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

April 21, 2022

The fourth meeting of the Joint Interim Standing Committee on Health and Human Services for the 2021–2022 Interim was held on Thursday, April 21, 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 MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Sarah Peters, Chair
Assemblywoman Robin L. Titus, M.D.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Dallas Harris
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II

COMMITTEE MEMBERS ATTENDING VIA REMOTELY:

Senator Fabian Doñate, Vice Chair
Senator Joseph (Joe) P. Hardy, M.D.
Assemblyman David Orentlicher, M.D.

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

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

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

AGENDA ITEM I—CALL TO ORDER

Chair Peters:

Welcome to the fourth meeting of the Joint Interim Standing Committee on Health and Human Services.

[Chair Peters reviewed meeting protocol and information related to providing public comment.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Peters:

As stated before, public comment will be limited to three minutes per speaker. Staff will time each speaker during public comment to ensure everyone has a fair opportunity to speak. We also ask that you do not repeat what a previous commenter has stated. An additional opportunity to make public comment will be available at the end of the meeting. We will start with public comment from those in the physical locations and then move to public comment from anyone who has called in.

Is there anyone in Carson City who would like to provide public comment this morning? I am not seeing anyone come up to the table.

Is there anyone in Las Vegas who would like to provide public comment at this time? I do not see anyone moving to the table.

Broadcast and Production Services (BPS), will you add the first caller to the public comment line?

BPS:

To give public comment, please press "raise hand" in your Zoom window or "*9" on your phone to take your place in the queue.

Chair, there are no callers for public comment at this time.

Chair Peters:

Thank you so much. There will be another opportunity at the end of the meeting for public comment if there are folks who would like to call in at that time.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON FEBRUARY 17, 2022

Chair Peters:

We are going to move to Agenda Item III, approval of the minutes for the meeting on February 17, 2022. Members, are there any questions regarding the minutes? I will entertain a motion to approve the minutes of the Committee meeting on February 17, 2022.

> ASSEMBLYWOMAN TITUS MOVED TO APPROVE THE MINUTES OF THE FEBRUARY 17, 2022, MEETING.

THE MOTION WAS SECONDED BY SENATOR HARRIS.

THE MOTION PASSED UNANIMOUSLY.

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

Chair Peters:

We are going to move on to Agenda Item IV, consideration of regulations proposed or adopted by certain licensing boards pursuant to NRS 439B.225. Eric Robbins, our Principal Deputy Legislative Counsel, will walk us through these regulations.

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

The Committee has four regulations to review today. As a reminder, the Committee does not formally approve or reject the regulations. This is an opportunity for members of the Committee to ask questions and provide feedback to the agencies concerning their regulations. The four regulations we have today are: (1) LCB File R007-21 of the State Board of Pharmacy (Agenda Item IV A); (2) R062-21 of the State Board of Health (Agenda Item IV B); (3) R064-21 of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board (Agenda Item IV C); and (4) R028-22 of the Board of Medical Examiners (Agenda Item IV D). We have representatives of the State Board of Pharmacy, the State Board of Health, and the Speech-Language Pathology Board available virtually, and a representative of the Board of Medical Examiners in Carson City to answer any questions members of the Committee may have.

Chair Peters:

I want to remind the Committee that this is informational only. Staff informed you about the status of the regulatory process for the regulations that we are now considering. I believe none of them have been approved by the agencies, so there are still opportunities for public input at this time. If you have a greater interest in participating in the development of these regulations, the process can be found on the LCB's website or you can reach out to staff for additional assistance. Committee review is an important process for follow-up on bills that have passed in the last couple of sessions, but we will not be taking any action on these items today.

Dr. Titus has a couple of questions on these regulations, please go ahead.

A. LCB FILE R007-21 OF THE STATE BOARD OF PHARMACY

Assemblywoman Titus:

I need some clarification as to why the oncology group practice is being identified as needing a specialty line. There are many group practices out there. In my office, we would have medicines that were considered dangerous medications, such as narcotics, et cetera, locked up, and there were several people in the office. Could you explain what prompted the oncology group practice to be identified as needing a special designation?

Dave Wuest, R.Ph., Executive Secretary, State Board of Pharmacy:

Practitioners do two things: (1) they administer; and (2) they dispense, similar to a pharmacy or a pharmacist. We are not talking about the administration. To your point, if doctors have a shared inventory of drugs, that is not what we are talking about today. We are talking about if they are going to actually dispense, put a label on it, counsel a patient, and give the patient a bottle of medicine to take home. They must get a separate dispensing license from the state to do that. Currently, the law—because they are all individuals—requires that inventory to be separate. The oncologists petitioned the Board—and we are in the middle of the process and hopefully approving this—where their drugs are very expensive, if they all had to have a $10,000 bottle of drugs, then they have to have $100,000. They were hoping the Board will allow them to be able to put those together, just for the dispensing. We are not talking about your typical practice; this is just for a dispensing practitioner.

Assemblywoman Titus:

To be clear, was this requested by the oncology groups?

Mr. Wuest:

It was requested by the oncology groups. I expect that other groups with other expensive drugs might request it down the road. The Board is trying to work through the regulatory process. Obviously, the Legislative Commission will approve it if they choose to approve it.

Chair Peters:

We are going to go through the regulations one at a time. Members, does anyone else have any questions on R007-21 for the State Board of Pharmacy? I do not see any.

B. LCB FILE R062-21 OF THE STATE BOARD OF HEALTH

Chair Peters:

We will go ahead and move on to R062-21 (Agenda Item IV B). Is there a representative from the State Board of Health available?

Leticia Metherell, R.N., C.P.M., Health Program Manager, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS):

Yes. I also have with me April Clyde, who is a certified nurse midwife and the owner and operator of our only licensed freestanding birth center in Nevada, to help answer questions.

Chair Peters:

Dr. Titus, please go ahead with your question.

Assemblywoman Titus:

I looked at the laundry list of fees. I just need some clarification on how you established that particular fee in the fee structure.

Ms. Metherell:

That was our existing regulatory fee for obstetrics centers, so we left it the same. I do not know how it was originally established.

Chair Peters:

Are there other members of the Committee for with questions? Dr. Hardy, please go ahead.

Senator Hardy:

On the freestanding birthing center, I only see oxygen being used on a newborn. Is there some other allowance made for making sure the newborn is appropriately treated?

Ms. Metherell:

Assembly Bill 287 (2021) required us to align our regulations with one of the standards listed from the Commission for the Accreditation of Birth Centers, which we adopted by reference. It is the indicators of compliance with standards for birth centers. It is extensive coverage of what is required in a freestanding birth center, and I am happy to provide that document to the Committee. It is over 200 pages and outlines all of the requirements. You do not see those in the regulations because they were adopted by reference.

Senator Hardy:

So, they are already adopted?

Ms. Metherell:

Pardon me, no they are not adopted. They were put in the proposed regulations to be adopted by reference if the Board of Health adopts them during its June meeting.

Senator Hardy:

What section is that referenced in?

Ms. Metherell:

Section 6 talks about being accredited by the Commission for Accreditation. Let me find the section that talks about adopting it by reference.

Mr. Robbins:

I believe it is Section 12.

Senator Hardy:

If we could have that information available to us before it gets to the Legislative Commission, I would appreciate it.

Ms. Metherell:

Yes, we will be happy to provide you a copy.

