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

Eighty-Second Session
February 15, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:30 p.m. on Wednesday, February 15, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Shuruk Ismail Committee Manager
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Susan Lynch, Hospital Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services
Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services
Cindy Pitlock, Administrator, Division of Child and Family Services, Department of Health and Human Services
Jacqueline Wade, Deputy Administrator, Residential Services, Division of Child and Family Services, Department of Health and Human Services
Dan Musgrove, Member, Clark County Children's Mental Health Consortium
Jacqueline Kleinedler, Chair, Washoe County Children's Mental Health Consortium
Melissa Washabaugh, Chair, Rural Children's Mental Health Consortium

Chair Peters:
[Roll was called. Committee rules and protocol were reiterated.] We have various presentations on behavioral health today. I know I am not the only one here who feels as though behavioral health care is something that we could be doing more with in the state of Nevada. We have some phenomenal champions in the state departments and in private industry and even in the public sector—private not-for-profits and for-profits—who are working in this space. Our goal is to try and make sure we are all working together to get us to where we need to be as a state. We will start with an overview presentation on behavioral health.

Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
It is my understanding that today you want to focus on youth and children. Much of what we work on in the Division of Public and Behavioral Health (DPBH) is not specifically focused on youth and children but rather more broad, but I will be happy to provide any answers to questions or follow up with any of you in the future and help you connect with the right people if I am not that person. I am using the term "behavioral health" to encompass mental health from serious mental illness to wellness and including substance abuse and use issues. You heard on Monday about the intersection of public health and behavioral health from my colleague Julia Peek. I want to point out that the truth is there is not a separation between public health and behavioral health. The separation is an artifact of our need to divide up the work in some way so that we can bite off these enormous pieces and get them done.

Behavioral health is public health, and members of the public will not be healthy if they are not healthy as related to substance use and mental health issues.

We are in the process of a state health needs assessment and one of the details coming out in that report is that 37 percent of the respondents indicated they had been diagnosed with depression or anxiety. Thirty-seven percent; so, it is affecting all of us. I will also say that health care is not public health, but access to health care is. Slide 2 [page 2, Exhibit C] is a very quick agenda of what I am going to try to cover today. This is our new mission and vision for the Division of Public and Behavioral Health [page 3]. It has been updated recently as part of our efforts toward national accreditation as a public health entity. I would like to point out that I am going to talk today about the parts of our division that are focused on behavioral health, and clinical services is one of those pieces. Those folks provide health care directly to Nevadans—direct services—and that group decided to go ahead and participate with us in this accreditation. It was optional, but they decided they wanted to, which is really cool. That state health needs assessment will be coming out in March as part of our efforts toward accreditation, and I urge you to have a look at that. We will make sure you get it. You will see that access to health care and mental health are the top two priorities that respondents to our survey identified, so those two things are our laser focus.

I included just a little bit about the boards and commissions that this body, and others, have created to help bring us information from the public about what we need related to behavioral health. There are two slides here that cover the boards and commissions [pages 4 and 5]. One thing you may notice is that there are a lot of boards and commissions. There is the Commission on Behavioral Health, the State Board of Health, five regional health policy boards, three mental health consortia, and the Behavioral Health Planning and Advisory Council that is a requirement of our Mental Health Block Grant. We have a lot of opportunity to have discussion and feedback from the community about what is needed to inform our behavioral health system.

On slide 6 [page 6] I have the organizational chart for the Division of Public and Behavioral Health (DPBH). Planning and regulatory services are the bureaus I oversee. There is a Bureau of Behavioral Health, Wellness, and Prevention in that group. The section of clinical services that lists underneath it our facilities—that is the section where we provide health care to Nevadans.

The Bureau of Behavioral Health, Wellness, and Prevention—sometimes referred to as SAPTA, or the Substance Abuse Prevention Treatment Agency—is a portion of the Bureau of Behavioral Health, Wellness, and Prevention [page 7]. These are the people who do the public health part of behavioral health. They oversee several block grants in collaboration with the folks at the Division of Child and Family Services (DCFS) as well. There are two block grants—substance abuse and mental health. There are certifications for substance abuse providers that we do out of this bureau to make sure there is a base level of quality being provided, and this group is doing the implementation of the crisis response system that

you may have heard about. It sometimes gets referred to as "988" and the 988 [Suicide and Crisis Lifeline] is a portion of that system. They are working tirelessly on the pieces to set this entire system up.

I have worked in this structure for 25 years and I will say that we have a somewhat unusual structure in Nevada. Some of that is a result of the history. Most states provide very little direct service, and it is significantly limited to in-patient and long-term care. Nevada has taken longer than most states to focus those services elsewhere and we are still making that transformation.

The next slide is the populations of facilities [page 8, Exhibit C]. These are the clinical services facilities we have. What is demonstrated here are the numbers of people they served in 2021 and 2022. I would be happy to provide you with any other detailed information that would be helpful about those facilities. Slide number nine [page 9] is a brief note on some of the successes we have had in the behavioral health area of the division. We have transitioned to that three-digit crisis call line, so that is operational. That being said, there is a great deal more work to be done on the implementation of the crisis response system in general, and we are making progress on that every day.

As the pandemic resulted in exacerbation of health issues, the division responded with the Nevada Resilience Project to give people support [page 9]; somebody they could call to get help connecting to services—where that was necessary—and to get solid information. During the pandemic, we were able to expand some of those mobile crisis services. Slide 10 [page 10] lists challenges in the behavioral health side of public and behavioral health. Forensic capacity is our capacity to provide evaluation of individuals' competency to stand trial and treatment back to competency so that they can be returned to the justice system. Infrastructure to support the large influx of federal dollars that we have seen. This is primarily related to that Bureau of Behavioral Health, Wellness, and Prevention that I described. They have had three times the workload that they had prior to the large influx of federal dollars, and they are working very hard to get that money out. Workforce, and having enough people who have the credentials necessary to provide professional mental health services, as we all know, is a challenge, and state workforce is a challenge. Finally, there is housing and other long-term support for people with behavioral health issues. That can be very difficult, particularly when we are talking about those folks who have serious and persistent mental health issues.

Chair Peters:
We have a couple of questions.

Assemblywoman Gorelow:
We hear about mental and behavioral health. Could you explain more specifically about forensic psychology and what that means? A lot of people might not realize how that differs from other treatments.

Cody Phinney:
I am not a psychologist, and I am not a mental health professional. My background is in public health, but I have worked in the system for many, many years and I have worked with these folks helping to manage these programs for many years. The forensic capacity I spoke about includes two facilities designed to evaluate competency of people who have been charged with crimes and either treat them back to competency or determine that they are competent. There are a lot of nuances to this that are beyond my capabilities, but in addition to that, there are programs that do this work outside of those facilities. The need for this work has increased significantly, and you will see projects in our budget to make sure that we have capacity to do this.

Assemblywoman Gorelow:
We are seeing a lot of vacancies in a lot of departments, and with clinical psychologists needing 10-15 years of training, how is that impacting these programs?

Cody Phinney:
I am going to invite Susan Lynch to come to the table in Las Vegas, as she may have specific details about the vacancy rate of clinical psychologists; and if she does not, she certainly can get them. We work very hard to get staffing by contract and/or state fulltime equivalents (FTEs) to provide these services.

Susan Lynch, Hospital Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services:
We have a multifaceted approach to try to fill all the vacancies we are dealing with throughout the agencies. Our psychology department has a couple of very robust processes to fill some of their vacancies, one of which is that we utilize contract staff as needed. Also, the psychology department works very strongly with the school of psychology, and they have a very strong internship program connected through the NV-PIC [Nevada Psychology Internship Consortium] program, so our director of psychology is constantly recruiting and working with new students in universities to fill some of those spots with the thought that we can eventually fill the fulltime positions or the contract positions with the students as they gain experience.

Chair Peters:
That brought up more questions for me about how an internship gets you 15 years of experience, but I understand that we are all dealing with the limitations of time and expertise in the state around this area.

