NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(Section 6 of Assembly Bill 443, Chapter 392, *Statutes of Nevada 2021*, at page 2505)

MINUTES

March 24, 2022

The third meeting of the Joint Interim Standing Committee on Health and Human Services for the 2021–2022 Interim was held on Thursday, March 24, 2022, at 9 a.m. in Room 4100, Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Joint Interim Standing Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblywoman Sarah Peters, Chair

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Dallas Harris
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Robin L. Titus, M.D.

COMMITTEE MEMBERS ATTENDING VIA REMOTELY:

Senator Joseph (Joe) P. Hardy, M.D.
Senator Patricia (Pat) Spearman (Alternate for Senator Fabian Doñate)
Assemblyman David Orentlicher, M.D.

COMMITTEE MEMBER ABSENT:

Senator Fabian Doñate, Vice Chair

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Senior Policy Analyst, Research Division
Kristi Robusto, Senior Policy Analyst, Research Division
Crystal Rowe, Research Policy Assistant, Research Division
Eric Robbins, Principal Deputy Legislative Counsel, Legal Division
John Kucera, Program Analyst, Fiscal Analysis Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicates a summary of comments.]

AGENDA ITEM I—CALL TO ORDER

Chair Peters:

Welcome to the third meeting of the Joint Interim Standing Committee on Health and Human Services. Please mark Assemblyman Hafen as present when he arrives.

Before we get started with public comment, I want to take a moment of silence for the folks in Ukraine who are dealing with the atrocities to their country and think about them for just a minute, please.

We have a full agenda today. This area of focus on our agenda today can be very personal to folks, and I appreciate and respect the emotions that may come up from the discussion. This is a heavy issue, so please let me know if you need to step away at any point.

[Chair Peters discussed meeting protocol and testimony guidelines.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Peters:

[Chair Peters provided information related to providing public comment.]

We will start the public comment from those in the physical locations and then move to public comment to anyone who has called in. Is there anyone in Carson City who would like to provide public comment at this time? Seeing none, we will move on to Las Vegas. Is there anyone in Las Vegas who would like to provide public comment at this time? I see someone approaching the dais. Please state your name for the record, and you may begin.

Char Frost, Director, Statewide Family Network, Nevada PEP:

I am so grateful that you are taking up this very important topic today. I am the statewide family network director for Nevada PEP and a certified family peer specialist. Nevada PEP is the statewide family network designated by Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services, to support families of children and youth with mental health care needs. We also sponsor Youth MOVE Nevada, which was named chapter of the year by Youth MOVE National and continues to be recognized nationally for its outstanding youth-developed podcast focusing on mental health recovery. Nevada PEP has served as the parent partner to the Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS), in all four of the Nevada system of care grants since 1998. Nevada PEP has also provided family-peer support to families across Nevada for over 24 years. Our family-peer support providers are nationally certified. Last year, Nevada PEP supported 2,786 families in Clark County, 399 in rural communities, and 563 in Washoe County, with 377 referrals directly from the Mobile Crisis Response Team (MCRT) and 262 from The Harbor programs in Clark County. We have served as a parent and youth voice on the rural, Washoe, Clark, and state consortiums—as well as other planning bodies—to improve systems that serve children and youth with mental health care needs. We are committed to being part of the solution for Nevada's children and families.

I want to mention that we do all this work from lived experiences. I am the mother of two young men who grew up in Nevada; both have behavioral and mental health care

needs. We support families to ensure that they have somebody who has walked that walk and can walk alongside them to support them in whatever way they need.

Chair Peters:

Are there additional folks in Las Vegas who would like to come up for public comment? I am not seeing anybody approaching the dais. We will move on to our call-in public comment. Broadcasting Production Services (BPS) staff will interact with those making public comment to facilitate participation in the meetings. Please add the first caller with public comment.

BPS:

To provide public comment, please press *9 on the telephone to take your place in the queue.

Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics:

I am the executive director of the Nevada Chapter of the American Academy of Pediatrics (Nevada AAP). In October of last year, the AAP, along with the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association, declared a national emergency in children's mental health, citing the serious toll of the Coronavirus Disease of 2019 (COVID-19) pandemic on top of existing challenges. The declaration called on federal and state governments to address the issue through several actions, including improving access to telemedicine, improving effective models of school-based mental health care, accelerating the integration of mental health care in primary care pediatrics, and strengthening efforts to reduce the risk of youth suicide. Today you will hear several policy suggestions, many of which pediatricians of the Nevada AAP support. Through me, my members are asking you to prioritize three in particular: (1) later school start times; (2) stronger gun laws; and (3) state support for the pediatric access line. I detailed all three in my written submitted public comment earlier today (Agenda Item II).

The Nevada AAP currently has 280 members, most of whom are board-certified pediatricians, both primary and specialty care. Members also include pediatric nurse practitioners, physician assistants, pediatric residents, and medical students, all of whom live and work in Nevada and have dedicated their professional lives to the health of all children.

Chair Peters:

Is there anybody else on the public comment line, BPS?

BPS:

The public line is open and working; however, there are no additional callers.

Chair Peters:

I want to remind the public that there will be an additional opportunity for public comment at the end of the meeting.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON JANUARY 20, 2022

Chair Peters:

These meeting minutes are substantial. They are verbatim minutes. Staff has reviewed them multiple times for accuracy and content. Members of the Committee, are there any questions regarding the minutes? [There were none.]

> SENATOR HARDY MOVED TO APPROVE THE MINUTES OF THE JANUARY 20, 2022, MEETING.
>
> THE MOTION WAS SECONDED BY ASSEMBLYWOMAN TITUS.
>
> THE MOTION PASSED UNANIMOUSLY.

****

AGENDA ITEM IV—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO *NEVADA REVISED STATUTES* (NRS) 439B.225

A. LCB FILE R040-21 OF THE STATE BOARD OF PHARMACY

B. LCB FILE R067-21 OF THE BOARD OF ENVIRONMENTAL HEALTH SPECIALISTS

C. LCB FILE R076-21 OF THE BOARD OF OCCUPATIONAL THERAPY

D. LCB FILE R118-21 OF THE BOARD OF MEDICAL EXAMINERS

E. LCB FILE R126-21 OF THE STATE BOARD OF HEALTH

Chair Peters:

We will move onto Agenda Item IV. Eric Robbins, Principal Deputy Legislative Counsel for our Committee, will review these proposed regulations.

Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB:

Pursuant to NRS 439B.225, the Committee has the responsibility of reviewing certain regulations proposed by health care licensing boards. As a reminder, the Committee does not take any formal action on the regulations, but it can ask questions of the personnel from the agencies and boards that adopted the regulations. There are five regulations on the agenda today: (1) R040-21 from the State Board of Pharmacy (Agenda Item IV A); (2) R067-21 from the Board of Environmental Health Specialists (Agenda Item IV B); (3) R076-21 of the Board of Occupational Therapy (Agenda Item IV C); (4) R118-21 of the Board of Medical Examiners (Agenda Item IV D); and (5) R126-21 from the State Board of Health (Agenda Item IV E). Regulation R040-21, R067-21, and R076-21 have all been adopted by the agencies and are awaiting final hearing by the Legislative Commission at its next meeting, which has not yet been scheduled. Regulation R118-21 and R126-21 have not yet been adopted; they will still have hearings with the proposing agencies.

Since we have a few regulations today, I thought I might ask the members which regulations they have questions about, and then we can go forward and call up the relevant agency personnel in order. Which regulations do members have questions about?

Chair Peters:

Are there any questions from the Committee regarding these regulations?

Assemblywoman Titus:

I want to acknowledge the State Board of Pharmacy's regulation where they are changing the terminology in Section 1 to use the term "reciprocity" without having to show the actual documentation. I appreciate that. I think we need this access to care, and some of the stuff we are doing is so important by expanding this process of licensure to expedite it. Thank you to the Board of Pharmacy.

Chair Peters:

I agree wholeheartedly, Assemblywoman Titus. Are there any other questions from the Committee related to these regulations? Seeing none, we can move onto the next agenda item.

AGENDA ITEM V—OVERVIEW OF NEVADA'S CHILDREN'S MENTAL AND BEHAVIORAL HEALTH SURVEILLANCE DATA

Chair Peters:

Today we have Dr. Megan Freeman and Samantha Cohen for this presentation. Please proceed when you are ready.

Megan Freeman, Ph.D., Children's Behavioral Health Authority, DCFS, DHHS:

As the state's Children's Behavioral Health Authority, I am thrilled that we will spend most of today discussing the needs of children and families.

I would like to talk about the national context surrounding children's behavioral health before I move into the data (Agenda Item V A-1). I agree that we need to use data as the foundation, but I have a few other thoughts to go over before we move into that.

I want to start by taking a step back and reflecting on stigma. I think it is important for society to look at the role stigma has played in shaping our behavioral health system into what it is today. *Stigma* is formally defined as a "negative attitude" or "discrimination towards a person or a group because of a distinguishing characteristic." In this case, it would be mental illness or behavioral health need. By increasing awareness and improving understanding about the struggles and needs of those living with behavioral health conditions, we are working to break down that stigma and reinforce the idea that behavioral health is a critical piece of overall wellness.

Violent behavior is a theme that comes up in the media frequently about folks with mental or behavioral health needs. In fact, the great majority of individuals suffering with mental or behavioral health illness are no more likely to be violent than anyone else.

Statistically, some of us in this room or on Zoom today either struggle with our own behavioral health or are supporting a loved one who does; however, very few of us here

would probably be willing to stand up and identify ourselves as such in a public forum. Eighty-seven percent of Americans agree that having a mental health disorder is nothing to be ashamed of; so why are we so reluctant to share this information with others if that is what we believe? The goal for those of us working in the behavioral health space is for it to be as acceptable to seek treatment for a mental or behavioral health need as it is to tell your friends or your boss that you went to the doctor to get your thyroid checked or because you sprained your ankle.

To set the stage for many of the conversations today, I want to draw attention to this statistic on childhood trauma. How many children in the general population do you think have experienced at least one traumatic event by the time they are a teenager? The answer is more than two-thirds. Childhood trauma places a person at risk for a number of negative outcomes, not only as children but also as an adult. This includes chronic health conditions as well as premature death. These are public health-level exposure statistics, outcomes, and prevention opportunities. We need to provide trauma-informed care as the rule and not the exception.

You might already think about this a lot, but I am going to pause for just a moment to give everyone a minute to reflect on this intentionally this morning. Who have you not seen in a long time that you missed because of the pandemic? What routines were disrupted that you never had a chance to pick back up? What life events or milestones did you or your children miss out on? Do you feel that anything good has come into your life or have there been any positive changes, either personally for you or for our society, because of the pandemic?

I asked you to reflect on your pandemic experience, partially because I think it is important for all of us to do that from time to time, and partially because it is impossible to talk about behavioral health or wellness right now without acknowledging the impact of the pandemic. The pandemic has had a ripple effect across systems where we all have our own individual experiences; we are coping with our own struggles related to it, and we all live within multiple systems that have also been impacted. For most people, that includes a family system, your employer, a system of health care providers that you depend on to keep you healthy and functioning at your best, and a support system of friends and acquaintances that you rely on for social support. Almost everyone I know has experienced disruptions in all these systems. Think about that for yourself as an adult.

For children, the impact has been magnified because outside their family system, the biggest system they rely on to ensure they are keeping on track with healthy development is their school system, or if they are a young child, a childcare provider. They experienced sudden disruptions in these systems as well as, in many cases, sudden isolation from extended family or caregivers they relied on, like grandparents, or a regular babysitter, or a nanny. At the same time, their parents or caregivers were likely experiencing one or many pandemic-related stressors like financial instability, food insecurity, or housing instability. They may have been working from home. School and childcare center closures were widespread, and then, of course, there was illness.

Many parents and caregivers are frontline workers, so they are at greater risk of COVID-19 as well as burnout. Nearly 2,200 children in Nevada have lost a parent or caregiver to COVID-19. Typically, in a disaster or emergency, we would move through a series of relatively well-defined coping stages, from initial impact through response and recovery. There are well-understood emotional reactions and milestones at each phase for an individual and for a community. The COVID-19 pandemic has been more of a circular experience. Every time we think we have made our way through a phase, something else happens or there is a new variant, and the whole thing starts over. This has impaired

psychological recovery for many of us, including our children. Although we may have created a new normal, the continued impact prevents us from fully moving on past uncertainty, fear, exhaustion, loneliness, depression, and loss.

Since April 2020, the U.S. Centers for Disease Control (CDC) has been conducting a weekly survey in collaboration with the U.S. Census Bureau and other federal agencies. It is called the Household Pulse Survey. The goal of this survey is to produce near real-time data on the social and economic effects of COVID-19. The most recent data I could get from the CDC was the week of January 26 through February 7 of this year. The data demonstrates that Nevadans are not doing okay. We are ranked fourth in the nation, and 37 percent of adults are reporting symptoms of anxiety or depression. It is more than one in three. Ranking fourth in this case is not a good thing. Check on your friends. Check on your neighbors and your family. Check in with yourself. It is okay to not be okay.

Moving on to the available data on children and adolescents. Data from a meta-analysis published in 2021 shows the impact of the pandemic on children and youth globally. One in five children and adolescents globally are currently experiencing clinically significant symptoms of anxiety. One in four are experiencing clinically significant symptoms of depression.

As Ms. McAllister noted during the public comment, a state of emergency in children's mental health was officially declared in October 2021. The reasons cited in the proclamation include the ongoing pandemic, physical isolation, uncertainty, fear, and grief that children are experiencing, as well as a 45 percent increase in the number of pediatric self-injury and suicide cases seen at children's hospitals during January through June of 2021 compared to the same period in 2019. Additionally, the proclamation highlighted the disproportionate toll on young people in communities of color and inequities related to structural racism. This declaration reflected escalating concerns among professionals everywhere due to trends that have been seen. These same trends are being seen in Nevada.

Following President Joe Biden's State of the Union Address on March 1, 2022, which I will talk about in a minute, where he specifically referenced children's mental health, the AAP is now calling on the Biden Administration to declare the children's mental health emergency a national public health emergency. The declaration by these groups urges policymakers to take several actions, including increasing federal funding to improve access to services, accessing telemedicine, integrating school-based mental health into pediatric primary care, strengthening efforts to reduce youth suicide risk, and addressing workforce challenges.

A couple of months later, the surgeon general released an advisory on protecting youth mental health. The surgeon general's advisories are relatively rare, and they are reserved for significant public health challenges that need the nation's immediate awareness and action. The advisory provides recommendations that individuals, families, community organizations, technology companies, governments, and others can take to improve the mental health of children, adolescents, and young adults. Later today, we will review the recommendations for state governments in detail, but overall, the advisory emphasizes a whole-of-society approach to addressing challenges that have been long standing for children's behavioral health. The solutions should be resilience-based, support families and communities, and mitigate the mental health impact of the pandemic.

Something we will talk more about today is the idea of mental health as an essential part of overall health. We need to recognize that behavioral health care is health care. You may have noticed that myself and others on the DHHS team use the term *behavioral health* frequently instead of *mental health* or in addition to *mental health*. That is because

behavioral health as a term includes both mental health disorders and substance use disorders and covers the continuum of services from health promotion and prevention through intervention or treatment and recovery support. It also encompasses health behaviors and other factors that may be influenced by social determinants of health. We really like it as a comprehensive term that emphasizes not only needs but also our approach to supportive services.

President Biden's State of the Union Address on March 1, 2022, reinforced many of the recommendations of the advisory. The plan calls for community-based, resilience-focused solutions. Essentially the recommendations were very similar with regard to schools and primary care clinics, integrating into other community-based settings that are more of a creative approach, like libraries or community centers. I hope the themes are emerging here so far. We need to invest in school-based behavioral health, natural supports, community-based care, and support for parents and caregivers. Of course, investment into the behavioral health workforce is critical, including mitigating the stress and burnout caused by the pandemic.

I will move onto a little bit of data, in terms of the baseline of where we are as we think about making changes that align with national priorities. I am sure that you probably heard that we ranked 51st overall for mental health as well as 51st for youth mental health according to the organization Mental Health America. They publish an annual report with rankings and break them down in several different ways. This has been the case on their annual report for the past several years. The rankings are based on different factors, including the prevalence of behavioral health disorders and access to care. We also have a local organization called the Children's Advocacy Alliance that does annual rankings on children's metrics. They recently produced a special children's mental health report card, which also indicated that we have substantial room for growth in our system to meet the needs of children, youth, and families.

In the conversation on workforce shortages, we need to keep in mind that all 17 counties in Nevada are designated as mental health provider shortage areas.

Regarding school-based behavioral health, despite the fact that we made significant recent gains—there has been a ton of hard work by Nevada's Department of Education (NDE) and our local school districts—we are still quite far off from the recommended targets for school support professionals, including social workers, psychologists, and counselors.

In terms of providers available overall throughout the public and private behavioral health systems, we again fall short of the recommended targets when it comes to licensed behavioral health professionals in Nevada.

To summarize, we have discussed the exacerbation of mental health need due to the pandemic, a system that was inadequate to meet the needs prior to the pandemic, and significant behavioral health workforce shortages that predate the pandemic. We are currently experiencing nationwide a record number of folks leaving the health care field, which includes behavioral health care. One of the consequences of this is that we have had a greater than average number of youths going into behavioral health crisis and seeking care in the emergency department. As one example, the department at the University Medical Center has seen increases in utilization. Similar increases have been reported nationally by the CDC as occurring during the pandemic. As I discussed earlier regarding the national children's mental health emergency declaration that was endorsed by the Children's Hospital Association among others, we are seeing reports nationwide from individual providers, hospital administrators, and hospital associations that changes in patterns of

behavioral health utilization in the emergency department setting is contributing to staff stress and burnout.

In addition to the emergency department, children and families experiencing behavioral health crises have been contacting the state children's MCRT at an increased rate since the onset of the pandemic. Thankfully, DHHS was recently granted funding through the American Rescue Plan Act of 2021 (ARPA) (H.R.1319 of the 117th Congress) to temporarily expand mobile crisis to meet the need, although the team does continue to work at or close to capacity.

Finally, I want to touch briefly on a well-being survey that was done in Nevada schools in winter of 2020, primarily so I can highlight this data from the caregivers and school staff. As I discussed earlier, children do not exist in a vacuum. At a time when we are seeing record increases in depression and anxiety among youth, we are also seeing decreased capacity in confidence among caregivers that they feel able to help their child when something is wrong. Additionally, educators and school staff are leaving their jobs in record numbers. Those who have stayed are worried, stressed, and burned out. To the parents, caregivers, or educators who are in the room or watching online—I see you. I acknowledge your struggle. I am a parent too. What you are going through right now is completely normal. It is not easy to fill any of these roles on a good day—two years into a global pandemic is an extra tall order. That is why now more than ever we need to find creative solutions to support children, youth, and families as well as everyone else in their orbit who has been so creative and dedicated in supporting them throughout this incredibly difficult time.

I want to end by highlighting some of the successes we have had so far in putting in layers of support for children and families. We have been working in an interdisciplinary fashion to find creative solutions during a time of significant upheaval. The Nevada Resilience Project is through the Division of Public and Behavioral Health (DPBH), DHHS. It offers resilience-based support and linkage to services throughout the community statewide through a number of different creative strategies. We have a large group of stakeholders and local and state government folks working to address the children's behavioral health emergency. In Nevada, through these partnerships, we are creating new service delivery opportunities to meet increased need, expanding the service array, offering different types of services, and, despite workforce shortages, trying to increase the capacity of the system.

Finally, this provides us with an opportunity to leverage the local and national awareness that we see coming out of the White House and in media reports and an increased awareness and willingness of folks to address the challenges of the children behavioral health system and acknowledge that changes are needed.

That concludes this presentation. I would be happy to take any questions.

Chair Peters:

I live this every day. I have three kids, two in public schools. We deal with my oldest daughter's anxiety daily. I want to take a moment of personal privilege to also share my own struggle with mental health. I have had debilitating anxiety and depression most of my life. It has made things very difficult, especially as a child without resources. I have turned into a functional adult, but I still deal with it regularly. Also, in the last year or so, I have realized that I have lived with undiagnosed attention-deficit/hyperactivity disorder (ADHD), which made life difficult for me. I have always thought I was weird, that I could not deal with things like normal people do. The more we can get children access to care, to

destigmatize the request for help, the more functional adults we will have in this world. I warned you all that this one was going to be a hard one.

Dr. Megan Freeman:

Chair Peters, thank you for sharing that with us. I know it is incredibly scary to share something like that with just one person and in a forum like this. Thank you for your incredible bravery. This is how we breakdown the stigma and build the system; we need to do exactly what you are saying and make it easier to get help earlier.

Chair Peters:

I want to thank all the folks who are working in this area and for the support that you are creating for this generation of kids. I hope that parents who are watching look out for access to support and take advantage of it as you can. Your children need support and need your help getting it. Without parents or other adults who can help children, it is difficult to have and find access to care and support. Are there any questions from the Committee? Senator Spearman, go ahead.

Senator Spearman:

Chair Peters, thank you for sharing your story. I think it is very important that for those of us in public service—to whatever degree people think we have been successful—people know that we struggle. My ADHD went undiagnosed up until I started my master's program. I always knew I was different. "There is always an amusement park going on in my head," I tell people. Trying to focus sometimes is a challenge, but I have learned how to do some of those things.

Dr. Megan Freeman, thank you for the report you gave. I have a couple of questions. These are things that I have addressed in other committee meetings, not just during the interim, but also during the session. I know that COVID-19 has had an adverse effect on children and families in general, but the complications and exacerbation that have confronted members of Black, Indigenous, and People of Color (BIPOC) communities is inescapable. It is not just people of color; I am especially thinking about those in indigenous communities. It has been my lament since we started talking about and tackling some of the vicissitudes of COVID-19 in the 2020 Special Session, that we have not, at least I have not seen programs that have been designed specifically and in a culturally sensitive way for the needs of those communities. For example, whatever mental and emotional health services that are available in communities of color, it cannot be something one over the world. Call the county, and they will direct you to someone. As someone who has been Black all her life, we just started believing in mental health services ten minutes ago. I am not going to go to someone that I do not know. Making it something as anonymous, and even in some ways innocuous, as go someplace to talk to someone about something. That is not going to happen.

We passed a couple pieces of legislation, and both bills were mine. In 2017, we passed a bill requiring the superintendent of public instruction to provide another column next to the star rating for schools that listed the social determinants. That was designed to alert legislators, and other agencies, such as DHHS, that these are areas that need targeted support. When you look at the effects of COVID-19, especially in BIPOC communities where there have been generational deaths in one family, that, I believe, is a social determinant. The fallout from the opioid abuse is a social determinant. That is across the social-economic spectrum, but it has been more prevalent in some of our more rural communities. We do not talk

about that because in the frontier communities, people are usually thought of as rugged and "We can do this," but that is not the case. What, if anything, have we done or we are planning to do to make sure that services are targeted specifically? I get the general, but I am speaking about things that we have to do with greater specificity if we are going to come out of this hole for BIPOC communities. How are we using the information that we are receiving from the COVID-19 numbers to push forward to the NDE to say, "These are some of the things that need to be included in the story"?

A suicide prevention bill—Senate Bill 204 of the 2019 Session—required that all schools would develop some system of education at the local level so that everyone who was in contact with students, such as teachers, staff, administrators, cafeteria workers, everybody, would be trained in understanding some of the basic red flags for suicide ideations. Now that we are back in school, students are dealing with this in a congregational aspect. That cannot be easy.

The other thing that we do not talk about a lot is lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) youth. It is not just the LGBTQ youth who identify themselves as such, but it is youth who are in same-gendered families or in families where the composition does not look like *Leave it to Beaver*. We must deal with this.

Then, we have our "seasoned" citizens whose isolation has exacerbated their loneliness. I do not think it is a coincidence that Nevada is number one or number two for the completion of suicide by seniors.

Last but not least, is there anything that we have done to work with the veteran affairs agencies, the U.S. Department of Defense, or some of the military bases that are in our communities to make sure these sorts of things are being addressed for military families? When I was overseas, all the schools were on base, so that community was there. In the United States, the schools are out in the community, but some people may not be attuned to the fact that someone may have a parent or even both parents who have been deployed, or a parent who has been wounded or injured, or a parent who has even been killed in combat. Social determinants—suicide prevention, LGBTQ youth, senior citizens, military families—put all of these together in targeted programs that are not agnostic but culturally sensitive to the needs in these communities.

Chair Peters:

You bring up some valid points, Senator. I appreciate all the work that you have put in during your tenure on these issues. A lot of your questions were questions that I also have, not just for Dr. Megan Freeman but for some of our other presenters, as we move through the agenda today. Dr. Megan Freeman, do you have any comments related to the questions that Senator Spearman has brought up? I would also ask that our other presenters here today consider some of those in their presentations. Dr. Megan Freeman, please go ahead if you have responses.