April Clyde, A.P.R.N., C.P.M., C.N.M., Owner, Serenity Birth Center:

A nurse practitioner and a registered nurse attend every birth and are required to be neonatal resuscitation trained. We are required to carry all of the medication to take us through the protocol of neonatal resuscitation, including epinephrine, which is all stocked and carried at the birth center.

Senator Hardy:

Do you have the ability to do umbilical cannulations?

Ms. Clyde:

Absolutely.

Chair Peters:

As a follow-up, would you mind sending that information to staff and staff will distribute it to the committee members? We can also add it to the meeting page for the public's information.

I do not see any more questions from the members. Thank you for being here. We look forward to seeing how these regulations are heard by the Board.

C. LCB FILE R064-21 OF THE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID DISPENSING BOARD

Chair Peters:

We are going to move on to R064-21 from the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board (Agenda Item IV C). We have Jennifer Pierce from the Board with us to answer questions. Thank you so much for being here this morning. I know Dr. Titus has a question related to these regulations.

Assemblywoman Titus:

I know this regulation is following direction from legislation passed during the last session. We passed a bill regarding professional licensure that cut back continuing education, across the board, from 15 hours to 10 hours and added the cultural competency education requirement. My question is, how do they get this hour of continuing education? Will they be allowed to sign on to a generalized education on cultural competency and is it available to everyone? Are we able to rev this up so these professional groups, specifically speech and pathology, will have access to this education?

Jennifer R. Pierce, Executive Director, Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board:

Our continuing education rules will blanket accept certain activities from affiliated organizations like the American Speech-Language-Hearing Association (ASHA), the American Academy of Audiology, et cetera. We also allow for any courses directly related to the profession completed through a university, school district, et cetera.

The recommendation to include the cultural diversity and cultural competency hours came directly from ASHA, which is the accrediting body for most of our speech-language

pathologists and can also be for audiologists—although we do not have quite as many, and they are changing their regulations. They currently require 30 hours in a three-year period, and their new requirements for continuing certification will be one hour of ethics and two hours cultural competency.

There are quite a few courses online that people take, and we are comfortable believing that there are lots of opportunities. Our rules are flexible enough at this point that somebody can find related content to the requirements for cultural diversity training.

Assemblywoman Titus:

For clarification then, I am hearing that you are going to be developing something—or something has already been developed—as opposed to having a health care class, so to speak, that covers it. Will the audiologists or speech pathologists have their own classes on cultural competency or related things? Is there some uniqueness for the speech pathology that would need to be included in the classes you are developing?

Ms. Pierce:

No, we are not developing anything specifically, but our current requirements around continuing education are fairly broad. Somebody could find training in cultural diversity that would likely meet the requirement for us. It would not need to be specific to speech-language pathology or audiology. AudiologyOnline, for example, is an online training database that many of our practitioners use for a lot of their training and there are opportunities to do ethics and cultural competency continued education through there. It does not have to be specific.

Assemblywoman Titus:

I think it is important that the courses are available, that folks have access, and it is easy for them to get this education. I just want to make sure there are no barriers.

Chair Peters:

Are there any other questions from the Committee on this regulation? I am not seeing any, thank you for being here.

D. LCB FILE R028-22 OF THE BOARD OF MEDICAL EXAMINERS

Chair Peters:

We will move on to our next regulation, R028-22 of the Board of Medical Examiners (Agenda Item IV D). We have Ms. Bradley available for our questions. I know Dr. Titus has a question.

Assemblywoman Titus:

Looking through this, I am concerned. We already have a limited amount of health care providers and getting people to work in doctors' offices, nurse practitioners' offices, and all providers' offices. Now having the requirement of a patient attendant to be there, in addition to everything else we must have in the office, I have some concerns about that. Having practiced many years, I know that sometimes you just have to go in and examine a patient; you have to take care of them and are not always able to have that extra body be

there. I understand having a patient attendant is for the patient's protection, but I am wondering how this is going to be enforced.

Sarah A. Bradley, J.D., MBA, Deputy Executive Director, Board of Medical Examiners:

The regulation, as drafted, does have an exception for emergency care in an emergency situation. It is also limited; it is not in every patient encounter. It is for patient encounters where there is a visual or physical inspection of genitalia, rectum, or breast of a patient or other kinds of more invasive procedures in those areas of the body. It is not for every single visit. There has been some conversation because, as you can imagine, we receive complaints about this a lot. The intent is to require this person be in the room when these things occur; their name is noted in the record, that way it is clear who was there. We got some of this guiding language from the Federation of State Medical Boards. Frankly, it is an issue that we are struggling with how to best protect the public. When we have a complaint come in, we have two physician members and a public member who review our investigative complaints. The board physicians are saying this is standard—you should have someone present when you are doing these types of examinations. Our concern is, let us codify that in the regulation. We do not enforce it currently. We recommend it when we get complaints regarding unwanted touch and improper things. We often recommend it, but we have not been requiring it unless it is a disciplinary case and then, sometimes, we will require it.

We have not done a workshop or public hearing on the regulation yet. I am, as you are, expecting to get a lot of comments. This person does not, obviously, have to be a physician. I would say it would be more like a medical assistant position. I agree with you, we know there are work staff shortages, so I do not know what comments we are going to get.

The intent is not to make things harder. The intent is to put into the law what, as I have heard from multiple physicians on the Board, is already the standard of practice when these types of exams are done.

Assemblywoman Titus:

I was a member of the Board of Medical Examiners in the late 1990s. I was part of the investigative committee, and we would look at charts, complaints, et cetera.

In my own practice, I would have that standard of care. If it was going to be an exam, I would have my medical assistant or the nurse be in the room with me. Other times, I would not have one; it was at my discretion. The standard of care would be to have somebody there, in certain situations, but to codify this has me a little bit concerned.

I will be curious to see what the comments are from the providers, especially in the rural areas, when you do have this public hearing. A little clinic in Austin, for example, sometimes the provider is the only person in the clinic. If there is a second person, they are answering phones and tending to other things and now they must be in the room. I understand this is just a proposed regulation, and you are going to have hearings. I agree with the standard of care, when possible, but sometimes that just does not happen. To propose disciplinary issues if somebody does not do that, I think is setting up health care providers.
I understand protecting patients, which is what I have done my whole life, but I do have concerns.

Ms. Bradley:

Just to clarify, I do not anticipate that we are going to go out to offices, look at charts, and inspect for this. Most likely, it is going to be a tool that when we get a complaint, we can look in the patient record to see if there was a patient attendant. If there was not a patient attendant, maybe this will be a way to curb some of this inappropriate touching or action. We do not have the resources to inspect every office and look at all the records.

A lot of times, we have he said/she said or she said/she said situations and we cannot always take action. We do not want people to ever be hurt. This way, they are required to put something on the record. If we get a complaint, we can see who is in the record, and we can then interview that person who can say there was nothing here. It gives us another investigative tool. Then, if someone is routinely not following this regulation, it gives us a disciplinary tool that maybe can help stop bad people from doing bad things.

Chair Peters:

I think this is an interesting topic to take on. The idea of consent has been something we have talked about in this legislative body at least the two terms that I have served. We have had a hard time figuring out what that means for everybody. This brings up the idea of patient consent to another observer in the room and what that means for the patient. Also important is a patient's knowledge and understanding of their rights and their right to ask for someone to be in the room to ensure that things are fine. I am thinking about when I go in for my wellness exam and if I ask for a breast exam that is maybe not part of my wellness exam. Does that mean I then take up more time with that doctor by having them go out and ask somebody to come in at those times?