Assemblywoman González:
Under your successes, you listed the Nevada Resilience Project [page 9, Exhibit C] that would respond to behavioral health needs related to the pandemic. What were those successes?

Cody Phinney:
The Nevada Resilience Project is an array of individuals who are stationed throughout Nevada who can provide their community health workers. They can provide information related to people who are having anxiety or stress or concerns about the pandemic. It was stood up as a pandemic response process with dollars related to that.

Assemblywoman González:
Does this project still exist, and in terms of dollars, how is it existing?

Cody Phinney:
The project does still exist. At this point, it is a bit smaller than it was at it is height. There is also the project where we are standing up the 988 crisis response line so no one in Nevada should be without someone to call. There is lots of work left to do, but lots of success being made as we move through this, and yes, the Nevada crisis response is still up and running with funding from crisis response dollars.

Chair Peters:
To those who are watching, please utilize 988 if you are feeling like you need help or if a loved one needs help. It is not just for people who are in direct crisis and threat of suicide, but for all people who need that extra bit of support or direction to services. Please use that line. We cannot staff it if we do not have people using it, so you help us justify making sure it is funded.

Assemblyman Hibbetts:
That is a wonderful segue because my question is about 988. Do you know if there was a change in the volume of calls between the 10-digit number to the transition to 988? If there was, do you happen to know what that change might be?

Cody Phinney:
I can provide to this Committee the data on the number of calls that we had to the previous 10-digit crisis response line and to the 988 number since that was implemented. I do not know it off the top of my head today.

Assemblyman Hibbetts:
Off the top of your head, do you know if it was an increase, a decrease, or roughly the same?

Cody Phinney:
My recollection is that there was an increase with the publicity of the three-digit number.

Assemblyman Nguyen:
Looking at slide number 8 [page 8, Exhibit C] in terms of population served, it seems like there was a decrease in most areas between fiscal year 2021and fiscal year 2022. Is that due to a vacancy in providers? It seems like the elevated need for mental health access points means a lot of folks want to have access to these services, but I am curious why we have declines in most of those numbers.

Cody Phinney:
I chose the years—2021 and 2022—which are years that demonstrate the pandemic, and these are primarily in-person visits. I suspect that if we get you some longer-term data, you are going to see different indications than a decrease ongoing.

Chair Peters:
I want to mention that we have Kyra Morgan from the Office of Analytics speaking next who may be able to answer more of your data and statistics questions.

Assemblyman Nguyen:
In terms of vacancies in your department, I noticed that the organizational chart [page 6, Exhibit C] listed fulltime equivalent (FTE) roles in the top three rows of the chart. Are there data available in terms of FTEs within the programs? If so, are you experiencing a high shortage in those positions?

Cody Phinney:
The FTEs you see listed on the organizational chart indicate that those positions are a single position. But yes, we can provide the numbers of FTEs for each of the programs and the vacancy rate for those. It is challenging to get professional staff at times, but we do fairly well, and we try to be as flexible as possible with the way people prefer to work—by contract or by employment, whatever options we can make available.

Assemblywoman Taylor:
My question pertains to the three-digit number. It sounds like it has been really successful. Do we have bilingual capabilities or other languages available for those who may call?

Cody Phinney:
Yes, there are some bilingual capabilities related to those services. Certainly, we can always do better and need to do better in making sure that there is accessibility for everyone, but there are some bilingual capabilities.

Assemblywoman Taylor:
I am thinking primarily of Spanish. Do we have others besides Spanish?

Cody Phinney:
We have primarily Spanish, but off the top of my head I do not know what else we have available, but I would be happy to get it.

Chair Peters:
The federal government is working on the 988 program and accessibility as well, so the state providing numbers for how our population and communities utilize 988 helps our federal partners in establishing what those programs can look like. I want to share that the 988 program is a network across the country. Nevada is lucky that we had a crisis call line available to integrate into the 988 program, so you actually talk to Nevadans when you call during the daytime in Nevada. We are integrated into that broader network now, which is

fantastic and allows for a much longer period of time for accessibility. Are there any other questions before we move on to the next presentation? Seeing none, next on my list is Kyra Morgan from the Office of Analytics.

Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services:
Today I am going to pivot a little bit and give a presentation on data and trends specific to substance use and abuse in the state of Nevada. I wanted to start by setting the stage with some national comparisons. On the slide that is on the screen now [page 14, Exhibit C], you will see some information from the Substance Abuse and Mental Health Services Administration indicating that the prevalence of past year substance use disorder in Nevada was 9.5 percent of our population. That is compared to a regional average of 8.1 percent and the national average of 7.4 percent. Similarly, the prevalence of past year alcohol use disorder in Nevada was 6.2 percent. That is compared to a regional average of 5.9 percent and the national average of 5.3 percent.

I wanted to also orient the Committee to some resources that are available online. If you click on the Office of Analytics' website link, you will see a suite of data dashboards, including those listed here, that will allow you to maneuver the data I am about to present at any time when I am not available as a resource. I also wanted to use the data sources on this slide [page 15] as a way to agendize the slides I will be presenting.

I am going to talk about self-reported substance use through our behavioral risk factor surveillance system [page 17]. That is a national survey, and it focuses on adults. Then I am going to talk about self-reported substance use in our youth through the youth risk factor surveillance system. I will segue into our hospital billing data, which is based on claims. We have statewide claims information for everyone who presents in an emergency department and anyone who is admitted in an inpatient setting, so we are going to talk about hospitalizations related to substance use and abuse. Then I will talk about some overdose mortality data from our vital records system and our statewide unintentional drug overdose reporting system.

It is important here to pause and orient the Committee to some definitions. There are different ways that we can look at hospitalizations related to substance use. A lot of times people think that when we talk about substance use hospitalizations that we are narrowly focused on an overdose. In this presentation, I am going to talk about hospitalizations more broadly. When I talk about alcohol- or drug-related emergency department encounters, those are individuals who present in an emergency room, and at some point in that visit it is identified that there are substance use or alcohol use behaviors, but it is not necessarily the reason for the visit. So those people are not actively overdosing at the time they are presenting to the emergency room. They might have a primary diagnosis of anxiety or depression, and then substance use or abuse is addressed in the visit, but it is not necessarily the primary cause bringing them to the hospital. Then I will proceed and get a little bit narrower when we talk about poisonings. Poisonings are specific to that acute potentially life-threatening event that we would think of synonymously with an overdose.

I will jump into the data again. This is self-reported drug use in the last 30 days for our adult population [page 17, Exhibit C]. Most significantly on this slide obviously is the increase in marijuana use over time, significantly increasing year over year until 2021, when it declined just slightly. In general, about one in five Nevadans self-report that they have used marijuana in the last 30 days. This is similar information, but for our youth, and the data is presented a little bit differently here [page 18]. This is a survey that goes out to our high school students. It is administered every other year, and here we are looking at the proportion of individuals who report having ever used marijuana, which was about 30 percent in 2021; those who currently use marijuana, which is 15 percent; and then there is an indicator asking if they had used marijuana before the age of 13. About 9 percent of our high school-aged youth indicated that they had. This is similar information related to alcohol. The proportion of students having ever drank alcohol really hovers around 50 percent. Similarly, about 1 in 5 reports that they are currently using alcohol, and about 1 in 5 also reported that they first drank alcohol prior to the age of 13. There is another question on the YRBS [Youth Risk Behavior Survey] that talks about self-reported lifetime drug use. This asks if they have ever used these substances. You can see that synthetic marijuana is the most common here on the slide [page 20]. About 7 percent of all high school students reported having used synthetic marijuana, followed by ecstasy at about 5 percent, cocaine about 4 percent, methamphetamine about 3 percent, and 2 to 3 percent of our high school students self-reported having ever used heroin.

