and ensuring the quality of care provided by contractors of services that will be privatized.
- Investigate a model of urban-rural collaboration to increase service capacity in the rural 'hub' clinics.
- Investigate the potential for support services (housing and transportation) that will enhance the ability of service recipients to function to their fullest potential and live in the least restricted environment.

Collaboration and Community Engagement

- Identify and recruit a diverse stakeholder base that will support and promote the systems transformation of MHDS/SAPTA.
- Develop a framework that will support on-going input from the stakeholders as the Division continues in its systems transformation efforts.

Emergency Room Overcrowding in Southern Region

As mentioned in the previous subsection, in the past 10 years, the Las Vegas Valley has struggled with a lack of psychiatric bed capacity. MHDS continues to look for solutions to this challenge. We are currently conducting a full analysis of the portal to services to assess the impact of various factors. The community continues to collaborate using the regional emergency services consortium. This has been a very challenging issue. This area that had grown rapidly for years struggles with access to various health care resources. Additional management resources have been added to the Rawson Neal facility in an attempt to ensure accountability and efficiency.

The Division continues to work with the community in Clark County on access to psychiatric hospital beds. The Division is implementing a two pronged approach to the problem. One avenue is maximizing the collaboration between SNAMHS, the Mobile Crisis Team (MCT) and the Emergency Departments (EDs). MCTs are available to assess individuals in the EDs and determine the need for hospitalization. When these teams find that the person is not in need of hospitalization, the EDs have the ability to contact SNAMHS for an appointment for those individuals. This allows the clients to access community based services without being unduly detained by a hospital admission.

The second front involves maximizing the efficiency of the Psychiatric Observation Unit and the Rawson-Neal Hospital. The observation unit is being reorganized to expand psychiatric coverage and reduce length of stay; the same is true of the hospital. Greater emphasis is also being place on working in collaboration with the hospital EDs to identify those patients with complex medical problems and co-occurring disorders. Direct admission privileges are also being considered for those psychiatrists employed by local hospital EDs. Close monitoring of the length of stay in the hospital is aimed at maximizing the efficient use of the hospital beds.

Specific efforts to mitigate the emergency room overcrowding problem in the southern region include the MCT, which is a specialized unit available through SNAMHS that works with the Las Vegas area hospital EDs. The MCT is comprised of Licensed Clinical Social Workers who travel to local hospital emergency rooms to evaluate psychiatric patients and, if feasible, develop safe discharge plans that are submitted to emergency room physicians for approval. This service averts unnecessary psychiatric hospitalizations, saves emergency room personnel time, and reduces the number of psychiatric patients in regional emergency rooms. Assessment services are provided from 7:00 am to 10:00 pm, seven days per week, in all 11 Las Vegas area emergency rooms.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

ADULT

Recent Significant Achievements

Statewide

- MHDS continued its participation in the Western Interstate Collaborative for Higher Education (WICHE) which is a regional user group for the Mental Health Statistics Improvement Program.
- Block grant funding was used to support Clinical Program Planner staff responsible for the compilation of a Needs Assessment, Consumer Satisfaction surveys and coordination of the Division's Disaster Response and Emergency Services Team.
- Block grant funding also supports Quality Assurance staff that monitor the quality of residential programs, investigate client treatment complaints and monitor community service quality. They also ensure compliance with standards and regulations.
- Collaboration with DCFS to educate Social Workers on tribal cultural competency issues was undertaken.
- In a year when travel was curtailed statewide due to budget shortfalls, the Rural Monitoring visits including participation by State staff was continued.
- The Mental Health Planning Advisory Council began conducting annual orientations for all members that includes guidance on effective advocacy, how to work collaboratively with other groups and how to establish priorities for the Council.
- Block Grant funds continue to be allocated to support Nevada's Commission on Mental Health and Developmental Services, particularly collaborative activities with the Council.
- The Division conducted training for staff on Investigations as well as on Root Cause Analysis to identify and correct system weaknesses. The goal was to improve patient safety and service quality.

Northern Region: Northern Nevada Adult Mental Health Services (NNAMHS)

- NNAMHS had its triennial Joint Commission Survey in February of 2008 and received immediate accreditation of both its inpatient and outpatient programs, as well as full accreditation of its Behavioral Health programs (Intensive outpatient for co-occurring disorders and PACT team).
- NNAMHS inpatient facility has developed and implemented a new treatment structure in which patients receive skill training, psycho education and group treatment, enabling them to be better prepared and more engaged in their treatment at the point of discharge.
- The 2009 legislature continued funding for the Mental Health Court program which serves 350 clients, including housing for 60 of those clients. The NNAMHS Mental Health Court Program is one of five nationally recognized learning sites for the National Judicial College and was selected for a 2009 Truckee Meadows Tomorrow Silver Star Award for Social Well-Being and Mental Health."
- The co-occurring disorders program, initially created and staffed by our own employees, has grown to over 260 clients and three levels: "Choices" for initial intake and

engagement; "STARS" for those committed to reducing the harm associated with substance abuse and are progressing in their journey toward sobriety while also receiving treatment for their mental illness; and "HEARTS", our intensive outpatient treatment program, which meets four hours daily for those committed to gaining six months of sobriety and developing the skills to maintain both their mental health and their recovery.

- NNAMHS has employed five Consumer Services Assistants, who are client peers. They operate the Drop-In Center (DIC), the employment learning lab (a Canteen), welcome every patient admitted to the Observation Unit and invite them to join the DIC on discharge, provide group support and training in anger management, and organize recreational outings for all interested outpatients. All four became officially certified this year by completing a rigorous week long course of study and three months of prior preparation in such topics as confidentiality, recovery activities, how to inspire hope, how to recognize the signs of suicidality, etc.
- NNAMHS has continued to maintain itself as a student learning site for nurses, social workers, psychologists, pharmacists and psychiatry residents.
- Maintained the low to no use for seclusion and restraint in our hospital well below the national average, in spite of funding and staffing reductions. In April, 2010 we received recognition from SAMHSA for being among the top ten hospitals in the nation having made a significant reduction in use of seclusion and restraint and maintaining that reduction for ten years.
- Implemented the Mobile Outreach Safety Team, which represents the first time the State has provided an outreach type of service. This program consists of two mental health workers who ride along with CIT trained police officers to do welfare checks on existing clients who have dropped out of treatment and to provide access to mental health services to those who are homeless.
- Established the "Change Agent Group" of staff who will guide the organization in becoming high quality, recovery-oriented, continuous, integrated, and complex-problem capable. This is a specific model developed by Dr. Ken Minkoff which will assist us to maintain and continuously improve our quality in spite of the economic downturn; enable us to further integrate clients with a multiplicity of diagnosis and problems, (which is more the norm now), including substance abuse disorders, medical problems, lack of support system, poverty, and lack of adequate housing; and help to guide the redesign of outpatient services to meet these challenges. In 2010, we completed the Compass assessment for our agency to identify specifically what changes/improvements we need to create the cultural change to be a complex-problem capable agency.
- Established a dialogue with the Assistant Sheriff for Detention for Washoe County to explore how we might work together to assist clients we share with the county detention system. In 2010, the Sherriff selected a new health services company that will provide the psychiatric medications our consumers need.
- Established a relationship with the Sparks City Police to expand opportunities for increasing the number of trained CIT officers. Although the Chief in Sparks has changed twice, we have an excellent relationship and wonderful cooperation from these officers and their Administration.
- On July 19, 2010, NNAMHS opened our first outpatient adult Intensive Outpatient Program with nine referrals. It will initially be a 10 member, 12 week program, three hours a day, three days a week. We are doing this with existing staff in an attempt to

more efficiently use our resources and provide intensive services on-site rather than exclusively through each service coordinator. Eventually we will not separate our Co-Occurring Disorders and Adult IOP's but integrate them.

- In September, 2010 we will launch a formal Outpatient Utilization Management system to identify type and level of intensity of service needed in order to better serve consumers as well as use our now more limited resources in a more effective manner.
- NNAMHS staff participated in the annual MHDS Regional Service Coordination Conference.

Southern Region: Southern Nevada Adult Mental Health Services (SNAMHS)

- SNAMHS continues its leadership role in developing and implementing the Crisis Intervention team (CIT) training program for the Las Vegas Metropolitan Police Department as well as neighboring law enforcement authorities and correctional officers.
- SAMHSA renewed its grant with SNAMHS for our senior outreach program which provide for home mental health visits for seniors.
- HUD and Clark County renewed/increased its award to SNAMHS for housing subsidies for the SMI population.
- All of the SNAMHS outpatient clinics continue to employ at least one bilingual clinical and administrative staff member and implemented bi-lingual patient related documents and telephone answering services. SNAMHS continues to contract for services through the Language Line which provides staff members access to multi-lingual translators.
- Expanded the psycho-educational group programs for consumers and their families to all outpatient clinic locations and Rawson-Neal Hospital.
- SNAMHS co-sponsored (with Nevada Psychological Association) a one year training program for certification in Dialectical Behavioral therapy.
- SNAMHS expanded its training program and now includes UNR medical school residents, Touro University medical residents, UNR and UNLV nursing students, and graduate social work students from several national universities.
- SNAMHS staff participated in the annual MHDS Regional Service Coordination Conference.
- Increased the size of our intensive outpatient co-occurring group program in association with Community Counseling Center and SAPTA.
- Expanded our ten bed residential group home (the first in the state) for individuals with co-occurring disorders and now have two additional homes and 20 additional beds.
- Established a 22 bed crisis program with a maximum 30 day length of stay.
- Established a homeless outreach team to work with other community agencies in an effort to provide outreach services to the homeless mentally ill.

Rural Region: Rural Clinics (RC)

- Rural Clinics' total caseload exceeded an average of 2,200 per month in fiscal year 2009. Services provided are outpatient counseling, service coordination, residential support, medication clinic, rehabilitation and mental health court. These services totaled 4,200 clients in June 2009 alone since many clients require more than one service.
- Medications donated to Rural Clinics' clients by pharmaceutical companies are valued at $1,224,502 for fiscal year 2009, thus saving the State general fund an equal amount.

- Telemedicine psychiatric services are provided to all center sites. Approximately 34% of medication clients are served by psychiatric telemedicine. Telemedicine services offer the potential of making mental health services available to rural Nevadans in the most remote areas of the state.
- The AVATAR management information system upgrade was installed in June 2009, increasing the speed of reporting and improving user capability. The information system has allowed the agency to more accurately track staff caseloads and productivity. A new intake format devised by a workgroup of Rural Clinics staff has resulted in more efficient and effective intake documentation.
- Evidence-based psychotherapy treatment is promoted in each clinic, such as cognitive-behavioral approaches for depression and anxiety disorders. Therapist toolkits that detail the procedures are available in each clinic. Clinicians recently completed Trauma Based Cognitive Behavioral training and implemented this approach with children in many of our Centers.
- A pilot program to provide "medication clinic only" services for individuals who no longer need therapy or group intervention or service coordination is working very well in Fallon and has increased the capability of the clinic to provide services.
- Rural Clinics has developed a Quality Improvement section that is developing strategies for training and supporting more effective services and measuring clinical and personal outcomes.
- Carson Mental Health Center is developing a pilot program based on the SAMHSA Evidence-based Practice *Illness Management and Recovery*. This program was developed for individuals with severe and persistent mental health disorders. Research provides robust support for improved outcomes which include increased medication adherence, decreased hospitalization, improved involvement of significant others in treatment and recovery. *Illness Management and Recovery (IMR)* emphasizes the personal journey of recovery for each individual, stressing the skills and experiences of others in group format. Through shared knowledge and validation of both struggles and triumphs, individuals in IMR expand their natural support systems, decreasing reliance on professional providers.
- Fernley Mental Health Center re-opened in September 2009 and now provides services to 75 individuals in North Lyon County. This same office provides cost-effective, integrated mental health and developmental services. At present the office and its operations are slated to transition into the state budget in October, 2010.
- Yerington Mental Health Center has adopted a variation on the Evidence-based Practice *Dialectic Behavior Therapy* (DBT). DBT teaches specific skills to improve emotional self-regulation. This modality is effective with individuals suffering from chronic personality disorders, or those conditions characterized by enduring patterns of inner experience and behavior which are rigid and inflexible leading to impairment, distress, and poor social and occupational functioning.
- The directors of the clinics and administrative leadership have developed a new strategic plan for 2010-2015. The Vision and Mission of Rural Clinics was also updated. The new Mission is: Working with Community Partners to Improve Quality of Life. This plan completely updated the organizational charts and structure by incorporating psychologists into supervisory and leadership roles in the clinics. Each clinic now has a leadership team comprised of a Clinical Program Manager and a Psychologist. The

Clinical Program Manager focuses on administrative and program requirements, while the Psychologist focuses on clinical supervision and program design. The long-term goal is to improve clinical design and outcomes within each center.

- Douglas Mental Health Center has streamlined its intake process so individuals seeking services are rapidly processed into treatment. Rather than waiting weeks or months, individuals are oriented almost immediately. Teaming clinical staff with service coordinators during the intake process ensures that all dimensions of client need are addressed. Even if the consumer does not become a client, we provide them with appropriate linkages and referrals to ensure that they receive needed services and do not "fall through the cracks." Treatment Team Meetings have been instituted to provide clinical consultation in a multi-disciplinary format three mornings a week for one hour. During these meetings team members share ideas and make recommendations for new clients after intake; keep each other apprised regarding any at-risk consumers; and problem solve difficulties which may arise with on-going clients. Community partners like Social Services and Tahoe Youth and Family Services (a SAMSHA entity) are invited to attend these meetings whenever possible in order to share information and enhance our working relationships.
- To improve caseload capacity, Douglas Mental Health has expanded provision of group therapy utilizing evidenced-based practices like DBT; Seeking Safety; Co-Occurring Disorders and IMR. Douglas currently offers10 different groups and plans to add several more in the fall.
- Mental health services were re-established at Tonopah Mental Health Center under the guidance of Ely Mental Health Center. The innovations in scheduling and telemedicine connections have doubled both caseload and hours of service provision.
- Rural Clinics staff participated in the annual MHDS Regional Service Coordination Conference.
- Ely Mental Health Center has added case management and psychiatric medication clinic services which had not been available in Ely for several years.
- Silver Springs Mental Health Center has added a full time psychiatric caseworker and has re-established psychosocial rehabilitative services and groups in that locale.
- Silver Springs Mental Health Center is now providing limited telemedicine psychiatry to children and adolescents, and provides the only psychiatric services to residents of Central Lyon County.
- Lovelock Mental Health Center's LCSW is connected to the local Multidisciplinary Team, Domestic Violence Prevention Group, and represents Lovelock Mental Health Center at Drug Court. A Mental Health Technician position has increased capacity for conducting Basic Skills Training for individuals in need of fundamental life skills.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

ADULT

State's Vision for the Future

As a result of the unprecedented challenges facing the State in general and MHDS in particular in the next biennium, the Division will focus on the redesign of the mental health care delivery system to maintain a foundation of core services for those who are the most ill and have the fewest available resources. The Division's management team has identified a tier of core services that will ensure preservation of life, meet regulatory standards, preserve safety, preserve quality of life, and address prevention in the event services must be reduced or eliminated because of budget cuts.

MHDS is consolidating and centralizing services as illustrated by the reorganization of Rural Mental Health Clinics (RC) and Rural Developmental Services (RDC) described in previous sections. Further consolidation and collaboration with other sister agencies within DHHS to create a 'one-stop' service delivery model for rural Nevadans is also being considered. Another arena of service delivery that is under consideration in the strategic plan is privatization of some MHDS services.

Implementation of Health Care Reform

The passage of the Patient Protection and Affordable Care Act in March, 2010 will bring significant changes to mental health in Nevada. As more people are eligible for Medicaid services the role of the State mental Health system will be transformed. Currently, MHDS is working with the State's Medicaid agency to ensure access to mental health services for those who become eligible. The concept of the health home for people with serious and persistent mental illness is a powerful one and MHDS has made it a high priority to establish this in Nevada. Additional efforts will be focused on opportunities to further the integration of private primary care providers with public and private providers of mental health services.

Consumer Involvement

Consumers are involved at every level of Nevada's mental health agency. At the front line, direct service level, there is the Consumer Assistant Program (CAP). This program created full time jobs with benefits for consumers. These positions work directly with consumers on achieving and maintaining recovery. There are Consumer Service Assistants (CSAs) in each of the three regions of the state. In each region, the CSAs run a drop in center or club house to facilitate engagement with people needing services and provide a setting for some of the consumer run services.

At the governance levels of the organization, Nevada has an active Mental Health Planning and Advisory Council. This group has been successful in recruiting consumer members for vacancies. Also at the Governance level, the Governor's Commission on Mental Health and Developmental Services includes a consumer member. This is a ten member board, appointed by the Governor and charged with oversight of MHDS and DCFS.

MHDS regularly seeks feedback from consumers and family members at multiple levels also. Annually, MHDS collects a survey from consumers and family members as a snap shot of consumer perception of care. On an ongoing basis, each of the mental health agencies within MHDS collects feedback, both positive and negative, from consumers as it is offered. This information is aggregated and used to inform management decision making.

Strategic Planning for the Transformation of Services

The Strategic Planning process, begun in 2008, identified the following priorities:

- Consolidating and centralization of some services and or infrastructure
- Identification of a comprehensive array of services and a tier of core services
- Defining the delivery system
- Workforce development
- Collaboration and community engagement
- Infrastructure development
- Transformation from a publicly funded and publicly provided system to a publicly funded and privately provided system

The MHDS leadership team was asked to identify aspects of a practical vision for Nevada without considering limitations. This would then become the foundation on which they would build an array of services for the future taking into account the reduced services and programs they might have to offer for the upcoming fiscal biennia. Their vision of a comprehensive community-based mental health system of care in Nevada includes the following:

- A single Information Technology system with modular components and flexibility;
- Flexibility in terms of service delivery;
- An effective and efficient delivery system for those who meet the profile;
- Services for the client population meet the "Five A's":
    1. Accessible,
    2. Available,
    3. Affordable,
    4. Appropriate,
    5. Acceptable
- Instill the nine dimensions of service:
    1. Practice,
    2. Quality of care,
    3. Performance,
    4. Education/career development,
    5. Collegiality,
    6. Ethics,
    7. Collaboration,
    8. Research, and
    9. Resource utilization.
- Collaboration with sister agencies and the private sector;
- Robust assessment defining care;
- Full spectrum of services for the rural areas:
- Person-centered, community-based;
- Evidence-based treatment models;
- Desired end state – help our clients reach their highest level of capacity and functioning.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

CHILD

Service System's Strengths and Weaknesses

The Center for Mental Health Services (CMHS) conducted its most recent Block Grant monitoring visit to Nevada on June 8-10, 2010. A variety of system strengths and challenges for children's mental health services were outlined in discussions at the end of the review.

Strengths

- Wraparound in Nevada (WIN) is a statewide program that uses the Wraparound model which is nationally recognized and provides care coordination services used to support children, youth, and their families with complex needs. The model includes a strengths and culture-based approach to individualized planning through a family-centered team that promotes family voice and choice. In Clark County, the DCFS WIN program participated in a NIMH study of the Wraparound model led by Dr. Eric Bruns which concluded data collection this fiscal year.

  In northern Nevada, a WIN expansion initiative, entitled Wraparound Washoe, is adding 3 additional facilitator positions to serve children and youth with a severe emotional disturbance in parental custody. Washoe County Juvenile Services, Washoe County School District, and MHDS' Sierra Regional Center are working with DCFS through a Memorandum of Understanding. The WIN expansion initiative includes a Wraparound Review Team that will approve care coordination plans, assist in overcoming barriers, and monitor service utilization. The initiative will be evaluated for child and system level outcomes.
- Neighborhood Family Service Centers in the Las Vegas area are considered a best practice program. These centers, originally funded by a SAMHSA System of Care grant, provide a broad array of comprehensive services to children, adolescents, and families and enhance the existing local interagency service system by developing interagency barrier busting (Neighborhood Review Teams) at neighborhood sites. The Neighborhood Review Teams are striving to prevent unnecessary out of community and out of state placements of children. Teams assist with the reintegration of youth that are returning from out of state placements. Neighborhood Review Teams are collecting data on each child and youth presented to determine if their efforts are working. Top level managers from the major youth-serving public agencies comprise a Clark County Review Team, which addresses barriers that the neighborhood teams are unable to resolve.
- Family involvement is strong in Nevada. There is family voice at all levels of the system of care to include family-to-family support services, child and family teams, and at the policy development level.
- Through the statewide Children's Behavioral Health Consortium, regional consortia, and the Commission on MHDS, a solid planning process for children's mental health is underway.

- Implementation of several evidence-based practices to include Trauma Focused-Cognitive Behavioral Therapy, Motivational Interviewing, Parent-Child Interaction Therapy, and Aggression Replacement Training.
- Quality Assurance/Quality Improvement activities include the Youth Services Survey, the Wraparound Fidelity Index, and participation in a validation study of the Early Childhood Service Intensity Instrument by the Early Childhood Mental Health Services.
- Two Oasis On-Campus Treatment Homes in Clark County exclusively serve children with co-occurring disorders of mental health and developmental delays.
- Collaboration with the University of Nevada Reno, School of Medicine provides child and adolescent psychiatric fellows that work in outpatient and residential services at NNCAS.
- DCFS Early Childhood Mental Health Services provides consultation to Head Start programs.
- Homeless youth in Clark County are served through the Nevada Partnership for Homeless Youth.
- From the Avatar database, point in time data is extracted for analysis.

Weaknesses

- Budget challenges and budget cuts for both MHDS and DCFS are impacting service provision. State employees are required to take one furlough day each month in an effort to save money to help balance the budget. This leads to a concern regarding meeting client needs. Other models of service provision could be explored.
- Lack of a children's mental health authority makes it difficult to do planning and have accountability for the system. Without authority, DCFS cannot develop the types of cooperative and collaborative relationships needed for an effective and efficient children's mental health system. Having said this, the Wraparound expansion initiative is an example of a cooperative and collaborative endeavor.
- There continues to be some fragmentation within the system. Nevada provides direct services in contrast to most states where services are contracted. DCFS provides children's mental health services in Clark and Washoe counties but MHDS provides children's mental health services in rural counties with the exception of the WIN program which is part of DCFS. Child welfare services are administered by Clark and Washoe counties but in the rural region, DCFS provides this service.
- Access seemed to be a problem based on the prevalence rate. Based on a 5% prevalence rate of severe emotion disturbance in the population of children age 0-17, the approximate number of children with severe emotional disturbance would be 34,591. The number of children served by DCFS and MHDS children's mental health is approximately 4,500 which is 13% of the population in need of services. However, MHDS and DCFS are not the only mental health services available to children and their families. In the Medicaid Redesign of 2006, Behavioral Health Community Networks were developed to serve Medicaid Fee for Service eligible recipients. In addition, Medicaid HMO recipients are served thorough two HMOs. A small fraction of children and their families are served through Health Maintenance Organizations for TANF and Nevada Check-up recipients receive mental health services. Private practitioners and non-profit agencies also provide mental health services.

- Waiting lists remain an issue across all regions in Nevada. Alternatives for children and their families waiting for services needs to be explored.
- Home-based services are not routinely offered to children and their families.
- There is a lack of vocational services for older adolescents.
- Social services are lacking in the areas of housing, homemaker services, and transportation in the rural region especially. It can be challenging for children and their families to get to a clinic for services.
- Youth voice is not represented on the Advisory Council or on consortia.
- Telemedicine is not fully developed in the rural region.
- Fiscal services are challenged with new staff and a lack of written procedures. Client level data and financial data are not tied together.
- There is limited ability to get approval for funding such as through grants. Suggestion to diversify funding streams.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

CHILD

Unmet Service Needs

Nevada Children's Behavioral Health Consortium (NCBHC)

The NCBHC implemented a finance assessment to collect expenditure and utilization data for children served in public agencies for fiscal year 2007. An in-state consultant gathered data and documentation and conducted much of the analysis for the assessment. A national consultant provided guidance and support to the in-state consultant to analyze behavioral health spending. She also brought a national perspective to the recommendations for actions that can be taken by the NCBHC. The finance assessment[14] sought to answer the following questions:

1. Which State and local agencies spend dollars on behavioral health services for Nevada children and their families, how much are they spending and what types of dollars are being spent?
2. What types of services and supports are these dollars buying?
3. How many and which children and youth receive behavioral health services?
4. What issues are raised by agency expenditures, types of services funded, and types of children and youth served?

A summary of the key findings from the finance assessment addressed unmet needs of the Nevada System of Care. The key findings were:

- Underutilization of Medicaid for home and community-based services; low level of spending overall on home and community-based services.
- Underutilization of Medicaid for adolescent substance abuse treatment services; low level of spending overall on substance abuse services.
- Lower level of child behavioral health spending through Medicaid managed care.
- Underutilization of the State Children's Health Insurance Program (SCHIP).
- Racial and ethnic disproportional and disparate access to services.
- Regional disproportional and disparate resources.
- Reliance on restrictive levels of care.
- Lack of a broad community-based provider network and an over-reliance on State facilities and public employees.
- Apparent lack of spending on evidence-based practices.
- Lack of school-based mental health services.
- Lack of appropriate services for children in child welfare.
- Under-utilization of Medicaid for youth in juvenile justice.
- Inconsistent use of targeted case management with no locus of accountability for high-utilizing populations.

[14] Pires, S.A. & Mayne, S. (Spring, 2009). *Report on Behavioral Health Spending for Children Across Public Child-Serving Systems.* Nevada Children's Behavioral Health Consortium.

- Questions about behavioral management skills and a concern about over-utilizing this service.
- Lack of identifiable spending on transition-age youth.
- Limited spending on family and youth run organizations.
- Lack of data on psychotropic drug use.
- Lack of data on tribal financing.
- Low level of spending for children's behavioral health services in total and per Medicaid enrolled child.
- Low service utilization.

The NCBHC chose to use these findings to design a more effective and efficient children's mental health governance structure. This recommended governance structure is described in State's Vision for the Future. National consultant, Sheila Pires met with Consortium members in September 2009 to design the recommended governance structure and to begin a 5-year strategic plan.

Regional Children's Mental Health Consortia

The 2009 Legislature passed Senate Bill 131 requiring each of the three regional Children's Mental Health Consortia to submit to the Director of Health and Human Resources a ten year strategic plan. Below is a summary of the priorities identified in the ten year plans by category.[15]

Priority needs identified by the regional children's mental health consortia are addressed by each consortium respectively through collaborative efforts with State, County, nonprofit, and private agencies within each of the three regions of the state.

Improved Infrastructure and Coordination

Clark County Children's Mental Health Consortium

Restructure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families.

Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

Rural Nevada Children's Mental Health Consortium

Promote the mutual sharing of regional resources to improve mental health services for families of children with mental illness and behavioral disorders in Nevada rural region.

Promote and support the use of technology to enhance mental health services for families of children with mental health and behavioral disorders in Nevada rural region.

[15] Clark County Children's Mental Health Consortium. (2010). *Ten Year Plan.*
Washoe County Children's Mental Health Consortium. (2010). *Ten Year Plan.*
Rural Children's Mental Health Consortium. (2010). *Ten Year Plan.*

Washoe County Children's Mental Health Consortium
Help families help themselves: Promote the coordination of formal and informal strategies and resources that support youth and family autonomy in actively managing and finding solutions to fit their needs.

Support youth to succeed as adults: Develop, fund and implement system-level policies coupled with successful strategies to help youth with mental health needs transition to postsecondary education, employments, and independent lives.

Improved Access to Behavioral Health Services
Clark County Children's Mental Health Consortium
Expand access to neighborhood-based financial supports and intensive services for Clark County's children with serious emotional disturbance who are living with their families.

Expand access to intensive care management using a wraparound model for children and youth with a serious emotional disturbance, including those involved with the juvenile justice system and those living with their families.

Rural Children's Mental Health Consortium
Investigate potential delivery of mental health services to families of children age 0-3 with possible mental health and behavioral disorders in Nevada's rural region.

Encourage mental health services to the families of children and adolescents in juvenile justice detention facilities in Nevada's rural region.

Explore the potential for mental health service provisions in public schools in Nevada's rural region.

Washoe County Children's Mental Health Consortium
Serve youth in their home communities: Enhance Washoe County's capacity to provide community-based treatment and care to serve youth locally in a manner that supports safety, stability, and permanency.

Help youth succeed in school: Work with community agencies and Washoe County School District to support system-wide implementation of Positive Behavioral Supports so that youth can develop pro-social skills while remaining in their home school and family setting, and the need for more intrusive or aversive interventions will be reduced.

Public Awareness, Early Identification and Prevention
Rural Nevada Children's Mental Health Consortium
Determine and promote awareness of the specific challenges families of children with mental health and behavioral disorders face in Nevada's rural region.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

CHILD

Plans to Address Unmet Needs

MHDS Commission, Nevada Children's Behavioral Health Consortium (NCBHC), and Regional Children's Mental Health Consortia

In the Unmet Needs section of this application, key issues drawn from the finance assessment report were highlighted. The NCBHC membership wanted to address these issues in a well-planned and thoughtful manner. In September 2009, the NCBHC invited Sheila Pires to Nevada to assist them in developing a strategic plan. Consortium members, knowing that Senate Bill 79 gave the MHDS Commission the responsibility for developing a statewide children's mental health plan, invited MHDS Commissioners to the meeting.