Dr. Megan Freeman:

Thank you so much for raising these important issues. We will talk more about system of care later today. We will define what that means as a philosophy and as an approach to children's behavioral health services, but one of the underlying values is culturally and linguistically appropriate services. I think that it is easy to put a check mark and say, "Oh yeah, we train our staff on that. We have a policy and are doing cultural competence or whatever." Obviously, that is not the solution. I felt like you were peeling an onion while

you were talking. At every layer, I was thinking, "Oh man, we need to be doing more on that." It is all very complex, and it is intersectional. Some children and families are going to fit into all the specialized populations that you just mentioned. While this is an area that we are extraordinarily committed to, DHHS has been committed to diversity, equity, and inclusion and has had some special initiatives related to that recently. It is something where you have never arrived; you are never culturally competent. I can say that we need to work harder at providing specialized services for these populations. We need to consider the impact of the pandemic and the intersectionality. There is absolutely room for growth here, and hopefully you will be willing to work with us because some of your thoughts and ideas are incredibly valuable.

Senator Spearman:

I am here and I am not going anywhere.

Chair Peters:

Senator Hardy and Assemblywoman Gorelow have questions. We do have quite a stacked agenda at this point, so I want to encourage these questions to be specific to the data that was presented by Dr. Megan Freeman, and other questions may be answered by some of our other presenters down the line. This is a dense issue, and there are, as Dr. Freeman said, a lot of layers. This is one of the reasons why it was important to me that this be a substantial topic for our committee in the interim. Please go ahead, Senator Hardy.

Senator Hardy:

Thank you, Madam Chair, I appreciate your courage. I come from a medical model, and I think one of the challenges that we have is being judgmental of people who, "may have a perceived weakness." The reality is that these are real entities that have treatments. It is up to us to make the treatments that exist affordable and available, and above anything else, the hope that parents and children can have that, and we can help. I think one of the challenges we have had, that I am not sure you mentioned, is the screen time issues we used to complain about. We magnified them when we sent the kids home with their tablets. It was not unanticipated that we would have problems, and sure enough, we have. However, I think there is hope. I think the medical model working with the behavioral model almost goes hand-in-glove on this. I suspect you are seeing the need for the medical model, as Leann McAllister was probably alluding to when she talked about the pediatricians.

Chair Peters:

Dr. Freeman, do you have any comments or response?

Dr. Megan Freeman:

I will say that integrating behavioral services into primary care is an extraordinarily effective strategy and works very well elsewhere. It is absolutely something that we should be keeping towards the top of our to-do list as a strategy.

Chair Peters:

I absolutely agree. I have had a number of friends, family members, and colleagues over the last two years who have successfully addressed some of their behavioral health issues through their primary provider. I think that has opened a door to folks thinking that there is something larger going on with them and not having to dissect what that looks like and

instead have it be more holistic and accessible. Assemblywoman Gorelow, please go ahead with your question.

Assemblywoman Gorelow:

I am very unsurprised at how short we are on behavioral health providers. We need twice as many school counselors. We are short 3.7 times for school psychologists and 35 times for social workers. What suggestions do you have on policy or things we could do to grow our own and encourage others from out of state to come in? How do we fill those openings?

Dr. Megan Freeman:

We need to start with the pipeline. Some of these initiatives are already happening. We are doing some great work already in Nevada. We want to work with institutes of higher education to more closely integrate the systems. We want to make sure folks know that working in public service or working in the schools is a great option to give them the baseline skills they would need to make that transition. We want to provide practical opportunities so that the transitions can be seamless, but we also need to better incentivize working in those settings. We need to invest more in recruitment, retention, and compensation for the folks doing this work. It does not have to be strictly salary. I think student loan forgiveness is a hugely under-leveraged strategy. There are other things we can do, but it will take a comprehensive approach to grow our workforce. We must show folks the benefits of coming into these types of careers.

Chair Peters:

We are going to move onto our next agenda item and dive into some more of these issues.

[Subsequent to the meeting, Dr. Megan Freeman provided a follow-up memorandum regarding crisis stabilization units and Governor Steve Sisolak's Health Care Provider Summit.] (Agenda Item V A-2)

AGENDA ITEM VI—YOUTH SUICIDE: TRENDS AND PREVENTION EFFORTS

Chair Peters:

The next agenda item is youth suicide trends and prevention efforts. This one is hard. Please take your time and think about yourself as we go through this topic. I know it is already bringing things up for me. I do not know many people have lived through their teen years and not lost a friend due to substance abuse. We have two presenters under this agenda item. We will first hear about youth suicide trends and prevention efforts from Misty Vaughan Allen, she is with the Office of Suicide Prevention. Then, we will hear about the SafeVoice program at NDE from Christy McGill, the director of the Office for a Safe and Respectful Learning Environment.

Misty Vaughan Allen, M.A., Coordinator of the Statewide Program for Suicide Prevention, DPBH, DHHS:

Madam Chair, I am grateful for your vulnerability and sharing your lived experience. At the Office of Suicide Prevention, we try to build a team that is willing to walk this talk. It is important that people can normalize these experiences. I do not know a person who has not been touched in some way or other by COVID-19 and the ongoing stressors. If they are not feeling these stressors and strain, they sure know someone who is.

I am the suicide prevention coordinator in the DPBH. I have been in this position since 2005, so I have had the opportunity to see the challenges Nevada has gone through when it comes to mental health and suicide. We were at the top of the highest rates in the nation, but that started to change in 2001 (Agenda Item VI A-1). I am going to give you an example of the 2020 statistics. Dr. Megan Freeman did a beautiful job of setting the foundation and the national trends happening. Our latest numbers are about 60,000 people in the United States took their lives with suicide. It is the first time that suicide deaths have been bumped out of the top ten nationally. Nevada dropped to ninth as the leading cause of death. I think the number of deaths from COVID-19 pushed that back out. Firearms continue to be the leading method of suicide—nationally, 52.8 percent, and in Nevada, 61.7 percent. When we focused on reducing access to lethal means program, we reduced our suicide by firearms deaths to 52 percent, almost the national average. Then, culture and circumstances changed, and COVID-19 happened, and firearm and mental health stressors increased. You can see the dramatic impact on firearm suicide deaths is up to 61 percent.

Every 11 minutes, someone takes their life in the United States. Nevada currently has the 13th highest rate in the nation. This is only the third time we have been out of the top ten. What I think is remarkable is that 13th is still tragically high, and every loss to suicide is tragic. You heard Dr. Megan Freeman discuss our workforce challenges and access; we are 51st on report cards and have Fs on report cards, yet our suicide rates in Nevada have maintained steady or even decreased. In 2018, we were the only state in the nation that decreased. I know we have a long way to go, but we are headed in the right direction. Suicide is the second leading cause of death for ages 8 to 44 for the past several years. It was the leading cause of death for young people, so that has moved up a bit. Senator Spearman mentioned that our elders have one of the highest rates in the nation. Over the decades, we probably have had the highest rate, but currently for 2020, we have the fourth highest rate. That has continuously been a challenging population to get support and resources to combat this suicide crisis. We lose more people to suicide than homicide and car crashes combined, and that has always been the case.

Focusing on our youth, ages 0 to 17, we wanted to show you data from 2010 to 2020. In 2020, there was a moment in time when there were several deaths by suicide in a very short amount of time. We received national attention. The spotlight was on a certain region, and people called it an epidemic. Our two highest years were 2011 and 2018. In 2011, I think we can deduce was probably linked to contagion, media contagion, linking it to bullying in a direct line. When we learn how to safe message and safe media reporting, that starts to reduce. In 2018, I am not certain, but 90 percent of that increase came in Clark County. I can only speculate on the impact of the October 1 mass violence maybe having a major impact on the community; however, we cannot link that directly. As you see, 2019 and 2020 are relatively similar with the 16 and 17 losses. The preliminary data from 2021 looks to be about the same with around 18 deaths, but we need to confirm that. As you can notice, the national rate has been steadily increasing for our youth; whereas, Nevada is all over the place. Part of that is to look at the years 2013 and 2014; it does have a link to social media and on-screen time. That absolutely has a huge impact on our data.

We had a wonderful report from the Office of Analytics, DHHS, in February of this year that went into great detail and was incredibly helpful in writing grants and our state plan. You can see the demographics of male to female. The national demographics for gender is about 4:1, typically. You can see our female rate is a little bit higher but still close to 4:1. We have the Hispanic/Latino population coming with about 30 percent of suicide deaths. We are paying attention to those changes in race and ethnicity, which is important. Black and African Americans are seeing some increases to which we need to pay attention. These are

losses to suicide. We really want to focus on suicide behaviors and the ideations, where I think some of the cultural impacts and the racial impact will be profound.

Firearms are a huge piece of method, as I mentioned. More male youths use firearms; with females, we see hanging, strangulation, and suffocation. In breaking down current data, it was almost 50-50 from our child fatality review data. We know one of the most profound programs that can impact suicide rates in our youth is reducing access to lethal means. We have focused on this during COVID-19. With COVID-19 relief funding, we continue to share this message across the state; however, it is very difficult to get this message to families and guardians. Gun safes, medication safes, and locks are crucial and can give time and space to that person with thoughts of suicide. As I mentioned, we shared suicide death data, but where we are really seeing the impact—I know our hospitals, emergency departments, and pediatricians, I am hearing this so much—is emergency department visits and inpatient care are increasing, especially for our youth ages 10 to 17. We are seeing dramatic increases there.

Senator Spearman brought up LGBTQ. We do not have sufficient data on this across the board. I think the most recent information I can find nationwide is 2016, and it is just not good enough. Culture and climate have changed. However, we know that for LGBTQ populations and youth, the high rate of suicide attempts and ideations double those who are non-SOGI (sexual orientation and gender identity). For transgender youth and individuals, 41 percent have said they attempted suicide. That is more than double those in the non-SOGI community. We must find better ways to connect these youth to resources and support. Research has shown if a young person comes out as LGBTQ and receives support, resources, love, and respect, that reduces their risk for suicide and other mental health challenges. If they come into a community or population where it is unsafe with discrimination, rejection, and bullying, it dramatically increases suicide rates. I know there were bills to focus on this education, and we cannot take our eyes off this. We need to develop safe spaces. The NDE has done a beautiful job with the Office for a Safe and Respectful Learning Environment. They have done incredible work, but we need to increase building this connection and building the safe places with respect for our SOGI youth.

Dr. Megan Freeman mentioned that the bridging of divisions and departments working together is important across agencies, the public, and private entities. One of our wonderful partnerships with the NDE is Project AWARE (Advancing Wellness and Resiliency in Education). It is a five-year grant; we are in year two. The Office of Suicide Prevention is just gearing up. Our role is to increase mental health literacy and training for family, school staff, and youth. With extra relief funding, NDE afforded the Office of Suicide Prevention to hire our first youth suicide prevention coordinator, a remarkable opportunity to focus on our youth needs. One of the products of that will be to develop a youth suicide preventive strategy. We have youth strategies in our overall state plan, but we want to hone in on the immediate needs with real-time data. Partnering with NDE and DCFS is imperative to that success. Training and family and youth voice, as you hear, those with experience guide us. We need those voices to help us develop the plans. We need equity and diversity to develop culturally relevant and appropriate plans, strategies, and programs. We hired a safe messaging expert with part of the Project AWARE funding. This person comes with experience and incredible knowledge on how to share our messages in a safe and healthy way and how to listen to the youth voice and gather messages from our young people. I know they are having many struggles with and after COVID-19, but I am telling you, this generation wants to talk about mental health, mental well-being, and suicide. They want to help their peers. I see this as a great opportunity in bringing them into this work. They are going to lead us into a healthier way with our behavioral health and suicide prevention.

The Washoe County School District (WCSD), the State Public Charter School Authority, and the Carson City School District are local education agencies that are Project AWARE partners. The Office of Suicide Prevention is gathering information through surveys on what the staff needs, what they already know, and what they see so we can develop specific, appropriate district training plans that will meet the needs of the staff, the families, and peer-to-peer programs for those youth. We follow a multi-tiered system of support (MTSS). This is an example of what that would be and how our work fits into that. We have the basic foundation. The Office of Suicide Prevention has been developing these trainings and awareness for 16 years, and now we need to get closer and closer to tier 2, where we have focus groups and focus training for parents or staff. Then, we get to the more suicide-focused treatments and access to those mental health professionals who can really deal with an individual's challenges to get them back into the tier 2, tier 3 needs. I know Christy McGill will answer any questions about this more eloquently than me.

I want to highlight some of our current resources. Great opportunities have come out of COVID-19, as we have learned, and have opened up the need for mental health support. The National Alliance on Mental Illness (NAMI) Western Nevada has had a Warmline going for many years; soon, they are going to have the opportunity to develop a teen line. When you reach out to someone with lived experience, as a peer, it shows the hope and possibility for recovery and that suicide is not the only option; there are other choices, and this Warmline gives that person support as they build their recovery and work their safety plans. Another project they have, not necessarily for youths, is Caring Contacts, which will help in the transition from care in an emergency department or inpatient care into their community and family with support as they work through their recovery and safety plans.

Our Regional Behavioral Health Policy Boards have developed incredible resources. The *Parent's Guide to Youth Mental Health in Nevada* shows how scary it is when parents need to take their young person to the emergency department or inpatient care. What happens? How do they bring them home safely? For the hospital, to support youth in that transition, *Hospital Guide for Youth Mental Health Crisis*, an excellent guide. I encourage wide disbursement of this important information; it helps this challenging and scary process become doable and safer, which benefits recovery for that young person and the support system that they need when they come home.

Dr. Megan Freeman covered this very well, so I am not going to go into great depth, but I want to connect you to the links on this. A couple weeks ago a Blueprint for Youth Suicide Prevention was developed with the American Foundation for Suicide Prevention (AFSP) and the AAP; it is an online toolkit with incredible resources. I presented to Renown pediatricians recently, and it had just come out that day. For those health care providers who are seeing the increases in youths with high anxiety, depression, and thoughts of suicide, this can be a beneficial tool. In line with the health care that came up from several of you, Nevada has had its Zero Suicide Initiative going for several years now. It just completed its second round 2.0 of a learning community where several entities, 48 individuals, attended a weeklong collaborative learning opportunity for health care improvement around suicide and safer care. Dr. Megan Freeman is right—the holistic approach is one of the most effective ways to reduce our suicide risk and behaviors, so it is not all on the health care providers or those hospital systems. The community must be that wraparound as well. How does a person get to care and what happens once they leave care? Transition and follow-up are crucial, so we are really building a crisis response system to make this a safer state for mental health crises and suicides. I will open it up to any questions.

Chair Peters:

Thank you, Ms. Allen. I want to point out for folks who are watching or listening that the links presented by Ms. Allen are on our legislative website under our Committee's meeting page, so if you are interested in looking more at some of those resources, they are available there. Are there any questions from the Committee? Assemblywoman Titus, please go ahead.

Assemblywoman Titus:

When you talked about the NAMI Western Nevada Warmline and Caring Contacts, you gave a number. I wonder about the status and coordination with the 988 hotline and I am worried that we may have too many numbers out there. Will that number be directly linked to a 988 number? Will it be automatically switched over there, or will there be a transfer when somebody calls so they get a warm handoff from that line?

Ms. Allen:

The interoperability challenges with 988 are being worked out. That is a very important question, so I will need to get back to you on that answer. Typically, NAMI deals with mental health challenges, isolation, and recovery with mental health. If there is a crisis of suicide, they would transfer it to the National Suicide Prevention Lifeline. I need to emphasize that 988 will begin in July 2022. We will continue with the suicide prevention lifeline for now, but absolutely NAMI Western Nevada and NAMI will be a part of that continuum of care. I need to follow up on exactly how that transition might happen once 988 starts. The building of 988 in the crisis response system, which will include a hub of the crisis hotline 988, 24/7 mobile crisis support, and stabilization units—which are so much more appropriate for mental health crisis and suicide in de-escalating a crisis in a therapeutic, less traumatic way with trauma-informed care, suicide-safer care—is crucial. It is being built. Nevada is ahead of most states in the nation. We have funding to support that effort, and the DHHS team has been working on this for years. We are poised to be a leading charge in this with Crisis Support Services of Nevada answering those hotline calls currently with the Suicide Prevention Lifeline. I will confirm how the NAMI Warmline will be linked as 988 comes online.

Assemblywoman Titus:

I look forward to moving ahead with 988. You presented the suicide ratio between men and women or boys and girls, youth categories, and different categories, but I did not see anything regarding suicide attempts. It is my understanding that women attempt suicide more than men, but men are more successful. Is that correct?

Ms. Allen:

The national ratio is women attempt suicide three times per one male. Typically, the lethality is due to the access of lethal means like firearms or hanging. As far as the attempt data, we have regulations coming on that to get more real-time attempt data. We do have trouble accessing that, but ideation attempt information is increasing. I do not have syndromic surveillance data on gender, but I have seen in the past where men are showing up at the hospital more often. I can check on that information for current data.

Chair Peters:

I believe Dr. Megan Freeman may be talking a little bit more about the transition to 988 during her crisis services presentation. Are there any other questions for Ms. Allen? Go ahead, Ms. Allen.

Ms. Allen:

I wanted to address Senator Spearman's wonderful questions from earlier, and I do have answers. Regarding service members, veterans, and their families, we have incredibly wonderful partnerships with Nevada's Department of Veterans Services (NDVS). We have a Governor's Challenge team to reduce suicide in service members, veterans, and their families. We have four Mayor's Challenge teams in Las Vegas, the Truckee Meadows area, Winnemucca, and Elko. Each community develops its own unique needs around how they reduce suicides with service members, veterans, and families. It is comprised of veteran-serving organizations, veterans, and spouses. My co-lead, Sarah Hogue from NDVS, is a military spouse, so we have great wisdom and experience with her. We have been brought into national presentations when they have the service member veteran's family policy academies for other states coming on board, and Nevada has been brought in to present as subject-matter experts; we are proud of where we are going as a as a team. As Dr. Megan Freeman mentioned, those cross-department partnerships are a bridge to more effective care.

As far as Indigenous communities and the BIPOC population, DHHS and Social Entrepreneurs, Inc., a wonderful resource, have held several town hall discussions in Clark County around suicide in African American and Black communities and recently with the Hispanic/Latinx communities. We have so much more work to do; most of that work is about listening and hearing the needs from community members about what they are seeing and learning and what is working for them. We also have been working with the Native American communities, and I noticed, even in crisis, that they have the resources and answers, and we can come in with funding resources, opportunities, and support in the crisis. Our role is to boost up those elders, those experts in the community, and bring in national resources who are more experienced in working with Native American communities. The community I am working with is bringing in a gathering of Native Americans in a few weeks, and it is a beautiful starting point to address grief and loss and prepare the community for healing and prevention. There are huge gaps, but we are trying to do better and support the communities who are doing successful work with suicide prevention and mental health. Thank you for the opportunity to clarify that.

[Subsequent to the meeting, Ms. Allen submitted a follow-up memorandum regarding the 988 hotline and statistics for suicide attempts.] (Agenda Item VI A-2)

Chair Peters:

I want to point out that last session I worked extensively on a bill with Dr. Woodard to address how to obtain suicide-attempt data. Hopefully, regulations will get us more access to that data and allow us to see the whole picture as we look at suicide attempts and what issues to address. I wanted to make a statement in reference to your comment and Senator Spearman's comment regarding cultural competency related to the Indigenous community in Nevada. This last session, we passed a bill waiving tuition fees for Native American students in Nevada, and I hope that access will encourage more of those community members to engage in higher education related to the medical industry and ensure they have representation so that they feel confident and comfortable reaching out to you but also

as competent and available to be at the table from which they have historically been left out. I look forward to seeing how that turns out for those folks. Are there any other questions from the Committee at this moment? If not, we have Christy McGill here to present on NDE's SafeVoice program, which we heard about extensively during the 2019 Legislative Session. I look forward to this update from Ms. McGill.

Christina (Christy) McGill, Director, Office for a Safe and Respectful Learning Environment, NDE:

I am here today to talk about SafeVoice, which is one way our students can express their concerns, either about themselves or others, around school safety issues (Agenda Item VI B). It is in the law, but I want to tell you what it really is on the ground. It is a project that needs many partners. It really is coordination, or a collective impact project, between the Department of Public Safety (DPS), NDE, our districts, and our schools. I would be remiss if I did not express my gratitude towards our students because during the pandemic when schools shut down, they made sure their peers were safe. Our students continued to use the program by not only reporting on themselves but also on their friends who they noticed on Instagram, or something of that sort, who were having real difficulties. In that way, we felt blessed to have this program up and going. It is anonymous and confidential, which the students say is an important component, but it also leads to some complications. Sometimes when youth are reporting on themselves or others and it is a life-safety issue, they must look at the pros and cons and decide whether to honor or break that anonymity and confidentiality.

The magic behind SafeVoice is the schools responding to different kinds of things; they have a multidisciplinary team that responds to the SafeVoice tips. The tips range from, "My teacher was being mean to me today," to "I am really worried that my friend is carrying a gun to school; I saw something funny in their backpack." The DPS monitors SafeVoice 24/7. If it is a public safety event, DPS brings in local law enforcement or the school resource officers, depending upon the district, to make sure there is a quick and safe response to each one of these tips, especially if they are elevated on school safety.

When school is not in session, SafeVoice is still live; we work hard with the districts to make sure that the ecosystem of support is around 24/7. We also work with our communities, especially around the mobile crisis teams, to come into the system, as well, to help. For those off hours when schools are not in session, we do not want our teachers, school counselors, and school psychologists to be on 24/7 for response; it is not healthy for them. We want to make sure we have some partners in the system who can take the reins when they are with their own families, on a much-needed vacation, or during off hours. We are working with Dr. Megan Freeman to see if we can embed the mobile crisis teams into SafeVoice so that they are an integral partner with our districts and schools to respond to these tips.

SafeVoice is one way that we promote our students to express themselves around school safety, but it is not the only way. We look at anonymity and confidentiality, and we always promote our students to have those relationships with their teachers and school counselors first. If they are at school, we always promote them going to talk with their trusted adult. If they are in a place where they do not have one, this generation feels comfortable texting, and they will tell us, "I could not say the words out loud, but I could text it." The texting component of SafeVoice is the main way the students interact with the platform. The only users that use SafeVoice by telephone are the adults. The youth have reported to us that texting is an important piece because sometimes saying the words aloud is more difficult for this generation.

Part of the new legislation that was added to the bullying laws, which was part of the reason SafeVoice was created, was to ensure school safety around school shootings and bullying—it came from Colorado—so that schools could intervene early and disrupt some of these patterns. Part of that bullying law was amended last year (AB 371 [2021]) to also include discrimination based upon race. Here are the definitions that we added into that law to make sure that SafeVoice and our bullying protocols included those elements.

I want to leave you with some of the important trends that we have seen in SafeVoice over the years since its inception. During the first year, most of our students used it for bullying; next was suicide threats; then we had the pandemic. In 2020, the most popular tip the students reported in SafeVoice was suicide threats; either they were worried about themselves, or they were worried about their peers. Again, a big shout-out to our students who attempted to take good care of each other during the pandemic. As the students went back to school, the suicide threats became less popular, and part of that, as this is an ecosystem approach, is we hoped when the students returned to school that there was earlier intervention so that it did not get to this point and things like bullying or concerns could be addressed earlier. I want to point out that this year has been difficult for our teachers, school counselors, school psychologists, and school social workers, and planned school attacks really climbed in use for this year alone, as you heard in the social media and the news. This created more chaos and stress in our schools as the schools tried to respond to each one of these as they came through. That threat to students has also increased, and we are seeing the conflict. As our students moved out of isolation and back into schools, many of the behaviors that we did not see before the pandemic have started to become more popular—fighting, arguing, those kinds of things. School employee complaints also rose this year as well. Those three indicators show that our schools have a hot climate right now, and as we lose many teachers, we have fewer and fewer adults in the building. We are really hoping that by all of us working together we can start to cool that climate for next year. This is it for my presentation, are there any questions?

Chair Peters:

Are there any questions from the Committee on this topic? Go ahead, Assemblywoman Titus.

Assemblywoman Titus:

Ms. McGill, you have certainly been engaged for a long time with these issues. I drove down to Las Vegas this week for several meetings, and I am staying at my stepdaughter's house, and we had a conversation the first evening I got here about the increase in these planned attacks on students at both of my granddaughters' schools, especially the junior high, and I am quite alarmed by that. It is real and gets taken down from social media fast, but those are realities that my grandchildren and other people's children and grandchildren are living with. It is not just here in Clark County, but it seems to be pretty dramatic in Clark County based on its population. I am concerned that you can identify them, but is there any kind of a plan or intervention? I am hearing that the teachers cannot intervene, and there is really no intervention; the teachers are frightened about intervening. Is that being addressed?

Chair Peters:

Thank you, Assemblywoman Titus. I want to point out that our next agenda item talks about this issue—prevention treatment efforts—but more specifically related to substance use disorder, so I ask our next presenters to please keep this question in mind as well. I had a similar question, and if I can tie mine in, if you do not mind, related to the numbers

of people calling in or sending in their concerns and the disparities between the three years that you have been in operation.

