MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Sixth Session
February 14, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 1:33 p.m. on Monday, February 14, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/76th2011/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven J. Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason M. Frierson
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood

COMMITTEE MEMBERS ABSENT:

Assemblyman Pete Goicoechea (excused)
Assemblywoman Debbie Smith (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Risa Lang, Committee Legal Counsel
Allison Combs, Committee Policy Analyst
Kirsten Coulombe, Committee Policy Analyst
Mitzi Nelson, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services
Jackie Harris, Chair, Clark County Children's Mental Health Consortium
Jan Marson, Chair, Rural Children's Mental Health Consortium
Pam Becker, Chair, Washoe County Children's Mental Health Consortium
Erin Russell, representing Clark County Children's Mental Health Consortium
Karen Taycher, Executive Director, Nevada Parents Encouraging Parents

Chair Mastroluca:
[Roll was called.] We will move forward with a presentation by Ms. Comeaux.

Diane J. Comeaux, Administrator, Division of Child and Family Services, Department of Health and Human Services:
With me at the table today is Pam Becker, the Chair for the Washoe County Children's Mental Health Consortium (WCCMHC); Dr. Jan Marson, the Chair for the Rural Children's Mental Health Consortium (RCMHC); and coming up to the table in Las Vegas is Jackie Harris, who chairs the Clark County Children's Mental Health Consortium (CCCMHC). I intend to give a very brief overview of the establishment and purpose of the mental health consortia (Exhibit C), and then we will turn the remainder of the presentation over to the Chairs to present their most recent plans.

As part of the 17th Special Session of the Nevada Legislature (2001), Chapter 433B of the *Nevada Revised Statutes* (NRS) was amended to establish mental health consortia in each of three jurisdictions in Nevada. These jurisdictions include Clark County, Washoe County, and the "region consisting of all counties whose population are less than 100,000." The functions of each consortium are to assess the needs for behavioral health (mental health and substance abuse) services for children in the jurisdiction; to assess how well the current system is meeting those needs; and to develop an annual plan on how the needs can be better met.

Madam Chair if you do not mind, we would like to have Jackie Harris in Las Vegas speak first followed by Dr. Marson.

Jackie Harris, Chair, Clark County Children's Mental Health Consortium:
I would like to give you an overview of the ten-year strategic plan for the CCCMHC (Exhibit D). Our long-term goals are based on the concept that children with serious emotional disturbance (SED) will thrive in their own communities; that children with behavioral health needs will have a comprehensive array of services available; that families will experience an organized pathway of care; that there will be a locally-managed system based upon a partnership between families, providers, and stakeholders, with services that are family-driven and culturally competent; that services will focus on the early identification of behavioral health needs; and that there will be a system where public awareness will be heightened to reduce the stigma associated with behavioral health and to empower families in that system. The CCCMHC takes a public health approach to children's mental health. We utilize the triangle throughout the report as the symbol of a balanced approach to the delivery of services. The base of the triangle represents the 80.7 percent of children who would benefit from social, emotional, and behavioral wellness activities. The middle tier, 13.3 percent of children, represents those that are in need of targeted intervention. The top tier, 6 percent of children, represents those that are in need of the most intensive services. At this time, the children's mental health system in Nevada would be represented by an inverted triangle, where funds support children with significant mental needs who did not receive these services when and how they initially needed them.

The CCCMHC also supports a local systems management and behavioral redesign. We support the efforts of the Commission on Mental Health and Developmental Services, the Department of Health and Human Services (DHHS), and the statewide behavioral health consortia to redesign the organization's structure and delivery of services to children and families. Redesigning and restructuring the current system can allow for redirection of expenditures from high-end services to those community-based programs and services that work to prevent future need.

In closing, I would like to review the priorities that were established in 2010. At that time, the CCCMHC was required to provide a yearly update on the progress of our priorities and goals. Our first priority was to restructure the behavioral health system to focus on quality, accountability, and positive outcomes. There has been some progress toward that goal, as well as a lot of work done toward the redesign of the system.