At the September meeting, Ms. Pires briefly reviewed the results of the finance assessment and presented examples of how other states are organized and structured. Participants were tasked with identifying goals for Nevada's system of care (see the subsection entitled "Goals for Nevada's System of Care" at the end of this section), a necessary step towards designing an organizational structure. By the end of the meeting participants had designed a recommended children's behavioral health structure (see section on State's Vision for the Future).

Concurrently, the MHDS Commission met and determined next steps in developing the required statewide children's mental health plan. Dr. Gretchen Greiner volunteered to lead the children's mental health plan subcommittee. In early February 2010, Dr. Greiner convened a two-day meeting to work on the plan. Dr. Greiner included statewide and regional consortia representatives because the plan had to include goals and priorities of the regional consortia 10-year plans per Senate Bill 79. State agency representatives were invited because the plan would impact their agencies. A framework was decided at this meeting and the subcommittee continued to meet monthly until the plan was submitted on June 30.

The MHDS Commission Subcommittee adopted the vision statement developed by the NCBHC to include in the plan.

> *"Nevada's System of Care meets the multiple and changing needs of families, children and youth through a strength-based, family-driven, culturally competent, comprehensive, integrated and coordinated continuum of services and supports."*

The State Plan for Children's Mental Health in Nevada integrated the recommended children's behavioral health governance structure design. The MHDS Commission's goals are:

Goal One: State Governance (2-Year Plan)

- Continue to fully operate and fund the regional consortia

- Expand the authority of the MHDS Commission to set policies for the care and treatment of children with mental health or co-occurring disorder provided by any public or private provider and facilities.
- Review and confirm authority of the MHDS Commission and maintain capacity to respond to this authority.
- Establish a children's behavioral health policy and accountability board to recommend policies covering public and private mental health services. The Statewide Consortium is an existing structure recommended to be reconstituted to form the board.
- Establish DCFS as the state children's mental health authority with the responsibility to set standards for practice and provider qualification; conduct quality assurance; develop and monitor contracts, provide financial oversight and performance monitoring for public and private children's mental health to include the power to adopt regulations.
- Identify any additional revisions to Nevada Revised Statues necessary to implement the intent of this plan.
- Develop capacity to provide the next two-year continuation plan (2013-14). Plan must align previous objectives and integrate findings from studies in Goal Two.

Goal Two: Determine the Impact of Federal Health Care Reform and Mental Health Parity (2-Year Plan)

- Analyze federal health care reform and determine impacts on children's mental health services in Nevada.
- Analyze mental health parity legislation and develop an implementation plan in Nevada.
- Based on the outcomes of the above analysis, conduct feasibility study related to implementation of the MHDS Commission's 10-year plan in the context of the Federal Patient Protection and Affordable Care Act.

Goal Three: Workforce Development to address the following issues (To be added in 2013)

- Cultural competence.
- Core competencies related to children's mental health.
- Evidence-based practice implementation.
- Communication plan and public awareness.

Goal Four: Statewide Service Delivery (To be added in 2013)

- Enhance family involvement.
- Public health approach.
- Service coordination.
- Crisis intervention and stabilization services.
- Develop and strengthen policies, programs, supports and community action.

Goal Five: Quality Improvement (To be added in 2013)

- Quality assurance.
- Developing quality of care standards.
- Data collection and program evaluation.

In preparation for the 2011 legislative session, DCFS Children's Mental Health moved forward with an implementation plan to develop a bill draft request for the recommended state system governance structure. In June 2010 a small workgroup convened that included consortia chairs and agency partners that would be impacted by the recommended organizational structure. National consultant Suzanne Fields drafted a bill that contains the following proposed legislative language.

- The Commission will set policies for the care and treatment of children with mental health or co-occurring disorders provided by any public or private providers or facilities.
- The Commission will appoint a subcommittee on the mental health of children called the Children's Behavioral Health Policy and Accountability Board.
- The Board will recommend to the Commission regulations and policies covering public and private providers and facilities.
- The Board will create a statewide plan, informed by each mental health consortium.
- Functions of the Board and membership are outlined in the proposed regulations.
- DCFS will serve as the children's mental health authority for the state and be responsible for:
    - Establishing policies and performance standards for public and private providers and facilities for the delivery of children's mental health and co-occurring disorder services;
    - Establishing qualifications for public and private providers and facilities delivering mental health and co-occurring services to children;
    - Conducting quality assurance of public and private providers and facilities of children mental health and co-occurring disorders;
    - Developing regulation on children's mental health in consultation with the Board for submission to the Commission;
    - Conducting investigations of complaints made by children and families receiving mental health services from any public or private provider of facility as directed by the Commission; and
    - Engaging in activities to support workforce development.

The bill draft for the restructured state system governance must be submitted by the Department of Health and Human Services by September 1, 2010. It will then be sent to the Legislative Counsel Bureau for consideration and statutory language revisions. The NCBHC will develop a communication and education strategy for informing key stakeholders, law makers, and others affected by the bill.

Goals for Nevada's System of Care

Nevada's System of Care has a clear governance structure that is accountable for system of care direct services and fiscal components of care delivery.

Nevada's System of Care has the ability to blend, braid and/or pool funding so that children and youth with behavioral health needs and their families have access to a full array of services and supports as determined by their strengths and needs with an emphasis on community-based services.

Nevada's System of Care has easy access to flexible funding that allows rapid response to needs of a child and family.

Nevada's System of Care has flexible fiscal systems that support changes to adopt emerging knowledge about behavioral health issues and adopt evidence-based and promising practices.

Nevada's System of Care includes administrative and data systems that allow for oversight, management and monitoring of service delivery, quality of care, client outcomes and utilization of fiscal resources.

Nevada's System of Care re-invests savings gained from service delivery changes.

Nevada's System of Care utilizes data to guide decision-making at all levels of the system.

Nevada's System of Care is based on strong collaborative agreements between member agencies.

Nevada's System of Care partners with parents, family members and youth in all aspects of planning, service provision, management, evaluation and oversight.

Nevada's System of Care employs an agreed upon standardized set of screening and assessment tools that identify children and youth who are eligible for services.

Nevada's System of Care serves children and youth and their families while they remain in their home and/or community at the least restrictive level of care that facilitates recovery and wellness, including home-based care.

Nevada's System of Care includes family support services that are provided by family members throughout the continuum of care from prevention through residential services.

Nevada's System of Care provides services that are responsive to the unique culture of each child, youth and family.

Nevada's System of Care includes the wraparound care coordination model which is an evidence-based practice.

Nevada's System of Care includes an array of evidenced-based and promising practices that are clinically and cost effective, achieve positive outcomes and are monitored for ongoing fidelity.

Nevada's System of Care is a navigable system that provides easy access to a comprehensive array of preventative, early intervention and interventions services to meet the needs of children, youth and their families in a timely manner for children regardless of their age or custody status.

Nevada's System of Care increases workforce capacity and competence in evidence-based and promising practices and in cultural responsiveness.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

CHILD

Recent Significant Achievements

Priority: 1. Fund Outpatient services and supports at Northern Nevada Child and Adolescent (NNCAS) Services, Southern Nevada Child and Adolescent Services (SNCAS)

Items:
- Clinicians
- Outpatient medications

Update: During SFY 2010, DCFS continued funding outpatient services at NNCAS and SNCAS. This includes salary allocation for 42 mental health professionals dedicated to providing services to children with SED or at risk of SED in the northern and southern region. Additionally, funds are used to supplement the provision of medications to children and adolescents receiving outpatient services.

Results: 42 mental health professionals' salaries were supported at a prorated rate statewide.

Priority: 2. Support Operation of the Legislatively Mandated Mental Health Consortia

Items:
- Administrative and travel expenses

Update: During SFY 2010, DCFS continued to allocate funds to offset administrative and travel expenses for three regional Children's Mental Health Consortia. These groups were established at the close of the 2001 Legislative Session and are described in the overview of the mental health system.

Results: Nevada's Children Mental Health effort to support System of Care statewide was sustained and expanded.

Priority: 3. Enhance Training for Mental Health Professionals

Items:
- Additional statewide training and consultation funds

Update: During SFY 2010, DCFS continued to allocate funds for statewide training for DCFS and community partner agencies' mental health professionals.

Results:
- Children's Mental Health Managers were able to receive Leadership Training. Newly hired Mental Health Technicians statewide were able to receive legislatively mandated training in Children's Mental Health. Mental Health Professionals statewide were able to receive mandatory CPR/First Aid certification, Car Seat Safety training, Aggression Replacement Training and Aggression Replacement Training of the Trainers (2 people trained as statewide

trainers). NETSMART and Crisis Training were provided. Public and private behavioral health practitioners were able to receive Child and Adolescent Functional Assessment Scale training, Preschool Child Functional Assessment Scale training, Child and Adolescent Services Intensity Instrument training, and DC: 0-3R training. Parents and caretakers in the northern region were able to view the training series "Floor Time", and "1-2-3 Magic".

Priority: 4. Clinical staff positions and program retention for SFY 2010

Items:

- Placement prevention funds
- Nevada Parents Encouraging Parents (PEP) sub-grant for system of care support
- Clinical Program Planner and Grants Manager
- Children's Mental Health Planning and Evaluation Manager
- Administrative support for Children's Mental Health Planning and Evaluation Unit
- Psychological testing materials, assessment and evaluations
- Program assessment and evaluation by the National Institute for Mental Health wraparound fidelity study
- Support for the University of Nevada School of Medicine (UNSOM) Child and Adolescent Psychiatric Fellowship Program

Results: All of the above programs, contracts, and staff positions were funded during SFY 2010 and accomplished the following outcomes:

- Placement prevention funds help augment mental health services with medications, medical assessments, and other services as well as critical basic needs designed to keep children and adolescents within their family unit.
- The sub-grant to Nevada PEP for system of care support statewide serves to strengthen the service delivery system infrastructure to ensure effective family-driven mental health services in Nevada for children with SED and their families. This includes collection of outcome data on program activities that empower families to help themselves through effective system advocacy and transformation of mental health services toward family-driven service delivery system.
- The Clinical Program Planner/Grants Manager is responsible for program planning, evaluation and grants management for DCFS Children's Mental Health programs.
- The Children's Mental Health Planning and Evaluation Unit Manager is responsible for coordinating performance and quality improvement for children's mental health services provided by DCFS and Specialized Foster Care providers in the community.
- Psychological evaluations supplement psychological and neuropsychological evaluations completed for children and adolescents with SED.
- Program assessment and evaluation funding is used to contract for assessment and evaluation activities of existing mental health programs to improve their efficiency and effectiveness.

- Support for the UNSOM Child and Adolescent Psychiatric Fellowship Program assists in addressing the shortage of child and adolescent psychiatrists in Nevada. Block Grant funds are used to provide consultation, medical management, and therapy services through this program.

Other Accomplishments

Statewide Mental Health Programs

- The Nevada Children's Behavioral Health Consortium (NCBHC) members include chairs of the three regional consortia, parents, and state, county and private agency stakeholders. The NCBHC provide a mechanism for stakeholders and families to work together to ensure that children's behavioral health needs are met through a developing system of care in Nevada.
- Continued partnership with the University of Washington, the University of Nevada, Las Vegas (UNLV) and the National Institute of Mental Health (NIMH) for the very first comparison study of wraparound case management to develop research determining the efficacy of this model.
- Continue to customize the programming of the HIPAA – compliant management information system to better meet the needs of practitioners and fiscal staff.
- DCFS worked in partnership with the MHDS Commission to produce the 10-Year Statewide Children's Mental Health Plan.
- Provider Support Team – DCFS leads this cross agency workgroup that focuses on quality of care, quality improvement and evaluation of Specialized Foster Care.
- Performance and Quality Improvement Plan with Specialized Foster Care Providers – In fiscal year 2010, providers submitted policies for review in order to meet contract requirements. Specialized Foster Care providers are participating in Quality of Care interviews and they submitted risk measures and departure conditions data as part of an ongoing quality assurance activity.

Northern Region: Northern Nevada Child and Adolescent Services (NNCAS)

- Continued the Fellowship Program for Child and Adolescent Psychiatry in Nevada in partnership with the UNSOM. Two part time Fellows were funded for SFY 10.
- Staff at DCFS treatment homes were trained in Aggression Replacement Therapy. The Intervention model was redesigned last fiscal year and continues to be updated as significant evidence continues to be released incorporating this evidence-based intervention with the Psycho-Social Educational model and the Trauma-Informed model.

Southern Region: Southern Nevada Child and Adolescent Services (SNCAS)-

- A manager and supervisor in Early Childhood Mental Health Services were sponsored by the county child welfare agency to participate in a research based model on infant attachment and bio-behavioral catch-up. The supervisor participates in a yearlong certification program.
- The continued partnership with DCFS, Clark County Department of Family Services, Clark County Department of Juvenile Services, Nevada PEP, and other community programs sustains the success of the Neighborhood Family Service Centers, a recognized best practice.

- The NIMH comparison study of the Wraparound service process with Children's Clinical Services and the WIN program ended this fiscal year. When available, final results will be shared with DCFS.

State-Sponsored Youth Suicide Prevention and Early Intervention

The Nevada Office of Suicide Prevention has been awarded a second, 3-year, $1.5 million grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) under the Garrett Lee Smith Youth Suicide Prevention and Early Intervention Initiative. The Office of Suicide Prevention received a similar 3-year grant in 2005. Although this is a new award, the project just funded will build upon the progress and lessons learned from the first initiative.

Nationally, the purpose of the GLS Youth Suicide Prevention Initiative is to support states in developing and implementing youth suicide prevention and early intervention strategies which are grounded in public/private collaboration. The initiative requires that such projects involve youth serving agencies such as schools, juvenile justice programs, foster care systems, substance abuse and mental health programs, as well as other child-serving organizations. Each project must be based on the individual state's suicide prevention plan, but focus on the development of community-based, direct services which may include public awareness activities, training, early identification and linkage to services for youth at risk, and strategies to assure emergency response capacity. Each funded project must form or participate in an existing public/private coalition of youth-serving institutions and agencies. In addition, each grantee must participate in a cross-site evaluation.

Nevada's project is entitled "*A System of Care for Youth Suicide Prevention in Nevada.*" This project will support, enhance and expand suicide prevention efforts with youth ages 10-24 within three regions of Nevada (Clark County, Washoe County and the Rural Counties) by implementing goals of the Nevada Suicide Prevention Plan and building on successes of current youth suicide prevention programs in Southern Nevada.

The overall goals of the Nevada Project are as follows:

1. Nevada will strengthen its comprehensive statewide Suicide Prevention Plan using a quality improvement process derived from lessons learned in prior suicide prevention efforts and continue to accomplish youth-focused goals that increase awareness that suicide is preventable and decrease suicidal behaviors.
2. Nevada will improve local suicide prevention planning services in its largest community (Clark County) while developing and implementing a local suicide prevention plan in its second largest community (Washoe County). In addition to Gatekeeper Training and screening, text-messaging will be implemented as a unique method of increasing youth awareness and encouraging help-seeking behavior.
3. Nevada will support stakeholders in at least two of Nevada's rural communities and partner to develop, implement and evaluate local suicide prevention plans.
4. Nevada will continue to evaluate youth suicide prevention plan and programs to improve training, policy, and community collaboration.

The following table identifies how the initiative will aid Nevada in achieving some of the specific goals in its statewide Suicide Prevention Plan.

Needs identified in State Suicide Prevention Plan	*How Needs are Addressed by the Proposed Project*
1.2 Increased awareness of available crisis services such as the Statewide Crisis Call Hotline	Develop and implement a text-messaging program in Clark and Washoe Counties to increase teen awareness and help-seeking behaviors. Continue public education.
4.2 Need for comprehensive, community youth suicide plans that incorporate evidence-based practices	Provide support for the development of comprehensive, local youth suicide prevention plans in two rural counties.
4.1 Need to increase implementation of evidence-based programs for youth suicide prevention	Expand TeenScreen Program in Clark County and implement new program in Washoe County.
6.1 Implement evidence-based training programs for physical and behavioral health care providers	Train professionals in child serving systems on assessment and treatment of youths at risk for suicide.
6.3. Provide suicide prevention gatekeeper training	Train gatekeepers in Clark, Rural and Washoe Counties.
4.5 Support innovative strategies that reach individuals at risk of suicidal behavior	Develop and implement suicide prevention screening programs for primary health care providers.

The State Children's Behavioral Health Consortium will oversee the implementation of Nevada's project. The regional consortia will oversee local suicide prevention planning and implementation. The consortia will be responsible for monitoring the progress of activities, and providing feedback on goals, objectives and timelines. Project funding includes $30,000 to assist the four consortia in assessment of community needs and oversight of project activities. The project also includes funds for planning and resource development in Elko and Douglas Counties.

Dr. Bill Evans of the University of Nevada, Reno will serve as the evaluator for the project. A full-time project coordinator provides day-to-day supervision of the project. The budget also includes funds for a part-time training assistant and resources to support the Nevada Coalition for Suicide Prevention in continuing their role in coordination of statewide gatekeeper trainings. There are contract funds to expand school-based screening in Clark County, especially to underserved schools, rural communities and middle schools. Support is also provided to expand the Physician Screening and Education Program piloted last year in Clark and Elko Counties. Funds will be provided to Educational Messaging Services and the Crisis Call to develop and implement the text message campaign to rural school districts and Washoe County. Clark and Washoe County Health District will be supported in continuing the public education campaign developed under the previous grant.

PART C. STATE PLAN

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

CHILD

State's Vision for the Future

As previously described in this grant application, the MHDS Commission as a result of the passage of Senate Bill 79 was tasked with developing a State Plan for Children's Mental Health. The following are the goals and objectives outlined in the first plan approved in July, 2010. Goals One and Two were identified as priorities for implementation in the first two years of the 10-year plan. The remaining three goals will build upon the results of the first two goals.

Goal One: State Governance (2-Year Plan)

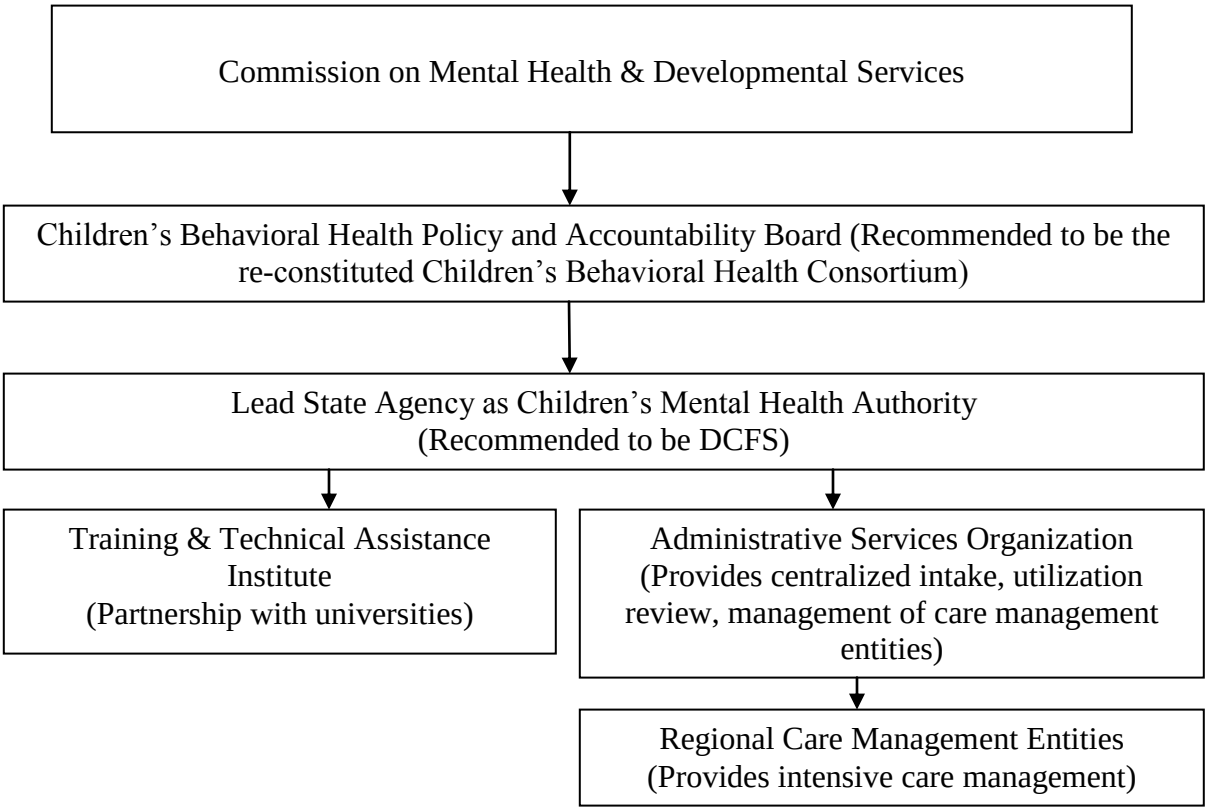
- Continue to fully operate and fund the regional consortia.
- Expand the authority of the MHDS Commission to set policies for the care and treatment of children with mental health or co-occurring disorders provided by any public or private provider and facilities.
- Review and confirm authority of the MHDS Commission and maintain capacity to respond to this authority.
- Establish a children's behavioral health policy and accountability board to recommend policies covering public and private mental health services. The Statewide Consortium is an existing structure recommended to be reconstituted to form the board.
- Establish DCFS as the state children's mental health authority with the responsibility to set standards for practice and provider qualifications; conduct quality assurance; develop and monitor contracts; provide financial oversight and performance monitoring for public and private children's mental health to include the power to adopt regulations.
- Identify any additional revisions to Nevada Revised Statues necessary to implement the intent of this plan.
- Develop capacity to provide the next two-year continuation plan (2013-14). The plan must align previous objectives and integrate findings from studies in Goal Two.

Goal Two: Determine the Impact of Federal Health Care Reform and Mental Health Parity (2-Year Plan)

- Analyze federal health care reform and determine its impact on children's mental health services in Nevada.
- Analyze mental health parity legislation and develop an implementation plan in Nevada.
- Based on the outcomes of the above analysis, conduct a feasibility study related to implementation of the MHDS Commission's 10-year plan in the context of the Federal Patient Protection and Affordable Care Act.

Implementation of Goal One has begun with a bill draft that expands the Commission's authority over public and private agencies and facilities, creates a Children's Behavioral Health Policy and Accountability Board, and establishes DCFS as the children's mental health authority. In the graph below the first three boxes represent the relationship between the Commission, the Board,

and DCFS in the recommended system governance structure. Policies will be developed by the Children's Behavioral Health Board and forwarded to the MHDS Commission for approval. DCFS will implement the approved policy.



Other structures in the recommended governance system are the Administrative Services Organization (ASO) and the Training and Technical Assistance Institute. The ASO key duties would be to:

- Provide centralized intake (1-800 number)
- Screen and triage
- Coordinate benefits
- Provide utilization management authorization for inpatient acute hospitalization, residential treatment centers, and treatment home services
- Maintain statewide information technology system for tracking data and report on system outcomes/required data elements
- Provide mobile crisis response
- Develop provider network
- Develop individual provider contracts
- Make provider payments

The Training and Technical Assistance Institute would be a training center and clearinghouse for evidence-based practices and promising practices, core competencies, and cultural and linguistic competencies. The Institute would provide training and coaching to contracted providers and

care managers. It would assist in workforce development with a focus on the core competencies required for mental health professionals.

The Regional Care Management Entity (RCM) would be responsible for intensive care management and would be the locus of management accountability for high utilizing children with multi-system involvement. The RCM's other responsibilities would be to:

- Conduct Children's Uniform Mental Health Assessments
- Coordinate child and family teams
- Provide services and supports planning using a high fidelity Wraparound model
- Conduct utilization management for the plan of care excluding acute inpatient hospitalization, residential treatment, and treatment homes which are authorized by the ASO
- Collect quality measures at child and family level
- Develop contracts with a broad range of providers and develop partnerships with natural helpers and supports

The ASO, the Institute, and the RCM are part of a long term strategy for the state to contract for services for children's mental health. Most states and counties have developed similar system of care management structures as a way to provide quality services to meet the mental health needs of the public sector and to redirect funding to be effective and efficient.

Comprehensive Community-Based Public Children's Mental Health System

Initiatives and activities described throughout this grant application affect the public children's mental health system. Some initiatives and activities are ongoing and should continue to have the following impact on the service delivery system.

- System of Care training – staff in all public agencies and most community agencies will have the opportunity to participate in a system of care training. Staff will be familiar with the System of Care principles and values and will have a basic understanding of how to integrate it into their work. System of care principles and values will be integrated into the administrative and managerial structure of agencies and be reflected in policies and procedures.
- The Children's Uniform Mental Health Assessment (CUMHA) will be implemented across child serving agencies. A family served by one agency can share the CUMHA with other agencies they seek help from without having to retell their story each time.
- Clinicians who serve very young children will be trained to use the Diagnostic Classification 0-3R for children ages birth through 3. The Diagnostic Classification 0-3R nomenclature will be applied throughout all public agencies that service very young children.
- Clinicians who serve very young children will be trained to use the Early Childhood Service Intensity Instrument (ECSII). DCFS Early Childhood Mental Health clinicians were recently trained to the ECSII. A training of trainers was also provided that will allow DCFS to train community providers and staff.
- The Wraparound in Nevada (WIN) program will deliver high fidelity wraparound process. This will be achieved through a quality improvement process whereby supervisors will provide coaching of skill sets to facilitators, they will observe Child and Family Teams and provide feedback to facilitators, and they will learn and apply

Wraparound supervision skill sets. The WIN program will receive feedback based on Wraparound Fidelity Index interview findings that can inform the program of their strengths and areas for improvement. This information will be used in a continuous feedback loop to modify and improve areas of deficiency and to sustain areas of competence.

- Children's Mental Health Services will implement evidence-based practices. Clinicians trained in TF-CBT, PCIT, and Motivational Interviewing will apply these intervention models in their practice. Processes will be developed to determine clinician competency in evidence-based practices.
- Specialized Foster Care providers will be responsible for Performance and Quality Improvement in identified risk areas such as medication errors and safety holds. Specialized Foster Care providers through the Provider Support Team will develop and address standards of practice to include policy development.

PART C. STATE PLAN

Section III. Performance Goals and Action Plans to Improve the Service System

ADULT

Criterion 1: Comprehensive Community-based Mental Health Services

Establishment of System of Care

Mental health services, in rudimentary form, have been provided in Nevada since the late 1800s. The Division of Mental Health and Developmental Services (MHDS) has been operational in its modern form since the 1960s. The description of MHDS's organized, community-based, system of care is included in the responses for each of the five criteria.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 1: Comprehensive Community-based Mental Health Services

Available Services

MENTAL HEALTH SERVICES

Inpatient Programs

Inpatient facilities at Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) focus on consumer stabilization and recovery:

- NNAMHS in the northern region provides 40 inpatient beds and 10 psychiatric observation beds.
- SNAMHS in the southern region is licensed to provide 287 inpatient beds, 30 of which are psychiatric observation beds.

Clients requiring inpatient services from rural areas are referred to either NNAMHS or SNAMHS, depending on their proximity to one or the other.

	North – NNAMHS	***South – SNAMHS***
SFY 2010 average monthly inpatient caseload:	17	159

Forensic services are provided by the Lake's Crossing Center in the north, co-located with NNAMHS. This currently includes a 104-bed facility that is designed to serve criminal offenders with mental illness, to evaluate competency to stand trial, to assess criminal responsibility, and to provide recommendations for treatment.

Forensic services include clinical assessment, forensic evaluation, and short or long term treatment as appropriate based on the nature of the court commitment. Approximately 99% of the clients are sent to the Center by the courts for treatment and to establish competency to stand trial, or for initial competency evaluations. This relationship between MHDS and the courts is defined in Nevada Revised Statutes (NRS) chapters 175 and 178.

Outpatient Programs

Psychiatric Emergency Services (PES)

The provision of Psychiatric Emergency Services (PES) allows clients in crisis to be stabilized and avoid admission to the hospital. At NNAMHS, PES consists of two departments:

1. Psychiatric Ambulatory Services (PAS)
2. Psychiatric Observation Unit (POU)

PAS provides outpatient psychiatric emergency services, while POU provides psychiatric emergency observation, in a secure environment, for up to 72 hours.

At SNAMHS, psychiatric emergency services are provided at each of the four community mental health centers in the Las Vegas metropolitan area as opposed to a centralized location in the city.

	North – NNAMHS	***South – SNAMHS***
SFY 2010 average monthly client contacts:	363	751
Number of POU beds:	10	30
SFY 2010 average monthly clients admissions to POU:	133	481

Outpatient Programs with an Intensive Care Focus

The Programs for Assertive Community Treatment (PACT) provides researched best practices, intensive community-based treatment and rehabilitation services to clients with SMI by using a multidisciplinary team (MDT) to provide mental health services. The goal of PACT is to reduce debilitating symptoms and minimize or prevent recurrent acute episodes of illness. Continuous rather than time-limited services and interventions are tailored to each consumer.