Ms. McGill:

Yes, each school and district have plans in place to address planned school attacks, but the frequency puts a lot of strain on the schools themselves. I have two representatives from our largest districts here with me for the next presentation who can go into more detail of what that looks like at the school levels. Yes, they all have plans to address this. It is like the onion question; there are many things going on. There are strategies around restorative practices and efforts to reduce suspension and expulsion. There are worries about fewer teachers in the building. We are doing listening sessions for the entirety of this week from our school system, and one of the clear asks that keeps coming up repeatedly is "We need more adults in the buildings." With all this turnover, our schools are not sufficiently staffed, and you are seeing some of the results of that, which is overwhelming. Yes, there are strategies in place and our districts do well with that, but if we do not have enough people in the buildings, these do not go as well as we hope. I can send a chart to all of you that shows exactly how many SafeVoice tips happen across months, across dates. We can differentiate that; they are in the thousands. We love that the system gives a voice to our students. It creates a significant workload for our school staff, of which most are happy to engage because they love the kids. They would rather address the issues than not, but one of the drawbacks is that without the number of school personnel in our buildings, it gets difficult.

Assemblywoman Titus:

One of the realities is that there are not enough adults in the room, and that sometimes takes a while to resolve. One observation I see is, instead of kids intervening and breaking up a fight, they pull out their cell phones and video the event. Nobody gets involved. Perhaps one of your solutions might be to engage the community of students to do more than just film it. Thank you for what you are doing.

Chair Peters:

Schools have planned attack plans, threat plans, but what is being done around the issues of suicide threats and bullying, and who are your partners in those efforts?

Ms. McGill:

We have our districts coming up to speak, and they will be able to tell you the specifics of what it looks like, but each school and district has responses to suicide threats that try to either work with community providers or our school-based providers to stabilize the students so that they are safe and can return to their school studies as soon as possible. As you heard in the last presentation, many of our community organizations have waits. This has put additional stress on the schools to try and stabilize these youth. When I look at the schools' responses to the SafeVoice tips, there is an overwhelming sense of care for the students, and they do try to engage the community partners to make sure those students are safe. Mobile crisis is key to those stabilization plans and why we really support our partners in the mobile crisis, not only coming into SafeVoice—they already do so much work with our schools—but also strengthening that. What does it look like to be collocated and to share resources and supports? That may be the next step up and providing that ecosystem of support that our students need.

Chair Peters:

When I was a student in Nevada, we had a peer mediation program. I am not sure how effective they found it to be or if it is still in effect at this point, but I would be curious to see if our schools still have those in place or if that is unique to each individual school. I believe ours was set up by the student council as an effort to reduce student violence against each other. I will ask those of the of the counties when they come up in a little bit. Are there any other questions for Ms. McGill from the Committee? I am not seeing any.

AGENDA ITEM VII—TRENDS, PREVENTION, AND TREATMENT EFFORTS RELATED TO SUBSTANCE USE DISORDERS IN YOUTH

Chair Peters:

We have three presentations under this agenda item. The first will examine trends; the second will review prevention efforts; and the final presentation will highlight challenges and opportunities related to substance use disorder treatment in youth. Our first presentation on mental health, substance use, and adverse childhood experiences is by the Nevada Youth Risk Behavior Survey (YRBS) presented by Dr. Kristen Clements-Nolle, professor and director of graduate studies at the School of Public Health, University of Nevada, Reno.

Kristen Clements-Nolle, Ph.D., M.P.H., Professor and Director of Graduate Studies, School of Public Health, University of Nevada, Reno (UNR):

I am the coprincipal investigator of the YRBS. I am going to present on behavioral health issues. Dr. Megan Freeman did a nice job of introducing this. You really cannot understand the trends and substance use without understanding the trends of mental health and all other aspects of youth's lives. I am going to jointly present some of this information. I want to thank our partners. We have a great deal of support from NDE; DPBH; the Nevada Statewide Coalition Partnership; school district superintendents and their district staff; all the school principals, administrators, and teachers; and certainly, the students and their families. We conduct the YRBS every other year in the odd years. In 2021, no students were in school, so we did not conduct a survey in the spring of 2021. Instead, we had to delay it to fall of 2021. We did exceptionally well—better than most other states—but unfortunately, we do not have that data. We only finished collecting data by the end of the semester. I would be happy to make those results available or come back to speak with you because I think the trends during the pandemic and the return to school are going to be very important for us to look at (Agenda Item VII A).

Just to make sure everybody understands the way the YRBS works in Nevada, we receive funding from the CDC, but that funding only allows us to sample 36 high schools for a state-level YRBS. Those high schools are primarily in Clark County because that is where most of our population resides. We have a handful, maybe four or five schools, in Washoe County and just a couple of schools in our rural and frontier counties. We are fortunate that for many years, DPBH has been contracting with UNR to sample all regular, public charter, and alternative schools. We also do a sample of all tribal schools and over sample in that population. What is unique in Nevada is we also include our middle schools, and today I would like you to pay very close attention to our middle school data because we need to be upstream and working with youth at a younger age. We are very fortunate to have the funding to be able to include middle school students in our survey.

We do work with districts. In 2019, we administered the survey with either active or passive parental permission. It was about half and half in 2019. As you know, with SB 69 (2021),

this has changed to passive permission statewide. This certainly helped us administer the survey at a time that was very stressful for schools, and it will only get easier in the future. We use a cluster random sampling design. I will not go into details but just know that we weight the data to make sure that it accounts for any nonresponse bias. Our estimates are reflective of the communities in which we sample and that we can compare over time. We do weight our data in our state at a district and regional level. These regions align with our coalition partnerships. It also ensures that we can present regional data without identifying the school—we never want to identify a school. In some of these counties, we might only have one school that is available. In 2019, we had over 5,000 students in our middle school sample and about 5,000 in our high school sample. That is typical. We will have a little higher sample size in 2021.

I am going to show you some data on substance use. This first graph is from the CDC sample. It goes all the way back to the 1990s, and you will see that use of alcohol, marijuana, and cigarettes peaked in the 1990s. I want to focus on the last ten years. From 2009 to 2019, alcohol continued to decrease throughout that ten-year period; that was a significant decline. There was a very significant and continued decline in cigarette smoking, and this is in the past 30 days. Use of marijuana has remained stable among high school students. In 2011, we did not have weighted data. In 2013, UNR took over data collection, and we have had weighted data since then.

If we look at our full comprehensive Nevada sample and compare what was happening from 2017 to 2019, you see that alcohol use and cannabis use is stable as we saw in the ten-year graph with cannabis. Cigarette use continued to decline to a very low level, but we saw a rapid increase in e-vapor product use, and this was similar to what we saw across the nation. Nonmedical use of prescription pain medicine in the high school sample increased slightly, but it was not a significant increase. There was a change in the way high school students were using cannabis; there was a decline in smoking cannabis and a significant increase in the use of e-vapor products.

Turning to middle school data, middle school youth are so young that it is important to look at lifetime use as well as past 30-day use. We see that the use of alcohol was stable. We saw a significant increase in the use of cannabis in lifetime from 9.9 percent to 13.4 percent. There was a continued decline in cigarette smoking, but it was not significant. We saw the same increase that we saw in the high school sample with e-vapor product use. We saw an increase in lifetime nonmedical prescription pain medicine use—and when I say nonmedical, the instructions are using it without a prescription or in a way that was not advised by a doctor—and that increased from 6.8 percent to 10.3 percent.

In terms of past 30-day use, we saw an increase in alcohol use. We saw a significant increase in past 30-day cannabis use from 5.2 percent to 7.9 percent. The past 30-day use of cigarettes was extremely low in both years, an identical 2.5 percent. The 30-day e-vapor use increases are similar to what we saw in lifetime use and in the high school sample. We did not previously have a past 30-day nonmedical prescription pain medicine variable. We do have that in all our surveys going forward. In fact, we are one of the only states that assesses past 30-day use in middle school youth, and it is very informative. Similar to the high school sample, we saw that middle school youth were switching from smoking marijuana to vaping it in this time period.

I am going to move on to some of the mental health or emotional health outcomes. If we look at the long-term trends, focusing on the past ten years, we see a very significant increase. The percent of youth who felt sad or hopeless almost every day for two or more weeks in a row where it inhibited their ability to do things increased from 30 percent to

42.5 percent in 2019, so we will be watching this trend very closely in our 2021 data. Suicide ideation is similar during this time of the last ten years, 18.4 percent—this is the past 12 months—a slight increase but not a significant increase over time in making a suicide plan. Although it went down slightly, this is not significant in terms of suicide attempts from 2009 to 2019. Looking at that last two-year period, we see that same increase, and it was significant in depressive symptoms from 34.6 percent in 2017 to almost 41 percent in 2019. All the suicide ideation, suicide plan, and suicide attempt variables remain steady in that time period. We ask a question on nonsuicidal self-injury; that increased slightly in this time period, but it was not significant. These are all indicators we will be watching closely when we get the 2021 data.

Nevada has a state-added question, trying to get from the youth's perspective whether they are getting the help they need. This would be when they feel sad, empty, hopeless, angry, or anxious. Again, I think it has that time period to the question. In 2017, 55 percent of the youths said they never or rarely get the help they need, and that was similar in 2019. We saw in the earlier presentation by Dr. Megan Freeman that one of the reasons Nevada ranks so low is because of access to services for youth, and the youth are feeling this as well.

I want to point out something very important. In 2019, we consulted with a number of stakeholders, including Ms. Allen and others, who want to evaluate the effects of their initiatives at the school district level, and to do that, a lifetime variable does not really help because you do not know when these things occurred. A past 12-month variable is much more sensitive. We had high rates of emotional distress in our middle school samples, so we decided to, in addition to lifetime estimates, get a sense of the past 12 months.

When we look at comparisons, the gray bar is 2017, which is lifetime, and the blue bar is 2019. They are not directly comparable because 2019 focused on the past year. Even with that restricted time period, there was an increase in feeling sad or hopeless for most days of the week for two or more weeks that interfered with their activities. About 22 percent reported suicide ideation in the past 12 months, whereas previously, it was about 21 percent in lifetime; 12.9 percent had made a suicide attempt, 8 percent had attempted suicide, and 19 percent reported nonsuicidal self-harm. All these indicators typically will see much higher prevalence in lifetime indicators. The fact that we are seeing similar, if not higher, prevalence with our past 12-month indicators suggests that for middle school students, these indicators were trending in the wrong direction leading up to the pandemic. We are going to be watching the middle school sample very closely.

There was a question earlier from Assemblywoman Titus regarding suicide rates, and yes, in both our middle school and high school sample, it is higher in our female population. It was particularly high in our middle school sample—10.9 percent of females attempted suicide in the last year compared to 5.4 percent of males.

Similar to what we saw with the high school sample, about half of the youth do not feel they are getting the help they need, and that did not improve from 2017 to 2019.

This was a question that Senator Spearman had asked; we do assess both sexual identity and gender identity in our high school survey only. Speaking to one of the questions around suicide attempts, it is certainly high in the group of students who self-identify as lesbian, gay, bisexual, or they are not sure of their identity—31 percent compared to only 11.6 percent of heterosexual students. The same is true for our students who identify as a gender minority, transgender, or they are not sure.

I was asked to talk a little bit about adverse childhood experiences (ACEs). We have a full ACEs report for both our high school and our middle school samples for every year. In 2019, we assessed six different adverse childhood experiences: (1) sexual abuse; (2) physical abuse; (3) verbal abuse, which is an indicator of ongoing verbal abuse in the household; (4) witnessing domestic violence; (5) household mental illness; and (6) and household substance use. The prevalence is a bit higher in the high school sample simply because they are older; they have had more time to witness adverse childhood experiences.

We have created an ACE score in some of our reports and publications. We look at four or five more ACEs. We look at a high ACE exposure category as three or more ACEs, and 20 percent of the high school sample and 15 percent of the middle school sample experienced three or more ACEs.

If we look at the relationship between ACE exposure and suicidal behaviors in the past 12 months, you see a very clear graded relationship as the number of ACEs increases. The prevalence of suicide ideation increases substantially, and this is very significant. In the past 12 months, for the youth who experienced three or more ACEs, 38.5 percent reported suicide ideation, 33.7 percent made a suicide plan, and about 20 percent actually made an attempt. There is definitely a subpopulation where we want to focus our prevention efforts, and Dr. Megan Freeman spoke to this as well. There is a need for trauma and forum services throughout our school system but also working a lot closer with our families.

We see a similar pattern in our data where ACEs tend to have a stronger impact on the younger youth. In the middle school sample, in the past 12 months, over 50 percent of the youth with three or more ACEs thought about committing suicide, 34.7 percent made a plan, and over 25 percent attempted suicide.

There is a similar [inaudible] response, or graded relationship, with all our substance use indicators. This is an example from our high school sample of some of our indicators for the past 30 days, and there is a significant increase. As the number of ACEs increase, so does the prevalence of cigarette use, vaping, alcohol use, and marijuana use. I could show you prescription pain medication, injection drug use—all the indicators follow the same pattern. In the middle school sample, you see a very strong impact in all of these indicators.

That is all I have right now, and I am happy to answer any questions.

Chair Peters:

Are there any questions from the Committee on this data? Assemblyman Orentlicher, please go ahead.

Assemblyman Orentlicher:

Regarding the substance abuse numbers, do you have data on frequency of use? I gather the questions are, "Did you use a substance at some point in the past 30 days?" Do you also have data on whether we are seeing changes in high frequency of use?

Dr. Clements-Nolle:

We do. We look at the frequency of use within that time period, so this is just dichotomized. Often, we will look at use of 20 or more days, which is nearly every day; we are going to be looking at that in the 2021 data. There is some indication that initiation of use may have decreased during the pandemic, but among users, frequency of use may have increased.

I also want to look very closely, and this speaks to another question earlier, whether there are health disparities in what we are seeing. For some youth, the stay-at-home orders may have been protective because youth were with their families, and their families had the ability to stay home with them; there was less access to substance use in some situations. In other situations, the families did not have that ability—a lot of our frontline workers and some people had to work multiple jobs—so youth did not have the support of the schools and were left at home and in their communities. We will be looking closely to see whether there are health disparities in substance use patterns. Yes, we do look at frequency of use.

Assemblyman Orentlicher:

You showed us upward and downward trends for different substances. Overall, what kind of trends do we see? Is there a rotation of which substances they use? If the population that is interested in substance use is stable, do they change which substance they use? Do we have a sense of that?

Dr. Clements-Nolle:

We have a sense that there is some substitution for alcohol use, cannabis use, and marijuana use in both the younger population and the high school population. Our trends are similar to the nation. From 2017 to 2019, our middle school trends in cannabis use are similar to what we see nationally; students in grade 8 through 12 prior to the pandemic had an increase in frequent use of marijuana. We did not see that in the older groups. There are some indicators that we need to be watching that early population because their initiation patterns may be different from what we see in the high school youth who may be substituting different things. The overall downward trend in alcohol use and smoking cigarettes is very similar to the rest of the nation.

Chair Peters:

What about illicit substances that are not listed in your slides? Can you talk about what those look like and if you have trends, and if you do not, why?

Dr. Clements-Nolle:

These are young adolescents, so they are all illicit substances for them. We do have indicators of methamphetamine, cocaine, heroin, and injection drug use. Generally, our rates are very low and have been stable. We have not seen increases in any of those indicators. As I noted, we did have our high school sample. I did not show you the lifetime data, but we did see an increase in prescription pain medication use in high school students for lifetime use, and there was an increase in the middle school youth as well. All other illicit substances are stable and very low in comparison, and they have been stable for a number of years.

Chair Peters:

Interesting. Are there other questions from the Committee? I am not seeing any, so we will move on to our next presentation. Our next presentation is on the Statewide Epidemiology Organization Workgroup (SEOW) and the Multidisciplinary Prevention Advisory Committee (MPAC). We have Elyse Monroy and Jamie Ross to present on this particular issue.

Elyse Monroy, Chair-Elect, SEOW:

The SEOW was established in 2016 per guidance from SAMHSA to promote data-driven decision-making in the state Substance Abuse and Prevention Treatment Agency (SAPTA) (Agenda Item VII B-1). The SEOW works to advise MPAC, which Jamie will present next, and the SAPTA advisory board and other programs and grants within SAPTA, DPBH, DHHS. The SEOW meets quarterly. While these groups meet specifically to advise SAPTA's groups and grants, the epidemiologic (Epi) profile that SEOW advises on, the data is used far and wide. The presentations you heard today from Ms. Allen and Dr. Clements-Nolle pulled data from the Epi profile. It is a great service to the state and public health and behavioral health. The SEOW meets to advise on an Epi profile.

The SEOW works in conjunction with the state's Office of Analytics to produce an Epi profile. These profiles summarize the nature and magnitude and distribution of substance or mental health-related concerns. For the 2020 Epi profile, the SEOW chose to focus on youth suicide because Committee members and the state were hearing anecdotal stories about the rise in suicides in our youth. This profile told us, as Ms. Allen and others alluded to today, while we know that historically suicide is the leading cause of death for adults in the state of Nevada, there is now a need to track and monitor the risk of suicide for youth or young adults.

The last thing I will point to with the SEOW is the diverse makeup of groups that advise and provide insight to the development of the Epi profile. Included with this presentation is an attachment of SEOW membership (Agenda Item VII B-2). You can see the diverse range of perspectives, professionals, and experts who advise on the development and creation of the SEOW, and this diverse range of experts and expertise provides for a well-rounded profile as we are picking which indicators and data to look at.

Our work with the SEOW hands directly off to MPAC, who takes the data in the profile that we put together and translates that into action.

Jamie Ross, Co-Chair, MPAC:

The SEOW finds the data, does the epidemiology, and translates the data into what it means. They give us a beautiful package, and we review the data so that we can guide priorities for actual prevention work in the state. We take this wonderful high-level data and make it granular to determine the priorities. As with everything in our community, we want to be evidence-informed and data-driven, and this is how we do that work.

We took all of the substances for both youth and adults—the YRBS is where the majority of this data comes from—and we focused on magnitude, time trends, comparisons, and severity. Magnitude is how big the problem is, and time trends is whether it is going up, down, et cetera. I am sure after watching Dr. Clements-Nolle, you have an idea of where this is going. Comparisons to other areas of the state and national and severity, consequence data. This process follows the SAMHSA Strategic Prevention Framework, the goal of which is to prioritize one to three substances based on all these data so that the resources that are limited can go to the areas that are most in need.

This is the actual document and the indicators that were prioritized. The MPAC decided which indicators had a four or a five in overall score; these are marijuana or cannabis, vaping products, alcohol, prescription drugs, and cigarettes.

These are the final priorities for the group. One of the issues that Assemblyman Orentlicher hit on and Dr. Clements-Nolle spoke on in depth is 30-day use versus lifetime use. We have

seen that lifetime use, overall, is not as good an indicator as 30-day use; although, more important for our middle schoolers, so that was taken out. The two areas of most concern for middle school students are marijuana or cannabis and vaping or e-cigarettes. For high school, it was use of alcohol and use of e-cigarettes or vaping. For adults, it was marijuana or cannabis, and for our LGBT+ population, it was use of marijuana or cannabis and tobacco. We know the limitations of this data. A lot of this data is from 2019; we are currently in 2022, and we have seen significant changes in the trends. The data, unfortunately, lags behind, so we are definitely continuing to carefully monitor fentanyl, pressed pills, kratom, et cetera.

From all those great priorities we move on to what is happening in each individual community. There is a coalition that covers every county in the state. We focus on those issues directly in our communities. I work at the Prevention, Advocacy, Choices, Teamwork (PACT) Coalition; we focus on Clark County and being able to take that data and utilize it in our communities is incredibly important.

To further tie all of this in—this is something that was in the MPAC report—all of this is publicly available on the DPBH website. I find the funding source interesting. We have spoken on the three or four substances that seem to be emerging over and over in all these presentations. Most of the funding is specific to opioids, and only $50,000 is specific to alcohol. One of the big priorities is that the drugs that are most affecting our youth are not really called out very much in this. Opioids are one of many issues in our community. Other ways we end up having to work is to leverage the funding that we have with opioids to work building systems on the back of these opioid dollars, and that does not translate into sustainable systems. It creates some issues, and most of this funding here is federal dollars; very little of it is state-generated dollars. Most of this is prescriptive from the federal government. We understand that is an issue that continues to affect our community.

You heard Dr. Clements-Nolle speak about SB 69 (2021), which created the passive consent of the YRBS. It also institutionalized the prevention coalitions, and it encouraged schools to create a list of evidence-based prevention programs, which really encourages that all areas of prevention programming in the state of Nevada move towards being evidence-based.

We would not want to finish this presentation without giving you some gaps and some needs. If you look at the continuum of care, there is more money available for what we call primary prevention, which is either for parents who are raising children who are not currently using drugs or young people who have never used drugs. Then we focus on what we call secondary prevention, which is folks who are at risk or currently using but do not meet diagnostic criteria. Then we have early intervention for those folks. Then we move into harm reduction, treatment, and recovery. There is very little funding for early intervention. Most of the funding that comes into our state is for primary prevention. The other issue we have is funding not tied to a substance. To give you an idea, the last time the State Legislature came together to fund specific issues around the substance was the first time we had our methamphetamine crisis. Obviously, methamphetamine has not gone away, but when we tie these drugs to a substance, then we must be more creative in how we create these systems to solve these problems. This is my contact information, and we are open for questions from the members.

Chair Peters:

Are there any questions from the Committee? Senator Spearman, please go ahead.

Senator Spearman:

We have consistently had issues around funding to combat substance abuse for the larger population but particularly when it comes to adolescents. Are there any plans to use part of the opioid settlement that will be administered? I think it is going directly to the Office of the Attorney General (AG), and he has put in place a group of people who will further identify areas where it needs to be used. Is there any way for us to use what you just presented in terms of the substance use issues, those substances that are not identified but are most likely to be available and used by students?

Ms. Monroy:

You mentioned the settlement funds. Through SB 390 (2021), the state has developed the Fund for a Resilient Nevada, which is how dollars are going to be funneled into communities and two counties. I was the AG's appointee on the advisory committee. I met this morning, and we got an overview of the One Nevada Agreement, which explains how funds are going to come to the state through the AG's Office, go to counties and municipalities, and then to DHHS. The advisory committee that I sit on is currently working through a needs assessment process to identify what some of our communities' needs are, with a focus on the historically marginalized and health equity, to ensure that we are building out using these dollars that are coming in from a settlement to meet gaps that have been long-time gaps in our community around these services. I am not familiar with the bill; I do not know if there is someone else who can speak to that, but yes, the settlement fund is looking to plug the holes that Ms. Ross mentioned.

Senator Spearman:

Are you working with the Office of Minority Health and Equity (OMHE), DHHS, on some of these issues? It seems like there is some type of intersection between the information that you discussed and their mission for this interim.

Ms. Monroy:

As it relates to the work on the SEOW, we do not engage directly with OMHE, but that is easy for us to change; we can start engaging with them. Ms. Ross, I am not sure if you work with them with the MPAC.

Ms. Ross:

The MPAC does not work with OMHE, but I believe, Ms. Monroy, the Advisory Committee for a Resilient Nevada (ACRN), along with the Nevada Minority Health and Equity Coalition, both presented on some of the work that they are doing, and they were intimately involved with the ACE. You sit on that; I remember listening in. Is that your recollection as well?

Ms. Monroy:

Yes, and if the Committee is interested, I am sure someone from the ACRN would be happy to come and provide an overview of the needs assessment or our process as it relates to filling and plugging in some of these funding gaps.

Senator Spearman:

It occurred to me that for the dollars that we have, if there is more capacity building and collaboration, we can stretch them, and there are some areas that OMHE would be able to identify that may not be on your radar and vice versa. Just a suggestion there.

Chair Peters:

Assemblyman Orentlicher, please go ahead with your question.

Assemblyman Orentlicher:

Dr. Clements-Nolle's connection of the ACEs to substance use makes me think there is some kind of self-medication going on. Ms. Ross talked about how we often make our funding substance-specific when different substances are being used. That makes me wonder if we are doing more treating of symptoms rather than causes, and that to get at substance abuse, we need to get more at the ACEs. Is that something we can do with the money that is targeted at opioid use to bring it down to earlier causes?

Ms. Ross:

I agree with you wholeheartedly that ACEs and addressing the trauma our youth and adults are experiencing is incredibly important in reducing our risk factors, not just for substance misuse but for all other negative outcomes. My partners in nonprofit, public, and governmental sectors are creative in taking opioid dollars because, as of now, most of the federal dollars are opioid heavy, and we must be creative with how we address some of those issues. In my field, we call that upstream prevention—let us build fences as opposed to pulling people out of the river once they have fallen in. That is important and something that those of us who are in the field of prevention are passionate about. I am hopeful that the decisions made at all levels of funding include a focus on giving students and parents more tools in their toolbox and the ability to be safe and healthy in their communities. Also, the federal numbers have just gone up; for every dollar spent on prevention, we save $18 in treatment and incarceration.