This is an interesting discussion, and I imagine you will get a lot of a lot of comments, and I hope you do. The conversation around what consent means in all places of our lives is an important piece for us to take very seriously in statute and regulation.

Any other questions from the Committee? Dr. Hardy has a question.

Senator Hardy:

We sometimes forget this protects the doctor as much as it does the patient. If there is a complaint made and the doctor says, "I had somebody in the room with me," that protects the doctor every bit as much as it protects the patient.

Now, if the doctor happens to be male and the patient is female, that would be where Assemblywoman Titus probably has an advantage over me when she is doing an exam over any male physician. Has there been any differentiation in the federal board that looks at the percentage of complaints as far as gender to gender or gender to opposite gender?

Ms. Bradley:

The Board has discussed it. We normally, as staff, come up with some potential ideas based on things that we're seeing and other things the Board has requested. At the March Board meeting, the Board reviewed this and talked about it. I expected them to bring this topic up, and they seemed comfortable with requiring it regardless of gender. At least that was the sense I got at the meeting and from a couple of board members when they said that to me.

Most of the complaints are female patients complaining about an improper touch by a male physician. However, we have had male and male complaints; I am not aware of female and female complaints. Given the changing landscape and trying to make sure everyone is accommodated, our thought was an improper action can happen from anyone. That is, at least, where we started with this. You are right, as a female patient myself, I understand the difference between going to providers of my same gender versus male. It is an interesting topic, and I am expecting a lot of conversation.

To address something the Chair mentioned, we are trying to be cognizant of having another person in the room. This is a sensitive situation. We have it in the regulation—and we want the patient to be informed about this—that the patient can say if they do not want another person in there; it is up to them. Our thought was, at least for now, that a third party be there. I know, at least in my personal experience, male physicians always do that. There are some that do not, and I think those are the ones we get the most complaints about.

We are trying to make sure that everybody knows this should be done, rather than just recommending it. When we recommend it, we are saying, if you do this you probably will not get future complaints, but we are not addressing whether something bad did occur. We are saying in the regulation that the patient attendant must report things to the Board directly. They are there more for the patient, which is good and part of our intent.

It is an interesting role because we want them to also know what the scope of the encounter should be, what should this exam entail, because how would you know if something improper was going on if you do not know what the exam should be. We are trying to address everything we can.

I have not yet scheduled the workshop or public hearing. We actually just got this draft back within the last two weeks. We submitted it in March, so it was a very fast turnaround. We have not had time to schedule. Our plan is to take whatever feedback we get and try to refine and have what we can to protect the public the best we can, that is our goal.

Senator Hardy:

This bill started out as a pelvic exam bill. As a family physician, I do not ever remember getting somebody in the room with me to do a rectal exam or checking for a prostate. What you just did with your testimony is you opened that up for male physicians to always have an attendant there. If I understood you right, whenever a male physician does a rectal exam on another male, a patient attendant has to be there. Is that what I heard?

Ms. Bradley:

Yes, that is in the language in the proposed draft. It says any of those exams.

Senator Hardy:

Was that in the bill?

Ms. Bradley:

This is not regarding a bill. This is a regulation the Board is bringing forth on its own given the complaints and issues we see. This is not related to a bill; I know what you are talking about, there was a bill regarding pelvic exams and other exams in emergency situations. It did not cause us to bring this; we are bringing this independently to try to address concerns we see.

Senator Hardy:

If a complaint goes to the Board that somebody did something inappropriate, the Board says yes, and the record shows that a patient attendant was there with the doctor when the doctor did whatever he or she was supposed to do, does that complaint now qualify for an investigation? Like all the complaints heretofore have happened recently, now the doctor has to say he or she was investigated on all of the national databases.

Ms. Bradley:

This does not change the Board's investigative process. When a complaint is received, it is reviewed, and if it is within the Board's jurisdiction, it is opened as an investigation, and an allegation letter will be sent to the physician. At that point, generally, we ask for the records and those records would show us the patient attendant's name and give us a witness potentially to talk to. It helps us in our investigation and it helps the physician or the physician assistant in the investigation as well. The intent is not to change the process for investigations at all with this regulation; it is just to aid investigations regarding an alleged improper touch.

Senator Hardy:

When an investigation is opened, what is your timeline of clearing investigations?

Ms. Bradley:

Generally, it depends. When a complaint is received, the licensee gets a letter saying an allegation has been made, they are given 30 days to respond and provide records. Then there is time for the Board's staff to review, and then all complaints are put on an investigative committee agenda, which meets quarterly. It would depend on when the allegation letter went out and what meeting it gets on.

If it is something where there is clearly nothing there when it is reviewed by the medical reviewer, it can be closed in a matter of a few months. Sometimes it takes longer depending on how long the doctor takes to respond. There are some we have to request a response multiple times. Then there are times when we get the complaint just before our investigative committee meets and it is going to have to wait at least three months. It is also up to the investigative committee, depending on what the records show and other things, they may ask for a peer review. Even if this is the only allegation initially made, the investigative committee could want to expand it.

It is not always as cut and dry as you are proposing. I would say a few months to potentially a year would be the time frame for the investigation. We do our best to keep the physician, the physician assistant, or other licensee informed during that process.

Chair Peters:

Thank you, Senator Hardy for your interest in this topic. These are great questions to bring up to the Board as they consider this regulation. Thank you, Ms. Bradley for your responses today.

AGENDA ITEM V—OVERVIEW OF CHILD WELFARE, CHILD MALTREATMENT PREVENTION, AND YOUTH HOMELESSNESS

Chair Peters:

Agenda Item V is an overview of child welfare, child maltreatment prevention, and youth homelessness. We have a couple of folks from the National Conference of State Legislators (NCSL) to discuss this issue. Please proceed when you are ready.

Jill Yordy, Senior Policy Specialist, Children and Families Program, NCSL:

We will be presenting on child and family well-being, child maltreatment prevention, child welfare, and youth and young adult homelessness (Agenda Item V). I am joined for this presentation by my colleagues, Heather Wilson and Cameron Rifkin. In this presentation, we will give a brief overview of the NCSL; discuss high-level themes around child and family well-being, including child maltreatment prevention; give an overview of child welfare and foster care trends; and talk about trends and data surrounding youth homelessness in Nevada. Finally, we will wrap up by connecting back to what research suggests children and their families need to thrive.

The NCSL is a bipartisan organization serving legislators and the legislative staff in America's 50 states, territories, and Washington, D.C. The organization creates opportunities for lawmakers and staff to share knowledge and ideas so they can enact laws and policies to improve the lives of their constituents. The NCSL also ensures states have a strong cohesive voice in the federal system with a strong belief in the importance of the legislative institution. The NCSL knows that when states are strong, our nation is strong.

I will hand it off to my colleague Heather Wilson to talk about child and family well-being in the context of the child welfare system.