Internationally, the PACT model has shown participants to have longer and more productive community tenure and to be able to better manage their impairment upon discharge from the program. The PACT Team in the north started serving clients at NNAMHS in 1999 and the first PACT Team in the south started serving clients at SNAMHS in 1998. An additional PACT team for SNAMHS was approved by the 2003 Legislature. This second PACT team is located in downtown Las Vegas and works with individuals who are both homeless and SMI. These teams were combined for efficiency and continuity under a single Coordinator in May of 2008. The expanded PACT team is located in downtown Las Vegas and works with individuals who are SMI and present with multiple social and medical challenges.

	North – NNAMHS	***South – SNAMHS***
SFY 2010 average monthly caseload for PACT:	86	124

Outpatient Programs Focused on Increasing Consumer Independence

Outpatient Psychological services include evaluation and diagnosis, goal-oriented Psychotherapy, Psychological testing/Neuropsychological screening, and behavioral management. These services focus on developing insight, producing cognitive and behavioral change, improving decision making, and reducing stress. Specialized services, including Family Psycho-education, are provided to families and couples to facilitate communication between patients and family members. Group Psychotherapy sessions include Dialectical Behavior Therapy, Cognitive Behavioral Therapy, suicide prevention, Psychiatric symptom management, Trauma groups, chronic pain management, and communication skills. Psychological services are focused to help guide patients through interpersonal conflict, improve positive communication, and enhance quality of life.

The Consumer Assistance Program (CAP) and the Psychosocial Rehabilitation Program (PSR) at NNAMHS have partnered, since the summer of 2008, to offer a broader range of recovery-oriented social, pre-vocational, volunteer, training and competitive employment opportunities for its mentally ill population.

The CAP at SNAMHS offers five business days per week of topic-focused support and problem solving groups, clubhouses and volunteer opportunities at its four Community Med Clinic sites and on the grounds of Rawson Neal Psychiatric Hospital. These programs are designed in partnership with consumers. They provide safe and generative environments in which isolated and generally stigmatized individuals may socialize, improve their relationship and self-advocacy skills and both discover and practice utilizing their strengths and resources. Large scale holiday and other celebrations bring clients and staff together in normalizing activities. Consumers are encouraged to attend program services in all our locations and as frequently as they wish to participate.

In partnership with PSR, the CAP assists clients in setting realistic personal, educational and vocational goals and mentors them in developing strategies and skills to meet them. Volunteers in the CAP Program function as group facilitators and co-leaders, offer clerical support in both CAP and PSR, act as 'troubleshooters' and Satisfaction Survey collectors in busy clinic waiting rooms and collaborate in identifying consumer needs and developing new services. They describe these experiences as increasing their sense of worth and of healthy community. Individuals who are approaching readiness for competitive employment are helped to self-assess as volunteers and/or may be placed in supported job assignments (also considered 'Community-Based Assessments') in various departments on the SNAMHS campus to prepare them for the world of work. The Nevada Division of Vocational Rehabilitation collaborates with PSR in providing further vocational assessment, training and assisted technologies for consumers determined to be work ready.

CAP and PSR work collaboratively with local universities to bring free, diversified outpatient services to our population. The programs have participated with Touro University, since November 2008, in a nutrition and weight loss program for individuals taking psychotropic medications. CAP and PSR have brought together a varied group of community agencies and consumers in an effort to further expand and enhance the range of outpatient mental health services available in the Las Vegas area. The 'Clubhouse Model', developed at Fountain House, in New York City in the late 1940's, demonstrates an effective and well-researched response to the high economic and human costs of mental illness.

Feedback from the treatment and service coordination programs suggests that clients who attend CAP programs are more accessible and articulate, better prepared to participate in treatment planning and more self-determining in their own recovery. They are re-hospitalized less frequently, resort to emergency room care for psychiatric symptoms less frequently and are more likely to maintain employment and housing.

At NNAMHS and SNAMHS, patients may be admitted into other outpatient programs, such as Service Coordination, once enrolled for general clinical services.

	North – NNAMHS	*South – SNAMHS*
SFY 2010 average monthly caseload for outpatient counseling:	723	932

Medication clinic services are available throughout the state and are provided by a physician or advanced practice nurse to evaluate, prescribe, and monitor medications for the treatment of psychiatric disorders. Services may also include pharmaceutical counseling and education provided by a pharmacist. Since medication is the foundation of treating most mental illnesses, the medication clinics comprise the Division's largest treatment program. Newer antidepressant and antipsychotic medications have had fewer negative side effects than older medications. While they cost more, they benefit consumer functioning and reduce the demand and duration of other expensive treatment forms

The use of new generation psychiatric medications has improved the quality of life for many Nevadans with SMI. Medication clinics provide newer and safer medications to clients who cannot afford medications and are not eligible for Medicaid. All three regional agencies have budgets to purchase medication for these clients. Additionally, all three agencies utilize indigent drug programs and sample drug programs to help provide medications to those without adequate financial resources.

In the SFY2010/2011 biennial budget, there is a reduction of over $12 million per year for medication costs. Surpluses in the medications budget were created by several factors including:

- Excessive prior year caseload estimates;
- Inflation calculation issues;
- A decrease in the cost per person served through improved caseload management;
- Improved use of free medications; and
- Increasingly successful efforts at deflecting clients with Medicaid and Medicare Part D benefits to private pharmacies.

MHDS is confident that the Division can withstand these reductions and continue to serve a medication clinic caseload of approximately 11,000 at NNAMHS and SNAMHS.

	North – NNAMHS	*South – SNAMHS*
SFY 2010 average monthly medication clinic caseload:	3,630	7,482

Outpatient Programs Provided by Rural Clinics

As mentioned in the New Developments and Issues portion of Section I., the Rural Clinics agency of MHDS is proposing a significant reorganization in an effort to increase efficiencies in service delivery systems, reduce administrative costs and discover more effective models for service delivery.

Historically, rural mental health clinics have been supervised by a central administrative office in Carson City resulting in problems with quality of care, staff supervision and operational efficiency. The reorganization divided the rural area into North and South, coinciding with the service areas of the Developmental Services Agencies.

Further efficiencies will result from the combination of the Rural Developmental Services and Mental Health Rural Clinics in the north into one agency. This would involve combining some of the business office functions as well as the quality management functions in the two agencies. In addition, the southern rural clinics are being consolidated into an existing administrative structure which has greater capacity to support clinic operations and provide close supervision. The consolidation of the northern clinics with rural development services will reduce duplication of support services, clinic sites and staffing.

Full implementation of this reorganization will require approval by the Nevada Legislature in its 2011 biennial session.

The tables below depict the proposed reorganized structure of the Rural Clinics.

NORTHERN NEVADA RURAL CLINICS		
Primary Clinics	**Satellite Clinics**	**Itinerant Clinics**
Carson City	Battle Mountain	Lake Tahoe
Douglas County	Fernley	Tonopah
Elko	Hawthorne	
Ely	Lovelock	
Fallon	Yerington	
Silver Springs		
Winnemucca		

SOUTHERN NEVADA RURAL CLINICS	
Primary Clinics	**Satellite Clinics**
Pahrump	Caliente
Mesquite	Moapa
Laughlin	

The 10 primary clinics provide the following services to the small mining and ranching communities throughout Nevada:

- Outpatient counseling
- Service coordination
- Medication clinics
- Residential supports
- Psychosocial rehabilitation
- Emergency services

Outpatient counseling is Rural Clinics' primary program, serving as the foundation for services to all rural clients. It is available at all 19 Rural Clinics locations.

	Rural – Rural Clinics
SFY 2010 average monthly outpatient counseling caseload:	2,208

Medication management programs are available at all Rural Clinics locations. These services are provided by traveling psychiatrists and psychiatric nurses at each location.

	Rural – Rural Clinics
SFY 2010 average monthly medication clinic caseload:	1,460

In SFY 2006, Rural Clinics initiated a pilot project on telemedicine, in large part due to the lack of availability of psychiatrists needed to staff satellite offices at necessary times. This pilot project resulted in off-the-shelf consumer-grade cameras attached to existing basic computers eventually being deployed in 18 Rural Clinics.

Although the pilot project has demonstrated that clients can be served remotely, there are many shortcomings throughout the Rural Clinics network. They include:

- Office space – in many locations, telemedicine equipment is located in cramped rooms that lack privacy.
- Equipment – the basic computers currently being used generally have low resolution screens and sub-standard audio components that hinder communication.
- Connectivity – the connections between locations are inconsistent and in most cases, insufficient to support real-time communication. As a result, there are often delayed video images and garbled audio transmissions.
- Staffing – the statewide hiring freeze and the one day per month mandatory furloughs have resulted in staffing shortages thus reducing the availability of telemedicine proportionally.

Rural Clinics has approximately half of its medication program consumers receiving telemedicine services. It is anticipated that this number will grow with the increasing issues regarding the economy, and the difficulty getting psychiatrist to travel to rural locations.

In addition to providing services to adults with SMI, Rural Clinics also provides services to children with SED in the rural areas in cooperation with DCFS. These services include the following:

- Emergency/crisis management
- Psychological assessment
- Outpatient therapy
- Family counseling
- Medication management
- Psychiatric evaluation
- Case management
- Residential supports

These services are provided by licensed staff including social workers, psychologists, nurses, and contract psychiatrists.

Rehabilitation Services

Psychosocial Rehabilitation: Psychosocial rehabilitation (PSR) is targeted to clients in need of an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community and to prevent acute inpatient care. Emphasis is placed on acquiring skills in the following areas:

- Survival and adaptation
- Symptom and medication management
- Problem solving
- Grooming
- Financial management
- Prevocational services
- Management of leisure time
- Social skills

These programs are individualized for consumers. Some services are provided under contract and may take place in a classroom setting or at the consumer's residence.

The Psychosocial Rehabilitation (PSR) program at both NNAMHS and SNAMHS is an outpatient psychiatric rehabilitation program. The mission is to provide individuals who have a mental illness with the skills they need to maximize their vocational potential and develop their own meaningful roles in the community. PSR focuses on empowerment and recovery through the provision of education & training, advocacy, support services and job development.

In the Northern region, the PSR program includes employment opportunities at the Canteen Employment Learning Lab which is a part of the Patient Worker Program. The Canteen provides drinks and snacks to consumers and staff at NNAMHS. Additional work opportunities for clients in the Patient Worker Program are occasionally available at both the Client Drop-In Center and on the NNAMHS grounds. The project is designed to provide consumers training in work skills, interpersonal communication, team building, food service basics, good work habits, time management, organizational skills, and customer service.

Additionally in the south and north, the PSR programs include the use of peer advocates, who are prior or current consumers of the mental health system. They receive training in work skills, advocacy, empowerment, and life management. They put this education to use in a peer advocacy internship. Working with other consumers, they provide a voice for clients in the mental health system. They are encouraged to participate in community advocacy and support groups to help foster their integration into the community.

In the rural areas, Rural Clinics utilizes evidence-based practices to provide PSR services based on the Boston Model and services developed by R.P. Liberman. PSR staff has received training in these models and field supervision to ensure the fidelity of program implementation.

	North – NNAMHS	***South – SNAMHS***	***Rural – Rural Clinics***
SFY 2010 average monthly PSR caseload:	53	116	261

Employment Services

Vocational Programs: Vocational programs include vocational guidance and counseling along with transitional planning. These programs also provide an array of skills training through school, peer advocacy, World of Work classes through the Bureau of Vocational Rehabilitation (BVR), and on-the-job training and apprenticeships. These programs assist with job seeking skills and provide support during job seeking. Clients are assisted through vocational assessment, work adjustment training, and post-employment services designed to maintain employment by focusing on decision making, problem solving, and establishing natural

community supports. Additionally, joint efforts between MHDS and BVR provide collaborative assistance to help clients achieve their vocational goals. In the southern region, BVR staff are co-located with SNAMHS staff at the main campus.

Housing Services

Group Housing: These housing services include group residential programs for consumers who do not require specialized intensive services. Group homes are owned or rented by a provider agency and licensed by the Nevada State Health Division (NSHD) Bureau of Health Care Quality and Compliance (HCQC). MHDS contracts with group housing agencies to provide room and board, care, and training for the people residing in the homes.

Supported Living Arrangements (SLA's): These housing services are intended to be flexible and offer housing based on consumer choice and individualized services tailored to the consumer's needs so that services have a wraparound effect and encompass the capabilities of the consumer. Consumers, families, and agencies collaborate in the development of a plan that will place the consumer in an independent setting.

Shelter Plus Care (SPC/S+C): this is permanent supportive housing funded by the Department of Housing and Urban Development (HUD), which includes – monthly rent payments, security deposit up to one month's rent, utility allowance, one additional month's rent for housing units vacated, as well as 8% of the grant total for administrative costs. The person must meet specific eligibility criteria. Types of SPC include: tenant-based, project-based, and sponsor-based.

Respite Care: This service is for consumers already enrolled in community outpatient services. Consumers must be in crisis but not eligible for inpatient hospitalization, and must need to be removed from their living situation for a short duration, not to exceed five days. The purpose of this service is to provide supervision and psychiatric attention to enable consumers to return to their original living situation and/or to give them time to locate a new living situation.

Specialized Residential: These services provide support and/or skills training for consumers with specialized service needs who also need psychiatric services. These programs include arrangements that are designed to meet the needs of the following individuals:

- Consumers with rehabilitative needs, specifically basic skills training
- Consumers with medical problems
- Senior citizens requiring assistance
- Consumers with severe behavioral symptoms
- Consumers with hearing impairments
- Consumers needing treatment for substance abuse.

Intensive Supported Living Arrangements (ISLA's): These housing services provide intensive support for consumers who otherwise would require inpatient hospital care. These services are provided in independent home settings in the community with additional individualized support services based on consumer's need and choice. ISLA's are designed to provide intensive supports for individuals with histories of extensive psychiatric hospital use. They have been found to be very effective in reducing the use of hospital services by such individuals. The ISLA program at NNAMHS began in October, 2001, and at SNAMHS in January, 2002.

	North – NNAMHS	*South – SNAMHS*	*Rural – Rural Clinics*
SFY 2010 average monthly group housing caseload:	58	421	n/a
SFY 2010 average monthly SLA caseload:	215	442	62
SFY 2010 average monthly ISLA caseload:	3	2	n/a

Educational Services

Educational services are provided statewide by referral and may be part of consumers' individual treatment plans.

In the northern region, PSR clients are encouraged to complete their General Educational Development (GED) High School Equivalency Diploma. Also, clients who have completed high school or equivalent are encouraged to attend Truckee Meadows Community College (TMCC) to work toward an associate's or bachelor's degree when appropriate.

In the southern region, clients are also encouraged to complete their GED and are referred to community GED programs. Service Coordinators monitor their progress and provide support as needed. Likewise, for those clients who have completed high school or equivalent, they are encouraged to attend local community colleges. In the past, SNAMHS has provided tuition support. Recently, due to budget constraints, clients are now referred to the Bureau of Vocational Rehabilitation (BVR) for financial support.

For families of consumers, SNAMHS makes referrals to the local chapter of the National Alliance for the Mentally Ill (NAMI), which provides a Family-to-Family education program. The NAMI Family-to-Family education program is a free, 12-week course for family caregivers of individuals with mental illnesses. The course is taught by trained family members. All instruction and course materials are free for class participants. The Family-to-Family curriculum focuses on schizophrenia, bipolar disorder, clinical depression, panic disorder, and obsessive-compulsive disorder (OCD). The course discusses the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively. To help support this program, SNAMHS provides training room space and administrative support to the trainers.

In the rural region, clients are also encouraged to complete their GED as part of their treatment plan. Family members of consumers are encouraged to participate in support programs and community groups such as those provided by NAMI.

Substance Abuse Services

Based on data from the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 23% of adults with SMI can be expected to have co-occurring disorders of both mental illness and substance abuse.[16] In the northern region, a licensed alcohol and drug abuse counselor is included on the staff of the Programs for Assertive Community Treatment (PACT) Team at NNAMHS to provide screening, diagnosis, and referrals for persons with co-occurring disorders. NNAMHS provides outpatient treatment in a specialized State-staffed program for consumers with co-occurring disorders. In addition, NNAMHS also has a cooperative agreement with a private provider, Family Counseling Services, for a co-occurring disorders counseling program.
In the southern region, a full-time Substance Abuse Prevention and Treatment Agency (SAPTA) counselor provides assistance to the two PACT teams at SNAMHS. Referrals are provided to the following designated SAPTA treatment centers in the Las Vegas area:

- Bridge Counseling
- Community Counseling
- Economic Opportunity Board (EOB) Treatment Center
- Healthy Families
- Las Vegas Indian Center
- Nevada Treatment Center
- Salvation Army
- Westcare of Nevada

When clients need inpatient substance abuse treatment they are placed in the Adult Rehabilitation Program (ARP), contracted through the Salvation Army. This consists of a 22-week residential program that also provides aftercare outpatient counseling upon completion of the inpatient program.

In the rural region, Rural Clinics has entered into a collaborative relationship with SAPTA so that substance abuse services are made available for clients with co-occurring disorders in certain Rural Clinics offices, including remote areas such as Pahrump, Mesquite, Laughlin, Battle Mountain, Ely, and Hawthorne.

Assembly Bill (AB) 2, enacted by the 2005 Nevada Legislature, provided for various revisions to Nevada Revised Statutes (NRS) Chapters 449 and 458 in order to transfer the Substance Abuse Prevention and Treatment Agency (SAPTA) from the Nevada State Health Division (NSHD) to MHDS. The transition of SAPTA to MHDS was completed on July 1, 2007.

Senate Bill (SB) 2, enacted by the 2007 Nevada Legislature (Special Session), establishes the Committee on Co-Occurring disorders, which will address the needs of persons with co-occurring mental health and substance abuse disorders. Responsibilities of the Committee include: 1) Studying and reviewing issues relating to persons with co-occurring disorders. 2) Developing recommendations for improving the treatment provided to such persons. 3)

[16] Epstein, J. et. al. (2004). *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders, 2002*. Rockville: SAMHSA, Office of Applied Studies.

Submitting a biennial report and recommendations for necessary legislation to the Director of the Legislative Counsel Bureau for distribution to the Legislature.

Medical and Dental Services

In the northern region, NNAMHS has agreements with local hospitals to provide medical services to adults with SMI. Free or low-cost medical and dental services are available to northern region consumers through Health Access Washoe County (HAWC), but without any formal agreement between NNAMHS and the HAWC clinics.

HAWC is a nonprofit community health center that provides services to the medically underserved, including low-income and homeless populations. Primary services provided include low-cost family practice, pediatrics, dentistry, and children's mental health services. HAWC has four clinics located in Reno:

1. HAWC Community Health Center: This primary clinic began operation in 1995 and targets the working uninsured, the uninsured, and those who cannot afford services from a private physician.
2. Dental Clinic: This HAWC clinic began operation in 1998 and dental services provided include cleanings, sealants, x-rays, restorative dentistry, endodontic treatments, and extractions.
3. HAWC Dental South: An additional clinic was added south of the Reno downtown area in 2003, located near predominantly Hispanic neighborhoods in order to more effectively target this high-need population.
4. Outreach Medical Clinic: This HAWC clinic began operation in 1998 in partnership with the Washoe County District Health Department (WCDHD) and ReStart, a local homeless service organization. Through this clinic, HAWC provides health and dental care to homeless individuals and families in Washoe County. Additionally, the Outreach Medical Clinic partners with other community agencies to provide comprehensive case management including referrals to drug and alcohol programs, temporary housing, vocational rehabilitation, and other social services to help reintegrate homeless individuals and families back into the community.

HAWC's total patient visits have grown every year beginning with 6,600 visits in 1995, and reaching over 63,000 visits in 2008. HAWC patient demographics vary, with the highest number of visitors being 80% women and children, with 60% from minority populations. About 10% of patients are private insurance or Medicare users, 33% are Medicaid users, and 57% are uninsured who pay for services based on a sliding fee scale.

In the southern region, when inpatient clients are in need of medical or dental services they are examined by the SNAMHS staff physician and prescribed medications as appropriate. After immediate care, clients are referred to a community physician or dentist depending on their insurance or Medicaid coverage. For clients with no medical coverage who are in need of urgent care, SNAMHS has a special fund that may be accessed to pay for required services. For clients with no medical coverage who have chronic conditions, a referral is made to the Clark County Department of Family Services (CCDFS). CCDFS then issues a medical card that may be used at a local University Medical Center (UMC) location for medical care and prescriptions. This card may be renewed annually.

In both the northern and southern regions, clients who receive services through Mojave Mental Health Services, described below under *Support Services and Programs for Special Populations*, also receive referrals for medical services. Mojave clients who present with medical problems are usually referred to Washoe Medical Center and specialists, as needed, after assessment by both nurses and attending psychiatrists. Because Mojave is affiliated with the University of Nevada School of Medicine (UNSOM), they also have access to the University's Family Practice Center and its pharmacies.

In the rural region, free or low-cost medical and dental services are available to rural consumers through Nevada Health Centers (NVHC), but without any formal agreement between Rural Clinics and the NVHC clinics.

Nevada Health Centers is a federally funded Community Health Center Program that has operated medical centers in Nevada for 29 years. NVHC operates 21 medical and dental centers throughout the state, including the Nevada Health Centers Mammovan, Miles For Smiles buses, School Based Health Centers, and two Health Care for the Homeless clinics in Las Vegas. NVHC also operates two WIC Centers in Clark County. NVHC rural clinics locations include:

- Amargosa Valley
- Austin
- Beatty
- Carlin
- Carson City
- Crescent Valley
- Elko
- Eureka
- Gerlach
- Incline Village
- Jackpot
- Wendover

In the Carson City area, Rural Clinics participates in a service integration project with the Sierra Family Health Center, operated by NVHC. This is a staff exchange program through which Rural Clinics sends a psychologist to Sierra Family Health Center to provide behavioral health services, and in return Sierra Family Health sends a physician's assistant to the Carson Mental Health Clinic to provide primary care services for clients.

Case Management Services

Service Coordination (Case Management): Service Coordinators organize treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure that clients access financial, medical, housing, employment, social, transportation, crisis intervention, public welfare, and other essential community resources. They also help mobilize family, community, and self-help groups on the client's behalf. They may provide direct treatment to clients when none is available through referrals or community agencies.

	North – NNAMHS	***South – SNAMHS***	***Rural – Rural Clinics***
SFY 2010 average monthly service coordination caseload:	544	576	474

Intensive Service Coordination: Intensive Service Coordination provides more intensive care for clients demonstrating need in southern Nevada. This growing number of clients tends to have numerous and long-term hospital stays as well as extended time in jails and/or prison. Each day a client is in the hospital costs approximately $650; each day a client is in jail or prison costs

approximately $120. Both settings are extremely costly for the State. These clients need intensive assistance to develop independent living skills, medication compliance, social skills, employment skills, and anger management skills to reduce or eliminate violent and/or criminal behaviors. The goal of Intensive Service Coordination is to assist clients in achieving the highest level of independent functioning possible, while reducing time spent in either the hospital, jail, or prison. The program began serving clients at SNAMHS in 1997 and in SFY 2010, the average monthly caseload at SNAMHS was 46.

At NNAMHS in the Northern Region, Intensive Service Coordination is provided by the Program of Assertive Community Treatment (PACT). PACT is a research based model of intensive service coordination designed to help clients maintain their stability in the community and avoid hospitalization. Through frequent weekly contact with the clients, service coordinators provide a highly predictable structure infused with teaching opportunities where independent living skills are taught and modeled as an alternative to unhealthy behaviors. The PACT Program has a current caseload of 85.

The Mobile Outreach and Safety Team (MOST) is community collaboration with law enforcement and NNAMHS. The focus of MOST is crisis intervention with distressed clients either living on the streets, or currently enrolled in NNAMHS services. The team is composed of two NNAMHS staff that ride along with specially trained Reno Police officers and respond to calls of clients who are decompensating and are in need of support to remain stable in their current home, or are in need of hospitalization to regain stability.

Reduction of Hospitalization

The ongoing commitment of MHDS to a community-based, comprehensive, and coordinated system of care has worked successfully to keep the rates of psychiatric hospitalization among the lowest in the nation, in spite of having one of the most rapidly growing populations of all the states. As the primary provider of mental health care in Nevada, MHDS has a rare opportunity to look critically at the efficacy of programs designed to minimize the need for hospitalization, and to monitor closely the issues of continuity of care, as well as both under- and over-utilization of the more restrictive levels of care. Programs designed to minimize inpatient care include the Psychiatric Emergency Service (PES) Units outlined above, which provide screening, short-term stays for stabilization, and referral to appropriate levels of care.

The growth of the Service Coordination system, coupled with Supported Living Arrangements (SLA's) and close working relationships with homeless outreach programs, is also mitigating the need for inpatient care. The State's adult system provides just 40 inpatient beds in the north and 287 beds in the south. Rural clients are referred to NNAMHS or SNAMHS when they require inpatient care.

Emergency Room Overcrowding in Southern Region

In the past 10 years, the Las Vegas Valley has struggled with a lack of psychiatric bed capacity. As a result, people have to wait extended periods of time in local emergency departments for psychiatric beds to become available. MHDS has made multiple efforts to address this problem. In 2003, a mobile crisis intervention team was initiated to increase the efficiency of assessment

in emergency departments. In 2006, Rawson – Neal Hospital was opened adding to the bed capacity in the valley. While each of these efforts had some impact on the problem, none have eliminated the problem completely. As the population in the region continued to expand, the need for psychiatric beds continued to expand as well. With the onset of the economic downturn, the numbers have begun to increase again. In 2010 the number of people waiting in hospitals and emergency departments is on par with those at the height of the problem. MHDS has continued to work on methods of increasing the efficiency with which people can be moved through the service system. The issue is complicated by a variety of factors, including but not limited to the availability of transportation, reimbursement policies, legal requirements, a lack of community outpatient resources and the geographic distribution of population in Nevada.

According to CMHS, the national average of publicly funded inpatient psychiatric beds is 33 per 100,000 of the general population. By contrast, the average number of publicly funded inpatient psychiatric beds in Nevada is approximately 12 per 100,000 of the general population.

The Division continues to work with the community in Clark County on access to psychiatric hospital beds. The Division is implementing a two pronged approach to the problem. One avenue is maximizing the collaboration between SNAMHS, the Mobile Crisis Team (MCT) and the Emergency Departments (EDs). MCTs are available to assess individuals in the EDs and determine the need for hospitalization. When these teams find that the person is not in need of hospitalization, the EDs have the ability to contact SNAMHS for an appointment for those individuals. This allows the clients to access community based services without being unduly detained by a hospital admission.

The second front involves maximizing the efficiency of the Psychiatric Observation Unit and the Rawson-Neal Hospital. The observation unit is being reorganized to expand psychiatric coverage and reduce length of stay; the same is true of the hospital. Greater emphasis is also being place on working in collaboration with the hospital EDs to identify those patients with complex medical problems and co-occurring disorders. Direct admission privileges are also being considered for those psychiatrists employed by local hospital EDs. Close monitoring of the length of stay in the hospital is aimed at maximizing the efficient use of the hospital beds.

Specific efforts to mitigate the emergency room overcrowding problem in the southern region include the MCT, which is a specialized unit available through SNAMHS that works with the Las Vegas area hospital EDs. The MCT is comprised of Licensed Clinical Social Workers who travel to local hospital emergency rooms to evaluate psychiatric patients and, if feasible, develop safe discharge plans that are submitted to emergency room physicians for approval. This service averts unnecessary psychiatric hospitalizations, saves emergency room personnel time, and reduces the number of psychiatric patients in regional emergency rooms. Assessment services are provided from 7:00 am to 10:00 pm, seven days per week, in all 11 Las Vegas area emergency rooms.

Support Services and Programs for Special Populations

Consumer Assistance Program (CAP): Since the mid 1990's, MHDS has been interested in hiring consumers to provide peer support as part of transitional mental health services. In partnership with the MHPAC, MHDS developed the Consumer Assistance Program (CAP) in

2000. This program enables Consumer Service Assistant (CSA) staff to help themselves by developing work and career skills, and to help other consumers by doing the following:

- Promote transitional skills to enter or re-enter the workforce.
- Mentor current and recently discharged clients.
- Assist with the development and use of consumer satisfaction surveys.
- Assist and advise MHDS regarding program evaluation and quality assurance efforts.
- Review client care complaints.
- Contribute to policy development efforts such as human rights boards.
- Design a statewide consumer advocacy network.

Specific day-to-day services include the following:

- Transportation to appointments.
- Lead group sessions including Comparative Shopping, Exercising, Life Skills, Understanding Depression, Peer-to-Peer Support, Understanding Medications, Crafts, Nutrition, Anger Management, Work Readiness, and Community Activities.
- Assistance with Social Security issues for consumers receiving Social Security and consumers that are just beginning the application process.
- Home Visits to consumers who may be ill and cannot attend appointments.
- Crisis intervention.
- Drop-in centers at NNAMHS and SNAMHS for socialization and support. The centers also provide daily nutritional snacks.
- Attending court appearances on behalf of consumers, release planning while incarcerated, and assistance to be successful with terms of parole.
- Work referrals.
- Assistance with completing other benefit applications.
- Assistance with the consumer survey process.