Chair Peters:

Those numbers are incredible when we talk about the amount of funding that goes into these kinds of programs and what we can expect to see on the other side. It is hard in a biennial budget cycle to look towards those kinds of benefits, but it is important to keep in mind as we talk about the risk, the cost, and benefits to our communities.

Are there any other questions from the Committee on this topic? I am not seeing any, so we will move on to the next portion of our presentation on substance use disorder treatment and youth challenges and opportunities. We have Mark Disselkoen, senior project manager at the Center for the Application of Substance Abuse Technologies (CASAT) at UNR.

Mark Disselkoen, Senior Project Manager, CASAT, UNR:

I want to thank you, Chair Peters, for sharing your story at the beginning. My brother has been in recovery over 20 years. He almost died about 22 years ago, and he has been clean that long. I just want to say that treatment does work, and it is important for people to share their stories.

I am going to talk today about substance use disorders, treatment, and youth challenges and opportunities (Agenda Item VII C). I have worked with CASAT since 2003. I am a licensed clinical social worker (LCSW) and a licensed clinical alcohol and drug counselor. I was a treatment provider in Las Vegas prior to working for SAPTA, where I worked from 1998 to 2003. It was the Bureau of Alcohol and Drug Abuse when I worked there, a long time ago. Then I moved over to CASAT and have been here ever since. The CASAT started doing SAPTA certification for prevention coalitions, primary prevention, and treatment programs in 2006. When I first came over to SAPTA in 1998, I did certification of programs. Now we have an excellent understanding of the treatment continuum in Nevada as we have been certifying programs since 1998.

The following information is a snapshot of adolescent treatment in Nevada. The SAPTA has adopted the American Society of Addiction Medicine as division criteria under Chapter 458 of *Nevada Administrative Code* (NAC) for the continuum of care in Nevada. It is a nationally recognized, evidence-based approach to developing a strong continuum of care for substance use disorders treatment and co-occurring disorder (COD) treatment. There are currently 30 level one and/or level 2.1 certified adolescent treatment programs statewide. I say "and/or" because level one is services that are under six hours a week for adolescents, and any service six hours or more is intensive outpatient treatment. There are six drug court-certified adolescent providers in the state. There is one medication-assisted treatment provider for adolescents, methadone and suboxone—age 16 is the U.S. Food and Drug Administration's minimum age that somebody can be on those two medications. There is an opioid treatment program (OTP) in Las Vegas, which does naltrexone as well. There are three level 3.1 and/or 3.5 certified residential adolescent treatment providers, one in Elko and two in Las Vegas. As you can see, Nevada has limited access to adolescent residential treatment options statewide.

Relative to funding and reimbursement options for SAPTA-certified providers, substance use disorders (SUD) and COD providers must be SAPTA-certified and either co-occurring capable or enhanced to enroll in Provider Type 17-215 with Medicaid, and that provider type is specific to both SUD and COD. It is not for mental health only, which would be like a Provider Type 14. Additionally, SAPTA utilizes the Substance Abuse Prevention and Treatment Block Grant to fund residential types of services, room and board, et cetera. Typically, outpatient services are covered by Provider Type 17-215 under Medicaid. Ms. Ross made a good point that a lot of dollars are being spent from the federal level on opioids, but in the last round, SAMHSA included stimulants along with opioids. Some of those dollars now are being utilized for not just opioids but also for stimulants, treatment, prevention, and so on. There is word that because SAMHSA understands there are other problems other than opioids in the country, they are thinking of including alcohol as well, so those state opioid response dollars that come from the feds to the state are looking at expanding their reach, going beyond opioid treatment. There are other providers that are not required to be SAPTA-certified in the state. In these cases, oversight is limited, and these providers typically take private insurance or private pay. There are people outside of the SAPTA-certified providers, but they are not receiving any Medicaid dollars or any block grant dollars from the state.

I want to talk about Certified Community Behavioral Health Centers (CCBHC) and youth. A team made up of the Bureau of Health Care Quality Compliance, DPBH, DHHS; Medicaid; SAPTA; and CASAT oversees this project. There are nine CCBHCs that fall under Provider Type 17-188, which is specific to CCBHCs, and six additional CCBHCs that are funded directly from SAMHSA. The CCBHCs are required to serve children, adolescents, and adults regardless of their ability to pay. There is no financial barrier to access these services. It is noted that CCBHCs, under the SAMHSA project, only provide outpatient

services, not residential services. Services that the CCBHCs provide are 24/7 mobile crisis teams; outpatient treatment, which would be like level one and 2.1; medication-assisted treatment, both for substance use issues and behavioral health; psychiatric rehabilitation and basic skills training; targeted case management; peer support services; and assertive community treatment services and teams. I want to go back to what Senator Spearman asked about earlier—under the SAMHSA requirements, each of the CCBHCs must specialize in VA treatment, and they are working with having care coordination agreements with all local VA providers; they are an extension of them and are able to provide services. Also, related to what Senator Hardy said earlier on primary care, two of our CCBHCs are also federally qualified health centers (FQHCs). We have two additional ones that are applying for FQHCs as we speak. Just to note, because it was brought up earlier, and this is not necessarily specific to CCBHCs even though they would need to provide this, is that I do work with indigenous people in the State of Nevada, helping them with enrollment in Provider Type 47, which is something for Native American populations, indigenous people, so they can bill for Medicaid for substance use and mental health services. I do that as part of my role at CASAT.

Let us talk about some of the challenges related to treating youth and adolescents in the State of Nevada. There is a workforce issue in Nevada, and right now, it is very competitive regardless of whether you are treating adults or adolescents. There are not enough clinicians who have the competencies to provide adolescent treatment. It is a very specialized level of service, especially when you get into the world of substance use treatment and co-occurring treatment. It even becomes more specialized, so we have a limited workforce that can provide treatment at a level of competency that would be required. Adolescent treatment is specialized and takes more intense treatment over longer periods of time to be successful. Additionally, transportation and parents working swing shifts create further barriers. I used to work for a provider in Las Vegas that had an intensive outpatient program for adolescents. One of our biggest challenges was getting the youth to the program. The person that I worked for at the time bought vans, and the insurance for those vans was astronomical as you were transporting youth. That is another challenge that is unique to Nevada—having three shifts that parents may work during a 24-hour period.

Another thing you must think about when working with adolescents is the developing brain, especially in early adolescence. Females use it for different reasons than males, and vice versa, and treatment providers need to know what they are doing related to screening assessment and making sure those individuals get the individualized care they need. Many providers do not want to engage in providing adolescent treatment due to hiring competent staff and the cost of providing that care. It is a lot more work than just providing a traditional adult program. The success of an adolescent treatment program is only as good as its ability to engage resources to create a warm handle. Adolescent programs try to engage with community partners to assure that there is a relationship there and that people are getting referred for services is critical. Adolescent treatment generally costs more due to the intensity of services and the extended length of care to ensure outcomes are maintained upon discharge. There are limitations related to cost of services when comparing adolescent to adult treatment that is not always reflected in the reimbursement of those types of services.

There are challenges, but there are also opportunities and strengths. In many ways, there are no limitations related to policy as there is a continuum of care with the means to pay for services. Provider Type 17-215 is an example of a reimbursement mechanism for SUD and COD for adolescent treatment. The growing number of CCBHCs is critical as these providers are required to provide treatment to adolescents, and it is very much supported by

SAMHSA. This creates competition and encourages CCBHCs to provide more expansive treatment options, including adolescent care. What is nice about the CCBHCs is they do not have a choice related to providing services to children and adolescents. They are required to do it and have the staff to be able to do it versus a standard SAPTA-certified program where they are not necessarily required to provide those services. Helping providers establish strong referral relationships with schools, law enforcement, and other stakeholders is critical. Part of our SAPTA certification is we provide technical assistance to treatment providers, and we are always trying to encourage them to reach out to school counselors, work with juvenile justice, and so on to build a very clear referral connection between those entities in themselves.

Education opportunities to build competency for counselors will encourage expansion of services to you, and education opportunities related to adopting and implementing evidence-based practices is critical. A provider simply cannot revise its adult program to treat adolescents. They must develop a person-centered care based on age and developmental stage. Working with adolescents with substance use or co-occurring disorder diagnosis involves a developing brain and the ability to take that into account when they are screening, assessing, and then treating. The other critical piece here is family therapy, which is a specialized level of service. If you are not doing family therapy as part of treatment to adolescents, your outcomes decrease significantly. Questions?

Chair Peters:

I am not seeing questions from the Committee. You talked about family therapy and the impact that has on success rates of treatment. Can you talk about the challenges of creating that kind of program and system for families?

Mr. Disselkoen:

What is critical—and I share this with anybody providing adult or adolescent treatment but especially adolescent treatment—is that you need to attempt to engage the family throughout the continuum of care. Too often what happens is that when you start off, the family is very resistant to getting involved. The goal is to use motivational interviewing kinds of approaches, try to engage the family at different points throughout the continuum of treatment to get them involved. That is one of the key factors. The starting point for treatment providers is that families must be involved. If they build a program, and they have staff that are competent, you will see an increase in the family engagement. I have seen programs that are committed to it and the families are involved, and I see programs where it is much less a part of their whole philosophy, and they have a harder time. The key is that it needs to be integrated into your treatment and you need to do it across the continuum and get anybody involved who is a part of the family union. It may not be the mom and dad; it could be grandparents or other significant others that you want to draw on as well. Do not just look at the smaller family units. Look at the larger family unit to bring those individuals in. Some of the data from SAMHSA shows somewhere between a 25 to 30 percent increase in outcomes when you do family therapy related to SUD and COD.

Chair Peters:

Those are important numbers. I think about the opportunities families have and some of the limitations that exist for families in engaging in these treatment scenarios, and the availability of sick time, paid leave. Those kinds of things are real inhibitors for family members being able to be as involved as we would like them to be, not just in this issue,

but across the board for behavioral health for students, children, and youth. Can you talk about peer resources that are helpful in these treatment opportunities?

Mr. Disselkoen:

The CCBHCs are required to have peer support specialists on staff or through contract, which has really enhanced treatment. Before peer support specialists, you would get somebody through treatment, they would be doing well, they would get discharged, and then it was like they fell off a cliff. The peer support specialists can come up alongside them before treatment ends and provide a warm handoff into the recovery community. We are seeing an increase in longevity of recovery because these peers come alongside and bring people into the communities. A licensed clinician cannot do that warm handoff and take somebody to a support group because it would be unprofessional under the licensing board, but with peers you can do that. We have seen an incredible amount of improvement related to clients having better outcomes because peers have come alongside while treatment is still in its active phase. Once an individual has successfully completed treatment, they can interact with the community.

Chair Peters:

I have a quick follow-up on that one. Is there a peer support opportunity for a family handoff because it does not end at treatment, even for the families?

Mr. Disselkoen:

No, it does not. The other critical thing is CCBHSs are required to provide both peer support to the client and to the families and get them connected to resources while the individual is in treatment, not at the end, whether it be Al-Anon or other types of support groups for those individuals to get involved in. We are working on that as well. It was a heavy lift for CCBHCs, and they have come a long way, and there is a long way to go. Because we have such oversight of them, the leadership of Dr. Woodard for example, we are moving in the right direction, and we see a lot of these things becoming more and more implemented and integrated into the community. The service is becoming more wide-ranging, including the family dynamic and the services that they get.

Chair Peters:

Any other questions coming from the Committee? Senator Spearman, please go ahead.

Senator Spearman:

The recurring theme in all these reports appears to be the connectedness between the individual who is in treatment and the family. Are there any requirements for family systems therapy training or continuing education units (CEU), or perhaps merging that with Assemblyman Orentlicher's comment about treating the symptoms and not the cause? In all the training of the people who are working in this space, do they ever look at anything like family systems training because there is a presenting problem? And there is a larger issue with the environment of the person who we are treating. If you do not address that, then we simply put a Band-Aid on it and send the person back into that environment, and the same thing happens over and over again.

Mr. Disselkoen:

Being a social worker, family systems therapy is the bedrock of what I do. All the licensing boards, and we have several in the State of Nevada, require clinicians to practice within their scope of work. Typically, that is more of a generalist kind of thing. When you get into other kinds of specializations, like treating families or doing substance use treatment, you are required to have a certain proportion of your continuing education every two years in those specialty areas. One of my specialty areas is SUD, which means I must have at least 15 CEUs every two years in that specialty area for me to say that I can do that in practice. Other ways to gain expertise, other than the education part, is to get clinical supervision from somebody who is an expert. Whether you are an intern working towards your license or you are already licensed and you want to build competency in a particular specialty area, it is important for that clinician to find a licensed person who can provide that supervision for them. I know that I received some of my family therapy experience early on in my career because I did joint therapy with a marriage and family therapist as an LCSW. He took me on. I did joint therapy with him, and that is how I built competency. Traditional continuing education, finding ways to be supervised, and finding a mentor to help you develop those competencies are extremely important goals for somebody who wants to develop a specialty area.

Senator Spearman:

I know we have got a number of community partners that are available, particularly the faith-based community, not for proselytizing, but adjacent to what the professional licensing boards do, if we are not, is there any opportunity for that? I also put into the chat a couple of bills that I spoke about earlier, SB 204 (2019) and SB 267 (2019). The faith-based partnerships are the ones that I think help us to extend the opportunity to do what we do without having all the money to do what we need to do.

Mr. Disselkoen:

Faith-based organizations are a critical stakeholder. Sometimes on the treatment side, we do not remember to reach out to faith-based communities and have them help us, and we can help each other. They refer people to the treatment system. The treatment system also refers back to the faith-based organization because of the support they provide. We know that any kind of structure, support, 12 steps or other, especially in the faith-based world, increase outcomes significantly. I am glad that you brought that up. We at CASAT did an initiative for an organization in Los Angeles about ten years ago related to faith-based; we helped them with some evidence-based practice, and they helped us on our end. That is an incredible thing to do, and I do tell treatment providers that. I mentioned juvenile justice and other kinds of entities in the community, and I should have mentioned faith-based communities as well.

Chair Peters:

I appreciate your presentation information and advocacy in this area. Are there any other questions from the Committee? I am not seeing any. We are going to go ahead and move on to our next agenda item.

AGENDA ITEM VIII—IMPLEMENTATION EFFORTS OF BEHAVIORAL SUPPORTS IN SCHOOLS THROUGH THE MULTITIERED SYSTEMS OF SUPPORT FRAMEWORK

Chair Peters:

We are going to again invite Director McGill to the table. Katherine Loudin will also be presenting with her. The Clark County School District (CCSD) is presenting as well.

Ms. McGill:

I am here today to talk about the health supports in schools, especially one systematic approach that we call MTSS (Agenda Item VIII). I am joined by two professionals in our districts, both at Clark County and Washoe County, who will be able to fill in a little more detail about what they are doing for supports around behavior health services.

The NDE has two pots of money, and the largest pot goes to the districts themselves around the recovery dollars, and the districts can decide where to place those dollars that best meet their needs. There is a smaller pot of money at the state level looks at systems approach. The NDE worked with its districts and key partners in DHHS to see what could be done to provide additional funding to help our districts recover. We looked at including additional dollars for school-based mental health professionals. We set aside $7.5 million. This is on top of what districts could set aside with their Every Student Succeeds Act (S.1177 of the 114th Congress) dollars. On top of that, we looked at, how do we strengthen? One of the things we learned through the pandemic was that schools that had intact MTSS fared a little bit better when getting supports out to children. I can share those results with you soon. We looked at how we can deepen that. We put in some coaches that the districts could hire to allow those people to come in and support the schools who wanted to deepen their MTSS. We also looked at restorative training support.

The 2021 Legislation looked at: how do we move away from suspensions and expulsions and be able to teach behavior instead of punish behavior? We looked at training; this was a big gap. It is also a big lift for our districts to do in the middle of the pandemic. We looked at how to create a system of "no wrong door" for training so that if schools and districts were ready for this kind of training, we either gave districts more money to train on their own, and we also created statewide trainings for our smaller districts so they could jump in and join. We also looked at SafeVoice program enhancements, especially around many of our after-hour calls, which are answered by our law enforcement officers. How do we mix that with mobile crisis? How do we really make sure that there is a holistic response to these well checks during afterhours? We are looking at rolling that project out soon as well.

Multitiered systems of support is nothing new for this committee and for my partners at DHHS; it is the public health system. Basically, education has taken a look at that and said, "How do we do that in school systems?" It is a system that looks at teaming; we want to make sure teachers do not feel they are independent in facing some of these struggles their students may be having. We also look at problem solving around data to make sure our districts are empowered. We have Washoe County here, one of the leaders in how they empower their schools and data-based decision-making. We look at systematic implementation and progress monitoring. It is not enough just to put in the behavioral health supports for students; we want to make sure that we have a system that can progress monitor and make sure those interventions are working. Tiered continuum of supports—a lot of times this is what people think of when they think about multitiered supports, and this is about differentiation. The goal is to get supports and interventions to

students early and to make sure, as soon as they have signs of struggle, that they have supports ready for them so that we are not catching them in special education, or three years down the line, or when they enter SafeVoice as really struggling with their behavior health. Tier one—which is something our schools do well—is good, strong preventive instruction across the board to all students. This is where our teachers come in, our school counselors and we look at regular screening and evidence-based interventions. This is the system around MTSS. Of course, it focuses on equity because if you have a system that differentiates support and interventions when students and staff need them, then you create more of a system that is equitable.

Just like the public health model, we have tier one, two, and three; universal support for all students; targeted interventions for students at risk; and individualized supports for a few students. That is where some of the clinical work can come in, and our school-based health can help support that.

Regarding some of the outcomes, we had ten districts look at this inclusively, which equals 149 schools, 99,000 students, and 41 trainings. This happened throughout the pandemic despite some of the difficulties.

Here is a quick reference to the types of trainings at the UNR Technical Assistance Center. I should preface that our office is quite small. We would not be able to do any of this work without our partners, and one of the key partners to MTSS is UNR's Department of Education, which has a technical assistance center that looks at positive behavior interventions and supports (PBIS), which is part of MTSS. These are the trainings that a school and district would go through if they selected to use the MTSS, which also helps them meet the requirements around Nevada's integrated systems that was also put into place two legislative sessions ago.

I want to end on some positive notes that when schools do this with fidelity, we do see improved climate for teachers and improved student outcomes. One of the goals is to tackle the issue of teachers and school counselors feeling that there is too much on their plate. How do we look at one system with multiple practices, not multiple systems with multiple practices? It feels very overwhelming. We have not got this down yet, obviously, but this is one of the things that we are working for.

You will notice some large data swings on the outcomes because of the pandemic. You will also notice that many of our MTSS schools that are implementing with fidelity have exhibited either as Title I or are struggling in some sorts, and so they are doing this. As you can see, the schools that have implemented MTSS had less harmful outcomes of the pandemic. They had more students coming; their absentee rates were better, and the violence to students, violence to staff, and progression of weapons have better outcomes than schools that are not. Also, we see results in trends and controlled substances. The MTSS is nothing more than a system of using evidence-based targeted interventions to issues that the schools have, to make sure that, when staff and students start to struggle, we have the appropriate interventions and supports at the ready as well as good teaching and prevention. We also see results in bullying.

I went through that very quickly because I wanted to allow some time for our districts to talk about behavioral supports and what they are doing during this time as well. As Dr. Megan Freeman noted, despite some of the ratios—and Nevada has not met its ratios on school counselors, school social workers, and school psychologists—this workload during the pandemic became a lot. We are striving to better those ratios and closely work with DHHS. One of those ways is to look at Medicaid, and instead of using educational funds for those

tier three services, which we are doing a lot of, bring in those Medicaid dollars to offset that. We hope this results in a larger budget for schools to have more people come into the schools, school sites, school counselors, school social workers to better those ratios. I am going to turn it over to Clark County, Director Weires and Joe Roberts.

Chair Peters:

Welcome. Thank you so much for being here.

Robert C. Weires, Director, Psychological Services, Dr. Beth Howe Center, CCSD:

As the director of psychological services, I have oversight responsibilities for all our licensed school psychologists providing psycho-educational services across our schools. I am actively involved with our MTSS efforts within the district. One of our specialized sub departments is our crisis response team. Mr. Roberts will speak to that and some of its responsibilities and roles. Our department has actively supported the development of schools that follow MTSS and PBIS with some collaboration through, as Director McGill said, the UNR PBIS Technical Support Center. We were up to over 100 schools that were actively pursuing the implementation of PBIS-related practices. I do a lot of communication and collaboration with other departments and key people related to health and behavioral health. We have active engagement and collaboration with our counselors; our wraparound services, which include social workers and Safe School Professionals; our health services; school nurses; and crisis response teams. We also have interface with community agencies and groups. I am the district representative to the Clark County Children's Mental Health Consortium. We have collaborative activities with the Mobile Crisis Response Team, The Harbor, and so on. I am also a standing member of our district's MTSS district leadership team. We are moving forward step-by-step. This past December 2021, we passed a district policy more formally endorsing MTSS practices in the district. That is a basic overview. There were some questions from earlier this morning that we can provide some feedback on, what is happening in CCSD. We are aligned with mental health types of services within CCSD.

Joseph A. Roberts, III, Director, Crisis Response Team, CCSD:

To address some of the questions and to speak to Director McGill's points regarding behavioral mental health supports for students in our schools, we have—and we did initiate prior to the pandemic—revised our suicide risk assessments to align with the Columbia Lighthouse screener. Moving forward and through the pandemic, we recognized the need, while we were close, to still have access to our school-based intervention team staff—school psychologists, school nurses, school social workers, and school psychologists in the district. We initiated a district-wide effort and collaboration with building principals, wraparound services, psych services, and school police throughout our district to engage in a term we coined the "Lifeline Project," which was to allow students to initially raise their hand during an online session and make an appointment to be seen at a school site for crisis support. We also embarked on a very lengthy and involved project with developing a panorama screener, and we are still using those tools today. We also engaged in alert monitoring district devices for students who were expressing suicidal ideation or even perhaps considering an attempt through what is known as Beacon GoGuardian, in addition to, and which complemented our efforts with our already engaged efforts with SafeVoice. Our numbers show we were able to turn the tide on our completed suicide rate.

Moving beyond that, we already had existing partnerships with The Harbor, the Clark County Mental Health Consortium, and the Mobile Crisis Response Team; however, coming through the pandemic and during the pandemic, we solidified those relationships even

more, and we appreciate our partnerships with those agencies. As far as other efforts are concerned, we increased our level of training for suicide prevention to all our staff in the district. We expanded some other key components like our Signs of Suicide (SOS) curriculum and training for our students grades 7 through 12. We can answer those questions more specifically in the next piece.

Mr. Weires:

Senate Bill 204 (2019) required increased awareness training relative to suicide prevention, warning sign indicators, community and school resources, and basic information. We included basic information and procedures. For the past two years, looking at compliance with SB 204, we have been offering suicide prevention training to administrative staff, licensed staff, and support staff. In terms of the earlier question about developing systems, we are working mightily to develop infrastructure for MTSS. We are playing a little bit of catch-up on the behavioral side. We are looking at the all-around development of students—academic behavior, social, and emotional—encompassing behavioral health. We are building infrastructure coming off the pandemic, which was a huge impetus for us, as Joe mentioned, through the Lifeline Project to develop multidisciplinary leadership teams, which are basically problem-solving teams for at-risk students to complement what we had available for academics, for kids. We are moving forward with developing infrastructure and practices. We are expanding upon mental health services and supports. Recently, the district engaged, by example, in working with Care Solace, which helps us facilitate connecting families with community providers. A number of activities are going on, and Clark County is in the process of developing step-by-step the infrastructure related to MTSS.

There was an earlier question about safety procedures and plans specific to suicide ideation. Mr. Roberts answered that in part, but I will try to add to that information. As Director McGill mentioned, schools all have safety plans in place. We have a plan for the entire district for large crisis events, whether that is a school, a group of schools, or the entire district. The Division of Emergency Management, Office of the Military, helps us run that. It ties into all elements in the district under the master plan. The best example of the last time that was fully engaged, apart from the pandemic, was the October 1, 2017, tragedy where we were mobilizing response resources. Each of the schools train every year on safety. They go through soft lockdown, hard lockdown, and evacuation procedures with assigned responsibilities at the level that applies to all facilities in CCSD. For example, I work at a centralized office, the Dr. Beth Howe Center, where I am on the safety team. My responsibilities are to help with headcounts, make sure everybody's accounted for, assess whether there are any mental health needs, and help provide and coordinate services, if they are needed.

Regarding heightened sensitivity, which was mentioned this morning, our last CCSD Board of School Trustees meeting specifically had an agenda item about safety issues. There are plans in place. There is heightened sensitivity, and the district continues to look at safety for all students and staff. Mr. Roberts and I align more deeply with the mental health side. We have a comprehensive suicide intervention protocol. We are talking about updating our risk assessments. Our procedures go from any kind of question or concern relative to a student, through a screening assessment and intervention at the school level, up to the few cases where we need to help facilitate hospitalization of students for appropriate assessment. Those are standardized procedures. We have done a very good job over the last five, six, eight years of standardizing those procedures, making sure we are clear about them. All our first responders at the school level—which is some combination for a given event on a given day of counselors, social workers, safe school professionals, nurses,

psychologists, and administrative support—when they are new to the district, are trained in our suicide intervention protocol, procedural steps, and forms. All of us occasionally receive refresher courses so that we are aware of our responsibilities.