I am going to pivot now from survey data to our hospital billing data [page 21]. These are encounters meaning an individual presented to an emergency room. At some point in that evaluation, a diagnosis code was attached to that claim related to substance use and abuse. You can see the trends related to both drugs and alcohol separated out. In general, significant increases in alcohol- and drug-related emergency department encounters until about the end of 2016, and we start to see that level off. Drug use as presented in an emergency department has been pretty stable for the last few years. Alcohol use has been increasing again, and in 2021 there was not a big difference where drugs or alcohol were more common than the other. They were about the same. To put numbers on that volume, in any given quarter of 2021 about 8,300 individuals presented to a hospital related to alcohol use and about 8,900 individuals presented related to drug use.

Here, we are just drilling down into that drug use to look at the specific substance that was present [page 22]. I think most noteworthy on this slide is the significant increase in methamphetamine, which is the dark orange line. There is an indicator on the slides for when the international classification of diseases was updated from the ninth version to the tenth version. When that happens, we do see some changes in trends in how things are coded, so there is an artifact there that could be in play. In general, there were significant increases until maybe around 2019 and we see a lot of these trends start to level off. The second most common drug that was addressed in emergency department visits—again, not related to overdose but visits in general—was marijuana. The blue line in the middle of this slide represents opioids. You can see a declining trend in opioids over the past few years.

This is similar information, but these people were admitted [page 23, Exhibit C]. Some of these individuals could have come in through the emergency room and it was determined that they needed to stay in the hospital for more than 24 hours. There is not a requirement that they came in through the emergency room, but it shows a similar trend. Up until about 2014, alcohol and drug use were on par with each other. We saw significant divergence and increase in drug use over the next three or four years until probably the beginning of 2019, and then those trends have leveled out a little bit. To put a magnitude to it, there were about 5,800 alcohol-related visits and 9,100 drug-related visits in any given quarter of 2021.

This is similar information but broken down into the specific type of drug [page 24]. You can see these are not overdoses, but you can see marijuana and methamphetamine being most commonly associated with inpatient admissions. Just to reiterate, those trends increased significantly from 2015 to 2019, and then we have seen them be pretty stable since then. The trend for opioids has actually declined.

I want to draw your attention to the stark differences between this slide and the previous slides I presented. This is specifically poisonings [page 25]. I have presented that methamphetamine and marijuana are commonly associated with visits to the hospital, not being the primary reason for the visit, but were addressed somewhere in the visit with that provider. When we look at poisonings—which are acute and potentially life threatening—we would not use it entirely synonymously with an overdose, but this is the closest thing we have to gauge overdoses in our community. Opioids are at the top of the chart. Although we see methamphetamine and marijuana being used commonly in the community, most of the individuals who are presenting in an emergency department and being admitted because of a specific poisoning are opioid-driven.

I am going to go over mortality data [pages 26 and 27]. These are overdoses that resulted in deaths and are sourced from our vital statistics data. You can see significant year-over-year increases both in alcohol- and drug-related deaths. The top graphic and bullet points are related to alcohol and the bottom of that slide is related to deaths. It is important to understand that a lot of times both drugs and alcohol are present, so these are not mutually exclusive. You could have an individual who overdoses, and they have both alcohol and drugs contributing to that. Most significantly here is the average year-over-year increase in alcohol-related deaths being 18 percent and in drug-related deaths being 21 percent. It is important to look at what drugs are present in those, so this is where unintentional drug overdose data comes in. We can see the drugs that were contributing to those deaths. I think most noteworthy on this slide are methamphetamine and fentanyl. Those are the two categories of drugs that we not only show make up a large proportion of drug deaths, but we see significant year-over-year increases in those drugs specifically. Keep in mind when you are trying to compare this slide to previous slides, that the top section is for non-opioid drugs and the bottom section is for opioids. If we were to combine the opioids, you would see that they outpace methamphetamine, but when it is broken down by specific type and you get that detail, then I think fentanyl is the one I would draw your attention to as being the most severe.

Chair Peters:
Are there any questions from the committee?

Assemblywoman González:
When you were talking about national and regional comparisons, do we have more updated data? Why is it from 2019?

Kyra Morgan:
We tried to update the slide to be 2021 data; unfortunately, a different methodology was used on the national Survey of Drug Use and Health, which is what sources this information. Because of the pandemic, they switched their survey methodology to be entirely electronic. Originally, they posted those data for states to use with a nuance that said they would not be comparable to previous years. They then retroactively pulled that data and recommended that states do not use it because of what is called a MOD effect in the sampling design. They did not think that it was comparable and should not be used until they vetted it further.

Assemblywoman González:
In this survey with youth [page 18, Exhibit C], are we asking questions about why they are using and why there might be changes? In 2020, marijuana use increased to 19 percent and then in 2021 it decreased, but then we also see increases in other drugs, so I was just curious if your survey asks them those qualitative questions.

Kyra Morgan:
I think you are looking at the slide for the adult survey for marijuana use increasing to 19 percent and then down to 18 percent [page 17], but the question probably still holds. I can provide full questionnaires for both the Adult Risk Behavior Survey and the Youth Risk Behavior Survey. There are a lot of questions that they ask related to experiences in the home and feeling depressed within the previous 30 days. There are questions they ask that I do not think are directly related like why they are using drugs. But inferences could be applied to compare these statistics to trends and depression and other household characteristics. It is a wide range of things beyond just behavioral health. It is access to health care; it is access to food. It is a really broad survey.

Assemblywoman González:
So just to clarify, we are not asking specifically why they are using, we are just asking if they are using?

Kyra Morgan:
I do not believe there is a specific question as to why, but I will follow up with the question and confirm that is accurate.

Chair Peters:
That is an interesting question. Why would you use a drug? The goal in the survey is to get at underlying factors more than asking a child their purpose. It will be an interesting exercise to go through, and it might be worth asking the university to come in and talk about it.

Assemblyman Hafen:
On slide 26 [page 26, Exhibit C] we see an increase in deaths related to drug and alcohol use starting in the pandemic. Now that we are out of the pandemic, is the preliminary data showing that those numbers are coming down? Are we still seeing the same high rate of deaths due to drugs and alcohol?

Kyra Morgan:
This report goes through 2021 data, so there is no opportunity to see. We still consider 2021 to include the pandemic in a lot of ways, so we do not have enough time to see if there is a bounce back or a recovery. We do have preliminary 2022 data that I can follow up with and provide to the Committee. I do not know off the top of my head if the 2022 data that are in so far imply that we might see a subsequent decline.

Assemblyman Hafen:
Our goal in this Committee is to try to prevent that, right? If it is because of the pandemic and they were not getting adequate care or using it as a coping mechanism, I think that is information we should know. If we are not headed on a downward trajectory, I would really like to know because that would be wonderful. We can blame everything on COVID-19 and the pandemic, and we can move on with life. That would be excellent. My second question is related to the youth marijuana use on slide 18 [page 18]. Do we know where the high school students are obtaining the marijuana? Are they going into stores using fake IDs, are they getting it from parents or older siblings, or are they getting it from the illegal market?

Kyra Morgan:
I do not know off the top of my head if that data is available in the survey or otherwise, but I will do some research and provide an answer to the Committee.

Chair Peters:
I am going to send out the link to that survey for everyone so you can look through it at your leisure. I also want to refer to your first question. The impact that the COVID-19 pandemic had on public and behavioral health was assessed during the study Senator Doñate led. There is a report on their findings that might have information regarding this issue, so I will ask that staff follow up on getting you that link.

Assemblywoman Taylor:
If we can go to slides 18 and 19 [pages 18, 19], you have some interesting information that is valuable in terms of drug usage for high school students. Do we have any national comparison data?

Kyra Morgan:
Yes, I should have included that in my presentation, so I will follow up with that, too.

Assemblywoman Taylor:
My second question concerns slide 20 [page 20, Exhibit C]. What is synthetic marijuana?

Kyra Morgan:
I need to defer this question, but I am not sure if I have a colleague who knows the answer.