The key to the success of the program is based on the idea of providing services for consumers by consumers. As noted in Section I, during SFY 2010 MHDS funded a total of 13.5 CSA positions supported by both CMHS Block Grant funding and State general funds, positioned statewide as follows:

Region	***Location***	***Positions***
North – Reno	NNAMHS	5.5
South – Las Vegas	SNAMHS	5
Rural – Carson City	Rural Clinics	1
Rural – Winnemucca	Rural Clinics	1
Rural – Minden	Rural Clinics	1
TOTAL:		13.5

Suicide Prevention Efforts: Nevada has been ranked number one nationally in the suicide rate per 100,000 population from 1996 through 1999, and remained one of the top five states each year from 2000 through 2005. Nevada currently ranks fifth highest in the nation for its suicide

rate.[17] Based on this discouraging history of high suicide rates, the Nevada Mental Health Plan Implementation Commission recommended that the Governor include funding in the Executive Budget for comprehensive, statewide suicide prevention and intervention programs. The Nevada Commission also recommended that Nevada develop, support, and maintain a statewide suicide prevention plan. This was accomplished in 2005 with the establishment of the Office of Suicide Prevention.

The Office of Suicide Prevention has been established for five years with the Statewide Coordinator in Reno and the Suicide Prevention Trainer and Networking Facilitator in Las Vegas. The most potent focus of this Office has been training. Training opportunities include a two day Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk and the Nevada Gatekeeper Training. The *Nevada Suicide Prevention Plan 2007 – 2012* was reviewed in 2008 during the statewide suicide prevention conference in Minden, Nevada, with the help of Nevada Suicide Prevention Coalition members, Rural Clinics staff, national experts, community-based service providers and survivors of suicide loss. This plan is closely based on the *National Strategy for Suicide Prevention, 2001*. The *Nevada Suicide Prevention Plan* has 11 goals and 35 objectives. These goals and objectives include three major focal points: Awareness, Intervention, and Methodology (AIM) for suicide prevention in Nevada. The AIM model includes the following key areas of focus:[18]

Awareness:

- Increase awareness through education, training, and media that suicide is a serious public health problem that can be prevented.
- Utilize the Office of Suicide Prevention as a clearinghouse of information regarding suicide and suicide prevention.
- Develop partnerships and strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
- Promote awareness that mental health is an essential component of overall health and wellbeing.

Intervention:

- Collaborate with communities and agencies to develop comprehensive suicide prevention plans.
- Enhance survivors of suicide loss bereavement services statewide.
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Improve access to appropriate treatment and care.
- Augment training opportunities targeting professionals to improve assessment and management of suicidal persons in their care.

Methodology:

- Partner with agencies statewide to advance suicide prevention research efforts to increase our knowledge of evidence-based practices.

---

[17] McIntosh, J. (2010). U.S.A. Suicide: 2007 Official Final Data. Washington, DC: American Association of Suicidology.
[18] Allen, M. (2010). *Suicide In Nevada Fact Sheet 2010*. Carson City: Office of Suicide Prevention.

- Improve and expand surveillance systems of suicide deaths and non-fatal attempts to more accurately inform prevention planning.

Administration of the statewide Suicide Prevention Hotline operated by the Crisis Call Center was transferred from MHDS to the Office of Suicide Prevention. The hotline continues to be funded $100,000 per year. The Crisis Call Center provides intervention, prevention, referral, and education services to the community surrounding suicide. The Suicide Prevention Hotline offers free and confidential support, intervention, or information for people throughout Nevada seeking help for themselves or their family members and friends who are experiencing suicidal thoughts. The Crisis Call Center Hotline is implementing a new training model, Applied Suicide Intervention Skills Training (ASIST), which has been used by the Office of Suicide Prevention for several years.

The Nevada Crisis Call Line is one of the first points of contact for adults in crisis who are seeking help, support, and information. Between 2005 and 2009, nearly 100,000 calls were made to the phone line, with 85% seeking information or emotional support, and the majority of hotline responders reporting that their suicidal callers were de-escalated from a suicidal state on post-call reports (unpublished report on Crisis Call Line data, 2009). Although an effective resource center for adults in Nevada, use of the Crisis Line by youth age 18 and under has remained disproportionately low in spite of targeted social marketing campaigns to increase their usage and in spite of high rates of suicide and suicidality in that population.

To further integrate Nevada youth into the Crisis Line services, the Nevada Office of Suicide Prevention, Educational Messaging Services, the University of Nevada, Reno, and the Crisis Call Center have collaborated to develop a new crisis line that accepts text messages instead of traditional phone calls. Because text messaging is a popular mode of social communication among youth and one in which youth may feel more willing to reveal sensitive information, it is hoped that this new text message-based Crisis Line will significantly increase the help-seeking behaviors of Nevada youth in crisis.

Adults with SMI Who Are HIV-Positive: In partnership with the Nevada State Health Division (NSHD), through the Bureau of Community Health, MHDS works to provide services to persons with SMI who are HIV-positive or diagnosed with AIDS. These services include mental health counseling tailored to address issues surrounding HIV and AIDS. This initiative was expanded in July, 2004, when SNAMHS began receiving Ryan White Care Act funding to provide a full-time counselor for HIV-positive persons with SMI in the Las Vegas area. Although this is a grant-funded position, it will be renewed on an annual basis. In addition, education and prevention efforts are jointly addressed by MHDS and NSHD.

As part of the agreement with NSHD, additional funding may be secured to complete related projects including:

- Provide training for MHDS and SAPTA professionals on related HIV/AIDS issues in order to help reduce suicide rates among consumers with HIV/AIDS.
- Improve access for consumers with HIV/AIDS that require mental health residential services.

- Monitor services and unmet needs and develop ongoing funding proposals for Ryan White funding through NSHD.
- Conduct additional research and analysis of the impact of HIV/AIDS on MHDS and SAPTA services.
- Increase MHDS and SAPTA presence in HIV/AIDS statewide strategic planning groups and service delivery systems.

Jail and Prison Services: MHDS works with local jail and detention authorities to address the needs of persons who are incarcerated and have mental health issues. In the north, one psychologist is located half-time at the Washoe County Jail and half time at Lake's Crossing Center. This allows MHDS to provide evaluation and mental health services at the jail. NNAMHS also has a contract with ReStart, a local homeless services agency, which provides outreach services to inmates. Additionally, NNAMHS allocates the staff time of a Service Coordinator to serve as a liaison with the jail and provide services to criminal offenders transitioning out of the jail.

	North – Washoe County Jail
SFY 2010 average monthly evaluations completed:	49
SFY 2010 average monthly consumer hours for direct services:	60
SFY 2010 average monthly staff hours, non-contact:	136

In the south, social workers had previously been placed at both the Clark County Detention Center and Las Vegas City Jail to provide mental health services through a Memorandum of Understanding (MOU). In the past, this MOU allowed judges and District Courts to transfer inmates with mental illnesses who need inpatient psychiatric care out of a jail environment. In December, 2003, this collaboration was replaced by the functions of Mental Health Court in the southern region, described below.

SNAMHS is involved in a community reintegration program, funded by the Department of Justice, to ensure that prisoners with co-occurring disorders do not fall through the cracks and receive transition services between the Department of Corrections and MHDS.

Throughout the rural counties, Rural Clinics staff works with local authorities to provide assessment and emergency mental health services to inmates. Additionally, MHDS personnel regularly participate in psychiatric evaluation panels at the prison. These panels provide evaluations of certain inmates who are eligible for parole to determine their psychological readiness for integration into the community.

Mental Health Court: In November, 2001, a Mental Health Court was established in Washoe County, through which offenders with mental illness who volunteer for the Court take part in a mental health treatment program instead of receiving jail time for criminal offenses. Offenders

diverted to the Court have long histories of criminal offenses and hospitalization with concomitant resistance to mental health treatment. The Court is serving to assist these individuals to get the treatment they need, thereby keeping them out of jails and hospitals. Participants in the program must check in with the Court regularly.

The Washoe County Mental Health Court Team recently conducted a study of 106 MHC participants who graduated in 2007. In the year prior to participation in Mental Health Court, defendants had a cumulative total of 5,011 days in jail. During their participation in MHC, defendants had 1086 days in jail. This represents a 78% reduction in jail days.

Of the 106 participants, 43 individuals have been graduated for more than one year. These individuals had 1988 days in the year prior to MHC. They have accumulated 162 days in jail during the year following graduation from MHC – this represents a 92% reduction. The rate of recidivism/re-arrest for this population was 13% during in the year following graduation from MHC. The recidivism rate for individuals not participating in a MHC program is 30%.

The Washoe County Mental Health Court is recognized nationally as a model Mental Health Court. Washoe County MHC was selected in 2005, by the Council of State Governments as one of five courts to facilitate peer-to-peer assistance among jurisdictions that have established, or are planning to establish, MHCs,

A Mental Health Court was established in the southern region in December, 2003, in order to expand this program to Nevada's largest population center. As a result of Assembly Bill (AB) 175 from the 2005 legislative session, the first rural Mental Health Court was established in Carson City in October, 2005. Each of the three regional mental health agencies allocates staff and services in partnership with the Mental Health Courts.

	North – NNAMHS	***South – SNAMHS***	***Rural – Rural Clinics***
SFY 2010 average monthly Mental Health Court caseload:	175	68	22

Disaster Response:
The Division of MHDS currently has a statewide mental health disaster preparedness and response plan in place. Beginning in 1998, MHDS developed a Disaster Preparedness Program and plan for its agencies. During officially declared disasters, MHDS's primary responsibilities are to provide Crisis Counseling services to victims, their families and first responders, and make its hospitals and facilities available for services to folks affected by the disaster. These responsibilities are specifically identified in the Nevada State Comprehensive Emergency Management Statewide Plan, which is coordinated and implemented by the Nevada Division of Emergency Management (DEM).

Following the tragic events of 9/11, and during SFY 2004, MHDS added specific funding to improve the disaster response capacity of the Division. Based on these efforts, MHDS received

substantial new federal grant funding from the following grant sources, totaling approximately $400,000 per year:

- US Department of Health and Human Services (HHS) – Health Resources and Services Administration (HRSA): National Bioterrorism Hospital Preparedness Program.
- National Centers for Disease Control and Prevention (CDC): Public Health Preparedness for Bioterrorism.

This funding increased the surge capacity of the Division, which is the ability to call on additional mental health/crisis counseling responders during large-scale disasters. Funding was used to update planning documents, equip responders with toolkits and instructional materials, provide training in Critical Incident Stress Management (CISM), plan and participate in workshops and functional exercises with other state agencies, and create inter-state linkages for disaster response. Originally, this program was under HRSA as the National Bioterrorism Hospital Preparedness Program. Oversight of this program was recently moved under the direction of the Assistant Secretary for Preparedness and Response (ASPR).

In SFY 2007, funding for the MHDS Disaster Preparedness and Response program was unexpectedly reduced to less than $100,000. This funding reduction triggered staff layoffs and severely curtailed the program.

In SFY 2008 and 2009, MHDS reconstituted the Disaster Preparedness Program to utilize contractors instead of state funded staff due largely to the instability of the ASPR grant funds, which, for SFY 2011, has been further reduced to approximately $60,000. MHDS has been working with a contractor to ensure that the MHDS agencies' hospital evacuation and mass fatality plans are updated and related agreements for alternative care and other sheltering locations are in place. The Division is participating in an internet based communication system to allow all hospitals in the region to share information about resources available in the event of an emergency, called HAVBed.

MHDS is also currently working with the Health Division, as part of a requirement by ASPR, on developing an online data registry, also known as the Emergency System of Advance Registration of Volunteer Health Professionals, or ESAR-VHP, where all of its Crisis Counselor volunteers can be identified and put into the registry, to increase communication between all involved state Divisions and agencies, when disaster response is required. Finally, MHDS continues to provide ongoing training for its DPRP volunteers, including Psychological First Aid for its Crisis Counselors, and training for its volunteers who would staff the State Emergency Operations Center (SEOC) during a presidential or governor's declared disaster.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

SMI Definition

The term SMI is an abbreviation for *serious mental illness* and is used by MHDS as appropriate by context and as defined in the Nevada Administrative Code (NAC) 433.040 as follows:

> Adults with a Serious Mental Illness are persons 18 years of age and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that meets DSM criteria (excluding the substance abuse or addictive disorders, irreversible dementia, as well as mental retardation), which has resulted in functional impairment, which subsequently interferes with or limits one or more major life activities.
>
> Functional impairment addresses the inability to function successfully in areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health – illness and viewed from the individual's perspective within his environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships, or safety.

Estimation Methodology

Up until SFY 2010, Nevada's estimate of the prevalence of SMI relied on a prevalence study conducted in 2004 specifically for Nevada for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) based on a national prevalence model developed by Charles Holzer, M.D., from the University of Texas. However, because of the impact of the recent economic distress in Nevada, the method for estimating the prevalence of SMI for this year's application is based on the CMHS/SAMHSA Adult SMI rate applied to current population projections from Nevada's State Demographer using the following steps.

1. Tabulate the estimated population by county for SFY 2009 from the United States Census Bureau in the first column.
2. Calculate the percentage of the estimated population that is 18 years of age or older by dividing the 2009 population age 18 and over in Nevada (1,951,264 per the National Association of State Mental Health Program Directors [NASMHPD] Research Institute [NRI] by the total population in Nevada (2,296,563 per U.S. Census Bureau).
3. Apply the percentage calculated in step 2 (73.83%) to the population by county to arrive at an estimate of the population that is age 18 and over by county.
4. Apply the national prevalence rate for SMI (5.4%) from the NRI to the population age 18 and older by county.

5. To determine the lower limit of this estimate, apply the national "lower limit of estimate" (3.7%) to the population age 18 and older by county.
6. To determine the upper limit of this estimate, apply the national "upper limit of estimate" (7.1%) to the population age 18 and older by county.

Estimate of the Prevalence of SMI

Summary data for SMI prevalence is as follows:

County	*2009 Population as Estimated by the U.S. Census Bureau*	*Percent of the Total Population that is age 18 and over (73.83%)*	*Population age 18 and over with SMI (5.4%)*	*Lower Limit of Estimate (3.7%)*	*Upper Limit of Estimate (7.1)%*
Carson City	55,176	40,737	2,200	1,507	2,892
Churchill	24,897	18,380	993	680	1,305
Clark	1,902,834	1,404,772	75,858	51,977	99,739
Douglas	45,464	33,564	1,812	1,242	2,383
Elko	47,896	35,359	1,909	1,308	2,511
Esmeralda	626	462	25	17	33
Eureka	1,707	1,260	68	47	89
Humboldt	18,260	13,480	728	499	957
Lander	5,159	3,809	206	141	270
Lincoln	4,794	3,539	191	131	251
Lyon	52,641	38,862	2,099	1,438	2,759
Mineral	4,662	3,442	186	127	244
Nye	44,234	32,656	1,763	1,208	2,319
Pershing	6,286	4,641	251	172	329
Storey	4,441	3,279	177	121	233
Washoe	414,820	306,242	16,537	11,331	21,743
White Pine	9,188	6,783	366	251	482
STATWIDE TOTAL:	2,643,085	1,951,264	105,368	72,197	138,540

Clients Served

Data for all clients served during SFY 2010 is as follows:

Agency	*SFY 2010 Total Served*	*Percent*
NNAMHS	6,805	23.1%
SNAMHS	16,475	56.0%
Rural Clinics	5,911	20.1%
Lake's Crossing	243	.8%
TOTAL:	29,434	100%

DATA NOTE: Total clients served by region in criterion two is greater than the total clients served reported in Section III under NOMS indicator 4.1, because clients are duplicated across service region. For example, clients who receive services initially through Rural Clinics may also receive services in one of the urban areas at NNAMHS or SNAMHS.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 2: Mental Health System Data Epidemiology

Quantitative Targets

Quantitative targets for the provision of services as described under criterion one are included under the National Outcome Measures (NOMS) indicator 4.1 for criterion two.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 3: Not Applicable

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

Outreach to Homeless

Description of Persons with SMI and SED Who Are Homeless

While recognizing the fact that no single definition or characteristic best describes all homeless people, MHDS relies on the federal definition from the McKinney-Vento Homeless Assistance Act to create an operational definition of *homeless*, which includes the following types of situations:

- Living in places not meant for human habitation (streets, cars, parks, etc.).
- Living in an emergency shelter.
- Fleeing a domestic violence situation and the person lacks resources to support their own needs.
- Living in a public or private facility that provides temporary living accommodations and the person was homeless upon entry into the facility, or could be homeless upon exit from the facility due to lacking the resources and support networks needed to obtain housing on their own.
- Living in transitional housing.
- The above definition does not include those individuals who may be considered homeless, or at risk of becoming homeless, because they are "doubled up" and the person's name is not on the lease and can be forced to leave and lacks resources and supports needed to obtain housing on their own.

Statewide Estimate of Individuals who are Homeless with SMI

A statewide estimate of individuals who are homeless with SMI is obtained each year using data provided by all agencies that actively participate in Nevada's Continuum of Care (CoC) process, which is described below.

As part of the CoC planning process, a Point-in-Time (PIT) count of persons who are homeless must be completed every two years. Northern and Rural Nevada have elected to conduct an annual PIT count, and Carson County completes an additional count each year in August. The PIT count for 2010 occurred simultaneously for the northern and rural CoC affiliates.

Rural counties participate in the PIT count to varying degrees based on the capacity of their local social service providers, law enforcement, and community volunteers. The participation for

2010 extended into counties that had not participated in the past and the degree of participation in several counties grew significantly.[19]

The regional estimates for 2010 are as follows. Estimates of persons who are homeless with SMI are based on Center for Mental Health Services (CMHS) estimates that 20% to 25% of homeless people have SMI.[20] The more conservative figure of 20% is used for the SMI estimate.

Region	***2010 Estimate – TOTAL***	***2010 Estimate – SMI at 20%***
North (Washoe County)	3,893	779
South (Clark County) from 2009	13,338	2,668
Rural areas	173	35
TOTAL:	17,404	3,481

The above numbers may not include persons at-risk, fleeing a domestic violence situation, or being evicted with no resources to obtain other living accommodations.

A count of people residing in motels is also conducted each year as part of the PIT count. This count is not required by HUD and people living in motels are not considered homeless, yet it provides data on people that are possibly under-housed or at-risk of becoming homeless.

	North	***South***	***Rural***	***Statewide***
Living in motels	2,568	400	504	3,472
Subset - in a motel for over one year	1,242	n/a	219	1,461

In the rural areas, there was an increase in the number of people families living in motels. The hotel residents are employed and not homeless, but underscore the need for workforce housing or a variety of affordable housing options in rural Nevada.[21]

Available Services

Nevada continues to be one of the few states that have successfully established a statewide Continuum of Care (CoC) initiative. CoC was established by the Department of Housing and Urban Development (HUD) to encourage states to develop a community plan to organize and deliver housing and supportive services to meet the specific needs of people who are homeless. There are three CoC affiliates in Nevada that cover the three primary regions of the state: north, south, and rural. All communities in Nevada participate in planning efforts as part of the CoC

[19] (2010). *A Study of Homeless in Rural Counties in Nevada. Rural Nevada Continuum of Care*. Reno: Social Entrepreneurs, Inc.
[20] National Mental Health Information Center (2007). *Homelessness*. Retrieved August 30, 2007, from http://mentalhealth.samhsa.gov/cmhs/Homelessness/.
[21] (2010). *A Study of Homeless in Rural Counties in Nevada. Rural Nevada Continuum of Care*. Reno: Social Entrepreneurs, Inc.

initiative. Because the three affiliates include the participation of various stakeholders in the three primary regions, they take a different form within each area.

Stakeholders in the CoC affiliates include the following:

- Federal agencies
- State agencies
- Local governments
- Public housing authorities
- Nonprofit organizations and service agencies
- Businesses
- Foundations
- Other advocates actively participating in CoC processes for their community

The following lead organizations have undertaken the CoC initiative in their respective regions:

Region	***Lead Organizations***
North (Washoe County)	• Social Entrepreneurs, Inc. • Reno Area Alliance for the Homeless – (RAAH)
South (Clark County)	• Southern Nevada Regional Planning Coalition (SNRPC) Homeless Task Force • Committee on Homelessness
Rural areas	• Social Entrepreneurs, Inc. • Rural Nevada Continuum of Care (CoC) Steering Committee

In the most recent year for which information is available (FFY2008), all three of the Nevada CoC affiliates were successful in obtaining HUD funding, totaling approximately $5.6 million to be used to provide housing and supportive services in the state. Additionally, the state received $884,398 in Emergency Shelter Grant (ESG) funds in SFY 2009, Regional funding is as follows:

Region	***2008 HUD Funding***	***2009 ESG Funding***
North (Washoe County)	994,235	89,635
South (Clark County)144	4,238,953	503,899
Rural areas	336,298	290,854
TOTAL:	$ 5,614,486	$ 884,398

Supportive and prevention services provided by participating organizations include the following:

Mental Health Services:

- Outreach
- Screening
- Diagnosis
- Case management
- Job training
- Life skills training
- Education
- Domestic violence counseling
- Mental health counseling
- Substance abuse counseling
- Gambling and other addiction counseling

Housing Services:

- Emergency shelters
- Group homes
- Transitional homes
- Permanent housing

Other Community-Based Services
Southern Nevada Adult Mental Health Services (SNAMHS) added a second Program for Assertive Community Treatment (PACT) team in 2004 focused on individuals and families in the downtown Las Vegas area who are homeless, have a serious mental illness, and also meet the admission criteria for the program. The average caseload for this program is approximately 64 clients per month.

Projects for Assistance in Transition from Homelessness (PATH)
MHDS has selected the same three service providers as last year to receive PATH funding. The following table below presents preliminary funding and service estimates for PATH providers during SFY 2010:

Organization	***Service Area***	***Amount Funded***	***Projected Clients to be Served***
ReStart	North	172,800	1,612
The Salvation Army	South	180,480	1,291
New Frontier Treatment Center	Northern Rural	134,400	1,231
Administration	Statewide	20,320	n/a
TOTAL:		$508,000	4,134

PATH provider agencies focus on providing the following services to persons who are homeless:

- Outreach
- Screening and diagnosis
- Habilitation and rehabilitation
- Mental health services
- Substance abuse services
- Service coordination
- Referrals to other services

Additionally, both The Salvation Army and RESTART have housing options for people who are homeless and can participate in treatment and comply with housing rules. New Frontier

Treatment Center provides transitional housing for people currently in their substance abuse program.

No PATH providers are currently set up as "wet" houses, which is an agency that provides housing regardless of substance abuse status. Therefore, these agencies may require that clients seek substance abuse services prior to admission to housing support services. All of these PATH-funded agencies work with local mental health agencies, social services agencies, housing authorities, and other nonprofit organizations that provide assistance to help clients obtain housing. These may include Emergency Shelter Grants, Supportive Housing Programs, Shelter Plus Care, Section 8, etc. PATH providers, mental health staff, and other CoC members are working on ways to ensure that people are not homeless upon exit from any program.

Shelter Plus Care

Shelter Plus Care (S+C) is a permanent supportive housing component within HUD's CoC initiative. S+C funding is aimed at linking rental assistance and supportive services to individuals who are homeless and disabled. Grant funds are obtained regionally through each of the CoC affiliates as follows:

Region	***2008 Amount***
North (Washoe County)	451,356
South (Clark County)	1,311,468
Rural areas	232,716
TOTAL:	$1,995,540

Note - Information on current funding amounts was not available at the time this application was submitted.

Barriers to Service Access and Efforts to Overcome Them

The regional CoC affiliates also conduct an annual needs assessment that includes identification of barriers to service access, gaps analyses, and needs assessments. Regional summaries are as follows:

NORTH

- Increase in the number of homeless families.
- Lack of affordable housing, specifically lack of new developments and loss of current affordable housing opportunities.
- Stagnant or reduced service funding.

SOUTH

- Increase in the number of homeless families.
- Lack of housing, specifically mobile home park closures and condominium conversions.

RURAL

- Lack of available resources.
- Lack of available housing, particularly affordable or subsidized housing.
- Housing and gasoline costs have increased greatly and incomes have not kept up.

- Many of the poorest Nevadans choose to reside in rural areas because of the lower cost of living and commute into the larger cities of Reno and Carson City. The increased cost of living in rural areas no longer makes this approach viable.
- Need for additional community-based, supportive services.

Efforts to overcome these barriers are made regionally by the CoC participants as part of annual strategic planning and service provision.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

Rural Area Services

Targeted services to rural populations are described in detail under criterion one of the adult plan. Therefore, the text of criterion four focuses on services for homeless populations and older adults, per the grant guidelines.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

Older Adults

In partnership with the Division for Aging Services, MHDS provides outreach for seniors with SMI through NNAMHS in the northern region and through SNAMHS in the southern region. The Senior Mental Health Outreach Program provides services to adults ages 60 and older who are experiencing symptoms of mental illness, with the primary goal to identify, evaluate, and provide effective mental health care through community outreach.

Direct care services including evaluation, counseling, and service coordination (case management) are primarily offered to seniors in their own home. Clinicians are able to complete intakes for new clients in the field. This program effectively addresses problems of access to mental health care for seniors that include lack of transportation or physical and medical obstacles to receiving services at traditional mental health facilities. Often community professionals, neighbors, family members, and others involved with seniors will suspect a need for mental health care and will refer the person to the program, as seniors are sometimes reluctant to go to an office to see a mental health service provider.

	North – NNAMHS	***South – SNAMHS***
SFY 2010 average monthly senior outreach caseload:	29	58

In the northern region, clinical staff for the program includes one Mental Health Counselor position. In the southern region, staff members include the Program Director, one Clinical Social Worker, and one Mental Health Counselor. The clinicians offer services in a non-threatening and supportive manner, which increases the likelihood that seniors will accept assistance when it is needed. Two Administrative Assistants support the program in the north and south.

A psychotherapy group for some clients of the program, called the Senior Transitions Group, is offered weekly at one of the SNAMHS clinics in Las Vegas. The Children of Older Parents Support Group is facilitated weekly in Las Vegas by the Program Director to assist family caregivers, specifically adult children, who are caring for or concerned about aging parents.

In addition to providing direct care services, the Program Director has developed and conducted training opportunities for people in the community, including professional service providers, on a variety of topics such as recognizing and treating depression, senior suicide prevention, addressing problem gambling, and maintaining good mental health in later life. In 2006, the

Program Director was named Educator of the Year for the ongoing training provided to the Las Vegas Metropolitan Police Department's Crisis Intervention Team.

In order to further meet the needs of seniors, the Senior Mental Health Outreach Program is an active participant on eight different community, statewide, and national coalitions. Issues addressed through participation with the various coalitions include meeting the needs of Alzheimer's victims and their caregivers, reducing the impact of problem gambling, suicide prevention, improved coordination of services to seniors both locally and nationally, geriatric education to professionals, and the reduction of homelessness.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Resources for Providers

Financial Resources

The legislatively approved budget for the Division of Mental Health and Developmental Services for SFY 2011 is as follows:

Item	*Amount*
• Mental health services budget	153,180,419
• Developmental services budget	140,830,127
• Administration	9,356,482
• SAPTA	29,054,569
SFY 2011 Legislature-approved budget:	$332,421,597

Staffing Overview

For SFY 2011, the regional budgets for the delivery of mental health services and the number of positions funded are as follows:

Region	*SFY 2011Budget*	*Positions **
North (BA 3162)	33,790,182	269
South (BA 3161)	94,031,005	734
Rural (BA 3648)	15,963,156	159
Forensic (BA 3645)	9,396,076	114
TOTAL:	$158,094,812	1,276

*Rounded to the nearest whole number

Staffing with Block Grant Funds

Currently, the bulk of CMHS funds are utilized to provide community-based direct service staff in the three primary regions of the state: north, south, and rural. Staff and other grant expenditures are summarized as follows:

NNAMHS: CMHS funds support salaries for two full-time and on half time Consumer Service Assistants as part of the Consumer Assistance Program (CAP). Funds also support salaries for one full-time Substance Abuse Counselor, one full-time Psychiatric Caseworker, and one half-time Psychiatric Caseworker as part of the PACT Team.

SNAMHS: CMHS funds support salaries for three full-time Consumer Service Assistants as part of the CAP. Funds also support salaries for one full-time Clinical Social Worker as part of the PACT Team.

Rural Clinics: CMHS funds support salaries for Psychologists, Psychiatric Nurses, and Clinical Social Workers. CMHS funds also support salaries for three full-time Consumer Service Assistants as part of the CAP, with one each positioned in Carson City, Minden, and Winnemucca.

Statewide: CMHS funds support a Clinical Program Planner and four Quality Assurance staff for the Planning and Evaluation Unit. Funds also offset one administrative support position designated to serve as staff to the Mental Health Planning Advisory Council (MHPAC).

Additionally, funds support annual innovative projects. For SFY 2011, this will include the, Quality Assurance staff training, annual WICHE dues and the following training endeavors:

- Root Cause Analysis
- Strengthening Supervisor Activities
- Investigations

Training Provider to Mental Health Service Providers

NORTH: Northern Nevada Adult Mental Health Services (NNAMHS):

NNAMHS provides annual and bi-annual training on a variety of topics to ensure all employees are up-to-date on skills and knowledge necessary to provide safe and quality treatment for the mental health consumers that we serve. The following is a list of the training provided.