From the suicide ideation side, which was a question earlier today, in my professional opinion, that is well-established, well-standardized, and it is a strength of the CCSD. A challenge of the district, obviously, is to move more proactively to get to the at-risk kids, move more into the educational. What are we doing with these kids? How can we increase awareness? Across the board, I want to share that we are making progressive steps that reflect Nevada legislation in relation to increased awareness, which includes training with students and staff. We have a mechanism in place for response in relation to suicide ideation. We are continuing to look at the district level for planning and support for schools so that we can progressively ensure that we are meeting the academic, social, emotional, and behavioral health needs of kids.

Chair Peters:

Thank you for making the distinction between the proactive efforts and the reactive efforts. It is necessary to have the reactive efforts in place, but we see the proactive pieces are making a difference to our students. I hope that our focus can continue to be in that space. I would like to hear from Ms. Loudin about what is going on in Washoe County.

Katherine Loudin, Counseling Coordinator, WCSD:

I coordinate school counseling and social work for the WCSD, our emerging school social work program. The WCSD has an MTSS department headed by Trish Shaffer, who also heads Social Emotional Learning. Our district has a robust website with lots of great information about how this incredible MTSS helps with data-based decision-making related to supporting schools and students in an individualized fashion. The collective impact of the pandemic on our students, families, and staff has been very significant. Many of you are aware that WCSD did open. This was very important for our families. We tried as a district to implement stress relief wherever possible for staff and others. We also worked collaboratively with our community members as well as state agencies, such as the NDE and DCFS, including Dr. Megan Freeman. We have found that due to the lack of availability of supports and the pipeline to success for these critical mental health personnel, what we really need, in addition to continued sustained funding for these positions, is collocated integrated supports. We need our mental health professionals and our substance misuse professionals to come into our schools and work side by side with us. That is something we have been implementing and working collaboratively toward. This is essential: to address the barriers to access as well as the critical needs that our students, families, and staff have; to enable our educators to build their own capacity to continue the work that is very important for them to do; and to address things like the psychological first aid of students. The WCSD implemented a behavior hotline for parents. We collaborated with marriage and family therapists on some teacher support groups and staff support groups and efforts. We accessed the NDE's trainings. We work to continue to expand what we were doing in telehealth, which is something that is also necessary, but there are issues with that, including costs. We responded to death, grief, loss, and crisis and have implemented our robust programming around suicide and substance misuse in conjunction with SB 204 (2019) and SB 69 (2021) as well as the reporting of suicide.

We in Washoe have continued to see increases in the outcomes as we have moved forward with what we have been doing with suicide prevention. We educate, through the SOS program, all grade 7 students and offer screening. We have seen substantial increases of

parents participate actively in that program with the reduction of stigma. We have also seen results in our 19 middle schools, with as many as 35 percent of students screened with that active permission coming up with needing some additional support. We have been collaborating with our Northern Nevada Mental Health Consortium, and I have contributed to their recommendations and access the professionals in that group. We are a SAMHSA Project AWARE school district; we appreciate its work with NDE and the stakeholders there, in addition to building the capacity to better record keep and support what has been happening with mental and behavioral health.

I think a missed opportunity for all of us, especially considering the individuals who are on the call today, is to share about the shared risk and protective factors that cross boundaries as we address things like suicide and substance misuse. As a district, we have suffered so much with student overdoses, particularly related to fentanyl, and that is a concern we have. When we are using and employing strategies to prevent suicide, we are preventing substance misuse; we are addressing gangs; we are addressing so many things in the field of prevention related to violence. I think we could learn and benefit a lot from that work and some of the prevention work that the CASAT and others have put into place.

In WCSD, we also participate in crisis management and emergency response; address crisis, death, grief, and loss in our schools; and serve on our district school safety team. We are all National Incident Management System compliant, and we have an emergency manager. We are working to improve our processes with our community agencies, including our local law enforcement and emergency management system. That is all I have for you, and we will answer more questions about this or other trauma-related things that you might have.

Chair Peters:

Thank you for the presentation on how things are going in our largest school districts. The emergency response teamwork is an interesting space. I get to do it with hazardous materials, but it is interesting when you dive into community emergencies. You do not need to respond today, but I would like to, from both counties, get any kind of reporting that you have on your implementation and progress monitoring efforts. If you have quantifiable or even qualitative indicators of how successful your efforts have been over the last five-year period to give us a couple of years before the pandemic, that would be great to see. I will open it to Committee questions. I see Senator Hardy has a question.

Senator Hardy:

You talked about fentanyl overdoses. Are those overdoses happening at school and do we have NARCAN/Naloxone available? Do we have those in the busses or are we equipping our people with ways to reverse overdoses?

Ms. Loudin:

Yes, we have experienced the impacts of overdoses that occur outside of school, and we have had overdoses, including fentanyl, on our campuses, which is a concern. We have taken advantage of the availability of NARCAN and collaborated with the community agencies that are in place to put that together. Our district has a policy through our director of school nursing, and we are implementing that currently and working on that and our district's policies at this time. The High Intensity Drug Trafficking Areas program had a presentation for us at the beginning of the year and connected us with some resources through our community coalition, joined together in northern Nevada, and then we collaborated with the other stakeholders to implement that in our schools.

Chair Peters:

Mr. Roberts, do you want to respond for Clark County?

Mr. Roberts:

While I am not actually responsible for the NARCAN that falls in line with our CCSD health services, we have had fentanyl overdoses in our district. We have employed the NARCAN antidotes we have in our schools and our nurse's health offices so they can be deployed if there is an overdose. To answer your question, yes, we have had that, and we have mitigating factors in place across our district.

Chair Peters:

Are there other questions for Clark County? Yes, please go ahead, Assemblywoman Titus.

Assemblywoman Titus:

I want to acknowledge the presentation. I appreciate Director McGill and the folks from Clark County and Washoe County. Looking at our schedule, this is probably the last item where we are going to hear from the schools, so I would like to circle back to the presentation initially on the trends and school discipline and behaviors. One of the things Director McGill mentioned is that some of the attacks and violence to students and staff is partly happening because there are not enough adults in the room. I am not hearing in any of the presentations about engagement with the teachers themselves. From what I understand, teachers are afraid and retiring. I wonder, if at some point, if we can get a presentation, or some analysis of why teachers are afraid, why teachers are leaving the classroom, and what resources do the teachers have because I believe it all ties together. I believe the teachers will be able to teach better if they feel safe themselves, and students will be able to learn better if they have teachers. I have not heard anything about engagement with teachers in this presentation. Is that something you are looking into? Is that something you have done? Are you doing surveys when somebody leaves early retirement on why they are retiring? I would rather have actual studies done and true documentation on what their answers are, why they are leaving, and why we cannot fill our classrooms. Is there anything being done along that line?

Ms. McGill:

We and the districts are doing that, and we can have that data for you when we start getting it in. We are doing some climate surveys with the teachers, and I know that our districts are doing some surveys as well. Those have not been concluded yet, but we can get that. We did do the well-being survey to some of our teacher population. We can get that data to you.

Chair Peters:

That would be great. I appreciate the tie-in to workforce and behavioral health services and even support services and schools in general. It is interesting to see how our committees overlap sometimes, and we have these intersectional issues that come up and where those conversations belong. We appreciate the follow-up when that data comes in.

Are there any other questions from the Committee?

AGENDA ITEM IX—OVERVIEW OF CHILDREN'S CRISIS SERVICES IN NEVADA

Chair Peters:

Today, we have three presenters—Dr. Megan Freeman, Dr. Andrew Freeman, and Samantha Cohen—who will present on this topic.

Dr. Megan Freeman:

Thank you for having us to discuss the crisis system for children in Nevada (Agenda Item IX). I want to talk about 988 as a quick refresher, and then I will turn it over to Dr. Andrew Freeman. He will talk in detail about our programming in Nevada.

As you might recall from the February meeting, 988 will be a single number to call in a mental health crisis, which we hope will become as widespread and stigma free as 911. Implementation of 988 is mandated by federal legislation, and it will go live nationwide on July 16 of this year. This is a major system shift, and most of us have never seen mental health reform like this in our lifetimes. If you have ever taken Psychology 101, then you probably have learned about the deinstitutionalization movement of the 1960s. This occurred in the context of the Civil Rights Movement. There were several contributing factors, including the introduction of the first-generation antipsychotic medications as a treatment option for adults and a belief that mental institutions were inhumane. Over the next 50 years, there was a push to discharge folks from institutions and transfer them to community-based care. There was approximately a 92 percent decrease in the number of individuals with mental illnesses living in institutions over that period.

At the time of deinstitutionalization, the plan, or the vision, was to substantially build out the community mental health system so that individuals with mental illnesses could receive treatment in the least restrictive setting possible. From the time of the deinstitutionalization through today, insufficient investments have been made in community-based mental health, resulting in large numbers of individuals with serious mental illness and severe emotional disturbance unable to get the care they need. Some people have called this transinstitutionalization because due to mental illness, many individuals end up receiving care in other systems, such as jails, prisons, or the juvenile justice system. They may also become homeless.

The hope is that 988, which is backed by a federal mandate, will help all states move towards greater investment in mental and behavioral health care. The goal of every contact with the 988 system will be to find the right level of care for the individual or family in distress, whether that be support through a hotline call or a warm handoff to psychiatric care, and all the different options in between.

When we look to the children's crisis system, we are missing some important components of a comprehensive crisis response system. Best practices, as defined by the National Association of State Mental Health Program Directors, outlined several touchpoints, including a crisis call center, crisis mobile response, and crisis receiving and stabilization centers. Underlying each intervention point are the essential principles and practices that have been developed through research and expert consensus. You will hear more about our children's mobile response and stabilization program, which we call MCRT, which is considered a national gold standard program. Our children's MCRT operates a 24/7 hotline, but because its purpose is to access services, it does not quite fit the definition of a crisis call center. There are no staff dedicated to simply resolving concerns over the phone, which

is what is required at a crisis call center. With the integration of the 988 system, the children's system will better achieve this touchpoint.

What we are currently lacking, but building, is our crisis receiving and stabilization centers. Dr. Andrew Freeman will provide some more detail on those, but we want these centers to serve the function that the emergency departments are currently serving. The crisis receiving and stabilization centers would provide a crisis assessment by behavioral health staff, immediate stabilization, and linkage to the next appropriate level of care. We want children, youth, and adults in crisis to be able to walk into a receiving center and receive care quickly from specially trained professionals instead of waiting for hours, days, or in some instances longer, in the emergency department, which was never designed to provide behavioral health care. We have some proposals and ideas in the pipeline for how to stand these up here, and we have a couple of pilot programs, or community partners, who are providing this service, and we hope to be able to implement it more widely as part of our children's crisis system model.

During the 2021 Legislative Session, substantial progress was made in laying the groundwork for a best practice crisis system in Nevada for both children and adults. Thanks to the hard work of many partners, some of whom are on this Committee and here today, Nevada was one of the first states to pass legislation creating infrastructure for 988 and other elements of the crisis system of care. Additionally, Nevada recently received several grants and awards for national technical assistance to support us in building out our crisis system as we continue to demonstrate that we are at the forefront of crisis work. I will turn it over now to Dr. Andrew Freeman to talk in more detail on what our children's crisis services look like in Nevada.

Andrew Freeman, Ph.D., Licensed Psychologist I, Temporary Manager, Children's MCRT, DCFS, DHHS:

I am currently the temporary manager of our child adolescent MCRT in Las Vegas and Reno, and I support the rural and frontier MCRTs offered through the DPBH as well. Our goal is to interrupt care pathways. Our goal is to meet youth and families when they are having urgent mental or behavioral health problems where they are in the community—not making them come to us, but we go to them—and then try to interrupt the escalation of care pathways and expense that comes with that. We are trying to provide family-driven, culturally sensitive care to the families in their homes as much as possible.

Our origination historically came out of the emergency room burden crisis that Nevada experienced in the 2000s through early 2010s. Mobile crisis started in Las Vegas in 2014 or 2015 and expanded to Reno in 2016 in Washoe County. In 2017, we expanded to cover the rural and frontier counties. The goal was to take youth out of higher levels of care and keep them safe in their homes and divert expenses in the system as a big-picture cost savings mechanism. When we think about where mobile crisis is now and where we need to go to integrate into the 988 system, one of the key messages that we send on a regular basis is that children and adolescents are not simply adults in small bodies. We have developmental trajectories that are different. We have environmental trajectories that are different, and we need to manage those specifically for children. We cannot simply take them and plug them into an adult system and hope everything works just fine.

What we are seeing in the national 988 conversation is that the model is coming out of an adult-based model that is running effectively in other jurisdictions, like Maricopa County in Arizona, the state of Georgia, among other places where they have a very effective crisis now implementation that diverts adults from higher levels of care. In Nevada, we are in the

opposite situation. We have very little to no adult mobile crisis services. We have an established child and adolescent MCRT. We are working very diligently to make sure that when 988 goes active in July and over the next couple of years that the child and adolescent system integrates into the larger 988 system.

Through DCFS, we provide MCRTs in person in Las Vegas and the Reno metropolitan areas. The DPBH, through their rural and frontier clinics, provides telehealth-based crisis services for the remainder of the state. We are a busy service. We tend to operate at or above capacity. In the last 12 months, we saw about 2,400 youth for initial responses statewide, with about 1,800 of those happening in Clark County and the Las Vegas metropolitan area. To give an idea of what this system will look like and probably grow in over the next five years, external consultants estimate that in Clark County alone, we should be doing between 3,800 and 4,000 responses a year for children and adolescents. We must take our entire system and double it just to meet the needs within Clark County. There is a lot of growth and potential for this to really change how children and adolescents access services. Our backbone of the service is a hotline. If a youth needs services, they call the hotline, and we operate our hotline 24/7. We share it throughout the state, and we have gotten substantially busier over the course of the pandemic. Our hotline has increased 20 to 40 percent. Our number of responses have increased about 40 percent over the last fiscal year.

When we talk about mobile crisis, we need to ask, "Who can get this service?" We operate on a fire department model, not on a doctor's office model. If your house catches fire, you pick up the phone, you call 911, and the fire department comes. They put out the fire in your house, and then they leave. They do not pull up to your house, call your homeowner's insurance policy and ask if prior authorization is necessary and what paperwork they need to send. They do not say, "Your insurance does not cover us. You need to call this other fire service, and they will come and help you when they have time." We serve any child or adolescent under the age of 18 in the state of Nevada regardless of ability to pay. For crisis services to work, we need a robust system that allows for all payers to contribute to the system. That way, we can serve every single child or adolescent in the state, regardless of their personal family's ability to pay for that service or not. To access us, all you have to do is call our hotline. For historical reasons, we have a Las Vegas number and a Reno number. The reality is that it brings everyone to the same place. The same people answer the phone. We centrally dispatch.

Once we dispatch, we try to create the safest environment possible in the family for the youth who is in crisis. One of our fundamental beliefs is that when a child is in crisis, their parent is in crisis. As a parent of a four- and an eight-year-old, when my children are struggling, I am struggling. What we try to do in that initial crisis response is a period of de-escalation and then a crisis assessment to determine the necessary appropriate level of care. That is driven by safety. Do we think we can comfortably, reasonably keep this child safe at home with their parents? The answer to that question—almost nine out of ten times or 87 percent of the time—is yes. Through intensive safety planning and follow-up services, we can keep a youth safe at home and divert them from having to go spend time in an emergency department or a psychiatric hospital. When we do that, we then provide intensive in-home services to help maintain a period of stability as we link and do care coordination.

Our referral patterns vary depending on where you are in the state. In Las Vegas, we were instituted primarily to help our emergency department partners with the psychiatric boarding crisis they are experiencing. We continue to serve emergency departments as a large proportion of our visits. We also serve CCSD and help our charter schools and private

schools. In Reno, we tend to do a little bit more of a split between emergency departments, parents, and schools. We do not quite have that same mix in Las Vegas. The rural frontier region distribution looks almost identical, except they serve emergency departments substantially less and have more self-referrals.

The 988 system is predicated on this triage level of care. The hotline will handle 80 percent of calls without doing anything else; they will simply talk to the person on the phone. They will take 20 percent of those calls and dispatch MCRTs. When we talk about children's mobile crisis, the emerging national standards, and the model that we work under, the goal is to get the child with a clinician and the family with a caseworker as quickly as possible. We tend to deploy 80-plus percent of the time. We do a lot less of this idea of care traffic control, or care coordination, over our hotline. We started to do it a little bit more to keep up with the demand we are experiencing; however, we really want to get professionals to the family for support as quickly as possible. That way, we can ensure appropriate levels of care are being provided.

Over the next couple of years, we are going to see a bridge from what we are currently doing to what we will need to be doing to function within the 988 system. In July, there will be four numbers that a person could call if their child is in crisis. There is always 911, which we discourage as much as we can, because a law enforcement officer is not who we want responding to a child in crisis; 988 will be active as well as our two mobile crisis numbers. The goal over the next five years is to have a very rapid 911-like implementation. I grew up in rural Ohio in the 1980s and moved to Nevada about seven years ago as a professional. I still remember as a child, when I would go to friends' houses or go to a cousin's house, there was a magnet on the fridge with the local police and the local fire number because 911 did not exist. Our goal is to do that exact same thing. Over the next five years, the local numbers will fade, and 988 will become the primary entry into the system for children and families in crisis, the same as it is for adults. We have work to do to get there. We must invest in our technology within our team, so that we can interoperate with the 988-care traffic control center appropriately, feasibly, and well. Part of this is also creating a safer environment for our mobile teams. When our teams go out into the field, we are working on investing in mobile technology that allows us to geolocate them at all times. It allows the teams to check in and out and have safety checks online via their phones. This is one of the joys of modern technology. We are allowed to keep our folks safer in the field with time.

There are three critical elements in the mobile crisis and 988 model: someone to call, someone to go, and somewhere to go. The children adolescent MCRT is fundamentally someone to go. During that crisis response, our goal is to be there in under an hour. In some parts of Nevada, that is feasible and easy to do. From our central location, we can get to most of Las Vegas within 30 minutes. In the Reno-metropolitan area, we can be most places within 30 minutes. Our rural frontier teams respond by telehealth and are usually connected with the family in under 15 minutes, but if we want to have people in person, that becomes substantially more difficult because we have large geographic stretches that we would have to travel. That is on the plate. We are working on solutions to that, including community-based partnerships with our CCBHCs, as well as a proposed multicounty MCRT that is county-supported in the rural frontier regions.

We send a master's-level clinician and a psychiatric caseworker who is a bachelor's-level paraprofessional. The idea here is that we can wrap you in services from day one. Our licensed master's-level clinician takes care of the mental health, behavioral health, and medically related needs, while our caseworker takes care of all those other supports with which a family in crisis needs help. The caseworker is the person doing a lot of lifting and linking and referring families to outpatient care, both therapy and medication management,

but is also building informal supports, activating family and friends and other supports in the community to help keep a youth safe at home as much as possible.

What do we do with youth after, and what do we recommend? We keep six out of ten youth internally for a period of crisis stabilization, internal to our team, where we see them about twice a week for 45 days. In the last year, during the pandemic, our diversion rate has decreased some due to the lack of access to community-based services. That moved online into telehealth. Those are starting to turn back on, so our diversion rate is moving back to our historical number of about 87 percent. We will refer about 15 to 18 percent of youth to psychiatric hospitals. When we do this, we facilitate that care. We contact the hospitals, we find the youth a bed, and we facilitate getting the youth to that hospital. For about one in five youth, we refer back to an existing community provider. If we can, we work with the family to get them back to that community provider faster when possible. When that is not possible, we will continue to provide check-ins to make sure everything is okay, even if it is two weeks from now when they see their psychiatrist or their nurse practitioner or therapist. Occasionally, families will say, "No, thank you." Very rarely, we will have instances where nobody in the response thinks additional services are necessary.

When we look at this compared to the adult model that is driving 988, the fundamental thing is that children are not tiny adults. They are not a grown-up in a small body. They have a lot of development ahead of them; they have a lot of growth to do. When we talk about children's mobile crisis, we are talking about a time-intensive de-escalation where we perform a comprehensive crisis assessment, and we try to do this without law enforcement present. It is not because we dislike law enforcement, but rather we think law enforcement is better served keeping the community safe and allowing mental health to be handled by mental health professionals. In the adult model, it is a rapid crisis triage, and a large chunk of it will be handled with law enforcement coresponse through crisis intervention trained officers. We are trying to shift who is going where to provide appropriate care. In the adult model, we move an adult to services very rapidly and let the next service pick up care as rapidly as possible. In the child adolescent model, we tend to stay with the families a little bit longer. When I say a little bit longer, we typically will stay with the family up to 45 days. In the adult model, it is usually a 72-hour intervention.

The biggest challenge we face is adequate staffing. I said earlier that we do about 1,800 responses per year in Las Vegas. We predict about 3,800 to 4,000 responses per year in the next five years. That requires a substantial expansion in staffing; as a state-provided direct service, we probably will not be able to meet that need. We are partnering with our CCBHCs to train their staff how to respond and provide a gold standard response to children and adolescents, as well as adults. We also have big picture safety concerns. When our implementation teams in the 988 system talk with our law enforcement partners, their number one concern is whether it is safe to send a clinician and a caseworker knocking on somebody's door. What I can say from our mobile crisis services in our seven years of experience, is yes, it is safe. We have had violence. I have had glass thrown at me. Six months ago, one of my clinicians had a brick thrown at them, but we have not been injured. We are able to keep ourselves safe. We have not had any critical incidences in terms of safety. The answer to our law enforcement partners is when we triage the system and we appropriately deploy law enforcement-based teams, we can keep everyone safe.

In thinking about the "someone to go" model, we are fortunate that our existing child and adolescent MCRT is one of three national gold standard models identified by SAMSHA and other partners nationwide. We are starting in a good place. What we have left to do in the big picture is expand our state-based services, but we also need to encourage and develop partnerships with private entities to start providing these services. We also need to expand

our hours of availability, but that is entirely dependent on staffing. Our hotline operates 24/7, 365 days a year. In Las Vegas, I can have a team to you in person 24/7, 365 days a year. In Reno, we have teams from 9 a.m. to 8 p.m., seven days a week. In our rural and frontier counties, we are available 9 a.m. to 8 p.m., Monday through Friday. Getting to 24/7 availability requires increases in staffing.

We also need to upgrade our technology. The MCRTs are a resilient group of people. When people ask me what my job is, I describe it as "organizing chaos." We respond when somebody calls us, not when we have time available in our schedule. We have bootstrapped our system over the years, and we have made do. We need a substantial investment in upgrading our technology to keep our team safe, to increase efficiency, and to get people to where they need to be faster.

Another big piece of this is our partnership with Nevada PEP, our family peer support specialists and partner in the children's crisis system. They were one of the driving forces to get children's mobile crisis up and running. One of the things that we are actively working on is increasing the use of our family peer supports. We are starting to lay the groundwork to start exploring coresponse models so we can have a true paraprofessional with the clinician instead of a fully trained and paid caseworker. We also need to increase the robustness of our casework training. One of the things that we have been working on is figuring out what exactly the limits are of a paraprofessional within the current Nevada Medicaid policies and procedures as well as licensing laws and rules, so that we can maximize our use of lower-level providers.

The 30 to 60 days after a child goes through crisis is the critical period where recurrence is most likely. That is where we start thinking about our crisis stabilization. When we talk about the 988 system, we are talking about two different places of crisis stabilization. One is the mobile crisis team responds, keeps the youth internally, and provides crisis stabilization. The second is this new entity called a crisis stabilization unit (CSU). The simplest way to think about a CSU is it is like urgent care. When you are sick, when your ear hurts, you do not need the full power of an emergency department, but you may need to go see a physician or a physician-like practitioner, like a physician's assistant or a nurse practitioner, to get ear drops or a prescription. They may see you, diagnose you, and say, "You actually do need to go to the emergency department because you are having a heart attack, not an earache." Hopefully that does not happen, but they do have that capability. Crisis stabilization units for children and adolescents must follow the same basic mobile crisis principles. They need to accept everybody regardless of their ability to pay. They need to accept everybody and not require medical clearance first. We do not want a situation in which we send you to the emergency department who says you are medically stable and then sends you to the CSU. We want them to have the ability to address mental health and substance use needs. We want our first responders and law enforcement, when they get called out and determine that a youth is crisis—they committed a crime potentially or a community member was concerned for them and called 911 because they did not know who else to call—to be able to rapidly drop a youth off. The goal is that law enforcement can drop the youth off in five minutes or less when we get this fully up and running; that is the hope, because law enforcement can regularly spend hours dropping a youth off at an emergency department. This is a way of diverting and changing the flow through the system.