Chair Peters:
It refers to "spice," which I am sure that you are aware of given your history on the school board. That is what pops up initially on the search engine. Are there any other questions from the Committee?

Assemblyman Gray:
Referring to slide 27 [page 27], there has been a lot of commotion about fentanyl deaths lately, and I know there is a huge problem. However, looking at methamphetamine, which has been around a lot longer, when you look at 2019 data, the deaths were 70 percent higher. In both 2020 and 2021, they were about 32 percent higher. What is going on with methamphetamine because, especially in the rural areas, that is still a huge problem.

Kyra Morgan:
If you are looking at intervention specific to methamphetamine, I can get with my colleagues and provide that to the Committee as well. I will say when we looked at the data throughout the opioid epidemic, we were not as good at breaking it down by specific opioid. When you look at opioids combined compared to methamphetamines, they are a lot more comparable. When we break down the opioids to separate fentanyl from heroin, from methadone, from prescription opioids, then it almost dilutes the magnitude of those numbers compared to methamphetamine, so that is part of the artifact you are seeing on the slide.

Chair Peters:
That is an interesting question and an issue we have been grappling with in the state for a long time, particularly in the rural areas and the impact it has on our communities. We can do some digging as well and see if we can find some answers for you. Are there any other questions from the Committee?

Assemblyman Orentlicher:
On slide 14 [page 14]—the comparison and prevalence of alcohol use disorder and substance use disorder—I was a little surprised. I thought alcohol would be higher. Then when we look at slide 26 [page 26], the deaths are considerably higher—50 percent higher for alcohol, which is more than I would have guessed. Is there something about the way they define substance use disorder versus alcohol use disorder? It may be because substance use is illicit substances, they have a lower threshold for calling it a disorder. We tolerate higher levels of alcohol before we call it a disorder, is that something that is going on or is it that illicit substances have overtaken alcohol?

Kyra Morgan
I cannot speak off the top of my head to the methodology used in the national data, but I will follow up on this as well. When we look at the emergency department visits for alcohol and drugs in Nevada, we do see that drug-related encounters in our hospital system have overtaken alcohol and are more common. How that transpires into the mortality data and why folks are still appearing to pass away from alcohol more frequently than from drugs is not something that I can speak to off the top of my head. I think it is important to note that when we break it down by drugs for mortality data, a lot of those are the same folks. A lot of people who overdose have both alcohol and drugs in their systems, so they are counted in both of those populations. Those are not mutually exclusive groups; they cannot be added together to come up with a complete picture. I will provide more details on that as well.

Chair Peters:
Are there any other questions? [There were none.] We will now move on to our next presentation.

Cindy Pitlock, Administrator, Division of Child and Family Services, Department of Health and Human Services:
We are going to talk about our favorite topic today, which is kids. We are going to start with what a system of care is, what healthy systems of care and continuums of care are, and why they are important. A system of care [page 32, Exhibit C] offers an organized framework and value base for system building for children and youth with complex behavioral health needs. It connects and coordinates the work of child serving agencies, key partners and stakeholders, which help to keep children, youth, and families in their homes, in their schools, and in their communities as much as possible. Nevada began integrating a system-of-care approach in 1998, and these principles are interwoven in everything we do.

A system of care is guided by three core principles: It needs to be family-driven and youth-guided, community-based, and culturally and linguistically competent. When we talk about a healthy continuum of care, what we are talking about relative to children's mental health is a complete continuum of care that provides full access for youth to different treatments, from the lowest level to the highest level, allowing for fluid movement up and down that continuum based on assessment and need. It should always be the goal for our youth to receive services in an appropriate setting in the least restrictive environment for the appropriate amount of time, and with smooth transition from one level of service to another. When we lack services in that continuum, we inadvertently bump youth into higher levels of service, and the recidivism rates increase without smooth transition back down to lower levels of care. High quality discharge planning when youth are in residential services begins, hopefully, prior to admission, but at least upon admission, with specific targeted goals in their care plan to step them down to lower levels of service on that continuum. When we talk about a continuum, we may identify gaps in that continuum, and that helps you understand why it is so important to have that full continuum.

This is a breakdown of the community services we have [page 34]. The Division of Child and Family Services provides community-based and outpatient services to youth, many of

whom would enter the child welfare or juvenile justice systems if those appropriate treatments and interventions were not available. The purpose of outpatient services is to provide comprehensive and individualized mental health care to emotionally disturbed children in the least restrictive environment—hopefully with their families and in their communities. Ideally, outpatient services are also utilized for that step down from a residential stay or from acute inpatient services. Our mobile crisis response team is a team of mental health professionals and psychiatric caseworkers designed to reduce unnecessary psychiatric hospitalizations and placement disruptions and to reduce the need for youth to go to emergency rooms to have their mental health needs assessed. These mobile crisis response team services are intended to be community-based where teams are dispatched to assess youth in crisis and provide services at the location of choice of the family. This also includes follow-up of services and the formation of safety plans with the family and youth. They also provide telephone triage, crisis response, stabilization, and after care with the goal to keep youth safely in their homes, communities, and schools, if at all possible. Another one of our community services programs is our Wraparound in Nevada for Children and Families (WIN) program which provides intensive clinical case management for children with severe emotional disturbance. The model we use is called High Fidelity Wraparound, which is a highly structured model that requires a significant amount of training and certification of staff as well as a fidelity to that model to make sure we are using that model effectively. This program focuses on a strength-based approach and working with the family. The family is at the center—identifying their strengths and individual needs. The families love the concept of having a voice about what is important to them and what is going to work for their families.

Children's clinical services provide community-based child, adolescent, and family mental health assessment and treatment at three neighborhood clinics in Las Vegas and one location in Reno. They utilize a very wide range of evidence-based treatment modalities that are specific to what the family needs based on their strengths and the mental health needs and assessment. Our infant and early childhood mental health services are provided to families and caregivers of children from birth to eight years old at three neighborhood clinics in Las Vegas and one in Reno. This is an interesting model in that it is a parent-child dyadic model for assessment and treatment specifically to the needs of infants, young children, and their caregivers in a trauma-informed and relationship-focused environment. This also includes coordinated case management. This is considered a safety net population as there are few if any community providers able to provide parent-child, infant-early childhood mental health services coupled with that paired relationship. Also, our youth parole teams engage our mental health counselors to assess youth committed to our services to determine placement options for our three state youth centers. If our mental health team determines the youth would be better served in a mental health arena, our team sends out referral packets and, hopefully, diverts those youth into appropriate mental health services versus correctional care. This concept is in recognition that many of our youth who are diverted into our services really need mental health services versus intensive correctional-type care.

For our residential services, we have Desert Willow Treatment Center [page 35, Exhibit C]. It is Nevada's only state-run locked psychiatric residential treatment facility. It has 32 licensed beds—8 acute and 24 residential. The acute unit is designed for short-term

diagnostic, stabilization, and treatment for those youth at imminent risk of harm to self or others. The residential treatment center portion is for adolescents who have not progressed in other settings, in a less restrictive setting and need the inpatient setting. At Desert Willow they provide individual, group, and family therapy, and offer quite a wide array of modalities that are based on the specific needs of the youth. We also provide skills training, nutrition, discharge and after-care planning, and the educational services for those youth are provided on-site by the Clark County School District.

Another one of our residential treatment facility settings is the psychiatric residential treatment facilities (PRTF): Oasis in Las Vegas, Enterprise in Reno and North in Sparks [page 36, Exhibit C]. They are a very important part of what we do. Youth in the PRTF model receive psychiatric and psychological services, applied behavioral health analyses, individual and group counseling, recreation, a wide range of therapies, and nursing and medication management. We currently have solicited for an RFP, a request for proposal, to outsource the PRTF at Enterprise in Reno because we were unable to staff it, so we have 16 beds empty. Hopefully, we will be able to partner with a community provider that can provide staff, and we can get those beds open to the community. Moving to our juvenile justice facilities, they also offer a broad range of mental health services as we have indicated on our slide here for you.