New Employee Orientation

All new employees of NNAMHS must attend New Employee Orientation within 20 days of hire. This orientation in an 8 hour class that covers the following topics:

- Review of NNAMHS Mission Statement and Strategic Plan
- Safety/Emergency Procedures/Fire Safety
- Infection Control & Standard Precautions
- Body Mechanics
- Confidentiality
- Abuse and Neglect
- Consumer Rights
- Seclusion and Restraints Initiative
- Incident Reports System
- HIPAA Regulations
- Information Technology Overview
- Medical Record Documentation
- Cultural Diversity
- Suicide Prevention
- LOCUS Assessment

For all new Registered Nurses, there is an additional 4 hour orientation that covers the following:

- Emergency Cart and use of AED
- Abnormal Involuntary Movement Scale
- Pain Assessment
- Fall Prevention
- Seclusion and Restraint procedures

Annual Training

The following is a list of annual training that is mandatory for all employees and is either provided in large group settings, or with PowerPoint presentations with testing over the email system that can be completed individually.

- Dealing with Difficult People
- Cultural Competency
- Fire Safety
- Emergency Preparedness,
- Infection Control and Standard Precautions
- Consumer Rights
- Professional Behavior of MHDS Employees
- Health Insurance Portability and Accountability Act (HIPAA)
- Incident Reporting
- IT Security Awareness
- Suicide Assessment/Prevention for all clinical staff

Bi-Annual Training

- CPR for all direct care staff
- Conflict Prevention and Resolution Training
- Pain Assessment for all direct care staff

Tri-Annual Training

- Fire Extinguisher training

Every 4 years

- Defensive Driving

Continuing Education

NNAMHS also hosts Continuing Education programs for clinical staff to enhance their skills and knowledge. During FY2010, the following training programs were provided:

- Staying on the Path towards a Healthy Lifestyle
- Resiliency in the Workplace: Personal and Interpersonal Dimensions
- Treating Chronically Suicidal People without Becoming Suicidal
- Life Meaning can Provide Strength and Direction
- Dual Diagnosis: An Integrated Approach
- Spirituality and Recovery from Mental Disorders
- Annual National Alliance of the Mentally Ill Conference

Mandatory Supervisor Training available online at: http://kaizen.dop-ad.state.nv.us :

- Evaluating Employee Performance
- Progressive Disciplinary Procedures
- Handling Grievances
- Alcohol and Drug Testing Procedures
- Introduction to Equal Employment Opportunity
- Interviewing and Hiring
- Orientation to State Employment
- Sexual Harassment Prevention - Revisited

Annual Competency & Supervisor Review of Clinical Staff

The supervisor is responsible for ensuring competency of the following:

- Treatment Planning
- Vital Sign Competency
- Progress Notation
- Emergency Cart - AED
- Mock Codes
- LOCUS
- Pain Assessment
- Emergency Behavior Management

Annual Competency of Nursing Staff

- Medication Reconciliation
- Medication Procedures
- Abnormal Involuntary Movement Scale
- Glucometer
- AWOL Policy

Nevada Employee Action and Timekeeping System (NEATS) Training

NNAMHS utilizes the State Department of Personnel training resources on NEATS as well as the State of Nevada Risk Management training. These are primarily related to employee and supervisory development and include the following:

- Evaluating Employee Performance
- Equal Employment Opportunity
- Interviewing & Hiring
- Alcohol & Drug Testing
- Progressive Disciplinary Procedures
- Handling Grievances
- Workers' Compensation
- Managing the Threat of Workplace Violence
- Supervisor Safety
- Communication
- Coaching for Supervisors

Intensive Training:
The following training opportunities were also available to staff during FY2010

- *Changing the World* – Co-Occurring Disorders all day training that was attended by most clinicians including Psychologists, Psychiatrists, RNs, LCSW, and Service Coordinators.
- *Certified Public Manager Training* – One staff graduated during this time period. This is an intensive16 month training in supervision and leadership within the State of Nevada.
- *Service Coordination Conference* – Intensive 2.5 day training for service coordinators.
- *Crystal Report Training* – Multiple staff attended several trainings on using and interpreting of management information reports
- *Workplace Spanish* – 25 staff attended 2 weekly sessions for 1.5 hours over 10 weeks to learn basic Spanish to improve communication with our Hispanic population.
- *Emergency Preparedness* – Numerous staff have attended training by Washoe County and Homeland Security on Emergency Preparedness.
- *NAMI Conference* – National Alliance of the Mentally Ill Conference

Release time of additional staff training
NNAMHS staff are provided up to 24 hours of release time to attend training that is relevant to their licensure. These training sessions included the following:

- Psychiatric Diagnosing
- Co-Occurring Disorders
- Anxiety
- Coding and Billing
- Activity Therapy
- Depression
- Cognitive Behavior Therapy
- Brain Injury
- Ethics
- Emotional Regulation
- Post Traumatic Stress Disorder
- Grief
- Methamphetamine Abuse Prevention
- Prescription Drug Abuse Prevention
- Hepatitis C

SOUTH: Southern Nevada Adult Mental Health Services (SNAMHS) and Southern Rural Clinics (Mesquite, Laughlin, Moapa, Caliente, Pahrump)

This section is intended to provide information about training and development at SNAMHS. To maintain a safe, trained, and motivated diverse workforce, employees are properly trained across all disciplines. Employee training and development contribute directly to the employee's personal and professional growth, and to the effectiveness and efficiency of the care received by the individuals served by SNAMHS. This is accomplished through:

- Helping to maintain and improve employee and agency performance through training and education.

- Providing employees with the job skills and competencies necessary to effectively carry out their jobs and to accommodate changing policies, technology, equipment, and the SNAMHS' mission.
- Keeping employees abreast of the current activities in their field and maintaining specialized proficiencies.

Another key objective to the FY 2010 SNAMHS' training program was to deliver and coordinate essential HR and management skills training for employees. While technical skills and the ability to successfully accomplish one's daily tasks on the job are essential, learning HR transferable skills and management techniques will extend the concept of personal development.

New Employee Orientation

SNAMHS provides a structured approach to new employee orientation, which provides the essential knowledge paramount to the employee's success and enhancement of skill sets and competencies. The importance of professional development is recognized as vital in maintaining a workforce with up to date knowledge and experience, capable of satisfying the demands of the work and the care and treatment of those individuals we serve. All new employees are provided with a binder of resources to include PowerPoint Presentations, policies, sample forms and other pertinent documents. Topics addressed include:

- Agency, Accreditation, and Functioning Teams Overview
- Stigma, Discrimination, and Recovery / Peer to Peer Support
- Computer Systems Training and Avatar
- Boundaries
- Nevada Employee Action and Timekeeping System (NEATS)
- Fire Extinguisher Training
- Sexual Harassment Prevention
- Client Rights
- HIPAA Awareness
- Cultural Competency
- Emergency Evacuation and Preparedness Training
- Standard Precautions and Infection Control
- Joint Commission's National Patient Safety Goals / Hand off Communication
- Internet and Email Use (Division Training)
- Treatment Planning
- Seclusion and Restraint
- Suicide and Risk Assessment / Danger to Self or Others
- Medical Records Standards
- Conflict Prevention and Response Training – Part A – Verbal De-escalation
- Conflict Prevention and Response Training – Part B – Physical Management
- Defensive Driver's Training Departmental Orientation
- Internet Security Awareness
- Workplace Violence Recognition and Prevention

Annual Requirements

The employees training knowledge and competency was assessed during FY 2010 using measurable methods, to include a knowledge review, both oral and written, observations, demonstration, and a review of work products. This is an annual assessment. If the employee is not able to demonstrate training competency / knowledge, they are required to attend additional training. The annual trainings included in the annual assessment packet are:

Required for all SNAMHS Employees:

- Emergency Evacuation and Preparedness
- Client Rights, and Abuse and Neglect
- HIPAA Awareness and Confidentiality
- Internet and Email Use Policies and Procedures
- Professional Behavior
- Standard Precautions / Infection Control
- Workplace Violence
- Joint Commission's National Patient Safety Goals / Hand off Communication
- Cultural Competency

Required for all Clinical / Direct Care Employees:

- Treatment Planning
- Seclusion and Restraint
- Suicide and Risk Assessment
- Medical Records Standards

Required annually for all inpatient and outpatient RNs and MDs

- Pharmacy Competency Training

Mandatory Supervisor Training available online at: http://kaizen.dop-ad.state.nv.us :

- Evaluating Employee Performance
- Progressive Disciplinary Procedures
- Handling Grievances
- Alcohol and Drug Testing Procedures
- Introduction to Equal Employment Opportunity
- Interviewing and Hiring
- Orientation to State Employment
- Sexual Harassment Prevention - Revisited

Required Every Two Years

The trainings below are provided in new employee orientation and then required every 2 years. These training are offered multiple times monthly in order to accommodate a 24/7 workforce.

- Fire Extinguisher Usage
- Conflict Prevention and Response Training
- Sexual Harassment Prevention
- Cardio-Pulmonary Resuscitation (CPR): SNAMHS is a certified CPR training center, which follows all American Heart Association guidelines. For inpatient staff, Healthcare

Provider CPR is required for all nurses, mental health technicians, and doctors. This certification must be renewed every two years. CPR certification is required for all direct care/clinical staff at the outpatient clinics. SNAMHS Training Department maintains all necessary training equipment.

Additional FY 2010 Training

A SNAMHS' needs assessment conducted, in conjunction with Administration, identified the areas below as education employees would benefit from.

Customer Service Training

SNAMHS employees are required to complete this in-house Customer Service Training. All topics included group activities and all employees are provided a workbook. Topics covered include:

- Awareness
- Understanding Our Product and Services
- Internal and External Customers
- Communication
- Business Terminology
- Cross Training for System Operations
- Conflict Resolution and Problem Solving
- Quality / Professionalism
- Teamwork

Nurse Supervisor Academy

These sessions all included group activities and a "take away" exercise. Additionally, all topics included a competency exam. All of these training sessions were designed to help the manager apply these concepts to their particular work setting. Other resources provided included our Agency forms and sample Agency memos.

- Strengthening Nurse to Nurse Relationships
- Horizontal Violence
- Dealing with Difficult and Disruptive Behaviors
- Conflict Management
- Leadership
- Communication
- Coaching
- Time Management and Delegation
- Disciplinary Process
- Legal Issues for Nurses
- Assessing Competencies
- Performance Appraisals

Suicide Prevention Gatekeeper Training

To provide employees with information that will increase their awareness of suicide as a serious, but preventable, public health problem in the United States and in Nevada – the state with one of

the highest suicide rates in the US. The Office of Suicide Prevention conducted this training for SNAMHS' employees.

Root Cause Analysis Training
A multidisciplinary group of employees were selected by the Appointing Authorities to attend a Root Cause Analysis Training Class conducted by HealthInsight.

Area Health Education Center (AHEC)
The Area Health Education Center of Southern Nevada provided the trainings listed below. The AHEC AIDS Education and Training Center's trainings, are designed for physicians, nurses, psychologists, social workers, marriage and family therapists, and other interested providers.

- "Sex, Drugs, Rock and Roll: Methamphetamine, Alcohol, and HIV"
- "Hepatitis A, B, and C"
- "Clinical Manifestations of HIV"
- "AIDS in the Elderly"
- "Risk Reduction Counseling: Assessing Risk, Inspiring Change"

Supervisor's Toolbox
This training demonstrates all the available online resources through the Department of Personnel's Office of Employee Development website. Many of the mandatory supervisory courses are now available online as well as supervisory information to provide quick reference when needed. This training is offered monthly.

Mental Health Technician Certification Program
The primary vehicle for training mental health technicians (MHT) is through the Technician Certification Program established by the Division and the Legislature, which is conducted by the College System of Nevada. This certification is the primary clinical training program for the mental health technicians. All mental health technicians are required to complete the certification program within two years of their hire date. Once certified, the MHT must maintain his or her certification by completing 20 hours of continuing education units every two years following the date on which initial certification was issued. The following Mental Health and Developmental Disabilities (MHDD) courses were offered.

- MHDD 101 – Role of the Technician
- MHDD 103 – Psychopathology and Developmental Disabilities
- MHDD 105 – Conflict Prevention and Response Training
- MHDD 107 – Medication Fundamentals
- MHDD 109 – Intro to Therapeutic Interventions
- MHDD 127 – Positive Behavior Supports
- MHDD 150 – Issues in Substance Abuse
- MHDD 152 – Allied Therapies
- MHDD 153 – Life Span Development
- MHDD 154 – Advanced Therapeutic Interventions

RURAL: Rural Clinics
Rural Clinics provided the following trainings or training opportunities during FY 2010:

Training Database

Rural Clinics maintains a training database including new employee orientation and annual / biennial training materials. Ten of these contain both PowerPoint Presentations and Competency Tests developed during FY 2010. Materials are also provided for Clinical staff members, Supervisory reports, Medication Training, Provider trainings, Webex use, and a variety of other topics (e.g., Basic Documentation, Addictions Overview, Interactive Journaling, Residential Supports, Support Programs Training. RC's widely disbursed staff members access these materials regularly. These materials exist to aid in compliance with MHDS Division policies.

Agency-Sponsored Trainings

Rural Clinics provided a variety of staff or other-sponsored trainings during SFY2010, including:

- AVATAR Scheduling
- AVATAR Field Orientation
- Dual Relationships
- HIPAA Awareness
- Applied Suicide Intervention Skills
- Client Rights / Abuse Neglect
- Problem Gambling
- Burnout Prevention
- Ethics in Action
- LOCUS / CASII
- Basic Documentation
- File Organization
- Treatment Planning
- Risk Assessment
- Cultural Competence
- Professional Behavior, Ethics, & Boundaries
- Treatment planning for Rehab
- Emergency Preparedness and Evacuation
- Suicide Overview (providers)
- SMI Overview (providers)
- Violence Overview (providers)
- Addictions Overview (providers)
- Cultural Competence

Rural Clinics also provides up to 24 hours of paid release time for staff to pursue training relevant to licensure. While the list would be too long to note here, examples include:

- Dialectic Behavior Therapy
- Emergency system response
- CPR training
- Treatment planning
- Best Practices, research-to-practice
- NAMI Conference
- Adolescent Co-occurring Disorders

During this period, Rural Clinics experimented with training via Webex, or distance interactive teaching. Experimental episodes included Sexual Harassment and Medication Training. These episodes were the precursors to mastering the technology which finally occurred in August, 2010.

Mental Health Technician Training

Rural Clinics maintains a budget of approximately $11,000 to provide Mental Health Technician development training through the Truckee Meadows Community College or the Community College of Southern Nevada.

Nevada Employee Action and Timekeeping System Trainings

Rural Clinics utilizes the Nevada Department of Personnel training resources on NEATS as well as the Nevada Risk Management trainings. These are primarily related to employee and supervisor development, including:

- Coaching for Supervisors
- Evaluating Employee Performance
- Nevada Alcohol and Drug Abuse
- Equal Employment Opportunity
- Handling Grievances
- Safety Training
- Workplace Violence Prevention
- Workers' Compensation
- Communication, What's My Style?
- Basic Business Writing
- Accident Investigation
- Mixing 4 Generations in the workplace
- Defensive Driving

Intensive Training

Rural Clinics provided intensive trainings related to:

- *Certificate in Supervisory Management*: Two staff participated in a 16 week program through Department of Personnel that included supervision and leadership skills.
- *Certified Public Manager:* One staff member attended the 16 month intensive, cohort-based training in supervision and leadership within the State of Nevada. This member completed the course and obtained CPM status in FY 2010.
- *Service Coordinator Conference:* Intensive, 2.5 day training on care for providers.
- *Crisis Prevention Institute:* Train the trainers and subsequent statewide intensive training in personal and client safety. Non-violent crisis intervention.
- *Provider training:* Training for contract providers delivering rehabilitative services to Rural Clinics clients.
- *Crystal Report Training:* Supervisory staff received multiple intensive trainings on use and interpretation of management information reports

Ad hoc training

Issue specific trainings are developed and offered to respond to a variety of quality assurance audits. Such trainings often include file organization, basic documentation, suicide or risk assessment, or supervisory report trainings.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Training for Emergency Service Providers

In the northern and southern regions, NNAMHS and SNAMHS staff have partnered with local law enforcement agencies to develop a Crisis Intervention Teams (CIT) in each region to address the specific needs of criminal offenders with mental illness. The training and implementation of this program is based on the *Police-Based Behavioral Intervention Program*, which is a national model developed in Memphis, Tennessee, in 1988. This model is designed for law enforcement first responders.

Police officers who become part of the CIT take part in a 40-hour, specialized training focused on learning about mental illness and effective intervention techniques in emergency situations. The training curriculum consists of three primary components:

1. Classroom training: Five hours of instruction is provided by NNAMHS or SNAMHS staff including a four-hour basic introduction to mental illness and one-hour introduction to psychiatric medications. Appropriate mental health intervention strategies are reviewed and discussed.
2. On-site training: Participating officers go to various service sites in their communities, including a full day at NNAMHS or SNAMHS, which includes a facility tour, face-to-face time with consumers who volunteer to speak with the officers, and informational interviews with staff.
3. Role-play scenarios: Staff from NNAMHS and SNAMHS participate to provide role-play scenarios for officers to practice and apply mental health intervention skills learned such as crisis communication. Scenarios are designed based on actual incidents that have occurred in the community. Specific police calls are re-enacted to allow officers to intervene and de-escalate emergency situations. Officers attempt to appropriately identify mental health issues and help individual consumers to de-escalate. Feedback is given by staff and trainers on both positive outcomes and constructive criticisms.

CIT officers include those who have trained in this program and are dispatched when mental illness is suspected to be a factor in an emergency call. The goal is to have the CIT officer interact within first few minutes of an emergency with the person, in order to stabilize the situation and reduce the likelihood of the use of force or a violent outcome. The CIT approach is a more compassionate and dignified approach when dealing with persons having mental illness.

The CIT training program began at SNAMHS in 2003 and at NNAMHS in 2004. These trainings are offered repeatedly throughout the year and have been shown to be effective in reducing arrest related violence and increasing access to mental health services for persons with

mental illness. It has also resulted in a better working relationship involving NNAMHS and SNAMHS, and their respective law enforcement area agencies

Mobile Outreach & Safety Team (MOST) Program

NNAMHS also has the MOST Program which was modeled after a program in San Diego. The concept is to assist law enforcement with situations that have a mental health component. Many of the individuals encountered by law enforcement have mental health issues but may not be receiving mental health services. Many of the officers have little or no training on addressing complex mental health problems that often require the assistance of a mental health professional.

To address this challenge, an advanced level clinician is assigned to ride with an officer on calls that involve mental health issues. The officer ensures scene safety and the clinician brings their expertise and resources to bear on the problem at hand. The goal is to intervene early enough to avoid legal holds or incarceration. Non emergency follow-up contact is focused on engaging the person and encouraging access to long-term mental health resources.

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Grant Expenditure Manner

Since the CMHS block grant was changed to a two-year award, MHDS has shifted the expenditure of grant funds ahead by one fiscal year, thereby matching the current federal fiscal year award to the budget for the following State fiscal year. Therefore, the revised expenditure plan reflects budgeted expenditures for SFY 2011, based on funds from FFY 2010. This meets the requirement for a flat budget projection across the next fiscal year covered in this plan as outlined in the grant guidelines under *Fiscal Planning Assumptions*. Given the flat budget projection, MHDS will continue with the funding priorities similar to those outlined in Section I under *Previous State Plan Priorities and Accomplishments*.

Based on the above, MHDS has planned expenditures of CMHS Block Grant funds in SFY 2011 based on the current FFY 2010 amount of $3,678,154 as follows. MHDS expenditures are highlighted in grey. The entire expenditure plan is included for reference:

MHPAC	***Amount***
Council operation and administration (administrative expenses)	140,848
Providing administrative support to the Commission on Mental Health and Developmental Services (NCMHDS) designed to strengthen the operation of the Commission and improve collaboration with the MHPAC.	48,620
Council travel to quarterly meetings and the rural monitoring project.	13,061
MHPAC TOTAL for SFY 2011:	$202,529

MHDS	***Amount***
Northern Nevada Adult Mental Health Services (NNAMHS): Staff including a Substance Abuse Counselor, Psychiatric Case Workers on the PACT Team, and Consumer Service Assistants.	249,693
Southern Nevada Adult Mental Health Services (SNAMHS): Staff including a Clinical Social Worker on the PACT Team and Consumer Service Assistants.	196,843
Rural Mental Health Clinics (RC): Staff including Psychologists, Psychiatric Nurses, Clinical Social	

Workers and Consumer Service Assistants.	649,750
Planning and Evaluation Unit: Staff including Statewide Residential Supports Coordinator and Quality Assurance Investigators.	460,201
Innovative Projects: Support for MHDS Investigations, Quality Assurance and Fiscal units, Annual WICHE dues, PASR activities and staff training initiatives.	120,758
MHDS TOTAL for SFY 2011:	$1,677,245

DCFS	***Amount***
Northern Nevada Child and Adolescent Services (NNCAS): Staff including mental health counselors, psychiatric case workers, a psychologist, a clinical social worker, clinical program managers and administrative assistants providing outpatient treatment and administering the SED drug program	410,221
Northern region placement prevention for children with SED at NNCAS	35,681
Southern Nevada Child and Adolescent Services (SNCAS): Staff providing community-based direct services including licensed psychologists, a mental health counselor, psychiatric case workers, a psychiatric nurse clinical program managers and administrative assistants.	632,944
Southern region respite care and placement prevention	53,903
Statewide Planning and Evaluation Unit (PEU) Manager to coordinate needs assessments and program improvements.	99,546
Clinical Program Planner and Grants Manager responsible for leadership for children's mental health policies and being a liaison between programs and stakeholders.	118,436
Administrative Assistant for the PEU.	53,408
Direct clinical services including a half time Psychiatric nurse, UNSOM psychiatric fellowship program and psychiatric evaluations.	110,148
PEU assessment and support activities including the Children's Mental Health Consortia annual report and updates.	40,000

Commission on Mental Health and Developmental Services administrative support.	5,000
Placement prevention funds to augment mental health services for children in the child welfare system.	26,000
Nevada PEP sub-grant for System of Care Support including collection of outcome data.	150,000
Children's Mental Health System Transformation Plan and Infrastructure Development.	31,000
Staff training and consultation on mental health issues.	32,093
DCFS TOTAL for SFY 2011:	$1,798,380
SFY 2011 BLOCK GRANT TOTAL:	$3,678,154

5% Grant Administration Check	***Amount***
Administrative Assistant for Council support	49,202
Stipends paid to Council members for administrative activities	10,752
Council travel for administrative activities	4,528
Grant writer	69,336
Operating supplies	1,500
Other	5,530
Total grant administration for SFY 2011:	$140,848
SFY 2011 Block Grant total:	$3,678,154
Percent of SFY 2011 Block Grant total:	3.83%

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Table C – Description of MHBG Funding for Transformation Activities

		Budgeted	Estimated
Goal 1: Americans Understand that Mental Health is Essential to Overall Health			
DCFS	Staff training and consultation on mental health issues	32,093	
MHPAC	Providing administrative support to the Commission on Mental Health and Developmental Services (NCMHDS) designed to strengthen the operation of the Commission and improve collaboration with the MHPAC.	48,620	
DCFS	Commission on Mental Health and Developmental Services administrative support	5,000	
DCFS	Nevada PEP sub grant for system of care support	150,000	
DCFS	PEU assessment and support activities including the Children's Mental Health Consortia annual report and updates	40,000	
	SUBTOTAL:	275,713	275,000
Goal 2: Mental Health Care is Consumer and Family Driven			
MHDS	Northern Nevada Adult Mental Health Services (NNAMHS): Staff including Substance Abuse Counselor, Psychiatric Case Workers on the PACT Team, and Consumer Service Assistants	249,693	
MHDS	Southern Nevada Adult Mental Health Services (SNAMHS): Staff including a Clinical Social Worker on the PACT Team and Consumer Service Assistants	196,843	
	SUBTOTAL:	446,536	445,000
Goal 3: Disparities in Mental Health Services are Eliminated			
MHDS	Rural Mental Health Clinics (RC): Staff including Psychologists, Psychiatric Nurses, Clinical Social Workers, and Consumer Service Assistants	649,750	
	SUBTOTAL:	649,750	650,000
Goal 4: Early Mental Health Screening, Assessment and Referral to Services are Common Practice			
DCFS	Northern Nevada Child and Adolescent Services (NNCAS): Direct clinical services including a half time Psychiatric nurse, psychiatric consultations and UNSOM child and adolescent psychiatric residency program	110,148	
	SUBTOTAL:	110,148	110,000
Goal 5: Excellent Mental Health Care is Delivered and Programs are Evaluated			
MHDS	Planning and Evaluation Unit: Staff including Statewide Residential Supports Coordinator and Quality Assurance Investigators	460,201	
DCFS	Statewide Planning and Evaluation Unit (PEU) Manager to coordinate needs assessments and program improvements	99,546	
DCFS	Children's Mental Health System Transformation Plan and Infrastucture Development	31,000	
	SUBTOTAL:	590,747	590,000
Goal 6: Technology is Used to Access Mental Health Care and Information			
	None	-	
	TOTAL:	2,072,894	2,070,000

PART C. STATE PLAN

ADULT

Section III. Performance Goals and Action Plans to Improve the Service System

Goals, Targets and Action Plans

Name of Performance Indicator: Increased Access to Services (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	25,502	27,817	28,817	28,000	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 4: Ensure that the service system meets the needs of adults in the public sector with mental illness

Target: 4.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adults receiving mental health services through MHDS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults served to hold steady.

Population: All adult clients, regardless of SMI status

Criterion: 2: Mental Health System Data Epidemiology
3: Children's Services

Indicator: Number of adults served within the State system of care.

Measure: Number of adults, ages 18 and older, served within the State system of care.

Source(s) of information: AVATAR

Special issues: DATA NOTE: As MHDS continues to refine its data collection through the AVATAR system, the elimination of duplicate client counts and data cleaning both continue to result in data fluctuations across years. Additionally, the significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Providing services to adults with mental illness is the primary purpose of the public mental health system.

Action Plan: MHDS will limit the decrease in the number of adults served primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) the number of adults served is likely to be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The Division's strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and how to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds – 30 days (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	17.67%	15.32%	19.39%	20.36%	N/A
Numerator	376	569	--	--	--
Denominator	2,128	3,713	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide high quality mental health services that are accessible, available, and responsive to the needs of individuals, families, and communities, emphasizing community-based services.

Target: 1.1: Limit the year-to-year increase to no more than 5% in the utilization of psychiatric inpatient beds demonstrated through the rate of readmission to State psychiatric hospitals within 30 days and 180 days.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of adults readmitted to State hospitals within 30 days and within 180 days compared with the number of adults admitted to State hospitals during the past year, expressed separately as two different percentages.

Measure: Numerator 1: Number of adult clients, ages 18 and older, readmitted to State hospitals within 30 days.
Numerator 2: Number of adult clients, ages 18 and older, readmitted to State hospitals within 180 days.

Denominator (for both): Number of adult clients, ages 18 and older, admitted to State hospitals during the past year.

Source(s) of information: AVATAR

Special issues: DATA NOTES: Because of the emergency room wait-time crisis in the southern region and the completion of the new 190-bed Rawson-Neal Hospital in Las Vegas, both of which are discussed in criterion one under Reduction of Hospitalization, MHDS does not project a decrease in the rate of readmission to inpatient facilities over the next several fiscal years. This is based on the demonstrated need for inpatient services discussed in criterion one, along with the economic distress in Nevada discussed in the Executive Summary.

Please note that data calculations for the 30-day and 180-day readmission rates are now in compliance with the method described in the grant application guidelines and the Uniform Reporting System (URS) tables. This is a result of Nevada's participation in the Client Level Reporting Pilot. In the SFY 2010 Application, readmissions were calculated for 30 days and 180 days prior to State fiscal year 2009. This means readmissions for the 180-day rate were captured from January 1, 2008 through June 30, 2008; and readmissions for the 30-day rate were captured from June 1, 2008 through June 30, 2008.

Significance: Reducing hospitalization for adults with SMI is a primary goal of MHDS and reflects an increased emphasis on community-based services.

Action Plan: MHDS will achieve this goal primarily through the implementation of services described in Section III under criterion one. In particular, MHDS remains focused on the reduction of hospitalization in spite of the high demand for services in the southern region of the state. As noted in criterion one, Nevada's number of inpatient beds relative to the population is well below the national average.

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds – 180 days (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	37.83%	32.72%	42.88%	45%	N/A
Numerator	805	1,215	--	--	--
Denominator	2,128	3,713	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal:	1: Provide high quality mental health services that are accessible, available, and responsive to the needs of individuals, families, and communities, emphasizing community-based services.
Target:	1.1: Limit the year-to-year increase to no more than 5% in the utilization of psychiatric inpatient beds demonstrated through the rate of readmission to State psychiatric hospitals within 30 days and 180 days.
Population:	All adult clients, regardless of SMI status
Criterion:	1: Comprehensive Community-Based Mental Health Service System. 3: Children's Services.
Indicator:	Number of adults readmitted to State hospitals within 30 days and within 180 days compared with the number of adults admitted to State hospitals during the past year, expressed separately as two different percentages.
Measure:	Numerator 1: Number of adult clients, ages 18 and older, readmitted to State hospitals within 30 days. Numerator 2: Number of adult clients, ages 18 and older, readmitted to State hospitals within 180 days. Denominator (for both): Number of adult clients, ages 18 and older, admitted to State hospitals during the past year.
Source(s) of information:	AVATAR
Special issues:	DATA NOTES: Because of the emergency room wait-time crisis in the southern region and the completion of the new 190-bed Rawson-Neal Hospital in Las Vegas, both of which are discussed in criterion one under Reduction of Hospitalization, MHDS does not project a decrease in the rate of readmission to inpatient facilities over the next several fiscal years. This is based on the demonstrated need for inpatient services discussed in criterion one, along with the economic distress in Nevada discussed in the Executive Summary. Please note that data calculations for the 30-day and 180-day readmission rates are now in compliance with the method described in the grant application guidelines and the Uniform Reporting System (URS) tables. This is a result of Nevada's participation in the Client Level Reporting Pilot. In the SFY 2010 Application, readmissions were calculated for 30 days and 180 days prior to State fiscal year 2009. This means readmissions for the 180-day rate were captured from January 1, 2008 through June 30, 2008; and readmissions for the 30-day rate were captured from June 1, 2008 through June 30, 2008.