Our next priority involved mobile crisis and stabilization teams for youth that are in the most need. There has been no progress with this goal. Another goal was to expand neighborhood-based financial and intensive support programs to allow children to remain with their families, particularly those children involved with the child welfare and juvenile justice systems. There has been no progress in this area either. We also planned to expand family-to-family support for families with children who have SED. Again, we have made no progress in this area. The next goal was to expand a wraparound model for youth who are involved in the juvenile justice system and remain with their families. Again, there has been no progress with this goal.

Another priority was to support early childhood and preventative programs that enhance the social and emotional development of children. There has been some progress with this goal, particularly in coordinating these services and identifying children with these health needs earlier. The final goal was to strengthen partnerships between schools and behavioral health providers. There has been some progress on this goal as well as ongoing coordination between the CCCMHC and the Clark County School District.

In closing, we are acutely aware of the current economic climate, but we are challenging Nevada to prioritize the needs of children and families to ensure the safety, stability, and productivity of its citizens for tomorrow. I would encourage you to review the entire plan. I will be glad to answer any questions.

Chair Mastroluca:
Thank you Ms. Harris. I appreciate this plan. I have seen it previously and it is very comprehensive. I like the way the plan is organized and explained. Thank you very much for taking the time to do that. We have a question from Assemblywoman Flores.

Assemblywoman Flores:
What is the main reason your organization has made no progress with your goals?

Jackie Harris:
As with most issues, it requires funding to expand services. Again, in a climate where we are merely hanging on to what we have, the ability to expand has not been available even for the most-needed services.

Chair Mastroluca:
Are there other questions for Ms. Harris? [There was no response.] Thank you very much for your presentation.

Jan Marson, Chair, Rural Children's Mental Health Consortium:
I have provided a summary of our ten-year plan (Exhibit E). In our plan for rural Nevada (Exhibit F), we attempted to estimate how many children and youth need services. Based on assumptions from the 2001 *Report of the Surgeon General's Conference on Children's Mental Health*, we estimated that 20 percent of all children have some mental health needs and concerns and that an additional 5 percent of all children have significant issues. We developed some focal points for our strategic plan that include school-based services, as well as services in the areas of youth and child welfare and juvenile justice, infant mental health and early intervention, substance abuse prevention and treatment, and suicide prevention and survival. There are very few organized mental health services available throughout rural Nevada. Many families have to travel great distances to receive services. Looking toward the future, we see great opportunity to use technology and the Internet as modalities to reach families.

We also have identified some additional obstacles, including the problem of how to sort out and identify children and youth in need of services at an earlier age. We would like to work with families and support them earlier—even at the infant stage—instead of waiting until major problems evolve. Currently, the early intervention system requires a child to be diagnosed with a condition or to have a significant developmental delay in order to receive services. We would like to develop some of the needed workforce by utilizing college and university interns and the behavioral health networks allowed by Medicaid to form groups that include marriage and family therapists (MFT). Normally, Medicaid does not allow reimbursement for MFTs and interns unless they are in certain organized networks. That would be one way to organize and pay for those services. The people in rural Nevada have a real can-do attitude. As we traveled around to the different communities there, we developed a sense that there is a need to home-grow that workforce. Bringing professionals into and out of the area to provide these services may not be the best long-term solution.

We see school-based services as the new frontier for administering services. This would be a way of providing for children and youth in their own communities, rather than having these families travel to a clinic out of the area or having the child go away to a residential juvenile treatment program. We are also concerned with developing parity. We have identified that a significant number of Hispanic and Native American children are being underserved in rural Nevada. We hope to redefine methods of identifying and screening in order to move forward with these groups.

Assemblyman Livermore:
Thank you so much for identifying the needs of rural Nevada. How does a patient in rural Nevada get medications? Who prescribes their prescriptions?

The biggest problem with mental health patients is that they are often noncompliant with their medications.

Jan Marson:
In rural Nevada there are child psychiatrists who work with local children in rural clinics. That is one way they receive their prescriptions. In addition, many children are traveling to Reno for medication and evaluation. School-based services would be funded to allow these services to occur right at the school. But there could be some barriers, because you want the parents involved. Our group is very dedicated to family involvement in all aspects and on every level.