These crisis stabilization units are responsible for coordinating care transitions through inpatient, outpatient, and connecting youth appropriate services rapidly. There is a version of this model that we are exploring where the mobile crisis teams may then also support those CSUs and provide more crisis stabilization, that intensive in-home 45-day period

where we see those youth for 2 to 3 times per week. Earlier presenters talked about when a youth is struggling and having difficulties. It is not just one-on-one therapy with the youth, it is working with the entire family system to get to a homeostasis or an even-keeled place where everyone is managing and doing okay and slowly building towards thriving.

So again, the goal of CSUs is to have extremely short-term care that is less than 24 hours, that coordinates ongoing care, and gets youth to the appropriate level of care without burdening our emergency departments. The whole idea here is to divert away from expensive care to less expensive care in the system, and for this to be successful, it requires coordination and partnership throughout the system. The reason why this is so important is that when we look at discharge rates from psychiatric hospitals, the recidivism rate, for lack of better terms, at which youth returned to care with typical discharge plans is somewhere around 25 percent—youth will be back in an emergency room within the next two months in the next 60 days. Our mobile crisis team has been able to show over the years that roughly nine out of ten youth do not return in the next four months to an emergency department for mental or behavioral health care, and they do not access psychiatric hospitals in the next four months. We are doing even better than our traditional inpatient unit with diverting from higher levels of care.

In the policy implications of standing up 988, when we talk about billing and getting all payers onboard, one of the best things that you could do for us is consider ways to get all payers in the system to reimburse for crisis services. Recently, the Medicaid managed care organization contract was rebid and reinstituted, and one of our small victories was that our Medicaid health maintenance organizations (HMOs) now are required to pay for our service. Now, about 50 percent of the youth that we see in Las Vegas are paid for through Medicaid, but this still leaves about one-third of our youth who have private, typically employer-based, or health care exchange-based insurances that do not support the mobile crisis system even though they access it.

The second big policy area is workforce development. We need more mental health providers; we are missing people from the system. Policy level consideration on how we expand our base of mental health providers is critical. Can our higher education partners do 3+2 models of clinical education that were pioneered in states around medical education where they have 3+4 for physician degrees? Can we do something similar for mental health professionals? Can we invest in and expand our university partners master's level clinician's programs? These are programs that tend to produce less research dollars, but they provide. a critical element of our provider base in the state.

The last big policy piece for this system to function is that metrics need to be reported. We need to know how each piece of the system is functioning, so that when we start to identify something that is not working, we can rapidly respond to it versus waiting for it to completely fall apart.

And lastly, when we start talking about the system of care that children and adolescents need, we are missing parts of the system. We do not have intensive in-home services. We have a small sliver of peer-operated respite care, but functionally, it does not exist for most of the youth in the state of Nevada. We do not have enough short-term residential facilities that are varying levels of care. As of right now, there is no crisis stabilization unit for children and adolescents in the state of Nevada, but we have identified a partner and we are working on helping them get set up so that we will at least have one to get us going in the very near future. We also are short on acute psychiatric beds, particularly for northern and rural Nevada.

Regarding the crisis level of care, we can help nine out of ten kids stay safe and thrive in their home environments. For one out of ten kids, they go to an acute psychiatric hospital; for a subset of those youth, they then need follow-up care. We are short on those beds within the state; we do not have robust intermediate care facilities or psychiatric residential treatment facilities. These are facilities for youth who are not so acute that they need 24/7 high-level care in an acute psychiatric hospital, but they are not quite to a place where they are ready to go back home; they still need a structured environment with ongoing support for three to six months. Increasing that access is critical to building a robust crisis system.

Thank you and I am happy to take any questions.

Chair Peters:

I appreciate you pointing out the gaps in places where we can work. I made some notes about why these places have not been able to encourage our private industry sector to move into. I have a couple of questions, but before I go ahead with mine, are there any questions in Las Vegas?

Senator Harris:

How do we get this going 24/7 across the entire state within the next five years? It would be great if we could do it tomorrow. Could you highlight some of the obstacles? Is the biggest obstacle staffing? How do we jump-start and expand this so that it is as effective as it can be?

Cindy Pitlock, D.N.P., A.P.R.N., C.N.M., Administrator, Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS):

That is an excellent question. We are working directly with the Office of the Governor; the Office of Finance, Office of the Governor; and Richard Whitley, Director, DHHS, to pursue opportunities to secure our funding to solidify and expand our mobile crisis unit. We are working hard together as a collaborative team to not only increase our services but also to increase our presence within the school districts as well as provide a complementary service to them.

Dr. Andrew Freeman:

We need to expand our provider base. When we set up our rural frontier mobile crisis team, the goal was to provide telehealth to the rural frontier region because we did not think we would be able to get in person because it is a very, very large area. With the transition to the 988 system, one of the key partners that is coming online are the CCBHCs, the certified community behavior health centers. They are required to stand up mobile crisis teams. They have a much greater reach throughout the state than we do. As those teams turn on, as they stand up, as we teach them how to do mobile crisis really well, how we help them and partner with them, we will get to more and more in-person responses throughout the state. There will still be pockets of the state that we may not be able to get to in person. Baker, Nevada, has a population of about 100 people and is hours from the next population center, so we may always be in a situation where some parts of our frontier region, some parts of the state, may be telehealth-based. Elko, Nevada, which is still considered rural, has a CCBHC that is farther along in standing up its mobile crisis teams than many of our other CCBHCs. We need to continue to partner with those groups and stand those up.

The other piece of this is exploring alternate models. The gold standard model is the clinician and the caseworker, or the clinician and a family peer support specialist show up in person. Oklahoma is a good example of what other states have done, particularly in their rural regions. They deploy a caseworker and a family peer support specialist in person and telehealth in the clinician. This way, in a region like Las Vegas where we have more clinicians than Elko or Pahrump, we can still be in person and provide the service. What is left on the plate is expanding the services, and a critical element of that is getting reimbursement rates to cover the cost of the service. Quite frankly, Medicaid accounts for about half of the youth that we see for about 30 percent of our budget.

Senator Harris:

I know we are focused on children in this meeting today, but I have been working on corrections issues and a lot of what I hear is we have people with mental health issues staying in jail for 90 days waiting to get a competency hearing. Could you talk about how this model might be used, once we stand 988 up, to possibly divert some of those folks from going into the system once they have had an interaction with police officers? Do you think we need a whole new model? Do you deal with that when you have juveniles who may have committed a crime in the course of having some mental health crisis?

Dr. Andrew Freeman:

Looking at the 988 system, the national data believes that somewhere between 10 and 15 percent of 911 calls are mental health-related and not criminal matters. Yet, Nevada, and pretty much everywhere in the United States, still deploy law enforcement. Things that could be handled in a mental health care setting now become a law enforcement setting. Now, in most places, the county jail is the single largest provider of mental health services in a county. The idea is, instead of calling 911, we call 988. Instead of a law enforcement officer showing up with handcuffs, a gun, a taser, and a badge and doing what they know how to do, a crisis response team shows up and engages and provides appropriate service. The goal for adults is diversion away from our criminal system, our legal system. For children, it is diverting them away from the legal system but also keeping them at home with their families as much as possible.

Assemblywoman Titus:

You testified that the crisis hotline was open from 9 a.m. to 8 p.m. in the north. Is that correct?

Dr. Andrew Freeman:

The crisis hotline is open 24/7, 365 days a year. We answer it primarily out of Las Vegas. It is always open. You can call that number and you should be able to get ahold of us unless we are having technical difficulties.

Assemblywoman Titus:

Okay. Maybe it is the response team I heard would be available 9 a.m. to 8 p.m.

Dr. Andrew Freeman:

Yes. Our response teams are in-person responses. In Las Vegas, our teams are on 24/7, 365 days a year. In the Reno metro area for most of Washoe County, we have teams on

seven days a week from 9 a.m. to 8 p.m. In our rural and frontier regions, we have teams Monday through Friday 9 a.m. to 8 p.m.

Assemblywoman Titus:

A crisis hotline for COVID-19 was identified in my county. Since I am the county health officer in my rural county, I called it one day just to see what the response would be. A recording said I had called after hours and to call back on Monday. Will there always be a voice answering the phone and not a recording when somebody dials the mental health hotline?

Dr. Andrew Freeman:

Yes. We answer the phone 24/7, 365 days a year, but our technology is bootstrapped; it is up 98 percent of the time, but that is not quite good enough. We are actively investing in upgrading our phone service so that we can be up 99.9 percent of the time, like Gmail or Outlook.

Assemblywoman Titus:

I have been in this legislative process and on this committee now for four terms. We hear the term *no wrong door*, and we have been talking about 211 for a long time. Will 988 replace 211 or just augment it? One of the goals of the 211 service is to get people to the right spot. I worry that we are throwing around a bunch of numbers. How do you educate a community not to dial 911? We still have a 211 number out there for other services, and now we are going to have a 988 number. Will they all be able to feed off each other when ultimately this gets done?

Dr. Andrew Freeman:

Dr. Stephanie Woodard is leading the 988-implementation initiative for the state for DPBH. I am involved in many of those 988 meetings. One of the goals is to get the phone numbers to work together so that if you call 911 for a behavioral or mental health crisis, they will connect you to 988. There are multiple models being explored, but I do not know whether the state has chosen a specific one. The goal is to get interoperability through our 988 call centers with our 911 call centers, specifically.

Assemblywoman Titus:

I am the legislative representative on our Northern Regional Behavioral Health Policy Board and have been since its inception. We continue to talk about the legal holds not only on adults but also on youth. When you have your mobile crisis, you mentioned responding in person and then diverting. As a doctor, I have spent thousands and thousands of hours in emergency rooms, and I have filled out those forms trying to find a place for these folks to go. Ideally, it is nice to divert them from emergency rooms to either get them care or diffuse the situation. One of the concerns during these legal processes is medical clearance, and you mentioned something in your presentation about not needing medical clearance. I have not seen where that legislation has happened. Although, we are working on our policy board to clarify that the mobile crisis team could perhaps do the basic medical clearance if you determine a person needs to be taken to a location. Are you addressing that at all for youths?

Dr. Andrew Freeman:

I believe the standards for the crisis stabilization unit are being set through Medicaid policy. Medicaid is setting the standards of care for expectations of what will be provided as a billable service, and that is the way we are implementing the no medical clearance. Again, the goal of a crisis stabilization unit is to function like an urgent care so that, I, as a mobile crisis team, could bring a youth there if necessary, or a youth could walk through the doors and receive care without having to call me or 988 first.

Assemblywoman Titus:

If a youth has low blood sugar and is acting out because they have overdosed, or perhaps the mental health crisis is related to a medical problem, are you going to be clearing these folks if you do not have a medical person there?

Dr. Megan Freeman:

Assemblywoman Titus, we can get you the requirements for crisis stabilization centers. There is a requirement for nursing on site, and I believe there needs to be a medical director, but I do not want to tell you the wrong thing. I hear your concerns. There are certain elements of the staffing built-in to ensure that although medical clearance is not needed, or necessary, or required, oversight is still occurring.

Assemblywoman Titus:

Great. I know these are hard questions, and I know that not everybody at the table has all the answers nor would I pretend that I do up here, but these are concerns that we have as we address this moving forward. I am highly supportive of the mobile crisis going to the scene, diverting these folks, young or old, sending them where they need to go, not just the youth, but across the spectrum on who they are—married to a retired sheriff, we certainly do not want them going to our jails. If we can divert all of that, I think it is a great idea. Coming to the scene is good, but there are lots of questions.

Chair Peters:

I want to ask a question along the same lines related to general access to some of these additional resources that you outlined in your presentation. Dr. Pitlock, I am grateful that you are here and for your statement about the ongoing joint efforts to address some of these dynamic issues. I am particularly interested in how we can help get private industry or other entities involved in some of these services that we really need to be available to our youth, such as peer support and in-service housing. You had a whole list of things that that we do not have enough of. Who are our partners, who do we need to be reaching out to, and what can we do to pull them in? What can we do to encourage those industries to place themselves in Nevada?

Dr. Pitlock:

This is a great opportunity for me to give a pitch for our provider summit that we are going to have in April. I am sorry that the exact date escapes me, but we will make sure to push that date out. The purpose of the provider summit that we are coordinating with and through the Governor's Office is to bring a huge array of partners to the table to talk about our service array, where the gaps are in that service array, and hopefully partner with businesses, entities, and stakeholders that be able may be able to help us fill those gaps. Of course, the conversations that we have been having all day today tie into sustainability. We

want to make Nevada a great place to live and work. We want to have Medicaid rates that are sustainable as an ongoing concern for these businesses that need to keep their doors open. We need to have a robust workforce to fill the needs as we bring these businesses in with these various specialty areas that we are talking about. You can see it really ties all into one big package, so I thank you for that question. We are looking at the whole system of care, finding out where those gaps are, and inviting players to the table to help fill those gaps. I know that was a very general answer, but I hope that I steered it somewhat for you. We are also looking at the opportunities for ARPA funding to get these things up and running and seed these opportunities; we then need to work together on the sustainability piece. Now is our opportunity for standing up and seeding these ideas and then we need to take that next step in the sustainability piece.

Chair Peters:

For the record and for our notes, that would be our intensive in-home services, peer-operated respite care, and short-term residential facilities with varying levels of care. I think those go beyond our need for children's behavioral health; I can see these expanding into women's behavioral health and being a model for other behavioral health demographics. I hope we get to see some great models come out of your efforts. Whatever we can do to help, please keep us posted, and if you could get us the date of that event, I think some of us would love to come and listen, to hear how stakeholders are feeling about your proposals.

Dr. Pitlock:

Yes, absolutely. While our provider summit is highlighting youth and families, we are also looking at filling the service array gaps throughout our populations of health. Our summit will not focus solely on children and families but throughout the lifespan as well. I really see this as a great opportunity to bring all of us together for this very important day, and we will make sure we get that information out to you.

Chair Peters:

Are there any other questions from the Committee? Seeing no further questions, we will go move on to the next agenda item.

AGENDA ITEM X—OVERVIEW OF SPECIALTY SERVICES FOR YOUTH WITH DISABILITIES AND BEHAVIORAL HEALTH NEEDS WITH A FOCUS ON GAPS AND CHALLENGES

Chair Peters:

This is the overview of specialty services for youth with disabilities and behavioral health needs with a focus on gaps and challenges. Please and introduce yourselves and proceed when you are ready.

Elaine Brown, Ph.D., Chief Psychologist, Aging and Disability Services Division, DHHS:

I have with me, Deputy Administrator Jessica Adams, along with Deputy Administrator Rique Robb, and Health Program Manager Samantha Jayme.

I will be talking for a few minutes about youth with disabilities and behavioral health needs (Agenda Item X). I will start with definitions and descriptions. We will then talk about some

special considerations, and I will go into, more specifically, our current system for youth and children with disabilities, and as was mentioned earlier, services gaps and challenges.

I will start by what is meant by *youth with disabilities*. I will emphasize that we are talking about youth first. If we are talking about all children, all youth, it will include youth with disabilities. This is important for informing policy and public health in determining the scope of need as we build our children's services.

Overall, the very broad term that is used from a public health perspective globally is *disability*—any impairment that makes it more difficult for a person to do activities or participate in their community life. For *developmental disabilities*, the CDC collects information and has a very broad term that is used for developmental disabilities occurring in a developmental period—typically that is under age 22—and that it results in impairment in physical, learning, language, or behavior areas. These are the conditions that can exist throughout one's lifetime, and about one in six children have a developmental disability. For example, a physical disability can result from scoliosis. A child can have a learning disability, a speech and language disorder, or a behavioral concern like ADHD. All of these can be considered disabilities under this definition.

The term *developmental disability* has a specific definition arising from the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (H.R.4920 of the 106th Congress). It is more specific to identifying disability as severe and chronic, is attributed to mental or physical impairments, is likely to continue indefinitely, and results in substantial limitations in three or more major life areas.

Intellectual disability is a condition where a child or adult evidence substantial limitations in intellectual functioning and adaptive behavior. We often use the term *intellectual and developmental disabilities* as a broad term that combines the field, and we use the acronym IDD.

We have definitions in Chapter 435 of NRS that are related to our long-term services and support system that is a lifespan for children and adults with intellectual and developmental disabilities. The main difference in the NRS definition of developmental disabilities from that of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 is it more closely matches the federal definition of a related condition. In other words, these conditions that may result in lifespan support needs for children and adults.

For the purposes of planning, it can be helpful to consider the prevalence based on these definitions. If I take a very broad definition of disability and youth with disabilities, we are looking at about one in six children, or 18 percent. If I am talking about intellectual disability, that is about 1 to 3 percent of our population. Autism, which is considered a developmental disability, is one in 44 children. There are many other conditions that we can identify where children may need more or less supports either early in their life or throughout their lifespan. For example, cerebral palsy is a type of developmental disability, one in 323 babies, and then there are all kinds of other types of conditions that can result in disabilities and support needs for individuals and for children.

When we talk about youth with disabilities and behavioral health needs, we are really talking about youth. I will talk broadly about intellectual and developmental disabilities and what we see in terms of the behavioral health needs available for these youth and children. The majority of children with developmental disabilities can benefit from the same behavioral health services, the same crisis intervention services that are provided to youth without any identified disability. These can be provided with little, if any, modifications to

the treatment and interventions. This is also true for many youth with autism, with intellectual disability, or with cerebral palsy. All these youth can benefit from the same behavioral health and health care in general that we provide in our communities.

Youth with intellectual and developmental disabilities have a higher rate of behavioral health disorders compared to youth not identified with disabilities. These estimates can range from 30 to 50 percent of youth. That is a huge variability, and it often depends on how you define disabilities, how you define the behavioral health disorders, but there is a definite need there for these youth and their families. Those estimates are in comparison, if you take some estimates for youth in general, the general population, you look more along the lines of 15 to 20 percent have a behavioral health condition that is identified.

There is evidence that the behavioral health disorders of youth with intellectual developmental disabilities are more predictive of barriers to community life and the quality of life than the severity of the child's intellectual or developmental disabilities. It is the largest barrier that they may experience. Additionally, the well-being of parents and families appears to be more strongly influenced by the severity of the co-occurring behavioral health disorder than by the severity of the child's disability. Within this special population, this is a significant public health issue for our communities.

Children with intellectual and developmental disabilities are more likely to have adverse childhood experiences, such as parental separation, death, and sexual abuse. The research also supports that adolescents with intellectual and disabilities will experience the same precipitating factors that are known to negatively impact the behavioral health for youth, but they experience more of them. They experience more of the bullying, more of the trauma, more of the isolation, and more of the stressors in general.

For youth with disabilities, it can be somewhat helpful to know about the increased risk. There are some types of disabilities that are associated with increased risk for behavioral health conditions, and I will briefly give some examples. For youth who have Down Syndrome, around 30 percent of young children have some type of behavioral difference—in other words, some barriers to participating in their family and social life and community life. For youth with Down Syndrome, about 15 percent experience depression and they have other types of behavioral health and behavioral challenges relative to their peers.

Fragile X is the leading inheritance cause of intellectual disability and has a very high association with multiple behavioral health disorders. This includes ADHD, a high association with anxiety, and a high risk for aggression and self-injury.

It is also well-established that autism spectrum disorders are associated with significant increased risk for many behavioral health conditions. These range as high as 75 percent in some studies that there are co-morbid behavioral health conditions for youth and adults with autism spectrum disorders.

There are times when specialized consultation or clinical services are needed when there is a greater degree of disability, but often it depends on the contributing factors. Is there a contributing health factor? Is there a severe behavior disorder that results in severe aggression or severe self-injury? Then we need to have more specialized services. Considerations need to be given to establishing our services and service delivery systems across all aspects for families and child support for behavioral health so that they are aimed specifically with the intention to include all youth and youth with disabilities.

Jessica Adams, Deputy Administrator, Community Based Care and Development Services, ADSD, DHHS:

Currently within ADSD, there are three different programs that can touch and serve youth. We have the Nevada Early Intervention Services. This serves very young kids from birth to age three who have a diagnosed disability or developmental delay. It is no cost to the family; it is all in their natural setting and provides several different types of services from service coordination to occupational therapy and speech therapy—basically, anything that the youth may need to hopefully overcome any developmental delay they have so that they can graduate at three and no longer need services from us.

The Autism Treatment Assistance Program, or ATAP, focuses on individuals who have been diagnosed with autism spectrum disorder, up to the age of 20. Its main service is applied behavioral analysis, or ABA. Anyone in the program has an assigned service coordinator who can help them with other sorts of services, like parent training, getting them connected with speech therapy, things along those lines.

Regarding developmental services, we are the group that serves people with intellectual or developmental disabilities per the definition in Chapter 435 of NRS that was mentioned earlier in the presentation. We have three regional centers across the state: (1) the Sierra Regional Center, which is in Washoe County; (2) the Desert Regional Center, which is urban Clark County; and (3) the Rural Regional Center, which has eight offices across the rest of the state and is based here in Carson City.

These services are lifespan services, but we will bring kids in as young as we can. We currently serve about 7,500 people, and 23 percent of that group is youth under the age of 18. Service coordination is one of the major services we currently give to children so that they can get connected with other services they may need. We have in-house psychological services, like Dr. Brown, that can give different levels of assessment and assistance. We have nurses who can help when some of the kids might be medically fragile. We also have some levels of services by contracted provider agencies that are meant to keep the child in the family home and get them services that are needed for their IDD.

Regarding service gaps and challenges, we have an inadequate provider network in the state. In the developmental services realm, we lack providers who have the needed skill and training to work with these kids who have very high-level needs. We have tried very hard to get national agencies to come into the state to work with us. We have heard two reasons why we cannot get agencies. First, our developmental service rate is $24 an hour, which is not very much money for what somebody needs to do in these family homes. A rate study was completed not long after the last legislative session ended. It was mostly based on data from 2019—since 2020, COVID-19 data skewed everything—but it found an overall rate increase of 26.9 percent was needed across all our services. However, those rates were based on an average staff wage of $13.90 an hour, which at the time might have been okay, but as we all know, with the current economic wage environment, that is not high enough. Even raising rates, 26.9 percent is not going to do much good.

The other reason we hear why providers are having difficulty coming into our state is they are worried about finding workers—not just those direct staff that go out to the homes but also the licensed professionals. Several of the out-of-state places are in much bigger areas where they have multiple colleges and universities around them, so they can have multiple internships and other sorts of training programs. The date for the provider summit is April 19 at the Las Vegas Convention Center, and we can certainly get you some more information on that.

Along with trying to get new providers, our current providers are experiencing extreme staffing shortages. Every provider that I have talked to has at least a 20 to 25 percent vacancy rate for staff—some are as high as 50 percent. As I said, we do serve lifespan. About 77 percent of our population is adults; many of those adults are living in their own homes; they are living in 24-hour settings. If we do not have staff working with them, it means they are going to be homeless and not have anyone there to help them. Staff does not get sent to those settings, at this point, because the staffing is so bad.

We just heard a lot about the mobile crisis teams. We have been trying to work with DCFS, but I have not had conversations with them about the mobile crisis teams yet. I think there is a good opportunity now for us to pair with them to make sure we have some specialized training, to see if there is a need for somebody who has an IDD background to sit on those teams. We can then make sure that people are getting the right services when one of those teams goes out and determines a child has IDD.

All respite care in the state right now is a self-directed model, which means we give money to a family, and they must find their own care. There is no drop-in center; there is little overnight respite care. Respite is essential for preventing caregiver burnout, so we must figure out ways in which we can boost up respite and make sure that it is easy for families to access.

Regarding daycare and before and after school care, there are few entities in the state that will accept children with various disabilities, including kids who have complex needs. Some states have added a childcare supplement to their home- and community-based waiver to incentivize providers to take kids who have special needs. That is something that our state could look at.

All our services try to coordinate with crisis prevention planning. We try our best to plan for crises, but when we have a lack of services to send people to, it limits what we can do.

You will hear later about the system of care with DCFS. Our biggest push within the system of care is that kids with IDD are a part of the system. You just heard from DCFS about the lack of beds for residential treatment centers and hospitalization. There are even fewer beds in the state that will take kids with IDD. Often, we have kids go out of state if they need that level of stabilization; and once that stabilization happens, we have even fewer settings for them to come back to. We have been working with DCFS, Washoe County, Clark County, our child welfare agencies, and some of the advocates and legal agencies across the state to figure out how we make appropriate 24-hour placements, whether they are step-down services so that kids can keep stabilizing prior to them going into the family home, or whether they need some sort of temporary out-of-home services to gain some skills. For those kids who have IDD and whose families are not ever going to be able to bring them back into their home, we need to figure out how we get them services and into placements that make sense. Settings that have been tried in the past have been mostly shift-staff settings, and I do not believe anyone thinks that a child should be raised with shift-staff. We have a lot more work to do to figure out how to get foster care settings that can work with this this type of youth.

More intensive in-home services are needed; if we can find the providers, we can get the rates. One of the things that goes along with this is the intensive service coordination. Currently, we only have our regional center in the south; the Desert Regional Center has a program called the Yes Program, which is a youth intensive support services program where the service coordinators carry a lower caseload. A full-time licensed psychologist and mental

health counselor work with those families and teams so they get a lot more services from us to learn skills and better keep their child in their own home. Any questions?