Under administration and support [page 38], our Planning and Evaluation Unit provides data analysis, planning, and program evaluation through utilization data, utilizing our data to determine outcomes through surveys, and making sure that we are using our evidence-based models to fidelity. We also have our system of care grant. That exciting program they initiated was a self-directed respite care pilot program in Nevada, which was the first one ever. We have a commitment to use data to inform our decision making, as you heard from our colleague here, and we partner with her quite a bit to utilize what we consider the highest quality data to plan our interventions and decide what our target populations are, what our greatest needs are, and how to plan upstream interventions as well.

We were very fortunate to receive a sizable investment of ARPA [American Rescue Plan Act of 2021] funding for services to address the children's mental health crisis [page 39]. Some of you were part of that and are very much appreciated for all the work you put into it. We are working toward sustainability of those services both by partnering with Medicaid and in our upcoming proposed budget. These investments included mobile crisis response in both the communities and in the Clark and Washoe County School Districts, intensive family in-home services, emergency and planned respite, family and youth peer-to-peer support, as well as replacing our UNITY [Unified Nevada Information Technology for Youth] system, which is our child welfare information system, workforce development, and some day treatment programs. As part of our goal for Desert Willow, we are going to be increasing to a total of 54 licensed beds, utilizing approximately $6 million in ARPA funding to improve the facility to reduce opportunities for youth to self-harm, and to improve security barriers for staff to reduce injuries. This will be a phased-in approach as construction is continuing to get those beds open as quickly as possible.

I would like to move our successes and challenges [page 40, Exhibit C]. Our infant and early childhood mental health program has succeeded in the creation of Nevada's first Infant Mental Health Association. This is exciting because it is going to support the ability to become a nationally endorsed association in the specialty area of infant and early childhood mental health. It makes Nevada one of our national leaders. It will create an additional grant opportunity and give us a rich training ground for all kinds of students who we want to get into our services to have those opportunities for student internships that could transition into working with us in Nevada. Our juvenile justice facility, Summit View, was recently recognized by the Nevada PBIS [positive behavioral interventions and supports] technical assistance center for their demonstrated excellence and leadership in the implementation of a multi-tiered system of supports called positive behavior intervention and support. This is an evidence-based, tiered framework supporting youth behaviorally, academically, socially, emotionally, and with their mental health.

With all of that comes some opportunities for us [page 41]. Of course, many of our opportunities are rooted in staffing issues. Like many other agencies, we are experiencing severe staffing shortages which were exacerbated by the pandemic. This has resulted in the need to outsource two of our PRTFs [psychiatric residential treatment facilities] and long waitlists for our services.

The people who work for DCFS in our mental health services are really unique people. It takes specially trained staff to work with youth who have severe, deeply rooted trauma and significant mental health needs. We see it to be physically challenging and emotionally challenging for staff, and with that comes a lot of turnover and burnout. A lot of these youth we serve experience emotional, physical, and sexual trauma that often starts at a very early age. We often find ourselves doing a lot of turnover training and retraining and bringing new staff in. Hopefully, we can think of ways to retain people in such a really difficult service area. We do recognize an opportunity working with Medicaid, because the lower reimbursement rates make it really challenging for community providers of behavioral health and residential services to come to Nevada to work. We do know that we have quite a gap in the community health area as far as opportunities and service array. Inadvertently, we are placing youth in non-therapeutic congregate care settings because there is no appropriate setting for them to receive their services. We also know that we lack step-down or transitional placements following residential care, and we send youth out of state for specialized treatment because those services are not available in Nevada. Last night I looked at the [DCFS] dashboard, and we have 70 youth currently in out-of-state placements. My concern for those youth is when we need to bring them back to Nevada, how do we reintegrate them back into the family home and community.

If I were asked what the biggest service gaps are, intensive outpatient and partial hospitalization services are quite a gap, as is respite care and opportunities for step down into family-like settings to reintegrate successfully with our juvenile justice facilities. If I were to be asked what our biggest concern is, it is staffing—safe staffing. We find that the behavioral health needs of our youth have increased in acuity. Our juvenile justice facilities, our correctional facilities, do offer mental health services, but some of those youth who are at

risk for self-harm often need 1-to-1 staffing. If we take staff away from an entire correctional facility environment, it creates an unsafe environment for everyone else when we have to place youth on 1-to-1 or 1-to-2 staffing ratios.

The United States Department of Justice released a final report titled "Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities." This report highlighted that we do not have adequate services in the least restrictive setting. There are not adequate community-based services, and we over rely on institutional settings. We also over rely on emergency departments for screening, assessment, and stabilization, and we also have youth with extended stays in non-therapeutic, congregate care types of settings. We are working across all of our divisions within the Department of Health and Human Services and with the Attorney General's Office for a high-quality response to that report.

We have long planned for the development of a children's behavioral health authority [page 42, Exhibit C]. In Nevada, there is no adequate, well-trained, behavioral health service workforce that can oversee our system to ensure that it is extremely high quality with proven positive outcomes. In other states, these functions have been called a children's behavioral health authority. Initially, what we are going to do is provide the structure and support and training to oversee those huge ARPA projects we are bringing online. On August 18, 2022, the Joint Interim Standing Committee on Health and Human Services issued a directive to us and DPBH to formulate a comprehensive state plan for behavioral health clinical standards. This includes clinical oversight of community-based settings and institutional settings. We were tasked with forming how we would certify or deny certification of behavioral health care programs. If those programs were not certified as having a high-quality standard of practice, they would be ineligible to receive state and federal funds. This could be a really exciting build out for us that we are hoping we can move forward with.

Chair Peters:
We have several questions.

Assemblyman Nguyen:
I am very pleased to see on slide 32, your core values [page 32], that culturally and linguistic competence are listed among your highest core values. Could you please give us an overview? Maybe go in depth on what that means?

Jacqueline Wade, Deputy Administrator, Residential Services, Division of Child and Family Services, Department of Health and Human Services:
When families come to DCFS, it is important that they feel comfortable and that they are receiving services in the language they speak. We use a language line, but it is important that we recruit staff who are versed in the language that comes to our agency and to our facilities. When we talk about linguistically appropriate, it means that the family is able to understand in layman terms, and in the language they speak, what is happening and what is being offered to them. This is opposed to having a family member interpret, because we find that is not the appropriate way to go.

Assemblyman Nguyen:
Do you have an idea how many languages you currently serve? If not now, could you send us that data? That would be helpful.

Jacqueline Wade:
I do not have that information available, but I will certainly get that to you if we have the data on languages.

Assemblyman Nguyen:
I look forward to seeing it. As you may be aware, we have a high percentage of Asian Pacific Islanders (API) in my district as well as across the state, and I would love to see if that data exists in your programs.

Chair Peters:
That is an interesting question. I remember hearing that there are contracted services with the state that offer interpretations or translation services. If your offices use those, that would be good to know as well.

Assemblywoman Newby:
Looking at the community services on slide 34 [page 34, Exhibit C], Children's Clinical Services are listed, but your service populations are on slide 37 [page 37]. Am I correct that the Children's Clinical Services/Outpatient saw about 170 clients in fiscal year 2022. Is that correct?

Cindy Pitlock:
Can we follow up with that in writing for you since we are having a little bit of a technical glitch?

Assemblywoman Newby:
When I look at these numbers, for a state of three million people, your outpatient services seem really low if it is 170 people. In addition, on a previous slide concerning Desert Willow, you said you had just funded—although you are trying to bump that up—the acute unit's 8 beds and the residential services has 24 beds. But in fiscal year (FY) 2022, you had one person in the acute unit and ten people in residential services. I am wondering why the numbers seem to be low. How long is the waitlist for children to access your services, and if they are not able to access these services, where are they going? You also mentioned there are 70 children out of state. Under the Average FY 2023 column it shows 14 being in Desert Willow, which I believe is your only residential facility here.