Assemblyman Livermore:
Can you give me some idea of how many juvenile psychiatrists and clinics are available to serve rural Nevada?

Jan Marson:
I serve on the University Center for Autism and Neurodevelopmental Assessment Team at the University of Nevada, Reno (UNR). We work with the Child Psychiatry Fellows program there, which is a nicely developed program that graduates two new child psychiatrists each year. There are quite a few practicing child psychiatrists in northern Nevada. Off the top of my head I would say. . .

Assemblyman Livermore:
How many psychiatrists does your organization have under contract? You have identified rural health clinics as the providers of these resources. Can you tell me how many people physically work for you on your staff?

Jan Marson:
Our consortium is an advisory group. We have members. . .

Assemblyman Livermore:
So basically you do not have anyone under contract? There are no juvenile psychiatrists that go to the rural clinics throughout Nevada?

Jan Marson:
I know for sure that at least one psychiatrist goes to Carson, Fallon, and Fernley.

Assemblyman Livermore:
I am disappointed to hear that, because the numbers do not justify the commitment and need that you just expressed.

Chair Mastroluca:
Mr. Livermore, I can appreciate your frustration. I think it goes back to Assemblywoman Flores's original question concerning the lack of available funding. That is a huge problem throughout this state—mental health is very poorly funded in Nevada and has been for a very long time.

Dr. Marson, you mentioned infant mental health twice. Can you tell me in what form those services are provided? Are they provided through a specific program, such as Family to Family Connection or Family Resource Centers? How are these services accessed?

Jan Marson:
I took the lead in developing this plan, because I was working on my doctorate at the time. The focus was on children's mental health and sensory regulation. We conducted a literature search and included a white paper in our plan. We would like to partner with Early Intervention Services to create an understanding about infant mental health for the staff. The Title I School Improvement Grant included funding for the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: DC:0–3R* diagnostic manual. It is like the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) that is used for adult mental health classification. A significant amount of funding went into training and creating a train-the-trainer model throughout Nevada. There are probably a least 50 clinicians who have received this training.

Chair Mastroluca:
Are these clinicians based out of Family Resource Centers?

Jan Marson:
There is a cross-section of trained clinicians that include individual providers, the Mojave Las Vegas Youth Clinic, Children's Behavioral Services, and quite a number of other providers in the Las Vegas area.

Assemblywoman Benitez-Thompson:
It can sometimes be abstract when we talk about infant and child mental health. Can you paint a picture about what these children look like from a behavioral standpoint? What are the diagnoses?

Jan Marson:
A person is not simply born bipolar or depressed, there are a series of circumstances that come together to create the disorder. There is evidence to support the belief that early intervention is beneficial. For instance, a baby that may be very colicky and difficult to soothe is at risk for abuse because his

temperament is quite difficult. On the other hand, a low arousal child that appears to be going down the track of depression may need a lot of stimulation. Such a child is not demanding, so may not receive the needed parental input. When the signaling between the caregiver—usually the mother—and the infant is not typical, it starts to set up a risky dynamic. The parents might say to us, "My baby does not love me," or "My baby does not like me." With a keen eye and early intervention, the child and family can be supported to lessen the blow of the child's biology and circumstance.

Assemblyman Anderson:
I wanted to first thank you for your concern about mental health. I think it is an important subject that is quite often under the radar, especially in Nevada. Having been raised by a father who is a high school guidance counselor, I am interested in school-based services. What do rural schools do now in terms of high school guidance and social services? It might be a good idea to build from what is currently in place.

Jan Marson:
During the formation of our plan, we spent a lot of time in Lovelock. Last year their school district had a four-day school week. The community members saw a possible need for additional student activities. That could be one way of providing mental health services. Another tool is TeenScreen, from the National Center for Mental Health Checkups. Some schools, mostly in southern Nevada, use this to identify at-risk children and youth. We contacted various coalitions around rural Nevada that had spoken with children that had gone astray. These children felt they began to go off track as early as fifth grade. We also found that being in the juvenile justice system and having mental health issues are comorbid.

I think each school district in rural Nevada has its own personality. There are many resources and prevention programs—such as suicide prevention—that can help identify and serve children quickly. We are not talking about heavy-duty psychotherapy.