Significance: Reducing hospitalization for adults with SMI is a primary goal of MHDS and reflects an increased emphasis on community-based services.

Action Plan: MHDS will achieve this goal primarily through the implementation of services described in Section III under criterion one. In particular, MHDS remains focused on the reduction of hospitalization in spite of the high demand for services in the southern region of the state. As noted in criterion one, Nevada's number of inpatient beds relative to the population is well below the national average.

Name of Performance Indicator: Evidence Based – Number of Practices (Number)

Transformation Activities: ☑ Indicator Data Not Applicable ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2	2	2	2	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 2: Utilize evidence-based practices in the delivery of mental health services.

Target: 2.1: Maintain the number of evidence-based practices provided by the State.

Population: Adults with SMI

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of evidence-based practices provided to adults based on six practices defined by CMHS for adults.

Measure: Number of evidence-based practices provided to adults, aged 18 and older, based on six practices defined by CMHS for adults.

Source(s) of information: AVATAR

Special issues: The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: The provision of evidence-based practice services is a goal identified by the President's New Freedom Commission (Goal 5, Recommendation 5.2).

Action Plan: MHDS will achieve the above goals primarily through the implementation of services described in Section III under criterion one. In particular, the MHDS strategic plan includes the development and implementation of evidence-based treatment as one of its six primary goals. The implementation of evidence-based practices was also a goal of the Nevada Mental Health Plan Implementation Commission, based on the goals of the President's New Freedom Commission.

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Supported Housing (Percentage)

Transformation Activities: ☑ Indicator Data Not Applicable ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	7.15%	9.88%	10.76%	10.22%	N/A
Numerator	1,384	1,754			
Denominator	19,347	17,755			

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 2: Utilize evidence-based practices in the delivery of mental health services.

Target: 2.2: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adults receiving supported housing, an evidenced based practice. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving supported housing services to no more than 5%.

Population: Adults with SMI

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Adults receiving supported housing, one of six evidence based practices defined by CMHS for adults.

Measure: Number of adults, ages 18 and older, receiving supported housing based on six practices defined by CMHS for adults.

Source(s) of information: AVATAR

Special issues: The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: The provision of evidence-based practice services is a goal identified by the President's New Freedom Commission (Goal 5, Recommendation 5.2).

Action Plan: MHDS will achieve the above goals primarily through the implementation of services described in Section III under criterion one. In particular, the MHDS strategic plan includes the development and implementation of evidence-based treatment as one of its six primary goals. The implementation of evidence-based practices is also a goal of the Nevada Mental Health Plan Implementation Commission, based on the goals of the President's New Freedom Commission. Nevada already implements two of the six evidence-based practices identified by CMHS.

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Supported Employment (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: Nevada does not offer Supported Employment for adults with SMI.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Assertive Community Treatment (Percentage)

Transformation Activities: ☑ Indicator Data Not Applicable ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.19%	1.33%	1.48%	1.25%	N/A
Numerator	230	237			
Denominator	19,347	17,755			

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal:	2: Utilize evidence-based practices in the delivery of mental health services.
Target:	2.2: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adults receiving assertive community treatment, an evidenced based practice. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving assertive community treatment to no more than 5%.
Population:	Adults with SMI
Criterion:	1: Comprehensive Community-Based Mental Health Service System. 3: Children's Services.
Indicator:	Adults receiving assertive community treatment, one of six evidence based practices defined by CMHS for adults.
Measure:	Number of adults, ages 18 and older, receiving assertive community treatment based on six practices defined by CMHS for adults.
Source(s) of information:	AVATAR
Special issues:	The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels. DATA NOTE: This number is being impacted by the decrease in the denominator. We believe this may be an artifact of a flaw in the data collection. It is our goal to maintain the number of people receiving PACT at roughly 230 but ensure that people are identified as having SMI appropriately.
Significance:	The provision of evidence-based practice services is a goal identified by the President's New Freedom Commission (Goal 5, Recommendation 5.2).
Action Plan:	MHDS will achieve the above goals primarily through the implementation of services described in Section III under criterion one. In particular, the MHDS strategic plan includes the development and implementation of evidence-based treatment as one of its six primary goals. The implementation of evidence-based practices is also a goal of the Nevada Mental Health Plan Implementation Commission, based on the goals of the President's New Freedom Commission. Nevada already implements two of the six evidence-based practices identified by CMHS.

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Family Psycho-education (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: Nevada does not offer Family Psycho-education for adults with SMI.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: Nevada does not Integrated Treatment of Co-Occurring Disorders (MISA) for adults with SMI.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Illness Self-Management (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: Nevada does not offer Illness Self-Management for adults with SMI.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Adults with SMI Receiving Medication Management (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: Nevada does not offer Medication Management for adults with SMI.
Significance:
Action Plan:

Name of Performance Indicator: Client Perception of Care (Percentage)

Transformation Activities: ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	57.69%	61.36%	62.86%	65%	N/A
Numerator	942	921	--	--	--
Denominator	1,633	1,501	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 1: Provide high quality mental health services that are accessible, available, and responsive to the needs of individuals, families, and communities, emphasizing community-based services.

Target: 1.2: Maintain or increase positive client perception of care, within a 5% year-to-year variance, demonstrated through the number of adults reporting positively about outcomes.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of positive responses reported in the outcome domain on the adult consumer survey compared with total responses, expressed as a percentage.

Measure: Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total number of responses in the outcome domain on the adult consumer survey.

Source(s) of information: Compilation of statewide survey data.

Special issues: None.

Significance: Client feedback regarding satisfaction with care is a major component of program evaluation and quality assurance efforts.

Action Plan: MHDS will achieve the above goals primarily through the implementation of services described in Section III under criterion one. In particular, the MHDS strategic plan includes consumer satisfaction with services as one of its core values. The adult consumer survey is now completed as part of program evaluation and quality assurance efforts.

Name of Performance Indicator: Adult – Increase/Retained Employment (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	21.31%	19.06%	17.03%	15.30%	N/A
Numerator	4,027	4,069	--	--	--
Denominator	18,900	21,353	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 3. Provide adults with a continuum of services that are tailored to their individual needs.

Target: 3.2. Given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults competitively employed to no more than 10%.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.

Indicator: Percentage of adult clients competitively employed full or part-time compared to all adult clients excluding persons whose employment status was "Not Available".

Measure: Numerator: Number of adult clients competitively employed full or part-time.
Denominator: Number of adults competitively employed full or part-time (includes Supported Employment) plus number of persons unemployed plus number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops and other) excluding persons whose employment status was "Not Available".

Source(s) of information: AVATAR and URS table 4

Special issues: This performance indicator was not reported in previous Block Grant Applications due to an oversight. Actual data from SFYs 2007, 2008 and 2009 was obtained from the URS tables and was used to establish a goal for SFY 2010 which was submitted as a revision to that year's application.

Significance: Increased/Retained employment is an important outcome measure related to the provision of a continuum of care.

Action Plan: MHDS will limit the decrease in the number of adults competitively employed primarily through the implementation of services described under

criterion one. Due to the significant reduction in available resources (both staffing and funding) coupled with the severe economic downturn in Nevada, the number of adults competitively employed will likely be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adult Decreased Criminal Justice Involvement (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	77.37%	56.10%	64.76%	65.00%	N/A
Numerator	106	69	--	--	--
Denominator	137	123	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 3. Provide adults with a continuum of services that are tailored to their individual needs.

Target: 3.3. The target for SFY 2011 is to hold steady the decrease in the percentage of clients with criminal involvement.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services

Indicator: Percent of adult consumers arrested in year 1 who were not re-arrested in year 2.

Measure: Numerator: Number of adult consumers arrested in T1 who were not re-arrested in T2 (new and continuing clients combined).
Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined

Source(s) of information: Compilation of statewide survey data and URS table 19A

Special issues: This performance indicator was not reported in previous Block Grant Application due to an oversight. Actual data from SFYs 2008 and 2009 was obtained from the URS tables and was used to establish a goal for SFY 2010

in a revision submitted for that year's application.

Significance: Decreased criminal justice involvement is an important outcome measure related to the provision of a continuum of care.

Action Plan: MHDS will limit the increase in the number of adults involved with the criminal justice system primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) coupled with the severe economic downturn in Nevada, the number of adults involved with the criminal justice system will most likely increase in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adult – Increased Stability in Housing (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	9.69%	9.50%	8.56%	8.00%	N/A
Numerator	591	2,040	--	--	--
Denominator	6,097	21,468	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 3. Provide adults with a continuum of services that are tailored to their individual needs.

Target: 3.4. Given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the increase in the number of adults who are homeless or living in shelters to no more than 10%.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services

Indicator: Percentage of adult clients who are homeless or living in shelters.

Measure: Numerator: Number of adult clients who are homeless or living in shelters.
Denominator: All adult clients with living situation excluding persons with living situation "Not Available".

Source(s) of information: AVATAR and URS table 15

Special issues: This performance indicator was not reported in previous Block Grant Application due to an oversight. Actual data from SFYs 2007, 2008 and 2009 was obtained from the URS tables and was used to establish a goal for SFY 2010 and was included in a revision to the application for that year.

Significance: The percentage of clients who are homeless or living in shelters is an important outcome measure related to the provision of a continuum of care.

Action Plan: MHDS will limit the increase in the number of adults who are homeless or living in shelters primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) coupled with the severe economic downturn in Nevada, the number of adults who are homeless or living in shelters is likely to increase in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adult – Increased Social Supports/Social Connectedness (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	58.83%	67.27%	66.75%	67.00%	N/A
Numerator	956	1,003	--	--	--
Denominator	1,625	1,491	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: Goal 1. Provide high quality mental health services that are accessible, available and responsive to the needs of individuals, families and communities, emphasizing community-based services.

Target: 1.3. Given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to hold steady the number of adults reporting positively about social connectedness.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services

Indicator: Percentage of adult clients reporting positively about social connectedness.

Measure: Numerator: Number of adult consumers reporting positively about social connectedness.
Denominator: Total number of adult consumer responses regarding social connectedness.

Source(s) of information: Compilation of statewide survey data and URS table 9.

Special issues: This performance indicator was not reported in previous Block Grant Applications due to an oversight. Actual data from SFYs 2007, 2008 and 2009 was obtained from the URS tables and was used to establish a goal for SFY 2010 which was included in a revision to the application for that year.

Significance: Client feedback regarding social connectedness is a major component of program evaluation and quality assurance efforts.

Action Plan: MHDS will limit the decrease in the percentage of adults reporting positively about social connectedness primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) coupled with the severe economic downturn in Nevada, the number of adults who report positively about social connectedness will most likely decrease in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adult – Improved Level of Functioning (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	60.57%	68.67%	65.68%	68.00%	N/A
Numerator	986	1,026	--	--	--
Denominator	1,628	1,494	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal:	1. Provide high quality mental health services that are accessible, available and responsive to the needs of individuals, families and communities, emphasizing community-based services.
Target:	1.4. Given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to hold steady the number of adults reporting an improved level of functioning to no more than 5%.
Population:	All adult clients, regardless of SMI status
Criterion:	1: Comprehensive Community-Based Mental Health Service System.
Indicator:	Percentage of adult clients competitively employed full or part-time compared to all adult clients excluding persons whose employment status was "Not Available".
Measure:	Numerator: Number of adult clients competitively employed full or part-time. Denominator: Number of adults competitively employed full or part-time (includes Supported Employment) plus number of persons unemployed plus number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops and other) excluding persons whose employment status was "Not Available".
Source(s) of information:	AVATAR and URS table 4
Special issues:	This performance indicator was not reported in previous Block Grant Applications due to an oversight. Actual data from SFYs 2007, 2008 and 2009 was obtained from the URS tables and was used to establish a goal for SFY 2010 which was submitted as a revision to that year's application.
Significance:	Increased/Retained employment is an important outcome measure related to the provision of a continuum of care.
Action Plan:	MHDS will limit the decrease in the number of adults competitively employed primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) coupled with the severe economic downturn in Nevada, the number of adults competitively employed will likely be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing

community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

State Performance Indicators

Name of Performance Indicator: Adults receiving service coordination

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2,769	2,481	2,675	2,500	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 3: Provide adults with a continuum of services that are tailored to their individual needs.

Target: 3.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adult clients receiving service coordination through MHDS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving service coordination to no more than 7%.

Population: All adult clients, regardless of SMI status

Criterion: 1: Comprehensive Community-Based Mental Health Service System.

Indicator: Adults receiving service coordination.

Measure: Number of adults, ages 18 and older, receiving service coordination as part of mental health services.

Source(s) of information: AVATAR

Special issues: DATA NOTE: This data includes an unduplicated count of clients only receiving service coordination and does not include those concurrently receiving other services. As MHDS continues to refine its data collection through the AVATAR system, the elimination of duplicate client counts and data cleaning both continue to result in data fluctuations across years. Additionally, the significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to

shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Service coordination (case management) is a primary community-based service that provides clients with a continuum of care.

Action Plan: MHDS will limit the decrease in the number of adults receiving service coordination primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) the number of adults receiving service coordination is likely to be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adults receiving outpatient counseling

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	7,579	7,212	7,495	7,120	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 5: Ensure that the service system promotes community-based services.

Target: 5.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adult clients receiving outpatient counseling through MHDS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving outpatient counseling to no more than 5%.

Population: All adult clients, regardless of SMI status

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Adults receiving outpatient counseling

Measure: Number of adults, ages 18 and older, receiving outpatient counseling.

Source(s) of information: AVATAR

Special issues: DATA NOTE: As MHDS continues to refine its data collection through the AVATAR system, the elimination of duplicate client counts and data cleaning both continue to result in data fluctuations across years. Additionally, the significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Providing community-based services is a primary goal of the block grant program.

Action Plan: MHDS will limit the decrease in the number of adults receiving outpatient counseling primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) the number of adults receiving outpatient counseling will almost certainly be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Name of Performance Indicator: Adults receiving medication treatment

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	18,211	19,497	20,018	19,017	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 5: Ensure that the service system promotes community-based services.

Target: 5.2: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adults receiving medication treatment through MHDS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving medication treatment to no more than 5%.

Population: All adult clients, regardless of SMI status

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Adults receiving medication treatment

Measure: Number of adults, ages 18 and older, receiving medication treatment

Source(s) of information: AVATAR

Special issues: DATA NOTE: As MHDS continues to refine its data collection through the AVATAR system, the elimination of duplicate client counts and data cleaning both continue to result in data fluctuations across years.

Significance: Providing community-based services is a primary goal of the block grant program.

Action Plan: MHDS will achieve this goal primarily through the implementation of services described under criterion one. In particular, reducing the cost per person served through improved caseload management, improved use of free medications and increasingly successful efforts at deflecting clients with Medicaid and Medicare Part D benefits to private pharmacies.

Name of Performance Indicator: Adults in rural areas receiving mental health services

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	5,234	4,753	4,812	4,571	N/A
Numerator	--	--	--	--	--
Denominator	--	--	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – MHDS

Goal: 6: Improve the delivery of mental health services to rural and homeless populations.

Target: 6.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of adults in rural areas who receive mental health services from community clinics. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of adults receiving mental health services from community clinics to no more than 5%.

Population: All adult clients, regardless of SMI status

Criterion:	4:Targeted Services to Rural and Homeless Populations
Indicator:	Adults receiving mental health services in rural areas.
Measure:	Number of adults, ages 18 and older, receiving services from Rural Clinics.
Source(s) of information:	AVATAR
Special issues:	DATA NOTE: As MHDS continues to refine its data collection through the AVATAR system, the elimination of duplicate client counts and data cleaning both continue to result in data fluctuations across years. Additionally, the significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.
Significance:	Nevada's population density is approximately 24 people per square mile, one of the ten lowest among the 50 states. Because of this, services to Nevada citizens who live in rural regions remain a critical and unique aspect of planning for Nevada's mental health system.
Action Plan:	MHDS will limit the decrease in the number of adults receiving mental health services through community clinics primarily through the implementation of services described under criterion one. Due to the significant reduction in available resources (both staffing and funding) the number of adults receiving mental health services through community clinics is likely to be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery. The MHDS strategic plan addresses how to maintain a core of services for those who are the most ill and have the fewest available resources and will look to replace high cost/low outcome services with low cost/high outcomes services.

Footnote to Adult Goals, Target and Action Plans

MHDS determined that several of the State Indicators were not meaningful and relevant indicators of the Division's effectiveness so they were deleted for SFY 2011. They were:
7.1 - Funding committed to Community Based Services (Percentage)
7.2 - Mental Health Expenditures Per Person (Rate)
7.3 - Mental Health Expenditures Per Capita (Rate)

State Indicator 6.2 (Adults who are Homeless Receiving Housing and Supportive Services) was also deleted because it is duplicative of NOM 3.4 (Increased Stability in Housing).

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 1: Comprehensive Community-based Mental Health Services

Establishment of System of Care

In 1991, the Nevada Legislature approved the creation of the new Division of Child and Family Services (DCFS), DHHS proposed consolidating services to children and families from the Divisions of Mental Health and Developmental Services (MHDS), Welfare, and Youth Services into a single, centralized division with the intent of providing a more integrated and seamless delivery system. DHHS divided the division into three major functional areas including mental health treatment, family support, and youth corrections.

DCFS currently provides services through three main systems:

1. Child welfare system
2. Juvenile justice system
3. Children's mental health service system

Children and adolescents who enter through any system have access to children's mental health services, which include some substance abuse services for those with co-occurring disorders. In this way, mental health is a cross-cutting service system that is linked to clients regardless of the system they enter.

Children with a severe emotional disturbance (SED) are identified through a strength-based, family-driven, culturally responsive, bio-psychosocial assessment process. Services are offered through State-operated, community-based mental health programs as well as private Behavior Health Community Networks for fee for services Medicaid recipients and HMO behavioral health providers for Medicaid HMO recipients. These services are provided primarily through the following agencies:

- Northern Nevada Child and Adolescent Services (NNCAS) in Washoe County
- Southern Nevada Child and Adolescent Services (SNCAS) in Clark County

DCFS regional mental health treatment services have the primary responsibility for providing services to children and adolescents with SED, independent of their service category status. For example, regionalized mental health treatment programs provide care for children with SED who enter the child welfare system and/or the juvenile justice system. In addition, these programs provide services to children with SED in parental custody through community-based programs in the major metropolitan areas of Reno and Las Vegas.

DCFS mental health services are managed by a statewide managers' team with parent members from both Washoe and Clark counties. Case coordination and treatment planning are done by

Child and Family Teams. Every effort is made to provide services that families require tailored to fit the individual needs of children and their families.

When children enter the system and have identified mental health needs, they have access to a continuum of mental health services including:

- Assessment
- Psychological evaluation
- Psychiatric assessment
- Medication management
- Therapies
- Clinical case management
- Non-residential rehabilitative services
- Residential rehabilitative services
- Inpatient residential treatment
- Inpatient acute psychiatric care

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 1: Comprehensive Community-based Mental Health Services

Available Services

Mental Health Services

Inpatient Programs

Desert Willow Treatment Center (DWTC): DWTC is a licensed 58-bed psychiatric hospital accredited by the Joint Commission that provides mental health treatment to children from throughout the state. The facility consists of two acute psychiatric units and three residential treatment units:

Acute Psychiatric Units – 20 beds	*Residential Treatment Units – 38 beds*
• One 12-bed unit for adolescents ages 14 through 17 years. • One eight-bed unit for children ages six through 14 years.	• Two 12-bed units for youth ages 12 through 17 years. • One 14-bed unit for males adjudicated on sexual offenses, ages 12 through 17 years.

These units provide psychiatric care to children and adolescents with severe emotional disturbances who require the highest levels of care, and represent the most restrictive service alternatives in the state. The children served here present risks to themselves and/or others in their community.

Residential treatment services provided by DWTC include:

- Psychological evaluation and consultation
- Psychiatric evaluation and medication management
- Clinical case management
- Individual, family, and group therapies and behavior management
- Special education through the Clark County School District
- Nutrition services
- Recreational therapy
- Nursing care
- Crisis intervention and stabilization

Community-Based Services – Treatment Homes and Outpatient Services

Treatment Group Homes: A community-based service which provides intensive strengths-based mental health rehabilitative services in a structured milieu for children and adolescents, ages six through 17 years. Child and Family Teams participate in the development of individualized treatment plans and services are integrated for each child with outpatient therapy, wraparound case management, psychological and psychiatric services. The need for out-of-home placement

treatment services is based on the intensity of need and must be authorized by Utilization Management vendors contracted by Nevada Medicaid. The following services are provided:

- Clinical case management
- Medication training and education
- Basic skills training
- Psychosocial educational model
- Psychosocial rehabilitation services
- Transportation
- Crisis intervention and stabilization
- Parent skills training
- School consultation

There are three State-operated treatment home programs for children and adolescents in Nevada:

1. NNCAS Family Learning Homes – Washoe County – five separate learning homes serving five youths within each home, ages 6 through 17 years
2. SNCAS Oasis Treatment Homes – Clark County – five separate treatment homes serving five to six youths each, ages 6 through 17 years; two are specialized for youth with dual diagnoses of severe emotional disturbance and developmental disabilities.
3. Adolescent Treatment Center (ACT) – Washoe County – ATC is a 16-bed residential program providing secure, 24-hour supervised treatment for youth ages 13 through 17 years. Additional services provided by ATC include:
    - Special education on site through the Washoe County School District
    - Nursing care

The two community-based service locations, Northern Nevada Child & Adolescent Services (NNCAS) in the north/Washoe County and Southern Nevada Child & Adolescent Services (SNCAS) in the south/Clark County, provide outpatient services through two primary programs:

1. **Early Childhood Mental Health Services**, targeting children ages birth through six years. The goal of these services is to strengthen parent-child relationships, support the family's capacity to care for their children, and to enhance the child's social and emotional functioning.
2. **Outpatient/Children's Clinical Services**, targeting children ages 6 through 17 years. These include community-based outpatient, individual and family-oriented mental health services.

Services within these programs include the following:

Early Childhood Services	***Outpatient/Children's Clinical Services***
• Psychological and functional behavioral assessments	• Individual, family, and group therapies and behavioral management
• Individual, family, and group therapies and behavioral management	• Psychological evaluation and functional behavioral assessments
• Psychiatric services	• Psychiatric services
• Day treatment	• Clinical case management

Early Childhood Services	*Outpatient/Children's Clinical Services*
• In-home crisis intervention • Childcare and pre-school consultation, outreach, and training • Clinical case management • 24-hour on-call emergency professional coverage	• Consultation with other stakeholders/providers • Walk-in crisis assessments • 24-hour on-call emergency professional coverage

DCFS services are designed to identify children and adolescents who have SED or at risk of having SED as early as possible, and provide services that enable youths to remain at home or in community-based care, whenever possible. Children at risk of out-of-home care and children discharging from out-of-home care are prioritized for services. Children and adolescents identified as having SED receive comprehensive assessment and treatment planning as well as linkages to other DCFS treatment service programs and intensive family services in an effort to preserve families and prevent out-of-home placement whenever possible.

Early Childhood Mental Health Services are devoted entirely to community-based treatment for children who have SED or at risk of having SED. The goal of Early Childhood Mental Health Services is to provide a range of early, intensive treatment services to the child and family in an effort to support their emotional well-being and prevent later, more costly (emotionally, socially and financially) out-of home care or institutionalization.

NNCAS Outpatient Services and SNCAS Children's Clinical Services are provided in office, home, and community settings. They address emotional and behavioral needs with the goal of successful functioning in the family and community.

For those children who cannot access private community psychiatric services, including those who are uninsured or have very specialized needs, psychiatric services are provided in DCFS community-based offices. These services include psychiatric evaluations and medication management provided by Child and Adolescent Psychiatrists.

Wraparound in Nevada (WIN) for Children and Families

WIN provides intensive targeted case management services to children with SED who are in the custody of public child welfare agencies. WIN provides families the opportunity to become equal participants in their case planning and receive the support necessary to gain familial independence. In addition to addressing mental health needs, WIN supports permanency goals for these youth through reunification with their families, guardianship with relatives, adoption or successful emancipation.

The WIN program uses a wraparound model of service delivery that emphasizes a strength-based, team decision-making, child focused, and family driven approach to service coordination.

Service Types Utilized

Basic Skills Training (BST): Services in this category are rehabilitative mental health interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients

acquire (learn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning and other training techniques. BST services teach recipients a variety of life skills. BST services may include the following interventions: basic living and self-care skills, social skills, communication skills, parental training, organization and time management skills, and transitional living skills. These services are provided in a variety of settings including community-based, clinic-based, and the home environment. This may be provided in a group or an individual setting.

Case Management: These services assist recipients in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Components of case management include assessment, care planning, referral/linkage and monitoring/follow-up.

Day Treatment Program: Day Treatment services are Rehabilitative Mental Health interventions designed to reduce emotional, cognitive, and behavioral problems and restore recipients to their highest level of functioning. Day Treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients with opportunities to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in safe settings. The goal of Day Treatment services is to prepare recipients for reintegration back into home and community based settings. Day treatment services are facility based and out of home services. Day Treatment includes, as part of its service package, a fluid combination of all the Rehabilitative Mental Health (RMH) Services.

Family-to-Family Support Services: These services are identified in the client's treatment plan and must be provided by a Family Supporter working collaboratively with the assigned case manager or the Child and Family Team. Family to Family support services may include: empathic personal encouragement, self-advocacy, self-direction training, and peer monitoring. These services can be provided individually or in a group setting.

Psychosocial Rehabilitation: Psychosocial Rehabilitation (PSR) services are Rehabilitative Mental Health interventions designed to reduce psychosocial dysfunction (i.e., interpersonal, emotional, cognitive, and behavioral development) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings. PSR services may include any combination of the following interventions: behavior management, social competency, problem identification and resolution, effective communication, moral reasoning, identity and emotional intimacy, self-sufficiency, life goals and sense of humor.

Crisis Intervention Services: Crisis Intervention (CI) services are Rehabilitative Mental Health interventions that target urgent situations where recipients are experiencing acute psychiatric and /or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions), and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning, and help prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric

emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit and electronically. CI services must include the following: immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization, a situational risk-of-harm assessment, and follow-up and de-briefing sessions to ensure stabilization, continuity of care and identification of referral resources for ongoing community mental and/or behavioral health services.

Access to Services

NNCAS recently integrated its Mill Street Center into its main service center in the Reno metropolitan area. This integration of services and staff into one location was done in response to budget cuts. This is a cost saving measure that will decrease utility and rent bills and provide on-site supervision to clinicians as the program manger position assigned to that office was also cut.

SNCAS continues to provide community-based services from five Neighborhood Family Service Centers located throughout the Las Vegas metropolitan area and serving the communities in which they are located. Partner agencies at these centers include county child welfare, county juvenile probation services, Division of Health early intervention developmental services, and private non-profit family support services. Each center collaborates with a Family Resource Center that serves the same geographic area. Community-based centers recruit diverse staff to meet the needs of their population and customize services to meet the unique cultural needs of their communities. Each center has collaborative work processes that support integrated services for children and families served across systems and agencies. The centers recruit diverse staff to meet the needs of their population and customize services to meet the unique cultural needs of their communities.

Cooperative Rural Services

MHDS continues to provide services to children and adolescents with SED who are in rural areas through the operation of its Rural Clinics system of mental health clinics and satellite offices. Complementing these, the DCFS Intensive Family Services program continues to provide assessment, crisis services, case management, and family preservation services to children in the child welfare system in rural communities. DCFS provides WIN wraparound care coordination services as well to children in child welfare custody in the rural communities. WIN staff are co-located with rural child welfare staff in these communities. DCFS rural child welfare and statewide children's mental health administrations work closely with MHDS to provide effective children's mental health services in the rural areas.

Flexible Funding

DCFS provides flexible funding to children and their families who are in DCFS community-based mental health services. These funds are used to purchase services that support the child's emotional health such as art classes, karate classes, and the purchase of psychotropic medications for the uninsured. These funds may also support the family's care of the child including emergency rent and transportation, to prevent removal of children from their home or to assist in the reunification of children with their nuclear or extended families.