Cindy Pitlock:
I will start this off. In short, the answer is staffing. It is heartbreaking to walk through a hospital and see empty beds that you cannot provide services for because you cannot safely staff. That is the bottom line. We need people to take care of children. As far as waitlists, who goes where, and air traffic control, I have my expert here who can answer that.

Jacqueline Wade:
Concerning the reduction in beds, we did have a diversion from kids going to our juvenile justice facilities in order to meet the needs of the psychiatric presentation of the youth. We had them diverted to Desert Willow, and with that diversion, we also saw externalization of behaviors. We saw high acuity, and with high acuity we had to staff safely, which is 1-to-1 or 2-to-1 in order to keep the hospital safe and the male youth safe so that we can at least provide treatment. So, the reduction and the one patient that you saw, it could be because of behaviors and also staffing. That might be an explanation of the numbers you are seeing because we did have beds diverted from our juvenile justice facilities with kids that have extreme trauma. Regarding the waitlist, we can provide that to you as well.

Chair Peters:
I am glad you asked that question because I was also wondering about waitlists for facilities. Can you talk about the movement around community-based services and how your agency is working with community-based services—or services provided under a different authority—and how your office integrates ensuring they are being provided adequately at those facilities? What does the future look like? Are we going to be able to staff at the state and continue to provide those direct services to kiddos, or do we need to look at a model where we are leaning harder on our community-based services and supporting them in providing these services?

Jacqueline Wade:
We are looking at a myriad of services across the state because we know that we have a heavy lift, and we know that we have a great need in the state. We are currently working with several providers, private providers, to take on some of the load from the state. Nationally, we know that a lot of services are being provided in the community as opposed to leaning on the state for services. That is one thing we are moving toward, but we have not gotten there yet because we need to provide care to those who are uninsured and underinsured. That is part of the population that is marginalized and disenfranchised, and we remain committed to providing care to those populations.

Chair Peters:
You do not need any additional weight on your back, but these are the things we are hearing from constituents. It is demoralizing and, in some cases, unsafe. We have 70 youth who are placed out of the state. Are they in states that care for their particular needs? We have a neighboring state that recently passed a law that puts a significant population of kiddos who need behavioral health services at risk for being in that state. This is dire, and I know you are working on plans. When can we expect a response and an action plan that we can look at and see where you are going with this?

Cindy Pitlock:
What we are focusing on intensely right now is building out of community-based services. If we can prevent these youth from needing inpatient services to begin with, that would be our first goal. I do not think we are ever going to get away from inpatient services, but we should limit those services. They should be for the least amount of time with as rapid a

transition back to home and community as possible. So, the intensive in-home services, the respite partial hospitalization, those are the kinds of things we want to work within the community-based setting to, hopefully, divert those youth from needing intensive in-patient services to begin with. We did receive a large ARPA award that we are wrapping into one big package. I am waiting for my colleagues at purchasing to get that RFP [request for proposal] released, so there is an entry point for those youth and families and some air traffic control to get those families landed and wrapped with services to, hopefully, prevent those youth from needing those beds in the first place.

Jacqueline Wade:
I want to follow up on those kids who are out of state. Those are services for kids on the autism spectrum. We also have kids who need juvenile sex offender treatment who are out of state. We are also seeing an increase in youth ingesting objects who need a psychiatric/medical facility for services. Those youth going out of state are going for services not provided here in Nevada. We can provide outpatient services for those on the autism spectrum by providing a behavioral analysis; however, those who are out of state need services we are not providing in the state of Nevada

Assemblywoman Taylor:
We are concerned about this vulnerable population of our youth. My question is related to page 37 [Exhibit C]. As I look at the fiscal years 2021, 2022, and through 11 of this current fiscal year, in most cases the numbers are trending down. Can you talk about why that is?

Cindy Pitlock:
Much of that is our capacity to take care of youth and seeing them has diminished because of staffing.

Jacqueline Wade:
It could also be in some areas where you see kids are staying in care longer, the ones that we currently can staff, making it difficult for others to access services in addition to staffing.

Chair Peters:
What is the biggest barrier for staffing?

Jacqueline Wade:
In addition to staffing, it is also pay, and the third one would be specialization. We need a workforce that has credentials specialized in mental health. What we have done is partnered with the universities across the state to help with our workforce development, specifically nurses, as well as nurses with backgrounds in psychiatry. So staffing, pay, and specialization in mental health services are the barriers.

Cindy Pitlock:
To put a number on this, in children's mental health, both in the north and in the south, I am down 180 people. These are people, these are not percentages. These are people, professionals we desperately need to take care of kids with severe trauma. I am not trying to

be dramatic, but you can throw the term "percentages" around; however, think of lining up 180 people and the impact that could make on a wide array of services.

Chair Peters:
You make an excellent point. We hear that in the state there is a vacancy rate of 25 percent, but in different departments it means different things. In an IT [information technology] department, it could be one person, but in the Department of Health and Human Services that could be hundreds, so thank you for that perspective. Are there other questions from the Committee?

Assemblywoman Newby:
In Clark County, I know there is an issue with overcrowding and not appropriate placement of children at Child Haven. What is your interaction with Clark County and Child Haven? How does that system work to get a better placement for some of those children?

Cindy Pitlock:
Part of the issue is getting specialized foster placements open and accepting youth in family like settings so we can get youth out of congregate care settings. We have had some recent wins there relative to an additional $200 a day to incentivize specialized foster care and provide a more sustainable rate to those who will accept youth. We are trying as hard as we can to move those youth out of Child Haven and into an appropriate placement for mental health services. It definitely is a staffing issue, but I am excited to see if we can get some momentum now that we have increased that specialized foster rate by an additional $200 a day. That expires June 30, and you will see it in our request for sustainability in our budget. The foster rates across the board for Nevada have not been evaluated since 2008, so we contracted with Mercer to review those rates and hopefully be able to get kids placed into family like settings. If we can get them in family like settings and wrap them in services, we can prevent some of that.

Assemblywoman Gorelow:
I want to circle back to the conversation we were just having about recruiting and getting staff. I understand pay is a huge barrier, but also getting people with the necessary credentials is an issue. I appreciate that you are working with the universities, but what does that actually look like? Are we offering stipends? Are we offering scholarships? Are we just targeting high school kids who are going into college? Are we trying to upscale current nurses? Can you elaborate about what that might look like?

Jacqueline Wade:
We are at the universities, and we are having them conduct internships or practicums at our facilities. It is bachelor's- and master's-level students. Of course, master's level students can do more than bachelor's level students. It is the same thing with our nurses. We are having them do their psychiatric rotations through the facilities. That is what we are doing currently, and we do have some availability. In one of our specializations, I think it is public service, we do offer some type of stipend, and that allows them to want to stay with the facilities or stay with DCFS. We are doing some creative things to contribute to workforce development

and have people excited about working in mental health. We also work with the university medical school so that we can teach and train residents and fellows who want to specialize in child psychiatry.

Assemblywoman Gorelow:
With many different professions we have a burnout rate. It seems like a very difficult profession, and I can see where the burnout rate might be a little bit higher than in other areas of medicine.

Jacqueline Wade:
We do have burnout, but we try to recognize it within our staff. However, I would like to tell you that we have a dedicated group of people in all aspects of our agencies and in our programs. If we were to give you some of the data, you would see that some of our staff have been here for 25 years, some of our nurses for 30 years, and I have been here for 16 years. We have some dedicated and committed individuals. If we can get you the data regarding staff retention or departures, we will do that, but I am very happy to say that I have been blessed and very privileged to work with a group of wonderful people.

Assemblywoman Gorelow:
That is a very, very difficult job, and we greatly appreciate each and every one of you.

Chair Peters:
Are there any other questions from the Committee? Seeing none, our next three presentations are from our regional Children's Mental Health Consortiums.