Assemblyman Frierson:
Assemblywoman Benitez-Thompson asked what infant mental health issues look like. Autism is the one that instantly comes to mind. I am curious about other mental health conditions we may be referring to when we discuss infant mental health issues. What other conditions and descriptions are there? I would like to have a picture of the infants we are discussing.

Jan Marson:
I know quite a bit about autism. Many times children that appear to be at risk for autism are actually not. For instance, child abuse and neglect can look like autism or pervasive developmental disorder. These young children are not sharing in attention, they do not have that gleam in their eye, and they do not interact back and forth. We say we want early identification, but development is a process and there is a lot of overlap. There is a significant number of children who appear to be at risk for autism, but if communication, motor skills, and parenting skills are used in treatment, those tendencies tend to remediate in about 20 to 30 percent of the children we see.

Chair Mastroluca:
If those interventions are started and then stopped before they are completed—for example, if a state were to no longer fund a program—what are the repercussions for the child and family?

Jan Marson:
There would be a lot of lost opportunity and potential. From the perspective of brain development, there is epigenesis—genes that are turned on and off. Receiving the proper stimulation, support, and environment allows for epigenesis and neurochemical reaction. This strengthens the structures in the whole brain and the development of the mind. I would think that if you remove that needed stimulation and support, you would be lessening the potential outcome of the child.

Assemblyman Brooks:
Is there biological evidence from a credible source regarding this or is this an opinion? Basically what you are saying is that if children are not given the attention they need early on, genes may not be turned on. I need to know if that is factual or ideological.

Jan Marson:
I just completed my doctorate and spent a lot of time looking at the evidence and reading reports. We have studied the brain down to the minutest detail and there is supporting evidence. If the Committee would like to have more back up in this area, it can be provided.

Assemblyman Brooks:
I would.

Jan Marson:
All right.

Chair Mastroluca:
Now we will move on to Pam Becker from Washoe County.

Pam Becker, Chair, Washoe County Children's Mental Health Consortium:
I want to ask you to share with me in our ten-year anniversary celebration. It is ten years ago today that the mental health consortia were formed after the 2001 Legislative Session. I think it is great that we are here to celebrate children, because I believe we do all love children and that is really important.

The consortia were established by legislation to include members from a broad range of community partners. We come together as a volunteer organization, so to answer a previous question, we do not employ anyone. We come together as a group. We at the WCCMHC have come up with four goals for our ten-year plan (Exhibit G and Exhibit H). Before we adopted the ten-year plan, we could not have given you such a report. We create yearly progress reports, but it has taken a long time to form this group and develop the trust that is necessary between organizations to get work done and see progress. We have come to know each other in our community; juvenile justice, social services, the school district, and private providers have all come to the table. We are truly sharing what we can do and how we can do things.

Our first goal is to serve youth in their home communities, "to enhance Washoe County's capacity to provide community-based wraparound treatment and care to serve youth locally in a manner that supports safety, stability, and permanency." We have partnered with the Division of Child and Family Services **(**DCFS), Washoe County Juvenile Services, the Sierra Regional Center, and the Washoe County School District to provide wraparound services for children in parental custody. In addition, the statewide model of Wraparound in Nevada (WIN) serves children who are in state custody. We wanted to provide similar services to children who were still in parental custody because we want to keep children in their family, if at all possible. We want to begin to shift the pyramid to begin services to children and families earlier. This model will enable us to achieve this goal.

We have a memorandum of understanding between the organizations and the DHHS. Each one of the organizations listed above has assigned a staff person to this process. They have shifted the responsibilities from the school district to the community. The DHHS has provided oversight, leadership, and training for this model, because we want to promote fidelity to the wraparound model. We think this will enable us to have good success with the program. Since we have just started this process, I do not have any statistics today, but I will be happy to provide statistics when they become available before the end of the session.

We believe the outcomes will mirror or be better than the state statistics for children and families. We currently serve 40 families.