Heather Wilson, Senior Policy Specialist, Children and Families Program, NCSL:

Today, I am going to start talking about some key national themes, trends, and messages that we are seeing throughout the child welfare fields. One is child well-being is inextricably linked to parental well-being. Children do better when their parents do better. Two, this work is interdisciplinary and the issues are intersectional. Children and families need emotional and economic supports to thrive. These broad indicators of well-being take a village—so to speak—of public, private, and community support. Next, prevention occurs on a continuum. Child welfare systems and agencies across the nation are actively working to move upstream to prevent child abuse neglect. This work is generational and happens on a continuum to disrupt the cycle of generational trauma for families. Finally, data trends reveal that families of color are disproportionately represented across child welfare systems. Racial disproportionality occurs at nearly every major decision-making point across the child welfare continuum from reports to screened-in cases, to out-of-home placements. Another trend that you will see is predominantly very young children, particularly those under the age of two, enter into the child welfare system.

To help prevent some of these traumas and to support families, The Center for the Study of Social Policy established a research-based approach to strengthening families and identified five interrelated protective factors that studies show are related to decreased likelihood of child abuse and neglect, as well as to the promotion of family strengths and optimal child development. Those factors include concrete supports in times of need. Families need stability in housing, food, transportation, and health care. Knowing that you are able to care for your children, significantly reduces anxiety.

Another protective factor is knowledge of parenting and child development—really understanding the unique aspects of child development, implementing development, and contextually appropriate best parenting practices. Successful parenting really fosters psychological adjustments, and it helps children succeed and thrive.

Next, parental resilience—managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity. Stress can make it harder to parent effectively. Helping parents develop resilience helps children thrive.

Next is the social and emotional competence of children. Children with strong social skills get along better with others. Parents are a child's first and most important teacher.

Finally, social connections—having healthy, sustained relationships with people, institutions, and the community are a force greater than oneself. Parents who have a social network of emotionally supportive friends are better able to care for themselves and for their children.

Knowing the protective factors allows us to work along a prevention continuum. We know that our bodies and brains can repair trauma and heal from adversity through positive interventions. When we look at a prevention continuum, particularly in the child welfare space, we are talking about primary, secondary, and tertiary prevention—you may be familiar with these from public health.

In primary prevention, we are talking about education and policies that are for an entire population to prevent trauma and maltreatment.

Secondary, our system support—those identified with risk factors to entering into our systems. Some of these interventions include public health or diversion programs and some child welfare, voluntary interventions. This is to mitigate risk factors and promote family protective factors.

Next is tertiary prevention. This is deeper-end prevention—working with children and families who have already experienced harm to mitigate the impact of that harm and prevent future harm.

I would like to pass it along to my colleague, Ms. Yordy, to share some data and policy trends.

Ms. Yordy:

We will start with a look at how the Nevada data from 2020 compares to national averages. This data is from the *Child Maltreatment 2020* report that was released earlier this year by the Children's Bureau, Administration for Children and Families, United States Department of Health and Human Services. While some states have already reported 2021 data, 2020 is the most recent year that we have access to data across a majority of states.

In 2020, Nevada's rate of children in foster care was 6.3 per 1,000 children in the population. This is higher than the national average. Nevada also has a lower rate of investigations, at 40.1 per 1,000 children in the population. Of those investigations, a smaller percent are substantiated than the national average. Of these investigations that were substantiated in Nevada, 83 percent involved neglect and 21 percent involved physical abuse. Both of these are higher than the national average. Finally, 7 percent of substantiated cases involved sexual abuse, which is lower than the national average.

When child abuse or neglect has an investigation that is substantiated and there is determined to be an immediate threat of harm to the child, foster care is one of the most

well-known types of intervention when a child is taken into state custody. Foster care refers broadly to when a child is taken into state custody and placed with a foster parent or family.

The type of placement can vary depending on the needs of the child. There are multiple different types of foster care that are licensed by the state. Traditional foster care involves the child being placed in a home, usually with somebody they do not know. Kinship care is when the child is placed with a relative, often someone who already knows and loves the child. Therapeutic foster care is a specialized type of placement, where the foster parents have additional training to support children who require a higher level of services or supervision. Finally, respite care and emergency placements are shorter term placements designed to provide short-term care for children in state custody.

There has been an important shift in many foster care systems to promote reunification of families so children can be safely reunited with their biological parents, rather than remaining in state custody for extended periods of time. In both Nevada and the United States more broadly, the majority of children entering foster care are under the age of five years old and, as my colleague mentioned, most of these are under the age of two.

You can see that both across the nation and in Nevada, the majority of removals involved neglect. In Nevada, neglect was listed as a reason for removal in 89 percent of those cases in 2020. This makes it important for policymakers and practitioners to understand neglect and its role in the removal of children from their families. In Nevada, during 2020, parental incarceration and parental substance abuse are reasons for removal in more than 10 percent of cases. For parental incarceration, this is higher than the national average and for parental substance abuse, this is lower than the national average.

I will briefly cover three major pieces of federal legislation that impact state policy surrounding child welfare and child maltreatment prevention. The first is the Child Abuse Prevention and Treatment Act (S.1191 of the 93rd Congress). This was enacted in 1974 and provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities. It also provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations for demonstration programs and projects. There is currently a reauthorization under consideration by Congress.

Next is the Indian Child Welfare Act (S.1214 of the 95th Congress). This was enacted in 1978 to protect the best interests of native children and promote the stability and security of tribes and families by establishing minimum standards for the removal of native children and placement of native children in homes, which could reflect the unique values of native cultures. This Act provides guidance to states regarding the handling of child abuse, neglect, and adoption cases involving native children. Given that Nevada has 20 federally recognized tribes and the native population of just over 32,000, this is a piece of federal legislation to be aware of.

The final piece of legislation is the Family First Prevention Services Act of 2017 (FFPSA) (H.R.253 of the 115th Congress). I am not going to go into much detail on this one because I know you have a wonderful presentation coming up after ours specifically on Family First.

Finally, I will go over a few trends that we have seen at NCSL regarding state policy across the nation. The first is that many states are revisiting how neglect is defined. In part, this is in response to our understanding that most removals occur due to neglect. The national definition of *neglect* is quite broad, and states and territories generally have their own definition of what constitute neglect. Recently, a number of states have been revisiting

things like separating poverty from neglect as a reason for removal or adding things like parental substance abuse that impairs the parent's ability to care for their child.

The next trend I will mention is attention to oversight and administration. These often relate to the emergence of new information or understandings about adverse impacts that children in care experience and attempts to remedy those situations.

The final trend we want to bring to your attention is the emphasis on preventing children from entering foster care in the first place. Research has shown that even when it is necessary for safety, separating a child from their parents is a traumatic experience. This is part of why we have seen a major shift in recent years towards the idea of preventing children from entering foster care. We also know that prevention efforts have substantial cost savings to states in many cases, in the long run, when compared to reactive interventions such as foster care after an abuse or neglect has occurred. Next, my colleague, Cameron Rifkin, will talk about youth and young adult homelessness.

Cameron Rifkin, Policy Specialist, Children and Families Program, NSCL:

Nationally there are over 34,000 youth ages 18 to 24 experiencing homelessness each night. This disproportionately affects people of color and LGBTQ youth.

Nevada has one of the highest rates of unaccompanied youth homelessness, depending on the year it ranges, but recent data has shown that Nevada ranks fourth for unaccompanied youth experiencing homelessness and first for unsheltered, unaccompanied youth. Current data shows that 570 unaccompanied youth are on the streets in Nevada each night. In southern Nevada, specifically, youth make up 22 percent of the total population experiencing homelessness. The national average is 6.54 percent. It is important to note that accurately measuring homelessness can be difficult and that these numbers are usually considered an undercount.