Dan Musgrove, Member, Clark County Children's Mental Health Consortium:
I have been serving on the children's consortium since 2014 and am very committed to working on these issues on behalf of the children in Nevada and especially those of Clark County. In 2001, this Legislature created the consortiums, it is a very unique setup. Back in the days when child welfare was bifurcated, Speaker of the Assembly Barbara Buckley made certain that bifurcation would end at the state and county levels. She created the consortiums because any event that involves child welfare is traumatic for the child, and she wanted folks to be focused on their mental and behavioral health as they transition and engage in the system. She created the consortiums by statute. Based on population, the state currently has three of the consortiums—Clark County, Washoe County, and the Rural Consortium. What I find unique about the consortiums is that the membership has been outlined in statute. You can look at *Nevada Revised Statutes* (NRS) 433B.333 to 433B.335. It is a very eclectic group that serves on the consortiums. We have folks from the school districts, we have parents, and we have private providers. I am a member and there are others from the business communities. I think the reason they asked me is because I understood the legislative process and could help them get their message known to folks like you. We have the school districts, we have juvenile justice, we have the DCFS at the state and local county level who serve on the consortium. Our real role when we step into those meetings is to take off the hats of the agencies we serve on and focus on what is in the best interests of children. We get into some really good discussions about what is in the best interest of those kids.

Sometimes we call on our school district member and ask why bullying is going on or why kids are not getting their individualized learning plans addressed, especially during COVID-19. But what we do as a group is come together to focus on what is in the best interest of children and their parents trying to navigate this very, very complicated system.

I congratulate all of you on the questions that you asked because you can see these are issues we have been dealing with for a very long time. In fact, in 2014 the Clark County consortium got the state to fund the first mobile crisis. That was something we had been requesting for many years and is such an integral part of children's crisis response throughout the state. You will see from our reports that there are a lot of things we are hoping for, and you have heard today that the ARPA dollars and staffing and programs can start to move the needle forward. The consortiums have been putting together plans since 2001. We submit them every year and hope that we can move the needle forward.

Jacqueline Kleinedler, Chair, Washoe County Children's Mental Health Consortium:
I have been a professional in Washoe County's mental health community for over 20 years. I am a licensed marriage and family therapist, and the department director for the Children's Cabinet's behavioral health programs. It has been my honor to chair the Consortium for the past nearly five years.

In March of 2020, the Consortium finalized our current 10-year strategic plan as required by the NRS. We identified three overarching goals to guide our conversation activities and advocacy at the local and statewide levels [page 48, Exhibit C]. In the effort to realize our shared vision of equitable and compassionate mental health care for all, we established our first goal to address multiple ongoing and projected community needs in the coming years. At every meeting we talk about what increased access, decreased barriers, and least restrictive environments really look like, and what it would take to make resources with these characteristics available to the youth in our community. Achievement of Goal 1 requires expansion of interrelated systems from private and public service agencies. For example, Washoe County is currently bringing together multiple stakeholders from the public and private sectors to organize and implement a youth-focused crisis care continuum.

We realize that primary preventive support of families and caregivers in their natural and overlapping systems is necessary, so our second goal is centered around activities that educate community stakeholders, including parents, about toxic stress, about ways to buffer children and build resilience, and strengthen protective factors. The foundation goal lies in the compelling research on adverse childhood experiences documenting future potential impacts of unmitigated toxic stress on children when they become adults and potentially parents themselves. Our third goal embodies our shared value that children thrive when their family is thriving, and families thrive when their community is thriving. Within this goal we will set out to bridge systems and identify key community factors that enhance physical and emotional health, safety, and well-being.

The aftermath and the opportunities of the COVID-19 pandemic continue to impact youth and families. We intentionally make space to hear the stories of members of our community

and look for ways to amplify their voices in local and statewide advocacy. Through this very process, we have come to understand that youth in our community are struggling with symptoms of depression and anxiety, emotional dysregulation, and difficulty connecting to peers and caring adults. In turn, the adults who wrap support around our youth are struggling with many of the same things. So, many youth families, educators, and helpers in our community are experiencing what can be characterized as toxic stress in the wake of the pandemic. Existing disparities in Washoe County around food, housing, employment, and security have been intensified as they have across the country. The need for mental health support across the continuum of care has also been intensified. In fact, a silver lining of the pandemic has been the growing awareness among youth and adults about the importance of mental health and a decrease in the stigma surrounding access to mental health care. We hope to press on this momentum and keep the attention paid to mental health at the forefront. We hope to continue to normalize mental health needs and access to mental health care as a necessary function of overall well-being.

Our attention is on finding creative ways to strengthen community collaboration with consistent messaging designed to destigmatize mental health needs and help families decide the best route of care for themselves and their children. We are working diligently to establish a crisis continuum of care for youth which necessarily includes support for the adults who wrap love and safety around children. A robust crisis care continuum will strengthen care of children, it will address increased reports of anxiety and depression in our youth, and it will continue our fight against the ever-existing youth suicide epidemic. I respectfully ask for this Committee to keep children and families in mind as you proceed through the legislative session.

Melissa Washabaugh, Chair, Rural Children's Mental Health Consortium:
I am a psychiatric nurse practitioner practicing in a rural setting, and I took over the Rural Children's Mental Health Consortium about a year and a half ago during COVID-19—right in the middle of a transition of priorities. There is a different culture in some of our communities in that we do not have physical access. I know that access is limited throughout the state, but when you live four or five hours from a large city, even getting to an appointment with a therapist can be an all-day hassle. For that reason, some of our priorities have been shifted more to the community-based setting for my consortium. The first one that we are focusing on lately is expanding and sustaining the system of care in the rural and frontier communities. We do this through community partnerships and increasing awareness of our partners such as Nevada PEP, which is a parent/peer support system where parents can find resources, work together, ask questions, and find educational materials on their own. Second is Youth MOVE [Nevada] which is a youth peer group where youth can find education and support by online means, social media, and things that are more interesting to them than sitting in a therapist's office.

Some of our community partners include the state. We work with DCFS programs such as Nevada System of Care and Nevada Peds [Nevada Pediatric Psychiatry Solutions] which is an educational-focused grant program. We like to integrate and get updates from all these partners to figure out where everyone is and how we are all meeting needs in different ways.

The other thing we are working on is increasing access to mental and behavioral health care. Access in the rural areas needs to be more creative. One thing we are working to do is create a comprehensive website where parents, teachers, and youth can find ways to connect to these resources. As a practicing provider, I find that families do not know these things exist at times. They are not well advertised, or they are difficult to find on search engines. For instance, I wanted to refer a patient to Wraparound in Nevada for case management, but I had to send three or four emails just to find the form to fill out.

What we would like to do with the website is provide pages that would say, "Parents, here is something that can help you; children, here are some educational resources, here are your rights, here is what would happen if you are on a mental health hold." To have one website. We can advertise it; we can put a QR [quick response] code on it so everyone can use it and find all the resources that they would need and how to access them. The next thing we are working on is increasing access to treatment in the least restrictive environment to determine how we can support children in their homes, in their school classrooms, at the ground level. We came up with an idea that sometimes it is not even therapy, it is not even medication that is needed. Sometimes it is a very small intervention that can make a big difference. For example, say you are a foster care child who is having trouble sleeping in their new placement. Maybe you do not need a sleeping medication. Maybe you do not need to wait three months to get into child psychiatry and have them give you a pill. Maybe you need a white noise machine and a weighted blanket. Maybe a poor family cannot afford to buy a self-help book that a juvenile could fill out to learn about their own mental health and some coping skills. Maybe a family is not able to afford Internet minutes to get on and do their online telehealth therapy. So, we have come up with a program where we are providing mental health wellness items to communities. We are purchasing items and giving them out to providers of mental health care, counselors who go to schools, and outpatient facilities within the rural areas to provide a service that does not exist, that was never defined. That can be extremely helpful on the ground level, at the least restrictive means.