Our second goal is to help families to help themselves. We want to "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." This has been one of the more challenging goal groups to organize. People have stepped forward to conduct leadership of this goal group, but there has only been one meeting. During that meeting, the group decided that suicide and bullying prevention need to be considered under this goal. If we can provide parents with tools and resources, they can help their own children. We are going to be working more on this goal and one of the media outlets is interested in assisting us with these concerns. We are also working with the Office of Suicide Prevention to work on this goal.

Our third goal is to help children succeed in school. The Consortium will work with community agencies and Washoe County School District to support system-wide implementation of Positive Behavioral Support (PBS) so that youth can develop prosocial skills while remaining in their home school and family setting to reduce the need for more intrusive or aversive interventions. Currently the school district is using the PBS system. Once we discover how in-depth the school district's system is, the Consortium believes we will be able to provide training to parents to give them the information they need to take these interventions into their home and help their families.

Our fourth goal is to support youth to succeed as adults. This is to develop, fund, and implement system-level policies coupled with successful strategies to help youth with mental health needs transition to postsecondary education, employment, and independent lives. We have identified that the need may be for an alternate kind of system for youth aged 18 to 24 years. Currently, a youth is supported very heavily by his family and agencies when he is under the age of 18. Once the youth turns 18, if he is out of school, he becomes an adult. He can stay in school a little longer if he has not graduated and is doing well in school.

The adult system is radically different. For example, a child with mental health issues has an appointment to meet with social services for intervention—perhaps with the WIN team. They bring in the family to discuss a plan and develop goals. Everyone is supporting the child to get healthy. Once the youth turns 18, he no longer brings his family to meetings. The youth sits alone at the Northern Nevada Adult Mental Health Services center without having an appointment and may, or may not, get seen. If the youth is not seen that day,

he is expected to come back the next day or until he is seen. There is quite a bit of difference in that situation.

In order for youth to be successful during this transition, perhaps we need to offer them a service that might include a drop-in center that has an option for physical and mental health. Certainly, substance abuse issues might be able to be dealt with and the youth might be able to talk with peers that are going through the same things. Providing independent living skills might help with issues of homelessness.

Our group has found a model that we are currently working on called the Transition to Independence Process (TIP) system. There is a book that goes along with this model called *Transition of Youth and Young Adults with Emotional or Behavioral Difficulties: An Evidence-Supported Handbook*. Our work group is reading this book and can take an Internet-based test that will help us achieve Tier-I status for TIP model implementation. We are looking at a way we can start such a program on a smaller scale as a drop-in center.

We certainly understand that there are probably no new funds available for any of these services, but because we know and trust each other so well, we are willing to think differently and expend some resources that we might not have readily given before.

With all the cuts that the county and cities are taking, it is difficult to have people regularly attend our meetings. Staff is being cut and supervisors have to do more and cannot get away to attend a meeting. This is unfortunate. We are bound by Nevada's Open Meeting Law, so we must have a quorum to hold an official meeting. We have had some very good discussions in lieu of meetings and we are moving forward and everyone is still committed. However, sometimes you get called away because a youth is in crisis, and you have to provide services.

If anyone is interested, I can give you more history about the consortia as a whole. I have been here since the formation of the consortia and I would be happy to talk to you if you have questions now or in the future.

Chair Mastroluca:
Are there any questions from the Committee? [There was no response.] What is the role of DCFS with the consortia?

Diane Comeaux:
The DCFS has members on each consortium who actively participate in the consortium and in developing their plans. Originally annual plans were required

to be submitted to the Director of DHHS for consideration of inclusion in our budget. Now the annual plan goes to the Director and the Commission on Mental Health and Developmental Services, which has oversight over the DCFS. We are very active in helping them review the annual plans. They also have a larger strategic plan that we participate in with the stakeholders.

Chair Mastroluca:
What are the differences between the RCMHC, CCCMHC, and WCCMHC, their goals, and the difficulty each of them might have in reaching their goals?

Diane Comeaux:
Let me take a stab at answering that question. When you look at these plans, you will see that there are many issues that are the same, such as the lack of mental health services, coordination of services, and standards for providing those services. You will also see some pretty significant differences between the three areas. That is the good thing about the consortia. They can each review their partnerships and the available community resources to figure out how to better use those resources or identify what is missing in their particular area.

Chair Mastroluca:
Are there any further questions for this group?