Potential strategies that policymakers have explored and enacted in recent time include drop-in centers. These have shown to have better outcomes for youth experiencing homelessness, including higher educational attainment, stabilized housing, and improved health. Drop-in centers usually involve areas where youth can come to charge electronics, get a hot meal, perhaps use the restroom, shower. Some drop-in centers operate nighttime shelters; others are just day facilities where folks can come and connect.

Another is consent and access to records and health care, specifically, access to their vital records and medical care without parental consent. This is to reduce administrative barriers and limit the red tape that youth experience while they are homeless. Nevada recently passed a piece of legislation related to this health care access for unaccompanied homeless minors without parental consent.

An additional strategy is expanding services for transition age youth and youth in foster care. The Family Unification Program of the U.S. Department of Housing and Urban Development offers Housing Choice Vouchers for 18- to 24-year-olds who have exited the foster care system. The voucher cannot exceed 36 months. Additionally, these vouchers are extended to parents or caregivers who are at immediate risk of losing custody of their children due to housing stability. If their housing situation is the primary cause for the removal of children, they are also eligible to receive these particular vouchers.

We will talk a little bit about the intersection of education and youth homelessness. The Stewart B. McKinney Homeless Assistance Act (H.R.558 of the 100th Congress)—also known as the McKinney-Vento Act of 1987—is the primary federal legislation related to students

experiencing homelessness and their rights. It outlines requirements that states and school districts must abide by for their students experiencing homelessness. These funds are distributed by the U.S. Department of Education to states who then allocate them through subgrants to school districts.

We have seen a few pieces of legislation recently in Nevada dedicated to expanding services for students experiencing homelessness. There was one bill in 2021 and two bills in 2019. Senate Bill 354 (2021) requires the consideration of the effects of homelessness in suspending or expelling a student from school. A student's housing status must be taken into consideration before they are removed from school.

In 2019, SB 147 was a piece of legislation that requires schools to assist students experiencing homelessness and students in foster care with earning full or partial credit for their coursework. Again, this is focused on improving educational services for youth experiencing homelessness, which can be a significant protective factor for mitigating youth homelessness.

The final piece of legislation in 2019 was AB 461, which was dedicated to postsecondary school. Those first two bills were focused more on K through 12 education; this final piece is dedicated to creating the position of the liaison for postsecondary education for homeless pupils. So that is a little bit more focused on postsecondary achievement. With that, I will be passing it back to my colleague, Ms. Wilson.

Ms. Wilson:

Today you are going to hear a lot of hard data points and statistics. I want you to remember the hopeful and preventative efforts and the tools, policies, practices, and programs we have to support children and families before they experience harm and mitigate the impact of that harm. Dr. Urie Bronfenbrenner of Cornell University said, "Children don't grow up in programs…They grow up in families and communities." As you listen to presentations today, and hear some hard facts and data, just remember that children do better when their parents do better, and we can move upstream to prevent child maltreatment.

Our contact information is at the end of the presentation if you have any follow-up questions that we do not have time for today. These are some of the resources we used during our presentation—you should have access to them—as well as other helpful pieces of information. I will turn it back to the Chair, and we are happy to answer any questions you might have.

Chair Peters:

I appreciate that all our meetings have started with a baseline. I think it is important for us to understand and be on the same page about the efforts that are occurring in our state compared to the baseline data. We have time for questions, but I want to mention the upcoming presentations will talk about the Nevada-specific programs and agencies that are dealing with these issues. They may be more likely to answer your questions in an effective way for policy building if you are interested in this area.

I will take a couple of questions, but we will move on to the next agenda item shortly. Dr. Titus has a question. If other members have questions, please raise your hand or turn your microphone on when it is time.

Assemblywoman Titus:

Can you provide clarification on the 22 percent homelessness rate?

Mr. Rifkin:

In southern Nevada, specifically, of all the people experiencing homelessness, 22 percent of those people experiencing homelessness are youth, ages 18 to 24. The national average is 6.54 percent. I am happy to provide further clarification.

Assemblywoman Titus:

Could you send us data or charts on trends? I would like to have more information on those kinds of statistics because it is only relevant at one point. I am curious about where the homelessness is scattered throughout Nevada and looking for a broader span of reference. Have we always been number one on our unaccompanied, not sheltered youth? Maybe the presenters from the state will be able to give us a better data on the trends in Nevada.

Mr. Rifkin:

Yes, I would agree to defer to some state experts later in this meeting to provide more insight. The studies we located were by the University of Nevada, Las Vegas (UNLV), the U.S. Interagency Council on Homelessness, and the Nevada Homeless Alliance who may have that specific data point you are referring to, and those are hyperlinked in the presentation. From our initial research, understand there is a heavier concentration in southern Nevada compared to the rest of the state and compared to national averages.

Chair Peters:

I believe we will get some of those answers today. There are other resources out there, such as the Nevada Homeless Alliance. I believe staff would be more than happy to help connect you with those statistics and information if you would like a follow-up.

Are there any other questions from the Committee before we move on to the next presentation? Dr. Orentlicher, please go ahead.

Assemblyman Orentlicher:

On the foster care reasons for removal, the data indicates the reasons for removal were well below the national average on parental substance abuse, which seems inconsistent. We generally have higher rates of substance abuse. Also, the neglect rate is much higher. I would have thought that might reflect parental substance abuse, in large part, but apparently it does not. What might drive our higher level of neglect?

Ms. Yordy:

I know from a national perspective sometimes parental incarceration can be included in that definition of neglect. It would come down to how those cases are classified by agency personnel. For Nevada specifically, I would defer to agency personnel who would be better able to answer that question of how those cases are classified.

Chair Peters:

We will have a presentation in a little while from Child Protective Services, let us hold that question and we can ask them about those statistics. Are there any other questions from the Committee before we move on? I am not seeing any.

Thank you to our presenters from NCSL; we really appreciate you being here and providing us with this baseline to start us off on our presentations today.

AGENDA ITEM VI—PRESENTATION ON THE FAMILY FIRST PREVENTION SERVICES ACT OF 2017 (H.R.253 OF THE 115TH CONGRESS), WHICH RELATES TO FAMILY SERVICES AND FOSTER CARE, AND ITS IMPLEMENTATION STATUS IN NEVADA

Chair Peters:

We are going to move on to Agenda Item VI, our presentation on the FFPSA, which relates to family services and foster care, and its implementation status in Nevada. We have our presenters in southern Nevada; please introduce yourself and proceed when you are ready.

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):

Throughout the day, you are going to have, hopefully, great presentations that build upon another. I will be here all day to add support and answer any questions as necessary with my team and my stakeholders and colleagues who will be presenting today as well. I would like to introduce Dr. Dominique Rice; she is going to educate us on the FFPSA.

Domonique Rice, Ph.D., Deputy Administrator of Quality and Oversight, DCFS, DHHS:

Thank you, Chair, for giving me this time to talk about the FFPSA. Today we will be discussing: (1) an overview of the FFPSA; (2) the FFPSA benefits to Nevada families; (3) the funding specific to the FFPSA; (4) any requirements we must abide by for the FFPSA; and (5) FFPSA implementation status in Nevada (Agenda Item VI).

The FFPSA was passed and enacted by Congress in 2018 with focus on the goal to enhance support services for families, to assist children in staying in their home, reducing the use of congregate care, and to build the community's ability to provide support to children and families.