The next activity that we had is increasing health promotion, prevention, and early intervention activities [page 51, Exhibit C]. Health promotion and prevention has been discussed many times throughout the meeting today. Staffing is an issue. Access is an issue. Not every family is going to be able to see a child-specialized psychiatrist or go to a therapy session once a week, so we want to educate community members on how to recognize signs of mental health or support children who might be at the beginning stages of anxiety or going through something difficult before it spirals into a crisis. Working with Nevada Peds and other providers of education, we want to target and encourage scout leaders, parents, coaches, juvenile probation and community members to take community-level, easy-to-understand trainings such as mental health first aid or signs of suicide where community members can recognize and support our children or at least recognize the signs and then be linked to care if it is needed.

The last priority we have been working on lately is developing, strengthening, and implementing statewide policies and administrative practices that increase equity to access to mental and behavioral care for youth and families, and that is through legislative support. We have a standing item on our agendas each month to look at the upcoming bills, talk about how each one might affect youth and behavioral health for our families, and provide letters of support for upcoming bills that we think would benefit Nevada. That was something we really wanted to focus on this legislative session.

Dan Musgrove:
I am the immediate past chair of the Clark County Mental Health Consortium. You have our PowerPoint in front of you [page 52, Exhibit C]. It is all about addressing the highest needs of children and families. We must have a comprehensive service array for all. It is so important to have no wrong door for services. As Melissa Washabaugh mentioned, every parent has trouble navigating the system. It is so hard to even know what is out there. We have great programs, but they are in silos. One hand does not know that a program exists on this side of town versus the others. Just imagine the problems of Washoe County and the rural areas magnified when they come to Clark County with our three million population. It is all about prevention, early intervention, and mental health. You have heard about that today already. We have got to raise awareness and support for mental health. It is so neat for our consortium that, as was mentioned, we have a group of folks that are part of Youth MOVE. We have students, we have under 18 folks who participate in our consortium and bring their needs to us. It is very important for us to deal with stigma and help them navigate and understand their rights and that they are not alone in this. It is important to have a locally managed system of care. What Clark County deals with is different than what the rural areas deal with, and you heard that today. It is so important to focus on what is unique for each community.

This Legislature and the previous administration put a lot of dollars in ARPA funding out there [page 54]. We see so much potential progress, but it is a matter of getting those dollars out the door, getting the RFPs through purchasing, working on getting those providers to come to Nevada, and building up the system. Whether it is sustainable funding for mobile crisis or whether it is expanding family peer-to-peer support, we are making progress and we think we will make a lot more with ARPA dollars, but as you go to the next slide [page 55], there are areas that have not yet been touched like the Building Bridges model of care to support youth and families. That is something we need as well as more service array options for youth and families.

If I could leave this Legislature with one thought, it is that ARPA dollars are great, but we have to focus on sustainability. Can you imagine a program that gets stood up for a couple of years and parents, families, and children are succeeding and doing well and then it is yanked away because we do not have the funding to continue it? That is a very, very scary prospect for all of us, so as we look at these programs, we have to focus on how we keep them sustainable. How do we grow this system and how do we make it better? I know that all of you are committed to that, and we thank you for the opportunity to come before you today.

Chair Peters:
You are right. We are all here with the goal of increasing our services and making sure the folks who are on the ground doing the good work are supported. It is difficult in the health care arena when it feels like we are competing with capitalism against our children and the cost never goes down. It is always going to be a cost for in-person services. It is impossible to get away from that, but we are here for these conversations to ensure that we are looking at what it is our kiddos need and how to get there. There are a couple of questions.

Assemblywoman Gorelow:
Could you elaborate more about how the consortiums work together and coordinate and what could be done to improve upon that?

Dan Musgrove:
We have a statewide consortium where all three of the local consortiums meet, but it is not put into statute. Assemblywoman Gorelow had legislation last session that would have put it into statute and mandated that we work together, not that we have ever had a problem, but it would have put together some processes and policies to ensure that we are communicating with leadership on what it is that is unique about each region and making sure we collaborate and look for ways in which we can help each other. So, there is a statewide consortium, but it is something we created and it is not in statute. We certainly would like to make sure that it continues.

Assemblyman Nguyen:
Mr. Musgrove, I am looking at your slide on the strategic overall overarching goal for the next 10 years [page 52, Exhibit C]. There are seven years left on this goal of addressing the highest need, but one of the things that I did not see on it is a cultural and linguistic competency piece in terms of your addressing the highest need. The district I represent is one of the highest API districts in the state. Does the consortium have any focus or is it a priority to address linguistic and cultural competency needs in terms of delivering care in your plans?

Dan Musgrove:
I would agree that it is absolutely important. We did not list it because it is not something we deal with every day; however, the folks who are on our each of our consortiums are very committed to making sure information is accessible to all and that we recognize the differences in culture, but it is an excellent point to make. There are laws that have been passed in previous sessions that illicit a response to all of that, but we can do more, and I will make sure we take it back to our consortium.

Assemblyman Nguyen:
I look forward to being part of the conversation, so please include me.

Chair Peters:
Are there any other questions from Committee members? [There were none.] I want to share my experience on the Washoe County Regional Health Policy Board because we had a conversation about our website, so I know exactly what you were talking about. People do not know where to access this information, and they struggle to discover who is the caretaker of this information that is the dependable solution for families looking for resources or individuals looking for resources. Even navigating your own insurance can be traumatic, as is trying to find a provider who is accepting new patients who is on your plan and in your network, et cetera, so I hope we can work out a solution for that.

It is not just us. I am going to put this out there for the tech industry folks who might be listening or those who might represent the tech industry. There has got to be a better way for search engines to direct people to these services. The fact that the state services get buried under advertisements, sponsored ads, and all kinds of push notifications is not fair to the people and communities that need these services. I think we can find a solution, but we have to work together to do that. If you would like to connect with the Washoe Regional Behavioral Health Policy Board, I would be happy to connect you because they are trying to do the same thing.

Are there any questions? [There were none.] That is the end of our presentations for the day. Our last agenda item is public comment. I will open public comment. We are asking that public comment be kept to two minutes to ensure equitability. Please avoid repetition of comments made by previous speakers. Staff will be keeping time for each speaker. We ask that you clearly state and spell your name for the record. Is there anybody in the audience who would like to come up for public comment?

Melissa Washabaugh:
We heard a lot about staffing issues and being a working floor nurse and then a practitioner, I have a lot of experience dealing with that issue. Looking through some of the bills that are coming up, one of them relates to nurses and would allow us to bring in nurses with out-of-state licenses. This would result in much less red tape and hassle either for part-time or traveling work, which I think could make a difference in some of these hospital staffing issues. There are also bills coming up concerning loan forgiveness for certain health providers or workers in limited access areas. Supporting those would help to bring down some of the staffing issues in health care.

Chair Peters:
I believe it is Assembly Bill 45 coming into our Committee out of the Treasurer's Office dealing with loan forgiveness, and we will be hearing that bill in the next couple of weeks.

Is there anyone else who would like to provide public comment in Carson City? [There was no one.] Is there anyone in Las Vegas? [There was no one.] Is there anyone on the public comment line who would like to provide public comment today? [There was no one.] With that, the meeting is adjourned [at 3:32 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sarah Peters, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint prepared by the Nevada Department of Health and Human Services, dated February 15, 2023, consisting of the following:

- "Behavioral Health Overview" presented by Cody Phinney, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
- "Substance Use in Nevada—Data Update" presented by Kyra Morgan, Chief Biostatistician, Office of Analytics, Department of Health and Human Services
- "Children's Behavioral Health in Nevada" presented by Cindy Pitlock, Administrator, Division of Child and Family Services, Department of Health and Human Services
- "Children's Mental Health Consortia" presented by Dan Musgrove, Member, Clark County Children's Mental Health Consortium; Jacqueline Kleinedler, Chair, Washoe County Children's Mental Health Consortium; and Melissa Washabaugh, Chair, Rural Children's Mental Health Consortium