Assemblyman Livermore:
Are the consortia funded by General Fund money? How are they funded? Is it Department money that you come together to create?

Diane Comeaux:
There is no funding for the mental health consortia. The bill you will hear next has a component for that. We also have included some money in the DHHS budget to help support the consortia. Through some grant funding, we have been able to help them with some of their programs, such as hiring someone to help them with the ten-year strategic plans. But when the bill was passed during the 17th Special Legislative Session (2001), there was no funding for the consortia.

Assemblyman Livermore:
I am trying to sort out your structure. Do you have 501(c)(3) nonprofit status or are you a state agency?

Diane Comeaux:
The consortia are a group of people, community stakeholders, who volunteer their time to develop a plan for children's mental health for their communities. They are not a 501(c)(3) or a formal organization.

Assemblyman Livermore:
Years ago, I helped develop the Carson City Mental Health Coalition, which developed a ten-year plan. We submitted a white paper to the Legislature and the Coalition received funding that went to Washoe County. We created a 501(c)(3) organization called Health Smart, with an executive director and a board of directors. It no longer exists because it lost its funding about four or five years ago. I think the intent is still there. I am trying to understand your operational issues. I apologize. I first thought that you were a state-funded agency. That is why I questioned how many services you had in rural Nevada.

Chair Mastroluca:
I would like Allison Combs, our committee policy analyst, to explain how the consortia came about and give some background from the statute.

Allison Combs, Committee Policy Analyst:
Under *Nevada Revised Statutes* (NRS) 433B.333, the mental health consortia were established in 2001 when the DHHS Division of Child and Family Services underwent significant restructuring. This statute specified that certain people in Washoe and Clark Counties would be appointed to the consortia, such as a representative of the DCFS, a representative of the agency providing child welfare services, a representative of the Division of Health Care Financing and Policy, a school board trustee of the county school district, a representative of the local juvenile probation department, a representative of the local chamber of commerce, a private provider of mental health care, a foster care provider, and others. There is a wide variety of representatives on each consortium appointed by the administrator of DCFS.

The next statute, NRS 433B.335, established the purpose of each consortium, which is to develop a long-term strategic plan for their communities. These are the exhibits that were presented today. All the representatives are volunteers who are appointed by the DCFS.

Assemblyman Livermore:
Okay, thank you.

Chair Mastroluca:
I think you have given us a lot of food for thought and we appreciate it very much. Thank you all for your work. It is amazing what volunteers can do when

they come together and are committed to a cause. These three groups are a perfect example of that. Thank you very much for your time and dedication to children's mental health.

Chair Mastroluca:
We will now open the hearing on Assembly Bill 48.

Assembly Bill 48: Revises provisions governing children's mental health consortia. (BDR 39-336)

Erin Russell, representing Clark County Children's Mental Health Consortium:
I first wanted to make sure you have a copy of the amendment (Exhibit I) in front of you regarding section 5 of the proposed bill A.B. 48. To begin, I would like to introduce Karen Taycher from Las Vegas who is present to speak on the bill and amendment. Ms. Taycher is the Executive Director for the Nevada Parents Encouraging Parents nonprofit organization. She is also very actively involved in the Clark County Children's Mental Health Consortium and in the planning work group that created the ten-year strategic plan.

Chair Mastroluca:
I want to make sure that everyone has found the amendment in the Nevada Electronic Legislative Information System (NELIS) system.

Karen Taycher, Executive Director, Nevada Parents Encouraging Parents:
Our work group came up with A.B. 48. As you heard, the consortia were established under NRS Chapter 433B. We are required by statute to report on the statewide status of children's mental health. As we gathered together in our individual groups, we learned much about each other and about our community's needs. We have determined that some of the solutions need to be administered at the local level. Assembly Bill 48 seeks to amend NRS 433B.333 in order to allow each consortium to develop partnerships to seek funding in their communities and work on specific local issues that meet the needs of the families and children therein. We hope that these changes will allow each consortium to be self-sufficient and to have the flexibility to seek funding and create solutions in their own communities. Some of the solutions may involve demonstration projects. Pam Becker mentioned the WIN expansion project that is helping in Washoe County. Should the language in this bill be approved, we believe that each consortium can develop those types of demonstration projects where different stakeholders will provide monies, staff, and resources—through the consortium—to improve services in their communities. Here with me, I have Jackie Harris, the chair of the Clark County Children's Mental Health Consortium. We are available for any questions you might have about the bill.