The bipartisan budget bill highlighted specific requirements placed on out-of-home placements, prevention services, and care of older youth. With out-of-home placements, Title IV-E federal funding payments were no longer allowed to be used beyond two weeks for residential childcare facilities, with the exception of specialized care settings and populations. The family foster homes will now need to meet new federal standards in order to be recognized as family foster homes.

With prevention services, Title IV-E federal funding now allows states to fund services for in-home parent skill-based programs, mental health, and substance abuse prevention and treatment. These services would be put into place to prevent the placement of children and youth into foster care systems. Chafee funding can now be used for services for youth who have aged out of care within the system, up to the age of 23. There are also education and training vouchers that can be used up to the age of 26 for youth.

Some other requirements for the FFPSA include providing documentation of youth who previously were in foster care; ensuring prevention service activities do not increase the juvenile justice population; and enacting background check requirements as well.

With the various changes to the FFPSA, there are still some areas that have not changed. Title IV-E continues to remain a federal entitlement program, specific to children involved in foster care and who meet the financial eligibility criteria. Title IV-E still allows for administrative and training dollars to assist with costs, and states are still required to spend

their own funding to provide support to child welfare, including prevention services expenditures.

There are still some exceptions to FFPSA such as, it does not represent new money. Instead, it allows the ability to utilize FFPSA federal funds to be more accessible to children, youth, and families. Our state will still have to submit plans to the Children's Bureau and track entitlements and expenditures. Finally, Title IV-E is a last resort payer; Medicaid funding should be utilized prior to the use of Title IV-E funding.

In order to access federal prevention service dollars, states must: (1) have an approved five-year prevention plan; (2) adhere to the residential childcare and qualified residential treatment program (QRTP) standards; (3) ensure at least 50 percent of services provided to the population meet the definition of well-supported services and services provided are trauma-informed; and (4) evaluate services chosen by the states if their designation is promising, supported, or well-supported practices, unless the states receive a federal waiver of requirements.

The prevention services must be available for up to 12 months at a time to children and youth who are candidates for foster care and pregnant and/or parenting youth in foster care. Children and youth who receive prevention services must have a prevention plan in place that identifies the specific prevention strategy for the child to remain at home or with a kin caregiver. A list of services, planned to be provided, also needs to be documented to ensure the success of prevention strategy.

The FFPSA has made some changes related to out-of-home placements as previously shared. There are new federal standards related to family foster care homes that include eligibility standards to become a foster parent, identification of capacity within the home, the sleeping arrangements, any emergency preparedness plans, and plans for transportation to name a few. States will not be allowed to use Title IV-E reimbursement for youth and children placed in childcare institutions beyond two weeks, unless childcare institutions are providing one or more of the following: (1) a program for pregnant or parenting youth; (2) an independent living program for youth age 18 and older; (3) specialized programming for youth who have experienced or are at high risk of human trafficking; (4) a residential substance treatment programming; or (5) a QRTP.

Some of the benefits to Nevada include: (1) allowing more flexibility to claim additional federal funds for prevention services, administrative costs, as well as training costs; (2) providing a framework to expand services; and (3) focusing on providing services in a family-based setting when an out-of-home placement is needed.

Title IV-E is entitlement funding. Nevada has to submit the necessary forms and plans to obtain approval, then we can submit for reimbursement for up to 50 percent for all eligible children and services. In Fiscal Year (FY) 2018–2019, Nevada reported a functional reimbursement rate of 25 percent based on the number of children and families in eligible services. The requirements vary by components of the FFPSA, but most require additional plans to be submitted and approved by the Children's Bureau and additional reporting of data is also needed.

Our current timelines for implementation are staggered with deadlines beginning in 2018 and continuing through 2027. Some activities are optional, and others are mandatory that we have to meet.

At this present moment, DCFS has worked towards the following FFPSA requirements:

- We have submitted an automated letter to the Children's Bureau for final review, as proof of foster care for youth, and we are working with the agencies to ensure the letter is provided to all youth in foster care;

- We have submitted a waiver for nonsafety licensing standards to model our licensing standards for foster family homes to the Children's Bureau for final review. The remaining requirement of this standard is aligned with the Children's Bureau's expectations;

- We are currently in the process of completing certification that provides Nevada will prevent increases to juvenile justice populations once we are able to finalize our Title IV-E plan and Title IV-E prevention services plan;

- The Division and jurisdictions are tracking each other's placements of children. We are ensuring ineligible placements are not claiming reimbursement for Title IV-E, which will keep us in compliance with the limitation specific to the placements that are not family homes. It has been submitted to the Children's Bureau for final review;

- We are currently in the process of working with each of the jurisdictions for designating programs. The Division and jurisdictions are currently working on a qualified individual review process. We have submitted a waiver to the Children's Bureau to provide flexibility and the designation of a qualified individual to meet the QRTP requirements;

- We initially submitted our Title IV-E prevention services plan, which is an optional component of Title IV-E, in August 2021. We have received feedback from the Children's Bureau regarding our plan and are currently making modifications, with a goal of resubmitting our plan during the summer of 2022; and

- We have submitted our electronic system that meets the requirements of the electronic interstate case processing system to the Children's Bureau for final review.

The FFPSA focuses on the following candidates for foster care:

- Children and youth at imminent risk of entering foster care who can remain safely at home—or in kinship—with services, who are in present or impending danger, and/or has one or more of the identified negative family conditions, but not necessarily meeting present or impending danger criteria that suggests an increased likelihood of entering foster care and/or has a reunification, adoption, or guardianship arrangement that is at risk of a disruption or dissolution that will result in foster care placement; and/or

- Is under 26 years old; is pregnant and/or parenting; has a history of being in foster care; and is not currently in foster care with the need that could result in foster care placement

The FFPSA interventions focus on in-home parent skill-based programs and services, mental health programs, and substance abuse programs and services.

The FFPSA model plans for child and family outcomes to increase caregiver well-being and protective capacity, increase family stability, increase child well-being, reduce mental health disorder symptoms, and increase family engagement. The model also looks to improve

process outcomes specific to ensuring interventions achieve their desired outcomes and provide increased access to specific interventions based on the population. The overall long-term outcomes the FFPSA model looks to reduce is the rate of foster care entry, the rate of foster care reentry, and the total number of youths in foster care.

The important drivers to implementation include that we focus on training and workforce supports; public and private partnerships that we presently hold and continue to build; data collection and analysis; continuous quality improvement involving our evaluation team; involving and engaging our stakeholders, both internal and external; developing a clear communication plan; interagency collaboration; and leadership support.

Our current activities as they relate to our prevention services plan include reviewing and revising the process for care planning and safety reviews for children, youth, and families that are not being served in the child welfare agencies. We are finalizing the list of evidence-based practices that we will include in our Title IV-E prevention services plan. We are presently working with providers to develop installation, implementation, and sustainability plans for evidence-based practices. Finally, we are collaborating with Nevada partnerships to develop training for public and private workforce, families, and other stakeholders on key components of the FFPSA.

Our next steps. Presently we are planning to resubmit are Title IV-E plan and Title IV-E prevention plan to the Children's Bureau for final review and potential approval. We are currently reviewing our cost allocation plans and we will be updating these to align for resubmission to the Children's Bureau in conjunction with our other two plans. The fiscal and information technology leads from each of the jurisdictions, including DCFS, will continue to meet on a regular basis to ensure the infrastructure is ready to implement all components of the FFPSA. Our priority continues to be the safety, well-being, and permanency of all Nevada children, youth, young adults, and families.