Chair Peters:

It sounds like there are a couple of things that we can knit together from these presentations we have had today, which is great and encouraging that we are bringing people into the right space to talk to each other. I hope that that continues outside of the walls of this room. We are here to help connect you if you need a space to do that. I am more than happy to do that.

Are there any questions from the Committee on this presentation?

Assemblywoman Titus:

How many Nevada children are currently housed out of state from mental health issues?

Ms. Adams:

I do not have the number of all mental health youth out of state, but I believe within the regional centers, we have roughly nine to ten, but I would have to get you the exact number. If you ask DCFS or the other counties, they may know of some other kids.

Assemblywoman Titus:

Perhaps our staff could look at that, too, and perhaps DCFS could help on getting an overall number of that reality.

How long does it take to train somebody? We hear all the time that we do not have enough staff; we do not have enough professionals; we have a shortage of doctors, a shortage of nurses. There is a national network called the National Healthcare Career Network that has access to the professionals throughout our nation. What solutions are we coming up with? In the interest of time, you may follow up with that. We are talking about inspiring more health care professionals; we are talking about a national network; we are talking about career development and competency standards for employment. I would like to hear from these different agencies that presented today regarding the solutions. We can complain all day long, but it would be nice to know how long it takes to train somebody and how we are solving this problem. I keep hearing that it is always a lack of personnel. You do not have to answer that right now, unless you have a quick answer; otherwise, I would love to have some follow-up on that.

Ms. Adams:

I do believe that if we can move forward with our rate study, that would help quite a lot. The rates were developed to make it into an actual ongoing job, including health benefits, paid time off (PTO), and other things that many of these people do not currently get. As far as training goes, we are looking at multiple, different ways to increase training. There are some national programs. We do not have an answer yet, but we are looking into it.

Chair Peters:

That was one of the questions that I had. To follow up, you said the 26 percent increase from the 2019 rate study is not sufficient. Can you send us a memo stating some rationale

about what you expect that to be? It does not have to be definitive, but just what you expect it to be so that we can start talking and thinking about it.

Are there any other questions for these presenters today? Seeing none. Thank you for being here, and I hope we can continue working together to further these issues.

AGENDA ITEM XI—PRESENTATION ON NEVADA'S CHILDREN'S MENTAL HEALTH CONSORTIA: STRUCTURE, ROLE, PRIORITIES, AND POLICY CONSIDERATIONS

Chair Peters:

I am going to and move to the next agenda item, which is our presentation on Nevada's Children's Mental Health Consortia's, structure, role, priorities, and policy considerations. We have allocated 20 minutes for this presentation; because of the time this afternoon, I am going to make a hard stop on that. I apologize, but I hope we can get in the information that we need during that period of time. I have Ellen Richardson-Adams, the chair of the Nevada Children's Behavioral Health Consortium, and Dan Musgrove, the chair of the Clark County Children's Mental Health Consortium. He is available to answer questions as we have them.

Ellen Richardson-Adams, Chair, Nevada Children's Behavioral Health Consortium:

With me today is Dan Musgrove, chair of the Clark County Children's Mental Health Consortium. As you have heard today, children's behavioral health is a top priority within Nevada. Thank you for this opportunity to speak on behalf of the Consortiums who have dedicated many years to strengthening systems of care, family focused supports, and respectful and individualized services for our children and adolescents in Nevada.

Nevada Revised Statutes 433B.333 and 433B.335 establish the mental health consortiums, which are to be based on county or regional populations, and outline the memberships and their missions. Currently, Nevada has three regional consortiums: Clark County, Washoe County, and one representing the rural communities. By statute, each region submits its 10-year strategic plan, annual status reports, and budget requests to DHHS. The statewide Nevada Children's Behavioral Health Consortium provides statewide governance and guidance related to children's services. It is constructed of regional members and stakeholders to provide a voice for families and children for an array of timely services in the least restrictive environments. Systems of care and financing of services for quality care are also reviewed. In addition, the group provides cooperation and consultation with the regional behavioral health boards and the Commission on Behavioral Health with DPBH and DCFS. The statewide role is to be the voice of the regional consortiums and elevate priorities in unison. While currently only the regions are listed in statute, there was an effort on behalf of the consortium last session to establish the statewide consortium through AB 273 (2021), sponsored graciously by Assemblywoman Gorelow. While the bill did not make it through the legislative process, the presenters appreciated the opportunity to attempt to memorialize the statewide consortium.

The handout provided today is a summary of the priorities of each of the regional consortiums (Agenda Item XI). The strength of each region is the demonstration of each community's needs and goals. Common themes across the three include prevention and early intervention with timely access to services; an array of service options to meet the unique needs of families and children; sustainable funding for existing programs, such as mobile crisis response teams, systems of care, and family peer-to-peer services; support

families and children through quality service options in the least restrictive environments; and supportive services and supports for youth transitioning back into their home communities. There are common themes amongst the regions for strengthening services for youth adolescents and their families. Each region has identified their unique methods and strategies to meet these needs. Some include policy support, while others identify fiscal sustainability., Thank you for this opportunity to present and I welcome any questions.

Chair Peters:

Thank you for this list. I encourage the Committee to review the detailed handout, which is on today's meeting page. Are there any questions from the Committee?

Regarding AB 273 that was referenced, my understanding is there was a fiscal note, which is what caused it to not make it through the process; that is something we can continue talking about if it is of interest to folks. I encourage you to reach out and work with our fiscal staff as well as the funding body.

Dan Musgrove, Outgoing Chair, Clark County Children's Mental Health Consortium:

I have been working in mental health issues for a very long time, and I feel it is important to stress that Clark County, Washoe County, and the rurals are in an absolute crisis right now. You have heard all day about the lack of adequate funding, the lack of folks who can help us, and skilled staff assuming a lot of the positions. We do not have enough private folks in the state; we do not have enough state facilities. I want to stress that from the Governor's Office on down, everyone is aware of it and working so very hard—the Governor's Office, Director Whitley, Administrator Pitlock, the Drs. Freeman, et al, Clark County, and all the folks who work in this area.

But, state government moves very slowly, and it is concerning to us that a number of these programs still have funding sources that could potentially go away—such as tobacco funds for mobile crisis or the ARPA dollars that we are using to backfill some of these programs. We need the help of the Legislature to support the governor and the executive staff as they build their budgets right now to look at augmenting these programs from top to bottom. There are families who are unwillingly turning their kids over to child protective services because they have no way of dealing with the issues that their children are going through. It is tragic.

I know a number of legislators are joining our weekly meetings and the monthly meetings that talk about Child Haven and what the employees there are going through. This is not just in Clark County; it is statewide. We just do not have facilities and places. Dr. Megan Freeman and Dr. Andrew Freeman talked so eloquently about the continuum of care and how we handle crisis. More importantly, how do we prevent folks from getting into crisis in the first place? How do we give parents and families the support they need?

As someone who has worked in this a long time, I thank the Chair for taking this long day to talk about children's mental health, for sharing our story, and making this such an integral issue that this Committee needs to look at and be prepared to work hard on during the next regular session. We thank you for your consideration today of all these issues.

Chair Peters:

We appreciate you and the work that you have put into this area and look forward to continuing to work towards a better Nevada for our kids.

I also want to take a point of personal privilege to reflect on my earlier sharing about my own story with mental health. Since sharing, I have received multiple messages from people in and out of different areas of my life who shared that they have also dealt with mental or behavioral health. You are not alone; none of us are alone. It is hard to talk about the things we go through, especially when it is vulnerable. I think it is important that we share with each other create these networks and have the necessary conversations to ensure our communities are whole and being taken care of and that the supports are there so that everybody gets what they need while we navigate this crazy world called humanity. Thank you for all who reached out. I appreciate it, and I hope that you are willing to share your stories with other people as well.

Unless there are other questions from the Committee, we will close this item.

AGENDA ITEM XII—TRANSITION TO A SYSTEM OF CARE MODEL IN NEVADA: COMMUNITY-BASED SERVICES AND SUPPORTS FOR CHILDREN AND YOUTH TO ADDRESS THEIR MENTAL AND BEHAVIORAL HEALTH NEEDS

Chair Peters:

We are going to go ahead and move to the next agenda item regarding transition to a system of care model in Nevada: community-based services and supports for children and youth to address their mental and behavioral health needs.

Elizabeth Manley, Senior Advisor for Health and Behavioral Health Policy, The Institute for Innovation and Implementation, University of Maryland School of Social Work:

I provide technical assistance and consultation across the country specifically around children's behavioral health systems design, how to organize the financial systems, policy practice, all kinds of things. I have been at this work for about four and one-half years, and prior to that, I was the assistant commissioner for New Jersey's children's system of care, which is an integrated system of care that allows for services and supports for children with moderate and complex behavioral health needs, intellectual and developmental disabilities, and substance use challenges. New Jersey has full-time 24/7 access to mobile response and stabilization. As you heard from Dr. Freeman, Nevada is working very hard to get there. They also have access to high fidelity wraparound, which is intensive care coordination and all kinds of other things that we will talk about here today. I am happy to take questions at the end after we work through some of these foundational elements that I think might be helpful (Agenda Item XII).

It is important to set the context, and the context is that what works best is anything that increases the quality and number of relationships in a child's life. It is the people, not the programs that change people. What is important in this idea is that we need skilled, trained adults who can help young people with some of the challenges that lie before them, in particular, as we move out of the challenges from COVID-19 and some of the other national conflicts that are happening at this time.

For me, it is about language. I want to let you know that one of the low-hanging fruit in systems transformation really starts in the way that we think about and talk about young people and their families. One of the most powerful tools in our tool belt is the ability to level the table and have parents sit with professionals as they make decisions about what is going to happen for their family as we bring in communities to help solve some of these major challenges. You will hear me through the course of today's presentation talk a lot

about the role of home- and community-based services and the role of ensuring that adults know what to do and how to do it in order to help their own children and to help their communities to be able to heal. We want to start by talking about children, youth, and young adults. It is important for us to understand that level center for a lot of systems transformation. I want to bring your attention to one other word and that is the difference between "treatment" and "treatment, interventions, and placement." This idea of where a child puts their head on the pillow is incredibly important for states to organize around treatment interventions being effective interventions and not just trying to find a safe place for a young person to sleep at night.

I want to talk about Olmstead, which is a Supreme Court decision that basically says that an individual has a right to live in the community and be provided services and supports that are necessary in order to meet their needs. What is also important to know is that this impacts children as well; children's rights can be violated if they are not in the right service at the right time for the right duration, and we can meet the needs for many, if not, the majority of young people in their homes and communities. We have demonstrated this work, not just in New Jersey, but in other states across the country. Many states have addressed Olmstead challenges through the framework of system of care. They use it as an organizing framework, and the core components are the way they transform and move away from Olmstead as a challenge. Illinois, Michigan, Massachusetts, and Washington have all used the framework of system care to begin to address their Olmstead challenges.

I want to talk about residential interventions and where they fit. One of the challenges that states and communities have around residential interventions is they tend to think they sit outside of the idea of the other services and services and supports in the array. What is important about residential interventions, is when they are most effective and impactful, residential best practices work really well. There are a couple of core components that are important. There is a ton of oversight, and that oversight is not just about following the rules; it is about moving towards best practices and making sure that we learn the lessons from practice-based evidence as we see young people do well and what interventions have been helpful for them to do well. So that is one important thing.

To do oversight, you must have a group of people who know and understand what residential best practices are. You must be trained and skilled and be able to coach and teach those residential partners. That is number one. Number two, it is also important to have the connection to home- and community-based services. In other words, young people who are in residential intervention are continually to be connected to their families, they are connected to their communities, and they are connected in the aftercare, or the next steps, while they are still in a residential intervention. These important concepts are necessary to understand how they fit within the system of care framework in order to fix it, in order to make sure that young people get what they need.

I will give you a couple of examples of what is important in this conversation. One is that we understand the scope and breadth of the number of young people who are in residential. Two, we understand how [inaudible] they are, whether they are in state or out of state, whether they return home quickly, and what the outcomes look like. The data and the ability to share that data and to share the stories of young people is important. We want to make sure access is available to the whole population of young people. They do not have to touch on a child welfare system. They do not have to touch on the juvenile justice system to access care. The funding is available for a young person who meets the clinical criteria and requires the treatment, and we can demonstrate the benefit for residential treatment. Three, we want to make sure that the length of stay is short and intensive, but not too short. By that, I mean, we want to make sure that the young person gets the right service

at the right time for the right duration in order to ensure that they are successful upon transition and that the transition back into the community includes the services and supports that are necessary for their success. Residential interventions are the costliest part of any service array. In any state it is where you put the money, and if we want that money to pay dividends in the long run, we need to make sure that we have the right children in those residential interventions and that those residential interventions are fully supported with the best evidence available in order to provide the best care available.

A system of care is about values, how we make decisions about where we are going to put resources, where we are going to support relationships, and how we are going to spend time putting things together for young people and their families. It also says that we value what young people and their families tell us both from a peer support perspective and from an advocacy perspective, but also at the table in which the decisions are made. Leadership and governance are part of the way in which oversight happens. Governance happens both at a state level and a local level, and these two components of governance are incredibly important to ensure:

- appropriate feedback loops are in place;
- that there is transparency around data;
- that there is transparency around gaps and services;
- how we are going to solve the problem of getting what young people need at the time they need it for the duration that they need it;
- that there is cultural and linguistic competence; that there is an equity piece that ensures any child who needs help is going to get that help at the time they need it; and
- that there is a robust service array that includes intensive in-home services but also includes informal supports or capacity to get informal supports for young people, including intensive care coordination, mobile response, and stabilization.

It includes services and supports like an in-home therapist and evidence-based practices, like functional [inaudible] therapy or multisystemic therapy. There is a whole service array that is important as part of this work. It is important that we meet the sense of urgency with a sense of urgency when families begin to experience or watch as their child experiences changes in their behavior. A parent begins to experience some worry and anxiety around that, and we want to meet that parent's sense of urgency with the same sense of urgency that they feel. That is trauma informed and that there is intensive care coordination to manage and work with young people and their families. This is an important concept that sometimes is misunderstood—how it works and how important it is in systems transformation and then certainly the data and the outcomes.

This is the definition of a *system of care*. We really want a comprehensive spectrum of effective services that is well-coordinated and that there is a real important focus on meaningful relationships, that we are spending time and attention around building those meaningful relationships to help young people and their families.

These are historic challenges that I see in many of the states in which I work. This was certainly New Jersey's story before we started the system's reform in 2000, and that is the lack of home- and community-based services and this idea that we are going to focus on a medical model. We know the patterns of utilization do not take into account what is happening disproportionally. We spend a lot of money on very poor outcomes. A lot of these states have rigid financing structures, and one of the challenges is how to fix those rigid financing structures. How do we bring stakeholders onboard and how do we train all the adults who are going to touch a child's life? All these things are important to consider.

This is how we get to transformation. We look at policy, the population of focus, we pay attention to the regulations. We want to make sure that management has the tools it needs around data collection and continuous quality improvement (CQI) systems; training, technical assistance, and coaching are all important. In practice, we want a single assessment tool across the whole population of young people that we are serving. Most states use a tool called the CANS, the child and adolescent needs and strengths tool, so that we can begin to see patterns of where resources need to go to meet the needs. More importantly, we are collecting the wide information to be able to ensure young people get what they need at the time they need for the duration that they need it, and community partners drive a lot of this work.

The frontline must change. We need clinicians to think differently about children, youth, and young adults. We need frontline staff to change, and I will make some comments about that later, but it is important to know that there are shifts in all parts of the system. At the end of the day, people begin to think differently about the work and how they provide the work, and that includes how they pay, how they bill, how they talk about it, how young people are diagnosed, and how the assessment tools are used. All those things shift in a true system of care.

You want to move from a fragmented service delivery system to a coordinated service delivery that is going to help you anticipate where and when you are going to have challenges and put the resources in those places. One quick example—when there is a natural disaster, as there was in in New Jersey when Superstorm Sandy hit, we knew exactly where to put those resources in order to meet the needs for young people to stave off the behavioral health tsunami that we saw coming after the impact of Superstorm Sandy. Good systems of care not only allow you to deal with the day-to-day, they allow you to get ahead of the curve on what is going to happen later.

The system of care is first and foremost a set of values and principles. It says that we are going to honor our children and families and their voice, and we are going to have those children and families at our table. It also says that we are going to meet their needs with the right services at the right time for the right direction. That includes a comprehensive service array. We do not make children fail up or fail down in services before they get what they need. In other words, when children need a residential intervention, we might get that for them when they need outpatient. In order to do that well and to ensure that it is the right service at the right time, there are many steps in between that have to happen. The system of care is trauma-informed and understands the impact of trauma, not just on the child, but also on the family and on the community. It pushes for partnerships and good care coordination so that everyone is on the same page, and there is a coordinated plan for what is going to happen next. All these things are incredibly important when we talk about what a system of care is. The other thing it does is it allows us all, as a workforce, to move in the direction together; we have a vision of where we are going to go; we speak the same language; we coordinate across disciplines to ensure young people get what they need without having to move from one direction or another, to go down the street to get those services.

One of the things that is important is that a system of care is about family-driven care, and that means parents play a role in a service like mobile response, as an example. You will notice that I do not use the word "crisis" when I talk about mobile response, and that is because, nationally, we know that parents think they have to be in a different point in order to ask for assistance and help, and professionals believe that young people have to wait longer in order to access services. In family-driven care, we are talking about when the

parent picks up the phone and asks for help, we are going to send it and provide that necessary care for them at the time they need it and in the place they choose.

Youth guided means that we are going to have young people sitting at our table. They are going to help us make decisions for what is in their best interest because they are going to guide us to what they are ready for, when they are ready for it, and how they are ready for the interventions that are necessary for them to get to the highest level of their own potential.

In the system of care, we talk about cultural and linguistic confidence. It is an important concept that we are happy to share later.

I want to talk about why it is important to have a customized service array for children, youth, and young adults. Adults require different things when it comes to meeting their needs from a mental health perspective. As an example, in the world of mobile response, we want young people not only to call, but we also want them to text if that is what is necessary for us to assist them. We want somebody to respond just like in the adult world. We want those responders to have the ability to do a crisis assessment, and we want to be able to connect the dots for families on what is necessary. The third part is we want a system to connect to. We want young people to stay in their own homes, schools, and community. We think it is important for all folks who are working with children, youth, and young adults to understand not only what is going on for that child, but what also is happening for their parents and their caregiver.

When you transform your behavior health system, it is important to think about not just one reform or one part, we want to reform all the parts that feed into the system. Using Medicaid as a vehicle for long-term sustainable change is important because they are the largest provider, the largest health insurer in any state. We want to use that Medicaid and health reform to be able to make differences for young people and their families, but also the Family First plan. We want to connect the dots between what is happening for Medicaid and what is going on in the Family First plan. We want to use things like alternatives to detention and restorative justice practices in the juvenile justice world to connect the dots and educational reforms as well. In other words, we want to create win, win, wins across the system to ensure young people get what they need without having to touch on other systems that they do not.

The question becomes, why are outcomes so poor and costs so high? A siloed approach to service delivery is problematic. You are paying costs over here, you do not have good assessment, and you do not know if you are providing the right service. There is no good coordination around whether it is working for the young person; you do not have good feedback loops, and we do not have the data that tells the story. It is a very expensive way to provide care. It is much more cost-effective to provide the right service, at the right time, for the right duration. Because then we are sure that those interventions are going to help those young people be able to thrive later, which is ultimately the goal. If we can have young people thrive right now, it is more likely they are going to complete school, that they are going to use behavioral health systems when they need it for the duration they need it, no more, no less, and they are going to move to the highest level of their potential. It is important for us to recognize not only how much it costs us in the day, but also how much it costs us over time if young people are in the wrong intervention. Then, what is the impact on that young person over time?

There is a growing conclusion by states, by tribes, and by local purchasers that we want to redirect spending from the highest intensities of service—such as residential interventions,

in-patient care, and emergency departments—to home- and community-based services, and we want those services to be delivered within a system of care framework.

In 2013, SAMHSA and the Centers for Medicare and Medicaid Services (CMS) sent a joint bulletin to the children's behavioral health directors across the country. I happened to be the children's behavioral health director at the time in New Jersey and this landed on my desk. The joint bulletin said that in every Medicaid plan, every child who meets the criteria, who needs these services, should have access to intensive care coordination using wraparound. They should have access to youth peer support services, intensive in-home services, respite, mobile response and stabilization, flex funds, and trauma-informed systems and evidence-based treatments to address trauma. That was all laid out in that letter. It is important to know that all these things can be available through Medicaid. Medicaid can support this work moving forward.

You already have many of the core components, as we heard from Dr Freeman today, around home- and community-based services, care coordination, on-site face-to-face therapeutic response. We would argue that we want on-site therapeutic response 100 percent of the time; when a parent picks up the phone and asks for help, we should send it. The access should be 24/7 because when parents learn that the behavior health system is not responsive, then they do not call back and they wait a long time before they pick up the phone and ask for help. All these things become important in terms of not just what you are trying to provide in the moment but also the message you are trying to deliver to the parents and the caregivers who you are trying to serve.

These are the core components of a system of care: (1) a single point of access; (2) mobile response and stabilization; (3) intensive care coordination with wraparound as the practice model to fidelity; and (4) youth and peer support.

The intensive in-home services support those foundational or our grounding components of high-fidelity wraparound, mobile response and stabilization, and youth and peer support, which are important parts of this work. The intensive in-home support may shift and change as the system grows and develops. What does not change is the need for mobile response and stabilization, the need for intensive care coordination, the need for youth and peer support. All these other things should be changed within the service array, but they need to be available within the service array to meet the needs of children, youth, and families.

Point of access means that we are going to answer the phone 24/7. If a parent has an issue or challenge, we are going to pick up the phone, we are going to answer that call, we are going to provide what is necessary. We are going to come if the parent asks for help. All calls are answered. When the parent and caregiver calls, the team goes, and we begin to collect information right from there, in a single electronic record that can help us communicate across teams, that can communicate across the system of care.

It is important to know that mobile response and stabilization is the first step in systems transformation—the availability of mobile response and stabilization, 24/7, the availability of specifically trained teams. I would argue that you can use bachelor-prepared folks as part of your team, or you can use peer support partners as part of your teams. We see that in second generation mobile response and stabilization, but it is the face-to-face that is important within the work.

The goal of mobile response and stabilization is that we must meet the sense of urgency that parents feel with a sense of urgency, because if the system moves when parents are feeling that sense of urgency, parents can do more of this work than we think they can, and

more young people can be served in their own homes, schools, and communities than we think.

Responsive stabilization has the home- and community-based services. These components are important, but we are not going to spend too much time on them.

I want to talk about care management. Care coordination is something that is necessary to transform in Nevada. It is important to know what care coordination is, what it does, and why it is so incredibly important. Many people just think it is a wraparound, and wraparound is important, but how wraparound is provided, the context in which you provide it, and who does it is equally as important as the intervention itself. In other words, intensive care coordination is a grounding principle of systems reform, and when care coordination is done well, it transforms communities to become part of the solution.

There are a couple of different ways to think about intensive care coordination, but what we know from the evidence is that stand-alone, conflict-free care coordination entities have the best results. We see that in Louisiana and New Jersey—the 2 states that have stand-alone, conflict-free intensive care coordination. In other words, those organizations only provide care coordination, and they connect the dots within the community to ensure young people get what they need. They are also responsible for building part of the service array, to ensure young people get in tons of in-home services at the time they need it for the duration. Ohio is currently building a model in which there is care coordination in a care management entity, but it is not a standalone; they have built firewalls, and we do believe Ohio is going to be successful in its implementation. We also know that Illinois and Massachusetts have done this work. Oklahoma has some practice models that may be helpful for Nevada in terms of trying to figure out how to get intensive care coordination available to the young people who really need it.

There is tiered care coordination that looks at multiple populations and can serve multiple populations. There are a couple of ways to think about that. There is the New Jersey model where all populations are served within a care management entity, but in Delaware, they are served in two different places. There are pros and cons to both models, and we are happy to talk through it. What is important is that young people with both moderate and complex behavioral health needs, have their needs managed within a model that says we are going to coordinate the care to ensure young people get what they need.

This is another way of thinking about tiered care coordination. We want to look at flexibility in serving more population. For example, New Jersey uses intensive care coordination not only to manage young people with modern and complex behavior health needs, but to also manage young people who have intellectual and developmental disabilities to ensure that they get what they need, when they need it.

Our partners are child welfare, juvenile justice, family courts, and education systems. We do not want child welfare or juvenile justice to build their own behavioral health system. You want a behavioral health system that serves young people who touch on child welfare, but those services can be coordinated and can continue whether they stay in the child welfare system or not. The family does not have to touch on child welfare, in order to access care, same thing with juvenile justice. It is important to think about when and how young people touch on services and supports.