Chair Mastroluca:
Ms. Russell, would you like to explain your amendment before we get too far, since the majority of the questions will probably pertain to that?

Erin Russell:
Section 5 of A.B. 48 deals with an appropriation of $75,000 per year for the consortia for fiscal years (FY) 2011-12 and FY 2012-13, a total appropriation of $150,000. In speaking with the consortia, we have put forth an amendment to look at deleting that particular section of the bill.

Chair Mastroluca:
Are there any questions?

Assemblyman Sherwood:
Ideally, what do the consortia look like? Is it a quasi-state government organization across multiple counties with no fiscal impact to the state?

Karen Taycher:
We are organized under NRS Chapter 433B. We are a group of stakeholders and parents. We would neither be categorized as a governmental agency nor as a nonprofit, but more as a group of stakeholders that can pool ideas, resources, and data to improve children's mental health in their local areas.

Chair Mastroluca:
Mr. Sherwood, I am sorry that you were not here to hear the explanation of how the consortium works, but I am sure that staff would be happy to...

Assemblyman Sherwood:
This sounds like a "no brainer" to me, because we are not on the hook for money, we are just helping.

Chair Mastroluca:
There is no money involved. This bill would actually give each consortium the opportunity to apply for grants, which they currently cannot do. It would also open up the door for them to create more public and private partnerships.

Assemblyman Brooks:
You just clarified what I was going to review. This bill basically allows the consortia to accept gifts and to further their agenda to carry out their vision. I fully support this bill and am glad to see it here before us. There is no financial component; that has been removed from the bill.

Assemblyman Anderson:
I would like to go on the record along with my colleagues, that I support the bill as amended. I think it would be fair to characterize this as allowing the consortia to have the tools to do good things in their communities. We are empowering our constituents and groups that care about mental health. I think it is a really, really good bill.

Assemblyman Hammond:
For the record, I think if I understand this right, we basically told the consortia to go out and do the best work they can. But we did not give them the ability to raise money. We did not fund the consortia, nor did we give them the ability to form private-public partnerships with other people. This bill basically unties their hands. I completely agree that this is a great opportunity to give the consortia the tools they need. I completely support the bill and amendment.

Assemblyman Hambrick:
With your concurrence I would like to suggest a do pass as amended, if it is in order.

> ASSEMBLYMAN HAMBRICK MOVED TO AMEND AND DO PASS ASSEMBLY BILL 48.
>
> ASSEMBLYMAN FRIERSON SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN GOICOECHEA AND SMITH WERE ABSENT FOR THE VOTE.)

Chair Mastroluca:
Was there anyone else who wanted to testify on the record? [There was no response.]

We are moving to public comment. Is there any public comment in Carson City or Las Vegas? [There was no response.]

The Health and Human Services Committee has been given four BDRs. If you have a suggestion for a possible bill, please see me for discussion. The BDRs are due by Friday, February 25, so do not wait too long. I also wanted to mention that on each Friday this Committee will meet immediately upon recess of the floor session so that we can try to move things along a little bit faster and possibly get people out a little bit earlier. Please make sure you note on your calendar that we will be meeting immediately after floor session recess.

Are there any comments from the Committee? [There was no response.] This meeting is adjourned [at 2:31 p.m.].

RESPECTFULLY SUBMITTED:

_____
Mitzi Nelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 14, 2011 Time of Meeting: 1:33 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Diane Comeaux	Prepared testimony
	D	Jackie Harris	CCMHC, ten-year Strategic Plan
	E	Jan Marson	Summary of RCMHC ten-year Strategic Plan
	F	Jan Marson	RCMHC Strategic ten-year Plan
	G	Pam Becker	Summary, ten-year plan
	H	Pam Becker	WCCMHC ten-year Plan
A.B. 48	I	Erin Russell	Proposed Amendment to A.B. 48