This concludes my presentation; I am happy to answer any questions.

Chair Peters:

Thank you for that overview, Dr. Rice, of the interesting work going on. I do not see any questions from the members, but I have a couple of questions. You gave a brief overview of the implementation, but can you speak on the status of implementation and the metrics of value you are using to ensure these implementations are bringing value to the state? Then, can you also talk about some of the barriers that you have experienced in designing these implementation plans and what those look like right now?

Dr. Rice:

As of now, our current implementation involves more of the policy development implementation on a state level and working with our jurisdictions to ensure they are also developing policy specific to their jurisdictions. We are working closely with the Children's Bureau to ensure that our policies are aligned with federal requirements.

The barriers are understanding the direction of the federal government and the larger picture. The FFPSA is a large change in certain areas and being able to identify various areas that we have to implement, such as the QRTPs—getting those up and running takes time. We are working with our jurisdictions to get those implemented and behind the scenes to create the infrastructure before we can implement and have it be beneficial to our families. Obtaining approval through the Children's Bureau is another barrier. We are

working with the court improvement program to get administrative court rules in place to be sure we are aligned with the QRTPs.

Dr. Pitlock:

This FFPSA is a tough concept to wrap our minds around. The bottom line is it is prevention services for families to keep them out of foster care or advancing in our system. This is a huge lift for the State of Nevada and staffing wise for the Division. The light at the end of the tunnel is, we will have an awesome program of prevention across the State of Nevada that will align with federal requirements and give the state a robust funding mechanism for these prevention-type programs.

Chair Peters:

How are you feeling about your staffing ability to meet these metrics and goals? I have been thinking a lot about how we ensure our state agencies are staffed sufficiently to meet the goals of our growing population and state needs. Can you give us an idea of what you are looking at staff wise, and if you are looking at that funding going to additional staffing needs as this implementation plan goes forward?

Dr. Pitlock:

Yes, we are all in the same boat; staffing struggles are immense. Right now, my Division's vacancy rate is about 36 percent. If you look at that in context, potentially one-third of the Division's work may not be getting done, unless it is getting done outside of hours as overtime and stretching our staff beyond the limits they can handle. We have to be transparent about our challenges.

Fortunately, I have a committed staff who is doing everything in their power to step up to implement the FFPSA. We are considering leaning more on our technical assistance contract and bringing in some extra help as we can. Director Richard Whitley, DHHS, is absolutely invested in the FFPSA and its success and has agreed to partner with me to make sure that we succeed. The challenges are immense. Staff is exhausted at best, but we will march forward. This is a great program for the State of Nevada and the youth of the State of Nevada. Ultimately, we want to prevent advancing into a higher level of services and this is part of that build.

We are also in the middle of budget build, and we know the sustainability of FFPSA needs to be wrapped into that. We are working closely, with the Director's office and all our stakeholders to collaboratively figure out how we are going to stand this up in the most robust way but also keep it sustainable.

Chair Peters:

I feel for you. For those regulatory agencies that have quality control metrics, it is difficult to ensure you have enough staff to meet those needs, which are the most immediate, ensuring that our children are in a safe place and getting the resources they need at that place, let alone trying to develop a brand new implementation program. I hope, as we move forward, if there are policy needs you need from us, submit recommendations for our Committee to consider. We are looking to support you in this effort; keeping kids and families whole is a huge part of this Committee's goal.

Are there any other questions from the Committee on this presentation? I am not seeing any. Thank you for what you are doing and this presentation.

AGENDA ITEM VII—OVERVIEW OF NEVADA'S CHILD WELFARE SYSTEM AND CHILD PROTECTIVE SERVICES

Chair Peters:

We are going to move Agenda Item VII, which is an overview of Nevada's child welfare system and child protective services. Thank you for being here; please introduce yourself and begin when you are ready.

Laurie Jackson, Rural Regional Manager, DCFS, DHHS:

I am one of the two rural managers for rural child welfare that cover the 15 rural counties. I am going to provide you with a brief overview of Nevada's child welfare system and will touch on the funding, child protective services, foster care, and independent living for youth (Agenda Item VII).

Nevada's child welfare system is determined by population concentration. The largest concentrations, which are Clark County and Washoe County, provide their own child welfare services. These services are provided through a block grant that is appropriated by the Legislature and they are also provided an incentive grant to help provide those child welfare services in their urban counties. Rural child welfare is funded through federal grants and the State General Fund. This allocation and these incentive grants help the urban counties to provide child welfare services within their county. Child welfare normally is known as child protective services (CPS), although there is much more to do with child welfare than just CPS.

Families and children come into contact with child welfare starting with a referral or call from a concerned neighbor or mandated reporter that has a concern about a child. This particular journey can take them through with us providing services and leaving their homes, or it can necessitate us having a stronger intervention, if no safety services can keep the child in the home.

It starts with child protective services if we have to take protective custody. Protective custody is a legal proceeding that is overseen by Chapter 432B of NRS. It defines what we are and what is necessary for us to do for families and children to get them reunified within their homes, which is always our primary mandate. It also has specific timelines for the child welfare court process. We provide a handout to our families that is easy to read and understand about a somewhat complicated process when it comes to court.

Child protective services is the first step to the safety and well-being of a child. An intake or an intake referral is a call from a concerned neighbor or mandated reporter that comes into a child welfare agency that talks about having a concern. These calls are entered into our unity system, which is our federally mandated child welfare database.

These calls can be handled in one of three ways. Information only means it does not meet a statutory requirement for investigation or assessment. This may be something as simple as a neighbor calling and saying they hear their neighbor's child crying. Differential response is determined to address a lack of resources situation, where maybe the loss of a job has impaired a family's ability to pay their heating bill in winter, so their house is cold. These are referred to community partners to address those needs of that family. Lastly, a report that comes in may meet the statutory requirement for assessment, also known as investigation, although we prefer assessment. When it is assigned for an assessment, referrals are then sent to a child protective services worker.

Of particular interest is 2020. We know the pandemic had far-reaching effects on many states and many agencies. For CPS intake referrals, both here and nationally, calls dropped almost 10 percent over that time period. This was when children were out of school, were not seen by medical providers, were not enrolled or participating in community events, and families were in their bubble, so even relatives and family members did not see them. The calls we did receive though, were much more severe in nature.

In the other presentation, there was a question about neglectful treatment or physical injury. These are defined in statute for which a parent can be substantiated. To briefly answer the question that was asked around substance abuse, there are many factors that go into assessing the substance abuse before a child is removed from the home. Some of which are the severity of the substance being abused, the age of the child, or protective factors such as family, sober adults, or people who can be placed in the home or work with the family to stop the removal of that child. Removal is always the last thing we want to do to a child because of the trauma.

If we do have to remove a child and there are no safety factors or a way to safety plan with the family, then the child will go into foster care. *Foster care* is defined as a "temporary short-term placement to address the safety effects or the safety factors that are requiring that child not to be in their home." It was never intended to be a long-term solution to family issues. There is a hierarchy we prefer to use that is in the best interest of the child. We prefer to keep them with a relative or fictive kin, someone they are familiar with or someone that lessens the trauma for them. After that is the family foster home or specialized foster care if needed, depending on the child's needs, their mental health, or their behavioral needs. Then we have group homes, residential treatment centers, and shelter care. On the DCFS website, there is a weekly updated census of children within the rural counties who are removed. About a week ago, we were at 393.