Independent Living Services

Nevada's Independent Living Program (ILP) is a set of services available to all foster youth from the ages of 15½ through 21 years. DCFS considers all eligible foster youth to include those youth who are in the care and custody of the Division, WCDSS, CCDFS, and tribes. The Division considers foster care to be the legal status of the child, and the physical placement of the child does not determine the eligibility for independent living services. Independent living services may continue with the child after permanency has been achieved, depending on the needs of the child. Nevada also extends independent living services to eligible youth who have relocated to Nevada from another state.

The ILP relies on the community to provide an environment in which adolescents can function as productive and self-fulfilled young adults. Collaborative services are provided by community-based organizations, area schools, and other public and private youth-serving organizations. ILP staff provide transitional planning and collaborate with social workers and service providers in order to meet the needs of youth in the program. Youth are responsible for taking part in the development of their ILP plan.

DCFS provides ILP services within the three primary regions of the state. Each of the regions has the autonomy to develop services and programs that meet the specific needs of local youth. Key elements of ILP services include the following:

- Independent living skills education including finding housing, workforce preparation, money management, planning meals, obtaining transportation, finding health care resources, and seeking legal services.
- Self-sufficiency training including addressing physical, social, and emotional problems and stresses; understanding existing challenges that influence current situations and future independent living; forming growth-producing interpersonal relationships with family, peers, and others.
- Workshops that address values clarification, navigating the system, domestic violence, dating, and relationship issues.
- Informational expositions and resource guides that explain available resources in the community including culinary union training, banking, military services, scholarships, colleges, trade schools, computers, family planning, Americorps, Peace Corps, Job Corps, medical services for the uninsured, and counseling services.

DCFS, Washoe County, and Clark County can allow youth to apply for and receive a driver's license under Nevada Revised Statutes (NRS) Chapter 41. A number of youth have received driver's education, obtained licenses, and purchased vehicles before leaving care.

Federal independent living funding is provided to all County and State programs to provide independent living services, expand existing services, and to establish new services to eligible children. Federal funds are combined with existing State funds to provide independent living services to eligible foster youth and former foster youth transitioning to independence. The three major sources of funding include:

1. John H. Chafee Independence Program funds
2. Federal Educational Training Voucher (ETV) funds
3. State funds through the Assistance to Former Foster Youth Program

Employment Services

Support for education, training, and employment services is provided as part of the ILP program outlined above. Primary supports in this area include the following:

- GED training, transitioning to community college, employment referrals, job search assistance, and job counseling.
- Otto Huth Scholarship Program: This private funding source provides a four-year college scholarship opportunity to youth who age out of the foster care system that includes tuition, room, and board.
- Educational Training Vouchers: These are federal funds designated to assist foster youth with their post-secondary education plans. Youth successfully enrolled in the program prior to their 21st birthday can receive funding through the age of 23. This program augments existing ILP services for former foster youth in Nevada.

Regional ILP programs may provide funds for job training, education credits, school activities and events, graduation, travel, and deposits for living arrangements.

Housing Services

Placement prevention funding, which is part of the DCFS budget for CMHS block grant funds, serves to help stabilize families in crisis and prevent the placement of children and adolescents into substitute care. This funding may be used to help supplement mortgage, rental, and utility payments in order to assist families in maintaining their housing.

For youth transitioning out of foster care, funding assistance may be provided for housing expenses, those who are working but need short term support, and emergency help for unusual situations. Administration of housing funds is integrated with case management. Case management services include working to overcome obstacles in finding housing, employment with adequate income, and "shadowing" the search for affordable housing and other community resources.

DCFS coordinates with regional housing projects, the Department of Housing and Urban Development (HUD), and housing authorities to promote housing opportunities. In Clark County, HUD and the City of Las Vegas set aside a certain number of vouchers annually for young adults aging out of care.

Educational Services

For children in Desert Willow Treatment Center acute and residential treatment services, the Clark County School District provides onsite classroom instruction for students in grades K through 12. Students in residential treatment can work toward completing their high school diplomas. Children in acute treatment services are able to attend school but currently are unable to receive credit for the classes taken through the District. Children in the Oasis On-Campus and Family Learning treatment homes attend regular community schools or homebound programs as indicated by their Individualized Education Plan (IEP). For youth in the Adolescent Treatment

Center treatment home, onsite classroom instruction is provided by the Washoe County School District.

Substance Abuse Services

As noted above, children and adolescents who enter through any system of care – child welfare, juvenile justice, or children's mental health – have access to children's mental health services, which include substance abuse services for those with co-occurring disorders.

When a child enters the child welfare system through DCFS, Washoe County, or Clark County and they are assessed and determined to be in need of mental health services, they become Medicaid eligible for fee-for-service benefits. This eligibility allows for access to inpatient or outpatient mental health services, which may be provided by DCFS or a Medicaid-enrolled provider. Through MHDS, the Substance Abuse Prevention and Treatment Agency funds community-based private substance abuse providers. These providers collaborate on service delivery when a youth is also served by another system.

In the rural region, services are provided in cooperation with MHDS through its Rural Clinics system. Rural Clinics coordinates with social service agencies to receive referrals to the system of community mental health clinics to schedule services. Rural Clinics has entered into a collaborative relationship with the Substance Abuse Prevention and Treatment Agency (SAPTA), now a part of MHDS, so that substance abuse services are made available for clients with co-occurring disorders in certain Rural Clinics offices, including remote areas such as Pahrump, Mesquite, Laughlin, Battle Mountain, Ely, and Hawthorne.

Through the juvenile justice system, the Youth Parole Bureau assigns Mental Health Counselors to youths at the time of their commitment to a correction facility, community-based service, or an out-of-state program. Clinicians work with youth and with other professional staff in identifying and implementing an appropriate treatment plan, which can include an array of mental health services. Mental Health Counselors provide assessments of all parole youth to screen and identify those who have SED and require treatment. Mental Health Counselors also work in each of the three juvenile justice facilities. General assessment, specialized assessment, treatment plan development, and referral for services through the juvenile justice system <u>all</u> include addressing co-occurring substance abuse disorders.

Through the children's mental health system, substance abuse services are provided by DCFS in Washoe and Clark Counties through linkages with community providers. Rural substance abuse services are provided by MHDS through Rural Clinics as described above. Residential and outpatient treatment for substance abuse and chemical dependency is provided by the private sector via contract with SAPTA and/or Nevada Medicaid. SAPTA provides Nevada's major funding to the nonprofit sector for prevention, outpatient, and residential treatment for substance abuse and chemical dependency. Nevada Medicaid covers inpatient substance abuse treatment for recipients.

<u>Title IV-B: Promoting Safe and Stable Families</u>

The primary goals of the Title IV-B, Subpart 2, Promoting Safe and Stable Families (PSSF) programs are to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by

reuniting them with their parents, by adoption, or by another permanent living arrangement. The programs include five areas of support:

1. Family support
2. Family preservation
3. Time-limited family reunification
4. Adoption promotion and support services
5. Family assessment services in the rural regions

Time-limited family reunification includes services and activities provided to children removed from their homes and placed in foster care or other residential settings. These services are intended to help parents and primary caregivers reunify with their children within a 15-month period and include the following:

1. Individual, group, and family counseling
2. Inpatient residential or outpatient substance abuse treatment services
3. Mental health services
4. Assistance to address domestic violence

Inpatient residential and outpatient substance abuse treatment services are provided through a network of community-based providers who competitively seek grant funding through this program for up to a 30-month period. Current providers offer time-limited family reunification services in the three main regions of the state as follows:

- North (Washoe County): Family Counseling Services of Northern Nevada
- South (Clark County): Bridge Counseling Associates
- Rural (Elko region): Hawthorne Family Resource Center, DCFS Rural Region Offices

The most recent PSSF program funding cycle began on July 1, 2007. This is a three-year funding cycle set to end on June 30, 2010.

Child and Adolescent State Infrastructure Grant (CA-SIG)

As discussed throughout this application, the NCBHC has become the over-arching statewide group that oversees transformation efforts for children's behavioral health. In order to facilitate planning for youths with co-occurring mental health and substance abuse disorders, representatives from the Substance Abuse Prevention and Treatment Agency (SAPTA) and community-based substance abuse providers were included in the membership of the NCBHC and its workgroups. Representatives from SAPTA also participate in the bi-monthly CA-SIG team meetings on a regular basis.

Additionally, under goal four of the Child and Adolescent CA- SIG, a workforce development plan was completed in January, 2007, that focuses on training and professional development for staff in evidence-based and science-based practices. In SFY 2008, the University of Nevada, Las Vegas (UNLV) completed phase I of the Workforce Development and Cultural Competency Needs Assessment that included an assessment of organizational readiness for evidence-based practices and an assessment of cultural competency strengths and needs. In order to ensure that the Workforce Development Plan includes strategies to improve services to youths with co-occurring disorders, DCFS developed the CA-SIG team in order to develop a training plan and informational educational dissemination plan. In SFY 08-09, trainings in evidence-based and

science-based instruments and interventions funded by this grant and the CMHS Block Grant were provided to DCFS, SAPTA, MHDS and partner agency staff to include DC: 0-3, CAFAS, CASII, TF-CBT- Phase I and Phase II, PCIT, Nevada's System of Care Statewide Training Initiative, and Motivational Interviewing. A Training of the Training component was incorporated in all trainings where the national trainers offered it. The State strategically initiated these efforts in order to sustain implementation and continue inter-agency training for new and existing staff. The no cost extension of this grant has funded the development of 10 year strategic plans by the three regional Children's Mental Health consortia, a state plan by the Commission on MHDS and technical consultation on the creation of a Bill Draft Request (BDR) to change statutes related to children's mental health as recommended in the state plan as well as an implementation plan for the state plan.

Medical and Dental Services

Medical and dental services for children not insured under private providers are obtainable through Title XIX Medicaid or the Nevada Check Up program, which is described in Section I under the *State Children's Health Insurance Program (SCHIP)* narrative. Some of the health services provided through these programs include inpatient and outpatient hospital care, mental health, dental and vision services, immunizations, Well Baby/Well Child programs, prescription drugs, laboratory services, and home health care.

Services Provided Under Individuals with Disabilities Education Act (IDEA)

The special education programs in Nevada are administered by the Department of Education (DOE). Local school districts, as direct service providers, serve students with diagnosed disabilities in a variety of areas pursuant to Nevada Revised Statute (NRS) 388, which includes serious emotional handicap (SEH). Eligibility for special education services is established through conducting a series of assessments, evaluating the results, and determining whether the student meets the criteria established in the Nevada Administrative Code (NAC) for each of the eligibility categories. Parents, teachers, school psychologists, and other specialists comprise the teams that make eligibility decisions.

According to law, special education means "specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability." Instruction can be provided in a variety of locations both inside and outside the general education classroom. Regardless of the location, the program must be provided in accordance with an annual IEP developed jointly by educators and parents. The law requires that students with disabilities be served in the "least restrictive environment," which means that removal of the student from the regular education environment must be based on the student's unique needs and justified through the IEP process.

Students with disabilities are entitled to receive related services if those services are necessary to enable the student to benefit from special education. Related services in the law means "transportation, and such developmental, corrective, and other supportive services as required to assist a child with a disability to benefit from special education." These supportive services include psychological services and counseling services, including rehabilitation counseling. The term also includes school health services, social work services in schools, and parent counseling and training.

Federal funding through the Individuals with Disabilities Education Act (IDEA) is available for supplementing the student's special education costs. Federal support for special education is generated on a census-based formula. Special education programs receive a combination of state, local, and federal revenue.

Support Services and Programs for Special Populations

Juvenile Justice Services: These services include Youth Parole Bureau and Youth Correctional Facilities. The Youth Parole Bureau assigns Mental Health Counselors to youths, ages 12 to 21 years, at the time of their commitment to a correction facility, community-based service, or an out-of-state program. Counselors work with youths and with other professional staff to identify and implement an appropriate treatment plan, which can include an array of mental health services. Mental Health Counselors provide assessments of all parole youth to screen and identify those who have SED and/or require treatment.

Youth Correctional Facilities is an additional operating unit of DCFS. The three correctional facilities include the following:

1. Nevada Youth Training Center (NYTC)
2. Caliente Youth Training Center (Caliente)
3. Summit View Center for the Serious and Chronic Offender (Summit View)

First time offenders are typically sent to NYTC or Caliente, whereas serious and chronic male offenders go to Summit View, which is a high security facility. These facilities provide direct services to youth adjudicated as delinquent. Generally, youth who are committed for care are placed in one of the centers for an average of six to nine months. Upon successful completion of the programming in the facility, the youth are released back into the community with supervision and case management services provided by the Youth Parole Bureau. Youth committed for mental health treatment are placed directly on parole and receive treatment and case management services based on their identified needs.

DCFS involves committed juvenile offenders in a specialized assessment process. During the time these offenders are in County detention awaiting State correctional disposition, Mental Health Counselors provide pre-emptive social, correctional, and mental health evaluations as well as therapeutic intervention services where indicated to the offenders and/or to their families.

Juveniles identified to be in need of ongoing mental health services will be provided these services upon reaching their designated correctional facilities. Each facility has mental health staff that provide assessment and treatment services in the facilities. Other juveniles might be diverted from traditional correctional placement and recommended for mental health treatment in alternative settings such as transitional community reintegration programs or community parole with required offender/family therapy. A goal of this program is to identify and treat the mental health service needs of adolescents with SED in the juvenile corrections system while protecting the community's need for safety and security.

Upon discharge from correctional facilities, youth with SED may be referred for mental health care in the community. DCFS mental health programs serve as providers for many of these youth.

Child Welfare Services: These services include child protective services, foster care services, adoption services, and foster home licensing. The counties of Washoe and Clark provide child welfare services within their jurisdictions and DCFS provides child welfare services to all rural counties. All three child welfare agencies have mental health staff that provide child and family assessments and family preservation services. Children who display indicators of mental health needs are assessed as they come into custody. Children identified as needing mental health services are referred for services to DCFS in Washoe and Clark Counties and to Rural Clinics in the rural counties. Children within the child welfare system access the full array of mental health services to include assessments, therapies, clinical case management, residential care, and both non-residential and residential contracted services.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

SED Definition

The term SED is an abbreviation for *serious emotional disturbance* and is defined in the Nevada Administrative Code (NAC) 433.040 as follows:

> "Child with a serious emotional disturbance" means a person who is less than 18 years old and has been diagnosed within the immediately preceding 12 months as having a mental, behavioral or emotional disorder as defined in the "Diagnostic and Statistical Manual of Mental Disorders," as adopted by reference in NAC 433.050 other than a mental disorder designated as a Code V disorder in the Manual, a developmental disorder or a disorder caused by an abuse of alcohol or drugs, which substantially interferes with or limits the child from developing social, behavioral, cognitive, communicative or adaptive skills or his activities relating to family, school or community. The term does not include a child with a disorder which is temporary or is an expected response to stressful events.

DCFS has expanded upon this definition for utilitarian purposes as follows:

> Children with a serious emotional disturbance are persons:
> a) from birth up to age 18,
> b) who currently or at any time during the past year (continuous 12-month period),
> c) have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV,
> d) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
> e) These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.
> f) Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skill. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment

criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

It is noteworthy that Medicaid added the Manual for Diagnostic Classification: 0-3 published by the National Center for Clinical Infant Programs. The principal Axis I diagnosis or the Axis II PIR-GAS score of 40 or less provide the clinical basis for treatment and must be reassessed every 6 months for children under age 4. The DC: 0-3 diagnosis may be used in place of the DSM Axis I diagnosis to determine eligibility and provide mental health services to recipients under 4 years of age.

Estimation Methodology

In recent block grant applications, Nevada's estimate of the prevalence of SMI relied on a prevalence study conducted in 2004 specifically for Nevada for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) based on a national prevalence model developed by Charles Holzer, M.D., from the University of Texas. However, because of the impact of the recent economic distress in Nevada, the method for estimating the prevalence of SMI for this year's application is based on the CMHS/SAMHSA Adult SMI and Child SED rates taking into account the State poverty level relative to other states. Using the United States Census Bureau's estimated population of children for SFY 2009, the following table shows the estimated population of children with SED.

Estimate of Nevada's Child Population 0-17	% of Children in Poverty	State Tier for % in Poverty	Children with SED at 5% of Population	Children with SED at 6% of Population	Children with SED at 7% of Population
691,821	14.5%	Mid	34,591	41,509	48,427

Clients Served

Data for all clients served during SFY 2010 is as follows:

Agency	*SFY 2010 Total Served*	*Percent*
NNCAS	692	15.6%
SNCAS	1,938	43.6%
WIN	758	17.0%
MHDS Rural Clinics	1,058	23.8%
TOTAL:	4,446	100%

DATA NOTE: Total clients served by region in criterion two is greater than the total clients served reported in Section III under NOMS indicator 4.1, because clients are duplicated between the WIN program and services in the northern and southern regions. For example, children who receive services initially through WIN may also receive treatment services in one of the urban areas at NNCAS or SNCAS. Similarly, children served by WIN in the rural region may also receive treatment from Rural Clinics.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 2: Mental Health System Data Epidemiology

Quantitative Targets

Quantitative targets for the provision of services as described under criterion one are included under the National Outcome Measures (NOMS) indicator 4.1 for criterion two.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 3: Children Services

System of Integrated Services

PLEASE NOTE:

- A detailed description of children's services is provided in the narrative for criterion one of the Children's Plan.
- Children's services for the rural areas are addressed in criterion one of the Adult Plan, because they are provided in these areas through a collaboration with the Division of Mental Health and Developmental Services (MHDS).
- Special topics are discussed here in order to meet the requirements of the application guidelines and to highlight key programs for children's mental health.

Access to Services

As noted in criterion one, the Division of Child and Family Services (DCFS) provides services through three main systems:

1. Child welfare system
2. Juvenile justice system
3. Children's mental health service system

Children and adolescents who enter through any system have access to children's mental health services, which include some substance abuse treatment services for those with co-occurring disorders. In this way, mental health is a cross-cutting service system that is linked to clients regardless of the system they enter.

Social Services

Under Nevada Revised Statute (NRS) 432B.325, the law requires that counties in which the "population is 100,000 or more shall provide protective services for the children in that county and pay the cost of all those services." In Nevada there are two counties that meet this criterion: Washoe County in northern Nevada and Clark County in southern Nevada. As a result, there are three separate agencies that provide child welfare and child protective services (CPS):

1. State of Nevada Division of Child and Family Services (DCFS)
2. Washoe County Department of Social Services (WCDSS)
3. Clark County Department of Family Services (CCDFS)

Subsequent to the integration of child welfare services within Washoe and Clark Counties, DCFS became responsible for oversight of county-administered child welfare services.

Currently, when a child is placed out of their family home through the child welfare system they become Medicaid eligible. This eligibility allows for access to inpatient or outpatient mental health services, which may be provided by DCFS or a Medicaid enrolled provider. If higher levels of residential care are required for children placed in foster care settings, DCFS and private providers provide these services in cooperation with Medicaid.

In the rural region, Rural Clinics (an agency within MHDS) coordinates with social service agencies to receive referrals to the system of community mental health clinics to schedule services. Children with SED who are in emergency situations are seen immediately. Rural Clinics staff members participate in multi-disciplinary team (MDT) meetings with social service providers on a regular basis. In return, social service providers participate in Rural Clinics stakeholders meetings. Staff members regularly collaborate with child protective services (CPS), schools, and any active service provider for the treatment of children.

Transition to Adult Mental Health Services

DCFS and MHDS have entered into a Memorandum of Understanding (MOU) designed to facilitate the transition from child to adult mental health services. The primary purposes of the MOU are to provide the best service possible to clients within the State system, allow for a smooth transition between service systems, and reduce duplication of effort. This MOU is based on the following principles of service provision for consumers:

1. Recognize that both MHDS and DCFS have responsibilities to the individuals and families being served and, as such, shall cooperate with one another to assure quality services are provided.
2. Recognize that the seamless transition between Divisions is essential for continuity of care and relapse prevention.
3. Recognize that time is of the essence to adequately serve the individual and satisfy requirements of the law and courts.
4. Work together to formulate and support a plan for children and youth with a dual diagnosis.
5. Work cooperatively in developing treatment strategies and services for children and youth with eligible conditions of mental retardation, conditions related to mental retardation, and/or Serious Emotional Disturbances (SED), referred to as dual diagnosis.
6. Recognize that both agencies have the responsibility for referrals, support and placements of children and youth with a dual diagnosis.
7. Recognize that children and youth with a dual diagnosis are eligible for all services available to any child in Nevada. MHDS will augment those services with specialized supports that may be needed.
8. Recognize that children and youth should be served in Nevada, and both agencies must work cooperatively to develop services in Nevada for children and youth with a dual diagnosis.
9. Recognize there are budget and staffing limitations for each Division.
10. Recognize the agency eligibility requirements to qualify individuals for services through MHDS and DCFS.
11. Share written admission/discharge criteria, case priorities, and appeal processes for services for both Divisions and ensure staff are trained in and follow this MHDS-DCFS MOU.

Relative to youth in need of ongoing mental health services who are approaching age eighteen, the MOU contains specific protocols and procedures as follows:

1. Referrals for youth in need of ongoing mental health services must be made by DCFS to MHDS at least 90 days prior to client's 18th birth date.
2. DCFS will provide to MHDS the most recent psychological information, medical history, social history and any other reports or information to assist with transition planning to adult services.
3. MHDS will work with the child's/youth's guardian/custodian to apply for benefits such as Medicaid, Social Security etc. that the child/youth may be eligible for. MHDS will assess the referrals from DCFS and determine type and level of services needed. The intake worker shall provide a preliminary assessment of eligibility within fifteen (15) business days of receipt of all of the required information.
4. Adolescents who present to DCFS for services who are between 17 years and 9 months and 18 years of age shall be jointly staffed by both MHDS and DCFS.
5. DCFS and MHDS will work together to incorporate transition steps to adult services in the case plan.
6. Both MHDS and DCFS will participate in Child and Family Teams to facilitate coordination of services within 30 business days of the person's 18th birthday.
7. MHDS will arrange for services to begin within one week following the person's 18th birthday.
8. MHDS and DCFS will work cooperatively in the development of providers who can provide services to youth transitioning to MHDS services.

The most recent MOU went into effect in August, 2006.

PLEASE NOTE:
Because children's services are provided by a separate agency in Nevada, as explained in Section I, a detailed description of children's services is provided in the narrative for criterion one of the Children's Plan. The following topic areas required in criterion three are already covered elsewhere in the grant application, as noted below.

Requested Topic Area:	***Covered By:***
Educational Services	Criterion one under *Educational Services*.
Services Provided Under Individuals with Disabilities Education Act (IDEA)	Criterion one under *Services Provided Under Individuals with Disabilities Education Act (IDEA)*.
Juvenile Justice Services	Criterion one under *Support Services and Programs for Special Populations*.
Substance Abuse Services	Criterion one under *Substance Abuse Services*.
Health and Mental Health Services	A brief overview of health services is provided in criterion one under *Medical and Dental Services*. All mental health services are described in detail throughout criterion one.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 3: Children Services

Geographic Area Definition

State of Nevada DCFS: All counties except Washoe and Clark (in gold)
Washoe County Department of Social Services (WCDSS): Washoe (in blue)
Clark County Department of Family Services (CCDFS): Clark (in pink)

Under Nevada Revised Statute (NRS) 432B.325, the law requires that counties in which the "population is 100,000 or more shall provide protective services for the children in that county and pay the cost of all those services." In Nevada there are two counties that meet this criterion: Washoe County in northern Nevada and Clark County in southern Nevada. As a result, there are three separate agencies that provide child welfare and child protective services (CPS):

1. State of Nevada Division of Child and Family Services (DCFS)
2. Washoe County Department of Social Services (WCDSS)
3. Clark County Department of Family Services (CCDFS)

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

Outreach to Homeless

Children who are identified as being at risk for or having a severe emotional disturbance who are also homeless or at risk of becoming homeless are often referred to DCFS Children's Mental Health Services.

DCFS Children's Mental Health uses the following descriptive categories to identify children and their families who are homeless or at risk of becoming homeless.[22]

A) share the housing of other persons due to loss of housing, economic hardship, or a similar reason (sometimes referred to as *doubled-up*)
B) live in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
C) live in emergency or transitional shelters
D) are abandoned in hospitals
E) await foster care placement (and presumably are in temporary sheltering)
F) have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings
G) live in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings
H) are migratory children and qualify as homeless because they are living in circumstances described above

DCFS Children's Mental Health have available placement prevention and flex funds for children and their families to pay for rent, utilities, food, medicine, etc. These funds can be used to prevent a family from becoming homeless and they can be used to obtain housing for a family who is homeless. During SFY 2010, 217 children who were homeless or at risk of homelessness were served through Northern Nevada Child and Adolescent Services (NNCAS) and Southern Nevada Child and Adolescent Services (SNCAS).

[22] Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act (Title X, Part C, of the No Child Left Behind Act, January 2002)

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 4: Targeted Services to Rural and Homeless, and Older Adult Populations

Rural Area Services

Targeted services to rural populations are described in detail under criterion one of the adult plan and criteria one and three of the children's plan.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Resources for Providers

The SFY 2011 legislatively approved budget for the Division of Child and Family Services is summarized below.

Item	*Amount*
Children's mental health services	35,147,154
Child welfare	119,600,694
Juvenile justice services	37,852,630
Administration and other programs	29,389,473
SFY 2011 Legislature-approved budget:	$221,989,951

Staffing Overview

For SFY 2011, the regional budgets for the delivery of mental health services and the number of positions funded are listed below:

Region	*SFY 2011 Budget*	*Mental Health Positions**
North: NNCAS	7,524,327	90
South: SNCAS	23,051,937	264
Rural: Child welfare mental health services	5,315,441	12
Statewide: Juvenile mental health services	1,137,724	19
Statewide: Wraparound in Nevada (WIN)	4,570,890	66
TOTAL:	$41,600,619	451

*Rounded to the nearest whole number.

Staffing with Block Grant Funds

Currently, the bulk of CMHS funds are utilized to provide community-based direct service staff in the northern and southern regions along with respite care services. Staff and other grant expenditures are summarized as follows:

NNCAS: CMHS funds support salaries for outpatient program staff as follows:

Position:	*Percentage of FTE:*
Clinical Program Manger II	50%

Position:	***Percentage of FTE:***
Clinical Program Manager I	50%
Psychiatric Caseworker II	50%
Psychiatric Caseworker II	50%
Psychiatric Caseworker II	50%
Administrative Assistant III	50%
Administrative Assistant II	50%
Administrative Assistant II	50%
Clinical Program Manager II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%
Clinical Social Worker II	25%
Mental Health Counselor II	25%
Mental Health Counselor II	25%

Additional expenditures for direct clinical services include a half-time psychiatric nurse, psychiatric consultation fees, funding for the Psychiatric Fellowship Program, and psychological and neuropsychological evaluations. Additional funds offset the cost of prescription drugs for children with SED, and offset operating expenses for the outpatient staff.

Northern region respite care and placement prevention: CMHS funds support contract services that provide interim respite care for children with SED or families at risk of entering higher levels of care within the mental health system.

SNCAS: CMHS funds support salaries for children's clinical services program staff as follows:

Position:	***Percentage of FTE:***
Licensed Psychologist I	25%
Clinical Program Manager I	50%
Mental Health Counselor III	50%
Administrative Assistant II	50%
Clinical Program Manager I	50%
Clinical Program Planner I	50%
Administrative Assistant III	50%
Psychiatric Caseworker II	50%
Administrative Assistant III	50%
Administrative Assistant II	50%
Administrative Assistant II	50%
Licensed Psychologist I	25%
Administrative Assistant II	50%
Administrative Assistant II	50%

Position:	*Percentage of FTE:*
Psychiatric Caseworker II	50%
Psychiatric Caseworker II	50%
Psychiatric Caseworker II	50%
Psychiatric Nurse II	50%
Administrative Assistant II	50%
Psychiatric Caseworker II	50%
Clinical Program Manager II	50%
Administrative Assistant IV	50%
Clinical Program Manager I	50%

Southern region respite care and placement prevention: CMHS funds support contract services that provide interim respite care for children with SED or families at risk of entering higher levels of care within the mental health system.

Children's Mental Health Planning and Evaluation Unit Manager: This position is responsible for developing and coordinating performance and quality improvement for children's mental health services provided by DCFS as well as community providers.

Administrative Assistant for Planning and Evaluation Unit (PEU): This position provides administrative support to the PEU.

Clinical Program Planner/Grants Manager: This position is responsible for program planning, evaluation and grants management under the PEU for DCFS Children's Mental Health programs.

Placement prevention funds: These CMHS funds help augment mental health services for children within the child welfare system, including medications, medical assessments, and time-limited mental health services designed to keep children and adolescents within their family unit.

Nevada PEP sub grant for System of Care support: Funding here includes a sub grant to Nevada PEP to strengthen the service delivery system infrastructure to ensure effective family-driven mental health services in Nevada for children with SED and their families. This includes collection of outcome data on program activities that empower families to help themselves through effective system advocacy and transformation of mental health services toward a family-centered and family-driven service delivery system.

Mental Health Training and Consultation: CMHS funds support staff training and consultation as described below.

Commission on Mental Health and Developmental Services and Mental Health Consortia: CMHS funds support travel and administrative costs for the Commission on Mental Health and Developmental Services and the three regional Mental Health Consortia, whose work is, described in Section I under *Overview of Mental Health System*.