It is important to plan from the beginning. We want to make sure that you are moving toward long-term sustainability and that you are using all the things that are necessary to get there. If you are going to build a system of care, you want it to work from the

beginning. We want to think about what it will look like in one year, in two years, in five years, in ten years. I can tell you, as somebody who was on the ground in New Jersey in 2000 when the concept paper was published, if you had asked me whether we would be here today, I do not know that I would have said yes, but I was certainly hopeful that we would. We not only met the needs in the vision paper that was published in 2000, we exceeded them by bringing in new populations and expanding out the service array in order to meet them. Plus, we have met every single goal that we have put out.

This is New Jersey, and I put the bridge in there so you can see we want to connect the dots, we want to keep young people in their homes, schools, and communities. This is important work and the way to do it is to connect to community, make sure that schools are working with the in-homes, and make sure people are coordinating across practices, across silos. We want to pull those silos down whenever possible.

Community engagement is a primary driver of systems reform. In other words, the communities help us figure out how to heal young people and their families.

It is important to be able to collect, share, and help communities understand the data. We want to collect information that is going to help us know how the system is doing. How are young people improving? Can we see that access is taken care of? Can we see that utilization is making sense? The data collection component of this is important.

Different uses of data are not planned. For me, I wanted data for planning to help communities understand what I need for accountability, to make sure that we are accountable to the young people and their parents, to ensure access is happening, that they are getting the best service, and that we are getting the best practices in place in a way that makes sense.

I want to share some leadership strategies with you because I think it is important in this moment in time for you to think about what you want it to look like for young people today, 5 years, and 20 years down the road. It is important to have a vision of what you want it to look like; to believe that young people can be served in their homes, schools, and communities means that we must be brave and move resources in a way that sometimes might be challenging but is important for us to do. We need to communicate that vision and make sure everybody knows that the vision is moving. New Jersey was brave enough to put its very bad data into its concept paper so that we could see what improvement was going to look like. We want to find champions, and those champions are all over your state. You have plenty of people who are interested and motivated for change and ready to do what is necessary to meet the needs of these children, youth, and young adults. We want to share that progress and report on that progress regularly. We want to be flexible and nimble in the way we build these systems so that we can adjust as we need to for things to work. One thing we really need to understand is that if you are going to do this work, people are going to have to change, grow, talk to each other, and be partners within the work.

Here are some resources for you along with my email address. I am happy to answer any questions that we do not get to today, or if you have any comments or feedback, I am happy to take them as well.

Chair Peters:

I want to extend my appreciation for you presenting on this issue, and we do have a couple of questions, so I hope you will stay until the end of this next presentation.

Dr. Megan Freeman:

I currently serve as the state's Children's Behavioral Health Authority. I want to start the conversation on the children's service array in Nevada by talking about the rights of children with disabilities. We have talked about this a little bit today and Ms. Manley brought up the Olmstead decision. We want to shift our thinking from the ways in which individuals with disabilities are different and what accommodations we can make for a child's limitations or impairments into thinking about what barriers exist within society that prevent that person from developing to their fullest potential, and how can we as a society. look at social barriers that we may be able to remove for them to have full access to society and fully enjoy their rights.

The important question for children with disabilities, including children living with mental and behavioral health needs, is not "whether" but "how" they can be fully included as members of their families, schools, communities, and society. These are some foundational principles that were decided globally some time ago, and they closely reflect the foundational principles of the system of care—doing things in the best interests of the child and family, respect for the views of the child, nondiscrimination, and making decisions with an eye towards their development.

The DHHS is committed to ensuring that every Nevadan has the opportunity to achieve their best possible quality of life. We have a behavioral health community integration plan, which was published several years ago; right now, we are updating it to reflect current needs. The plan was created with the goal of building a behavioral health system that maximizes community integration and discourages the unnecessary use of higher levels of care. At the same time, we must ensure that services across the spectrum meet all the needs, including for those who may need in-patient or residential care. We must attend to prevention efforts and opportunities to divert youth from system involvement.

We want to center community integration in our discussion of expanding children's behavioral health services so that we can reduce unnecessary segregation from society and unnecessary institutionalization. In some cases, higher level of care is necessary, but in many cases, when we have adequate capacity for intensive community-based services, like Ms. Manley was describing has been the case in other states, such placements can be avoided.

Regarding our existing service array, I have divided the services into several categories. Within each category, there are two slides—one for the lower-intensity end of the array, things like prevention and early intervention, and a second slide for higher intensity, which are the formal intervention services. My hope is that looking at the services this way will help you to visualize where we have built out services and where we have some room to grow.

As we look at the development of our service array, if we start over, essentially where we want to be, where we have a well-established model, we know how to do something, we have adequate capacity to serve everyone who needs to be served, and there is sustainable funding. We are getting good outcomes. We want to continue doing these things as we are doing them. Looking at the lower-intensity end of the service array and then the higher-intensity end, we do not have any services that I think we can fully put in this category. I am happy to be proven wrong; if anybody here disagrees, please let me know during questions, or please, anybody watching, feel free to contact me back channel. I would love to be wrong about this, but I think in most cases, when we look at our service

array, we are missing one or more critical pieces of this capacity funding. We have not developed a model here.

Here we have services that we know how to do it, but we may need to further expand them, like into rural, or frontier, or other areas. We might need implementation support, we may not have adequate capacity or sustainable funding, or some other kind of support is needed. I did not put respite care on the slide, but we have been talking about that today, and I would put it on this slide. We know how to do this; we just need help doing it so that we can get the service to everybody who needs it.

This is the higher-intensity end of that service array. I put 988 here because we are still starting, and as we discussed earlier today, when we start this, it will be an iterative process of figuring out what pieces are good, what pieces do we need to tweak, and then the expansion so that it is implemented more like the best practice. Family peer support is an incredibly important part of the service array, and it is currently not a Medicaid billable service, although we are doing some work in that area.

This is the part of the service array where significant work remains, or we may be overcoming barriers. I put Project AWARE here as well as trauma-informed schools more generally, primarily because we do not have uptake statewide, yet, and this is such a critical part of what we are doing. We need to see this used more widely. The work that is being done in Project AWARE is amazing and we want to take it more broadly.

On the higher-intensity end, where we have some significant work to do, is a lot of our services, particularly what we think of as our key services in a traditional service survey, like traditional outpatient services. We are still building out the crisis continuum of care as we discussed earlier, and this whole block of intensive community-based services, which Liz mentioned, and which I want to highlight: the wraparound intensive care coordination, intensive in-home services, intensive outpatient, and partial hospitalization. This is where we can serve high-risk youth who are at risk of going into higher levels of care. They may be at risk for involvement with juvenile justice or child welfare. If we can implement these services at scale, we can prevent a lot of youth from having to leave their home and get service system where they may not get the best outcomes. We want them to learn the skills that they need in their natural environment. We are also lacking some specific types of treatment for youth who need to be in a residential treatment environment. I would consider special populations to be things like what Dr. Brown and her team spoke about earlier—the dual needs youth who have severe emotional disturbance and intellectual disabilities, youth who have aggressive behaviors, youth with substance use disorder needs, youth who are survivors of commercial sexual exploitation, and other populations as well.

This is a part of the service array where we have not started building services yet or we have tried and there are substantial limitations. Ms. Manley talked earlier about dealing with the day-to-day versus getting ahead of the curve. I would put these two services here, or it is not exactly a service, but having a state plan and explicit infrastructure for responding to disasters and emergencies. Many youth and families are going to cope just fine, but we need to be able to provide support assessment and early intervention for those youth and families who are not doing okay to prevent that behavioral health tsunami that we have been talking about and that we are seeing now related to the pandemic. Also, general hospital pediatric consultation liaison services are another opportunity to intervene with families at a time that can be very traumatic. Building and implementing services here would represent an investment in getting ahead of the curve.

There are some services that we are doing really, really well, such as the school-based behavioral health services and the multitiered systems of support, but when we look at those tier three services where youth need individualized interventions, where we want to provide them with traditional therapy services on site at school, that is where, although some parts of the system are built out well, some parts we still need to put more attention to. We need to put more attention to the substance use service array, although we had a great talk earlier from SAPTA. Care coordination for youth returning from higher levels of care is a key part of the system because, as Dr. Andrew Freeman mentioned earlier, it is an opportunity to catch youth at a vulnerable time and prevent further system involvement.

I want to talk about bed availability briefly because this is a topic that comes up frequently with respect to Nevada. This is also an issue elsewhere right now outside of our state for lots of reasons. Using recommendations provided in a recent paper from a panel of global experts, acute psychiatric hospital beds—not residential treatment beds, that is a separate issue—for youth who are in imminent danger, they need to be in the hospital for several days or a week. It looks like we are experiencing a severe shortage. We should have somewhere between 30 and 60 beds per 100,000 youth, and we have between 13 and 15 depending on how you look at it. This is one of the reasons that we see bottlenecks in the emergency department. We also have a discrepancy right now between licensed beds and staffed beds, which is related to the block force shortages. Although a facility may be licensed for 20 beds, for example, they might only be operating 16 beds due to staffing shortages, which further limits the ability of the system to meet the needs.

A generally accepted definition of *behavioral health safety net* is "a set of services for low-income, uninsured, and underinsured children, youth, families, and adults." The services are relatively easy to access, and they are adequately funded so that nobody who needs the care will never go without care. Typically, this is your public behavioral health system probably provided by a state or a county or through some sort of contracting process.

In Nevada, we do have some statutes related to this, so there is some clear legislative intent regarding the purposes of DCFS to provide a comprehensive system not only for juvenile justice and child welfare, but also for the mental health of children. This includes ensuring that they are placed in the least restrictive environment and coordinating and providing services for youth. This does not necessarily mean, literally, that the state provides all the services, because as we have been talking about today, that is clearly not a good strategy. We are not going to be able to meet the need, but it is the responsibility of the state to ensure that an adequate service array exists.

I will talk a little bit more on the ways that this touches on behavioral health. The DCFS shall establish and coordinate a system for diagnosis and assessment and assessment referral to appropriate services and care coordination. Without the proper infrastructure, oversight, and data monitoring, it would be difficult for the state to execute this area of the legislative intent. This is a big ask. It is really important, and right now, we are lacking some parts of our service array. It is something that we need to pick up, but we also need to make sure that we have all the tools that we need in order to do this.

It is the generally accepted definition, the legislative intent, what we know we should be doing, and what we would like to be doing. The post-COVID-19 reality is that as we have been talking about all day, we have folks leaving the workforce. Those who are left behind to carry the load are incredibly burned out because of the shortage of healthcare professionals overall. I found an interesting statistic that goes across all industries, not just health care, but the majority of those leaving jobs in 2021 cited mental health as the driver.

For "millennials," that was two out of three folks, and for "Generation Z," the younger generation, who is the newer generation in the workforce, that was four out of five or 80 percent of folks saying that when they left their job, the reason was because of their mental health.

Not only is our workforce struggling, but the mental health workforce shortages are affecting the care of youth and adults. Virginia stopped admissions to five of its eight state hospitals due to their staffing shortages, and folks are leaving community mental health clinics because of low salaries, burnout, and other reasons. It is difficult to serve in that role as the safety net, not just performing the services, but also coordinating services, ensuring they exist when we are missing some of these key parts, and working in this incredibly difficult time to provide health care services.

You have heard today from a wide range of folks and many thanks to all the awesome people who testified today. We have an amazing team at the state and from our local partners. There is a tremendous amount of really good work happening here, like Mr. Musgrove said, to support children, youth, and families. We are supported by the Governor's Office and his staff; we are supported all up and down the line, but we still have a lot of work left to do. When we look at the service array from a 30,000-foot view, we can see that we are lacking evidence-based and evidence-informed services at the right capacity supported by sustainable funding. The recommendations, or at least one of the recommendations to start addressing, is to improve data collection and surveillance efforts so that we can fully understand the need. This is the first step in creating the infrastructure that I have been talking about, that can address the quality and completeness of the service array, and we will also inform requests for funding strategies. The next area of our service array that needs to be built out is intensive community-based services, which I showed you earlier on the service array slide—partial hospitalization, intensive outpatient, intensive in-home, wraparound, and intensive care coordination services. The bone of an individualized strategy for every youth accessing these types of services and using this strategy will provide the best possible support and outcomes to youth who are at risk of out-of-home placement.

We need to significantly increase capacity to provide wraparound or intensive care coordination services. Again, the state cannot provide all those services right now. That is the model, but we have put in some requests to expand and engage community partners. This will allow us to better support youth who are at risk, which includes not only risk for a higher level of care, but also involvement in the juvenile justice system or the child welfare system. In the event a youth does need a higher level of care, this is another area of our system where we have significant and meaningful gaps, which has come up earlier today. Youth with specialized needs do tend to go out of state, such as youth with comorbid, intellectual, and developmental disabilities, and community stakeholders have lost confidence that our in-state residential treatment system can meet the needs, even for youth who do not have specialized treatment considerations. We need to look at our strategies regarding residential treatment and make any adjustments that might be needed to ensure that we are aligned with best practices.

Regarding workforce challenges, we have discussed potential strategies like creating a pipeline from local institutions of higher education and explicitly incentivizing behavioral health care work. We could use strategies such as student loan repayment or even cash bonuses. While public employees, including school district employees, are feeling the largest salary gap with the private sector right now, it would be beneficial to be able to provide incentives and bonuses across both public and private settings.

What I would really like to highlight here is the opportunity to build out school-based behavioral health services. You heard earlier from Director McGill, as well as the Clark and Washoe School Districts about the extensive and very thoughtful programming that is already happening in our schools. We know that especially for those in need of those highest-level tier three services, which would be individualized interventions, what we have now is not enough. Director McGill mentioned the use of Medicaid dollars. We do have a small team of folks working across DHHS and within their across multiple divisions, as well as the Department of Education, to support the implementation of Medicaid billing in schools. The revenue will be reinvested in schools to further build out behavioral health services, but not every youth who needs behavioral health services is Medicare-Medicaid eligible. We want to dedicate more staff resources and more funding to take school-based behavioral health services to scale statewide, and this will increase access for all youth and allow for more equitable service delivery by removing barriers to care.

Ms. Manley mentioned the importance of oversight and ensuring that best practices are delivered, and youth are receiving quality care. She mentioned that the way to accomplish this is by having a dedicated team of folks attending to this infrastructure. You also heard earlier about an infrastructure like this used by SAPTA in Nevada to oversee the substance abuse prevention and treatment system here. We want to do something similar to what SAPTA has done for substance use provider certification and treatment for children's behavioral health. We want to know how many providers there are, what services they are providing, and we want to certify them through a vetting and enrollment process so that through these processes, we can better ensure that there is a full and adequate service array. This will also give us oversight over services and outcomes, which helps to better ensure clinical quality. As Dr. Andrew Freeman mentioned in his talk on pushing mobile crisis services out to the community, when we start growing the community-based service array, it is important to ensure that the standards of care and best practices are maintained. We need these formal mechanisms for oversight, quality assurance, and quality improvement. We do not want to make the process so burdensome that providers do not want to participate, or they cannot meet the requirements. We do need to strategically monitor certain metrics so we can provide training, technical assistance, and corrective action, as needed, so that we know what's happening in the system.

We do not want to set expectations for providers without providing the scaffolding to ensure that they can meet the expectations. This is the clinical excellence side of the house for the Nevada Children's Behavioral Health Authority that we would like to build. The clinical excellence side of the house is designed to support both providers and the service array overall, and different offices and centers would work collaboratively with those on the policy and oversight side to ensure that the authority is providing adequate support and attention to clinical quality. The state would make technical assistance and training available, which includes engagement with vendors and providers of evidence-based models of care. There would be several areas of the authority specifically dedicated to specialty areas of youth treatment, like substance use disorder, school-based behavioral health, and the special populations that I talked about earlier. Underlying all the work of the authority will be support for whole-child and whole-family health awareness of the significant impact of the pandemic on children and families and awareness and mitigation of social determinants of health. In some senses, showing these separately is an artificial separation, and even putting these offices into separate boxes is an artificial separation because there is so much interdependence among training, technical assistance, oversight policy, working with Medicaid, working with NDE. We are already doing the interdisciplinary thing, and this would be sort of further integration in an interdisciplinary manner to fully support the needs of youth and families.

The overarching theme that I hope you are hearing today is that we need behavioral health system transformation, and it is hard to achieve radical change incrementally. This is the time; this is the opportunity to leverage the current environment that is ready and willing to talk about the needs of children and families and is ready to talk about making changes so that we can achieve that radical change with some big ideas. That is the end of my presentation, and Liz and I are happy to take any questions.

Chair Peters:

Thank you for presenting on this really important issue. I appreciate the outline of what you are thinking about, and I look forward to working towards what it is you need to stand this up. I think we need to talk about the funding piece, which is a separate and robust conversation, as well as what infrastructure you need. I love this; everything that you are discussing related to the transition into this care model is spot-on for me and my experience as a millennial with children and having dealt with my own mental and behavioral health issues while being a support for other people who are as well. I am very excited for us to be moving in this direction, and I hope that we can tie some things together this next legislative session. I look forward to your recommendations on bill draft requests.

Are there questions from the Committee based on these two presentations?

Assemblywoman Titus:

I do think there has to be a change, and we must augment what we are doing. I recognize that we are on a policy committee, and as the Chair pointed out, most members of this Committee are also on the Interim Finance Committee (IFC). My question is for staff. How much of our ARPA funds have been committed to our mental health programs? I would like to see if any of that money has been spent on solving some of these issues that have been presented over this day. I would like to see that total and maybe staff can get it from our finance folks.

Chair Peters:

That is a great question, Assemblywoman Titus. I think we will see some additional information on that during the next IFC meeting. I know that is a little way off, but we should expect that paperwork to come in anytime between now and the first couple of weeks of April for us to review, if not a little bit later than that.

Are there other questions from the Committee?

As we work to stand up this type of system, how do we communicate with parents and work to destigmatize the ask for help? I do not believe the service is meant to be a last resort; instead, it is designed to be a community support, much like the saying "that it takes a village." If that is incorrect, please correct me. I think there is a gap on how we communicate that purpose within the community. How do we get parents to call and let these supports help them and their families? Maybe that is a question for all of the folks who have participated in the meeting today, but if you have any response, I would appreciate it.

Ms. Manley:

It is important to make sure you have the services up and running because you do not want to let parents down. Also important is that when you roll things out, you are going to get out to parent groups. You are going to ask parents to try the service, you are going to ask

them to trust you in the work. As you move out, parents will come once they have a good experience. You are beginning to see that in the world of mobile crisis response. Parents are experiencing the service; they are getting what they need at the time they need it. The more you can do that, the more you can demonstrate to parents to use the service. One other thing that is important—the lesson from 20 years on the ground—is that you must continually communicate; we cannot let it go. We must always be attentive to communicating with parents, with schools, with pediatricians, and with law enforcement. We need focused attention in those areas because when parents begin to experience challenges, they talk to teachers, guidance counselors, pediatricians, and they come across law enforcement from time to time. We want everyone working on the same page. That is how you do it—slow and easy—making sure parents use the service, making sure you advertise. Sometimes we put things in young people's backpacks as they go home. We spend a lot of time talking to vice principals, principals, and guidance counselors in schools to make sure they know. All that communication is really important.

Chair Peters:

I agree. Having lived in Nevada all my life, I know we have bit of a tie into fierce independence, and it is really hard to break through that in our communities but finding those community partners is key and then keeping them engaged. I look forward to seeing how we do that and if we need to make a robust coordination office to ensure that that is happening across the board and continuously as you said.

Are there any other questions from the Committee? Seeing none, I am going to close out of this item and move into our last agenda item today, which is public comment.

AGENDA ITEM XIII—PUBLIC COMMENT

[Chair Peters repeated the protocol for public comment.]

Chair Peters:

Seeing no public comment in Carson City or Las Vegas, we will give BPS a minute to see if anyone calls in on our public comment line.

BPS:

Chair Peters, the line is open and working. However, there are no callers at this time.

Chair Peters:

This is an important issue for the state of Nevada and especially for those of us who are very passionate about this space. I appreciate everyone hanging in there, and I appreciate all the folks who are working in this area. Thank you for your time and effort today and for the information you have provided.

Our next meeting will be held on April 21, 2022, at 9 a.m., hopefully in person.

Subsequent to the meeting, the following public comment was submitted for the record:

- Tiffany Tyler-Garner, Ph.D., Executive Director, Children's Advocacy Alliance (CAA) (Agenda Item XIII A);

- Darlene Anderson, Member of the Public (Agenda Item XIII B);

- Lindsey James, Senior at UNR; Intern at CAA (Agenda Item XIII C);
- Ariana Montez, Public Health Student at UNR (Agenda Item XIII D);
- Carissa Pearce, Nevada resident (Agenda Item XIII E);
- Nicole Talton, Public Health Student at UNR (Agenda Item XIII F); and
- Zhimei Yuan, Student at UNR (Agenda Item XIII G).

AGENDA ITEM XIV—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 4:29 p.m.

Respectfully submitted,

_____

Julianne King
Assistant Manager of Research Policy Assistants

_____

Patrick B. Ashton
Senior Policy Analyst

APPROVED BY:

_____

Assemblywoman Sarah Peters, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II	Leann McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics	Public Comment
Agenda Item IV A	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R040-21 of the State Board of Pharmacy
Agenda Item IV B	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R067-21 of the Board of Environmental Health Specialists
Agenda Item IV C	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R076-21 of the Board of Occupational Therapy
Agenda Item IV D	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R118-21 of the Board of Medical Examiners
Agenda Item IV E	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R126-21 of the State Board of Health
Agenda Item V A-1	Megan Freeman, Ph.D., Children's Behavioral Health Authority, Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item V A-2	Megan Freeman, Ph.D., Children's Behavioral Health Authority, DCFS, DHHS	Memorandum
Agenda Item VI A-1	Misty Vaughan Allen, M.A., Coordinator of the Statewide Program for Suicide Prevention, Division of Public and Behavioral Health (DPBH), DHHS	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item VI A-2	Misty Vaughan Allen, M.A., Coordinator of the Statewide Program for Suicide Prevention, DPBH, DHHS	Memorandum
Agenda Item VI B	Christina (Christy) McGill, Director, Office for a Safe and Respectful Learning Environment, Nevada's Department of Education (NDE)	PowerPoint Presentation
Agenda Item VII A	Kristen Clements-Nolle, Ph.D., M.P.H., Professor and Director of Graduate Studies, School of Public Health, University of Nevada, Reno (UNR)	PowerPoint Presentation
Agenda Item VII B-1	Elyse Monroy, Chair-Elect, Statewide Epidemiology Organization Workgroup (SEOW)	PowerPoint Presentation
Agenda Item VII B-2	Elyse Monroy, Chair-Elect, SEOW	Member List of SEOW
Agenda Item VII C	Mark Disselkoen, Senior Project Manager, Center for the Application of Substance Abuse Technologies, UNR	PowerPoint Presentation
Agenda Item VIII	Christina (Christy) McGill, Director, Office for a Safe and Respectful Learning Environment, NDE	PowerPoint Presentation
Agenda Item IX	Megan Freeman, Ph.D., Children's Behavioral Health Authority, DCFS, DHHS; and Andrew Freeman, Ph.D., Licensed Psychologist I, Temporary Manager, Children's Mobile Crisis Response Team, DCFS, DHHS	PowerPoint Presentation
Agenda Item X	Elaine Brown, Ph.D., Chief Psychologist, Aging and	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Disability Services Division (ADSD), DHHS; Jessica Adams, Deputy Administrator, Community Based Care and Development Services, ADSD, DHHS; Rique Robb, Deputy Administrator, Aging, Physical Disabilities, and Children's Services, ADSD, DHHS; and Samantha Jayme, Health Program Manager, ADSD, DHHS	
Agenda Item XI	Ellen Richardson-Adams, Chair, Nevada Children's Behavioral Health Consortium	Nevada Children's Behavioral Health Consortiums Priorities
Agenda Item XII	Elizabeth Manley, Senior Advisor for Health and Behavioral Health Policy, The Institute for Innovation and Implementation, University of Maryland School of Social Work; and Megan Freeman, Ph.D., Children's Behavioral Health Authority, DCFS, DHHS	PowerPoint Presentation
Agenda Item XIII A	Tiffany Tyler-Garner, Ph.D., Executive Director, Children's Advocacy Alliance (CAA)	Public Comment
Agenda Item XIII B	Darlene Anderson, Member of the Public	Public Comment
Agenda Item XIII C	Lindsey James, Senior at UNR; Intern at CAA	Public Comment
Agenda Item XIII D	Ariana Montez, Public Health Student at UNR	Public Comment
Agenda Item XIII E	Carissa Pearce, Nevada resident	Public Comment

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item XIII F	Nicole Talton, Public Health Student at UNR	Public Comment
Agenda Item XIII G	Zhimei Yuan, Student at UNR	Public Comment

The Minutes are supplied as an informational service. All meeting materials are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. For copies, contact the Library at (775) 684-6827 or https://www.leg.state.nv.us/Division/Research/Library/About/Contact/feedbackmail.cfm.