Training Provided to Mental Health Providers

DCFS utilizes the resources of the Nevada Department of Personnel and the Risk Management Division to provide training required of all State employees as described in Part C., Section III,

Criterion 5, Resources for Providers of the Adult Plan. In addition, DCFS recently provided the following mental health service provider training:

Nevada's System of Care Training Initiative
The DCFS)sponsored an initial System of Care training in October 2008 that included a training of trainers. System of care expert Sheila Pires trained people from across the state and across agencies and organizations to include Nevada PEP, the family advocacy organization. System of care trainers have created the Nevada system of care training curriculum and will sustain the training efforts statewide.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
This evidence-based practice was initiated in May 2008 with training of supervisors. Participants applied the model with children while receiving coaching from the model developers for over a year. In January 2009, direct clinical staff was trained on TF-CBT and received intensive coaching by the developers as they learned to apply the model. Coaching ended in August 2009. Clinical supervisors and direct service providers trained in TF-CBT were DCFS, MHDS and community providers from across the state. Supervisors trained in TF-CBT provide individual training and coaching to their staff.

Motivational Interviewing (MI) Training Initiative
Through collaboration efforts with The University of Nevada Reno- Center for the Application of Substance Abuse Technologies (CASAT), DCFS provided training on MI. Both public and private providers of mental health and substance abuse treatment were sponsored.

Parent Child Interaction Therapy (PCIT)
DCFS provided PCIT training to staff throughout the state and completely set up a total of 5 PCIT clinical therapy rooms statewide. Training of trainers continues for selected Early Childhood Mental Health staff members. PCIT is an early childhood evidence-based practice model for very young children and their parents or caregivers.

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)
DC: 0-3 training was provided to staff statewide that included a training of trainers. DCFS now has a cadre of DC: 0-3 trainers to provide training to DCFS staff and community providers who work with infants and very young children.

Early Childhood Service Intensity (ECSII)
ECSII training was provided by the developer of the instrument. The ECSII is analogous to the CASII for use with children ages 0-5 years. The ECSII was developed to assist providers and others caring for young children in determining intensity of services need for infants, toddlers, and children.

Child and Adolescent Service Intensity Instrument (CASII)
The CASII is used as a common framework for making decisions on the level of service intensity for children and adolescents ages 6-18 years. DCFS staff provides CASII training on an ongoing basis to DCFS staff and community providers.

Child and Adolescent Functional Assessment Scale (CAFAS)
The CAFAS measures impairment in day-to-day functioning in children and adolescents who have, or are at risk for, emotional, behavioral, substance abuse, psychiatric, or psychological problems. DCFS clinicians must take and pass the class to become a CAFAS reliable rater. Clinicians must participate in a CAFAS refresher course to maintain reliability every two years.

Crisis Response Training
DCFS clinicians participated in a Crisis Response Training provided though the Office of Suicide Prevention. This training assisted in preparing clinicians for being on-call for client emergencies.

Leadership Training
DCFS Provided in Collaboration with the University of Nevada Reno a course to discuss roles in leadership, effective followership and leadership, the leader's and follower's role in change, and shared group responsibility. The class was facilitated by Dr. Bret Simmons, to DCFS managers and supervisors statewide.

Aggression Replacement Training (ART)
DCFS ART trainers provided training in this promising practice to the DCFS residential program staff statewide. In addition, NNACAS staff trainers provided booster training and cohort implementation in the Southern Region.

Wraparound
The Wraparound in Nevada program provides ongoing training and coaching to the wraparound model for staff. Training in specific aspects of the wraparound model is provided to ensure fidelity.

Cardiopulmonary Resuscitation (CPR) Training and Recertification
DCFS Clinicians and staff are required to be CPR certified. DCFS provided CPR certification/recertification to those employees statewide who were not currently certified and offered recertification to those employees who needed recertification.

Car Seat- Child Passenger Safety (CPS) Certification
Child Passenger Safety Certification is required for Early Childhood Specialists. DCFS provided this training to all Early Childhood Specialists in the Southern Region by utilizing Safe Kids Clark County to conduct the trainings.

1-2-3 Magic Effective Discipline for Children 2-12 DVD Training Videos
DCFS purchased this DVD video series to be shown as a training tool while families are waiting for their appointments in the waiting room.

Floor Time DVD Training Videos (set 1-3)
DCFS purchased this DVD video series to be shown as a training tool while families are waiting for their appointments in the waiting room.

Mandatory Therapeutic Intervention Courses for Mental Health Technicians
DCFS requires Mental Health Technicians to progress through the Mental Health Technicians training courses offered through Truckee Meadows Community College. DCFS continues to support this effort for existing staff and new hires into this classification.

Netsmart Fiscal Training Initiative
DCFS and Netsmart entered into an agreement to provide DCFS identified fiscal staff with onsite billing training to include setting up guarantors, client ledgers, types of services, reading 837s and 835s, aging reports, rebilling claims and adjustments, 3rd party liability and Medicaid.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Emergency Service Provider Training

The Crisis Intervention Team (CIT) and Peace Officers Standards and Training (POST) approach described in the Adult Plan under criterion five address both adults and children with mental illness who may be encountered in an emergency situation.

DCFS has participated in CIT training in Clark County to educate law enforcement on children's mental health issues. The DCFS training emphasizes the differential response to children and their families. DCFS is available to participate in CIT training throughout the state.

In addition, DCFS has received training on suicide prevention and awareness through the Office of Suicide Prevention, Department of Health and Human Services. This training was directed toward clinicians who are on standby to assist clients in emergency situations. DCFS provides crisis intervention for its clients after hours and on weekends.

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 5: Management Systems

Grant Expenditure Manner

Since the CMHS block grant was changed to a two-year award, MHDS has shifted the expenditure of grant funds ahead by one fiscal year, thereby matching the current federal fiscal year award to the budget for the following State fiscal year. Therefore, the revised expenditure plan reflects budgeted expenditures for SFY 2011, based on funds from FFY 2010. This meets the requirement for a flat budget projection across the next fiscal year covered in this plan as outlined in the grant guidelines under *Fiscal Planning Assumptions*. Given the flat budget projection, MHDS will continue with the funding priorities similar to those outlined in Section I under *Previous State Plan Priorities and Accomplishments*.

Based on the above, MHDS has planned expenditures of CMHS Block Grant funds in SFY 2011 based on the current FFY 2010 amount of $3,678,154 as follows. DCFS expenditures are highlighted in grey. The entire expenditure plan is included for reference:

MHPAC	***Amount***
Council operation and administration (administrative expenses)	140,848
Providing administrative support to the Commission on Mental Health and Developmental Services (NCMHDS) designed to strengthen the operation of the Commission and improve collaboration with the MHPAC.	48,620
Council travel to quarterly meetings and the rural monitoring project.	13,061
MHPAC TOTAL for SFY 2011:	$202,529

MHDS	***Amount***
Northern Nevada Adult Mental Health Services (NNAMHS): Staff including a Substance Abuse Counselor, Psychiatric Case Workers on the PACT Team, and Consumer Service Assistants.	249,693
Southern Nevada Adult Mental Health Services (SNAMHS): Staff including a Clinical Social Worker on the PACT Team and Consumer Service Assistants.	196,843
Rural Mental Health Clinics (RC): Staff including Psychologists, Psychiatric Nurses, Clinical Social Workers and Consumer Service Assistants.	649,750

Planning and Evaluation Unit: Staff including Statewide Residential Supports Coordinator and Quality Assurance Investigators.	460,201
Innovative Projects: Support for MHDS Investigations, Quality Assurance and Fiscal units, Annual WICHE dues, PASR activities and staff training initiatives.	120,758
MHDS TOTAL for SFY 2011:	$1,677,245

DCFS	***Amount***
Northern Nevada Child and Adolescent Services (NNCAS): Staff including mental health counselors, psychiatric case workers, a psychologist, a clinical social worker, clinical program managers and administrative assistants providing outpatient treatment and administering the SED drug program	410,221
Northern region placement prevention for children with SED at NNCAS	35,681
Southern Nevada Child and Adolescent Services (SNCAS): Staff providing community-based direct services including licensed psychologists, a mental health counselor, psychiatric case workers, a psychiatric nurse clinical program managers and administrative assistants.	632,944
Southern region respite care and placement prevention	53,903
Statewide Planning and Evaluation Unit (PEU) Manager to coordinate needs assessments, and program improvements.	99,546
Clinical Program Planner and Grants Manager responsible for leadership for children's mental health policies and being a liaison between programs and stakeholders.	118,436
Administrative Assistant for the PEU.	53,408
Direct clinical services including a half time Psychiatric nurse, UNSOM psychiatric fellowship program and psychiatric evaluations.	110,148
PEU assessment and support activities including the Children's Mental Health Consortia annual report and updates.	40,000

Commission on Mental Health and Developmental Services administrative support.	5,000
Placement prevention funds to augment mental health services for children in the child welfare system.	26,000
Nevada PEP sub-grant for System of Care Support including collection of outcome data.	150,000
Children's Mental Health System Transformation Plan and Infrastructure Development.	31,000
Staff training and consultation on mental health issues.	32,093
DCFS TOTAL for SFY 2011:	$1,798,380

SFY 2011 BLOCK GRANT TOTAL:	$3,678,154

5% Grant Administration Check	***Amount***
Administrative Assistant for Council support	49,202
Stipends paid to Council members for administrative activities	10,752
Council travel for administrative activities	4,528
Grant writer	69,336
Operating supplies	1,500
Other	5,530
Total grant administration for SFY 2011:	$140,848
SFY 2011 Block Grant total:	$3,678,154
Percent of SFY 2011 Block Grant total:	3.83%

PART C. STATE PLAN

CHILD

Section III. Performance Goals and Action Plans to Improve the Service Systems

Goals, Targets and Action Plans

Name of Performance Indicator: Increased Access to Services (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	4,082	4,190	4,179	3,970	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 4: Ensure that the service system meets the needs of children in the public sector with mental illness.

Target: 4.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of children receiving mental health services through DCFS and MHDS Rural Clinics. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of children served to no more than 5%.

Population: All child and adolescent clients, regardless of SED status

Criterion: 2: Mental Health System Data Epidemiology
3: Children's Services

Indicator: Number of children served within the State system of care.

Measure: Number of children, ages 0- 17, served within the State system of care.

Source(s) of information: AVATAR

Special issues: The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Providing services to children and adolescents with mental illness is the one of the primary goals of the child and family services system.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on improving the quality and effectiveness of services through the coordinated work of the Statewide Children's Behavioral Health Consortium and the regional Mental Health Consortia which are working on specific transformation efforts surrounding the provision of children's mental health services.

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds – 30 days (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.97%	4.96%	5.29%	5.00%	N/A
Numerator	4	12	--	--	--
Denominator	203	242	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.1: Limit the year-to-year increase to no more than 5% in the utilization of psychiatric inpatient beds demonstrated through the rate of readmission to State psychiatric hospitals within 30 days and 180 days.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of children readmitted to State hospitals within 30 days and within 180 days as compared with the number of children admitted to State hospitals during the past year, expressed separately as two different percentages.

Measure: Numerator 1: Number of children with SED, ages 0 – 17, readmitted to State hospitals within 30 days.
Numerator 2: Number of children with SED, ages 0 – 17, readmitted to State hospitals within 180 days.
Denominator (for both): Number children with SED, ages 0 – 17, admitted to State hospitals during the past year.

Source(s) of information: AVATAR

Special issues: DATA NOTES: Please note that the data calculation for the 30-day and 180-day readmission rates varies from the method described in the grant application guidelines and Uniform Reporting System (URS) tables. Originally, calculation of theses rates included readmissions in the numerator and discharges in the denominator, per CMHS guidelines. Based on this, the 180-day rate would have to be calculated through December 30, 2010, in order to capture clients who may have discharged the last day of the State fiscal year (June 30, 2010) and readmitted up to 180 days later. However, this is past the September 1 due date for the Block Grant application and the December 1 due date for the Implementation Report and therefore cannot include a full 180-day calculation. In order to correct for this, readmissions are calculated for 30 days and 180 days prior to the State fiscal year. This means readmissions for the 180-day rate are captured from January 1, 2009, through June 30, 2009; and readmissions for the 30-day rate are captured from June 1, 2009, through June 30, 2009.

Furthermore, staff have observed that discharges can occur for clients entering at any point in time, not just the prescribed 30-day and 180-day periods, which may skew the data. Therefore, admission rates are calculated based on readmissions in the numerator and admissions in the denominator, in order to more accurately measure readmissions against the total admissions for the year in the denominator.

Significance: Reducing hospitalization for children with SED is a primary goal of DCFS and reflects an increased emphasis on community-based services.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds – 180 days (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	5.63%	6.52%	5.37%	5.00%	N/A
Numerator	16	21	--	--	--
Denominator	284	322	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target:	1.1: Limit the year-to-year increase to no more than 5% in the utilization of psychiatric inpatient beds demonstrated through the rate of readmission to State psychiatric hospitals within 30 days and 180 days.
Population:	Children with SED.
Criterion:	1: Comprehensive Community-Based Mental Health Service System. 3: Children's Services.
Indicator:	Number of children readmitted to State hospitals within 30 days and within 180 days as compared with the number of children admitted to State hospitals during the past year, expressed separately as two different percentages.
Measure:	Numerator 1: Number of children with SED, ages 0 – 17, readmitted to State hospitals within 30 days. Numerator 2: Number of children with SED, ages 0 – 17, readmitted to State hospitals within 180 days. Denominator (for both): Number children with SED, ages 0 – 17, admitted to State hospitals during the past year.
Source(s) of information:	AVATAR
Special issues:	DATA NOTES: Please note that the data calculation for the 30-day and 180-day readmission rates varies from the method described in the grant application guidelines and Uniform Reporting System (URS) tables. Originally, calculation of theses rates included readmissions in the numerator and discharges in the denominator, per CMHS guidelines. Based on this, the 180-day rate would have to be calculated through December 30, 2010, in order to capture clients who may have discharged the last day of the State fiscal year (June 30, 2010) and readmitted up to 180 days later. However, this is past the September 1 due date for the Block Grant application and the December 1 due date for the Implementation Report and therefore cannot include a full 180-day calculation. In order to correct for this, readmissions are calculated for 30 days and 180 days prior to the State fiscal year. This means readmissions for the 180-day rate are captured from January 1, 2009, through June 30, 2009; and readmissions for the 30-day rate are captured from June 1, 2009, through June 30, 2009. Furthermore, staff have observed that discharges can occur for clients entering at any point in time, not just the prescribed 30-day and 180-day periods, which may skew the data. Therefore, admission rates are calculated based on readmissions in the numerator and admissions in the denominator, in order to more accurately measure readmissions against the total admissions for the year in the denominator.

Significance: Reducing hospitalization for children with SED is a primary goal of DCFS and reflects an increased emphasis on community-based services.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Evidence Based – Number of Practices (Number)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: **This table is not applicable.**
Target:
Population:
Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Indicator:
Measure:
Source(s) of information:
Special issues: DATA NOTE: DCFS is no longer contracting with foster care providers for therapeutic foster care. As a result of the Medicaid Behavioral Health Redesign, therapeutic foster care providers now enroll and enter into provider agreements directly with Nevada Medicaid.

DCFS is pursuing its commitment toward implementation of evidence-based practices. DCFS has implemented Trauma–Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). The wraparound model is implemented statewide through the Wraparound in Nevada (WIN) program an OJJDP "promising" treatment model. DCFS staff also received training on Motivational Interviewing.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Children with SED Receiving Therapeutic Foster Care (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues: DATA NOTE: DCFS is no longer contracting with foster care providers for therapeutic foster care. As a result of the Medicaid Behavioral Health Redesign, discussed under criterion one, therapeutic foster care providers now enroll and enter into provider agreements directly with Nevada Medicaid.
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Children with SED Receiving Multi-Systemic Therapy (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Special issues:
Significance:
Action Plan:

Name of Performance Indicator: Evidence Based – Children with SED Receiving Family Functional Therapy (Percentage)

Transformation Activities: ☐ Indicator Data Not Applicable ☑

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator					
Numerator					
Denominator					

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: **This table is not applicable.**
Target:
Population:
Criterion:
Indicator:
Measure:
Source(s) of information: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.
Special issues:
Significance:
Action Plan:

Name of Performance Indicator: Client Perception of Care (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	79.35%	74.29%	81.64%	81%	N/A
Numerator	392	208	--	--	--
Denominator	494	280	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.2: Maintain or increase client perception of care, within a 5% year-to-year variance, demonstrated through the number of clients reporting positively about outcomes.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of positive responders in the outcome domain of the community based mental health services survey expressed as a percentage.

Measure: Numerator: Number of positive responders reported in the outcome domain of the community based mental health services survey.
Denominator: Total number of qualified responders in the outcome domain of the community based mental health services survey.

Source(s) of information: Statewide DCFS survey data. URS Table 11 (3)

Special issues: None.

Significance: Client feedback regarding satisfaction with care is a major component of quality assurance efforts.

Action Plan: DCFS will achieve this goal primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on its mission statement for children's mental health which includes a strength-based, family-focused approach that seeks to provide a continuum of care for children with SED. The child and family consumer survey will be completed at least every two years as part of program evaluation and quality assurance efforts.

Name of Performance Indicator: Child – Return to Stay in School (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	21%	21%	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.5 Maintain or increase the percentage of children who return to/stay in school, within a 5% year-to-year variance.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Percent of parents reporting improvement in child's school attendance.

Measure: Numerator: Number of parents reporting improvement in child's school attendance.
Denominator: Total responses.

Source(s) of information: Statewide DCFS survey data.

Special issues: This is the first time Nevada will be reporting on this indicator.

Significance: Client feedback regarding school attendance is an important outcome measure.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Child – Decreased Criminal Justice Involvement (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	21%	21%	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.6: Maintain or decrease client involvement with the juvenile justice system within a 5% year-to-year variance.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Percent of children/youth consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined).

Measure: Numerator: Percent of children/youth consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined).
Denominator: Number of children/youth consumers arrested in T2 (new and continuing clients combined).

Source(s) of information: Statewide DCFS survey data.

Special issues: This is the first time Nevada will be reporting on this indicator.

Significance: Prevention of repeat involvement in the juvenile justice system is an important outcome measure.

Action Plan: DCFS will achieve the above goal primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Child – Increased Stability in Housing (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	12.13%	10.80%	8.22%	8%	N/A
Numerator	310	279	--	--	--
Denominator	2,555	2,583	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.7 - Maintain or decrease the percentage of child/adolescent clients who are homeless or living in shelters, within a 5% year-to-year variance.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: The percentage of child/adolescent clients who are homeless or living in shelters.

Measure: Numerator: The number of child/adolescent clients who are homeless or living in shelters.
Denominator: All child/adolescent clients with living situation excluding person with "Living situation Not Available".

Source(s) of information: Statewide DCFS data collected in the Avatar database.

Special issues: This is the first time Nevada will be reporting on this indicator.

Significance: The prevention of child/adolescent homelessness is an important outcome measure.

Action Plan: DCFS will achieve the above goal primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Child – Increased Social Supports/Social Connectedness (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	84.15%	91.76%	94.94%	94%	N/A
Numerator	292	256	--	--	--
Denominator	347	279	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.4: Maintain or increase the percentage of families reporting positively about social connectedness, within a 5% year-to-year variance.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: The percentage of families reporting positively about social connectedness.

Measure: Numerator: The number of families of child/adolescent consumers reporting positively about social connectedness.
Denominator: Total number of family responses regarding social connectedness.

Source(s) of information: Statewide DCFS survey data.

Special issues: This is the first time Nevada will be reporting on this indicator.

Significance: Social connectedness is an important outcome measure.

Action Plan: DCFS will achieve the above goal primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the expanded use of Medicaid funds for community-based residential alternatives, intake and assessment that focuses on appropriate levels of care for children with SED, wraparound services through the WIN program, and coordinated mental health service provision in conjunction with juvenile justice facilities.

Name of Performance Indicator: Child – Improved Level of Functioning (Percentage)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	74.04%	77.45%	81.18%	81%	N/A
Numerator	308	213	--	--	--
Denominator	416	275	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 1: Provide children with high quality mental health services and resources, emphasizing community-based services.

Target: 1.3: Maintain or increase, within a 5% year-to-year variance, client perception of level of functioning, demonstrated through the number of clients reporting positively about function upon survey.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.
3: Children's Services.

Indicator: Number of positive responses reported in the function domain on the child consumer survey compared with total responses, expressed as a percentage.

Measure: Numerator: Number of positive responses reported in the function domain on the child consumer survey.

Denominator: Total number of qualified responses in the function domain on the child consumer survey.

Source(s) of information: Statewide DCFS survey data.

Special issues: None

Significance: Client feedback regarding satisfaction with care is a major component of quality assurance efforts.

Action Plan: DCFS will achieve this goal primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on its mission statement for children's mental health which includes a strength-based, family-focused approach that seeks to provide a continuum of care for children with SED. The child and family consumer survey will be completed at least every two years as part of program evaluation and quality assurance efforts.

State Performance Indicators

Name of Performance Indicator: Child – Case Management Services (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2,428	2,492	2,492	2,370	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 3: Provide children with a continuum of services that are tailored to their individual needs.

Target: 3.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of parental custody and DCFS custody children receiving mental health treatment services through DCFS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number parental custody and DCFS custody children receiving mental health treatment services through DCFS to no more than 5%.

Population: All DCFS child and adolescent clients, regardless of SED status.

Criterion: 1: Comprehensive Community-Based Mental Health Service System.

Indicator: Case management services provided to parental custody and DCFS custody children receiving mental health treatment services.

Measure: Number of children, ages 0 – 17, receiving case management services that are in parental custody or DCFS custody.

Source(s) of information: AVATAR

Special issues: None.

Significance: Case management is a primary community-based service that provides clients with a continuum of care.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on the fact that case management is a primary element of community-based treatment for children and adolescents in Nevada.

Name of Performance Indicator: Child – Children Receiving Outpatient Treatment (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2,297	2,625	3,007	2,900	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 5: Ensure that the service system promotes community-based services.

Target: 5.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of children receiving outpatient mental health treatment through DCFS. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of children receiving outpatient mental health treatment through DCFS to no more than 5%.

Population: All DCFS child and adolescent clients, regardless of SED status.

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Number of children receiving outpatient mental health treatment.

Measure: Number of children, ages 0 – 17, receiving outpatient mental health treatment.

Source(s) of information: AVATAR

Special issues: The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Providing community-based services is a primary goal of the block grant program.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described in Section III under criteria one and three. In particular, DCFS remains focused on providing services in the least restrictive environment which is part of the DCFS mission statement for children's mental health and is supported by block grant funds.

Name of Performance Indicator: Child – Children with SED Served Through the WIN Program (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	799	807	758	758	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 6: Provide mental health services based on system-of-care principles.

Target: 6.1: Utilize budgeted funding for a wraparound service model to augment direct services to families and children, demonstrated through the number of children with SED served through the WIN program.

Population: Children with SED.

Criterion: 3: Children's Services

Indicator: Number of children with SED served through the WIN program.

Measure: Number of children with SED, ages 0 – 17, served through the WIN program.

Source(s) of information: AVATAR

Special issues: The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.

Significance: Providing community-based services is a primary goal of the block grant program.

Action Plan: DCFS will achieve the above goals primarily through the implementation of services described within the narrative for criteria one and three. The quality and effectiveness of services will be improved through the implementation of the WIN program which provides services with a nationally recognized wraparound model.

Name of Performance Indicator: Child – Children Served in Rural Areas (Number)

Transformation Activities: ☐

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1,417	1,081	1,058	1,050	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

PERFORMANCE INDICATOR DESCRIPTION – DCFS

Goal: 7: Coordinate with the Division of Mental Health and Developmental Services (MHDS) to facilitate a continuum of services for children and adolescents in rural areas.

Target: 7.1: In prior years, Nevada's goal was to maintain or increase, within a 5% year-to-year variance, the number of children served in rural areas. However, given the significant reductions in resources due to the severe economic downturn in the State, the target for SFY 2011 is to limit the decrease in the number of children served in rural areas to no more than 5%.

Population: All child and adolescent clients, regardless of SED status.

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: Number of children served in rural areas.

Measure: Number of children, ages 0 – 17, served in rural areas by Rural Clinics and DCFS rural programs.

Source(s) of information:	AVATAR
Special issues:	The significant reductions in resources (staffing and funding) due to the severe economic downturn in Nevada, has made it necessary to shift expectations from expanding the number of clients served to avoiding reductions in service levels.
Significance:	Providing services to children and adolescents with mental illness is the one of the primary goals of the public mental health system.
Action Plan:	As noted above, services to children in the rural areas are provided through the MHDS system of Rural Clinics. Services to children who are homeless are provided through child protective services agencies in Washoe County and Clark County, nonprofit agencies, and DCFS agencies in the northern and southern regions. Due to the significant reduction in available resources (both staffing and funding) the number of children served in rural areas will almost certainly be reduced in SFY 2011. The MHDS strategic planning project will focus on ways to maintain the quality and effectiveness of services by emphasizing community-based services, implementation of evidence-based practices, and consumer involvement in service planning and delivery.

Footnote to Child Goals, Target and Action Plans

DCFS determined that State performance indicator 9.1 (Funding committed to community-based services) was not a meaningful or relevant measure of the agency's performance so it has been deleted.

In addition, State performance indicator 8.1 (Children who are homeless or at risk of homelessness receiving mental health services) was determined to be duplicative of NOM 1.7 (Increased stability in housing) so it was eliminated.

PLANNING COUNCIL LETTER FOR THE PLAN

A letter from Nevada's Mental Health Planning Advisory Council is on the following pages.

JIM GIBBONS
Governor

STATE OF NEVADA
MENTAL HEALTH PLANNING ADVISORY COUNCIL
4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-4295 • Fax (775) 684-5964

RENE NORRIS
Chair

PATRICIA PETERMAN
Vice Chair

ALYCE THOMAS
Past Chair

August 30, 2010

Ms. Barbara Orlando
Grants Management Officer
Division of Grants Management, OPS
SAMHSA
Room 7-1091
1 Choke Cherry Road
Rockville, MD 20857

Re: Nevada's CMHS Block Grant Application for FY 2011

Dear Ms. Orlando:

I am writing to you regarding the Community Mental Health Services Block Grant Application submitted by the State of Nevada for State Fiscal Year (SFY) 2011. The Nevada Mental Health Planning Advisory Council (MHPAC) has conducted a review of the application and I am providing feedback on the Council's behalf. At the MHPAC's quarterly meeting on August 12, 2010, key components of the application were displayed using a video projector connected to WebBGAS and discussed.

The MHPAC would like to highlight its Rural Monitoring Committee. In SFY 2007, the MHPAC developed a structured, service provision monitoring project to help better meet the federal mandate for Mental Health Planning Councils to monitor, review, and evaluate the allocation and adequacy of mental health services within the state. The MHPAC formed a Rural Monitoring Committee that developed a plan and format for conducting quality assurance site visits to the system of Mental Health and Developmental Services (MHDS) Rural Clinics, with a focus on consumer satisfaction with services.

Since the inception of the project, the Rural Monitoring Committee has conducted monitoring visit to Rural Mental Health Clinics in Ely in 2007, Pahrump in 2009, a combined visit to Fallon and Silver Springs in 2009 and most recently, Mesquite in 2010. In all of these visits, the committee identified several unmet needs such as psychological testing software as well as supplies, equipment and other interpretive resources necessary to enhance Rural Clinic staff's ability to treat children. At the request of the MHPAC, MHDS agreed to allocate block grant funds to address those needs.

In the interest of using block grant funds for monitoring, advocacy and innovation, the MHPAC requested MHDS to continue to provide funds to the Nevada Commission on Mental Health and Developmental Services to strengthen the operation of the Commission and improve collaboration with the MHPAC. MHDS agreed to continue fund research and data analysis services, administrative support and travel monies, in support of the Commission.

In June of this year, representatives from the MHPAC participated in the CMHS review of Nevada's Block Grant and requested Technical Assistance (TA) from CMHS on the following issues:

- Improving advocacy in regards to the legislature.
- Interpreting and utilizing NOMs data and the URS tables to identify important trends.
- Reviewing the annual plan in a more efficient and timely manner.
- Obtaining and improving telemedicine in rural Nevada.

The MHPAC is also interested in receiving frequent and timely updates on the implementation of the federal health care reform and, more specifically, the impact it will have on mental health services.

Finally, the MHPAC expresses great concern about the impact of the dramatic decline in Nevada's general fund revenue on health and human services agencies in general and those providing mental health services in particular. Nevada's economic downturn now ranks as one of the worst among the 50 states and the outlook is grim for the foreseeable future. There will be fewer clients served, longer waiting lists for services and state agency workforce reductions.

In light of the declines in State general fund revenue, the Council is grateful for the continued federal funding received by CMHS to support vital community-based services for children and adults with mental health needs. Please accept this letter on behalf of the MHPAC as a statement of its support of the funding priorities set forth by MHDS and DCFS. Together, MHDS, DFCS and the Council will continue working toward the common goal of improving the lives of children and adults with mental disorders, despite the funding and resource barriers we face.

If you have any questions or need additional information, please feel free to contact me at (702) 498-9757 or by email at renenorris@ymail.com.

Sincerely,

Rene M. Norris

Rene Norris
Council Chair