Another effect of the pandemic was the decrease of licensed foster care providers or homes across the state during 2019 and 2020, which caused possible placements and bed availability to decrease. This affected both of the urban areas also.

During the 2019 Legislative Session, AB 298 was passed, which is the foster home recruitment and retention plan. This plan requires DCFS to post our retention plan on our website. Our potential homes, or the homes that we would like to have in each of our rural areas, are divided by our district offices. District 1 contains Elko, White Pine, Lander, and Eureka counties. These were determined by looking at the removal of children who required specialized homes—like multiple sibling groups—and are based on the number of homes we currently have. District 2 is Carson City, Douglas, Lyon, and Storey Counties. They are three of our more populous counties, with Lyon being the county that is increasing and is the now third largest county in the state. We did not meet our goal of calculated homes, but we are building our budgetary request to address these deficiencies.

For youth that come into care or that have contact with child welfare, we have an Independent Living Program. Youth are referred to that program from ages 14 to 21, regardless of when they have come into care. Our Independent Living Program is funded three different ways: two federal grants—one is the Chafee Independent Living Grant, and the other is the Educational and Training Voucher Grant; the additional grant is the Funds to Assist Former Foster Youth, which helps fund those programs for youth to attain skills for self-sufficiency.

Some of the supportive services that our community providers provide for our youth is passing the high school General Educational Development (GED) test or obtaining diplomas, or it can be as mundane as figuring out how to do laundry and how not to turn things pink.

These children form lifelong connections to these workers. They will reach out long past the age of 21 for information, for support, and even to share life events.

Senate Bill 397 was passed during the 2021 Legislative Session requiring us to look at extended foster care. The program is currently in a statewide work group with all the jurisdictions to develop a comprehensive program based on the federal requirements.

The Division's many successes and accomplishments and even our challenges—that I will speak about in just a moment—revolve around removing children in foster care. Two years ago, Washoe County implemented the Safe Babies Court Team. It is an amazing program in multiple states to address safety factors that require children, especially young children, to be removed from their home of origin. We know that removal—at any age—causes trauma, but for younger children it can cause developmental issues also. This particular program is also being piloted in Carson County and I believe it is going to be piloted in Clark County, with an idea that we would love to expand it to all of our rural counties.

Binti Software and our foster care website are two things we developed during the pandemic. Binti Software is specific to foster care licensing. My best allegation would be that this is revolutionizing how we do foster care licensing like how banking software revolutionized banking. I have four licensing workers for 15 counties and this software limits the amount of drive time for those workers, and it has decreased our postage costs because they can take pictures of documents and upload it to the software. It is an app they can download, and it is very easy to use, since many of our potential foster homes are somewhat older and not as tech savvy.

We also have a dedicated Foster Care Website. It shows my four licensing workers, recruiter, and supervisor as a team. It provides information and frequently asked questions. Also, potential homes and current homes can obtain and download forms from the website without having to contact a licensing worker.

As I said, a referral for child welfare is the first contact that comes in from a call. We have a dedicated intake unit because the most important decision that gets made is whether something is assigned. The information they provide to us helps us make better decisions on what is assigned and what is diverted to a differential response.

The Division is contracting to have an actuarial foster care rate completed to update our rates; they were last updated in 2006.

There were some high points even after the pandemic. We did 56 adoptions in 2021 and we are currently at 31 adoptions in 2022. Those are children who are now in their permanent living situation and out of the child welfare situation.

The Higher Level of Care Unit was developed to monitor children and youth who were coming in and out of residential foster treatment centers. It provides them with the supports they need when they are coming back and being placed in specialized foster homes or regular foster homes.

Our clinical services are amazing. They provide therapeutic and consultative services to our four district offices and our satellite offices. They staff every child within those offices, the courts when they have a clinical question, as well as providers within the rural counties who may not be as proficient at understanding trauma and child welfare.

We are not without our challenges. Again, the loss of foster homes for all of us throughout the state has been somewhat devastating. For the rural child welfare, we are limited in the amount of foster care trainings we can provide. They are required to go through the

licensing process, and since it can only be provided by my supervisor, myself, or my manager, we are limited in the number of trainings that we can provide.

We have seen an increase in the requests for the Interstate Compact on the Placement of Children, also known as an ICPC. This is a process where children in other states' custody can be placed in Nevada with a relative or an adoptive family. We make sure that home is safe, we do a home study, and then we monitor that placement for the other state, as they do for us.

Our LCB partners have completed an audit and found we utilize relatives whenever possible, but there is not the same amount of structure that we have for licensed foster homes. We are implementing some more structure around that. We are providing training to our relative foster homes or fictive kin foster homes through the Kinship Navigator Program. It has a training specifically for relatives because it is a dual role where you are providing safety for a child, but you are also dealing with your family member, and we are trying to reunify the child with that family member.

There are limited transitional placements for independent living youth or extended foster care youth. One of the struggles is while we do have housing and urban development (HUD) vouchers, right now housing throughout the state is incredibly difficult to locate and very expensive. It is very difficult, even with a voucher, to find a place that you can rent. Our vouchers at the most pay a portion of the rent for that individual or youth.

Lastly, there is a lack of services and service providers in rural areas. There is a lack of acute residential and community-based mental health providers in some of our more rural areas.

Our strategies include the following:

- Increasing our use of effective technology—work smarter, not harder;
- Contracting for the actuarial study because we believe that will help us obtain more foster homes since our base rates are low but also our ancillary rates—things like clothing allowances;
- Utilizing the Kinship Navigator Program to provide relative and fictive kin training;
- Using contractors to meet the needs of our foster care population when we need to;
- Revising our procedures to provide better oversight and support to our relative and fictive kin homes;
- Working with the Aging and Disability Services Division, DHHS, on dual licensing for intellectual and developmentally disabled and autistic youth to increase placements; and
- Collaborating with Carson Tahoe Health for expansion of its Mallory Behavioral Health Crisis Center to take acute minors. As we have seen, it is problematic with the closure of one of the psychiatric hospitals in Reno. There are no other facilities available within the rural counties, such as Elko or Lander Counties. Everyone must come either to Carson or Reno.

Ryan Gustafson, Division Director, Child Protective Services, Human Services Agency of Washoe County:

I will be brief and focus on the successes and accomplishments for the Human Services Agency of Washoe County, child welfare, as well as some areas we continue to have challenges in and continue to work towards (Agenda Item VII).

In FY 2020–2021, we were able to reunify more than 250 children back to their families. We were also able to provide clinical assessment and services to nearly 850 children and family members. We have, as Ms. Jackson said, seen tremendous success in our Safe Babies Program, which we have had operational for about two years in Washoe County, with well over 90 percent permanency rate for children within 12 months of entering the Safe Babies Program. We were able to finalize 87 adoptions in FY 2020–2021 in Washoe County. With the Coronavirus Disease of 2019 (COVID-19), we took advantage of the opportunity to pivot and create a virtual training platform for incoming foster parents; successfully piloted two community-based emergency homes; and launched several campaigns, including a fostering campaign, suicide prevention campaign, safe sleep campaign, and human trafficking campaign.

We have some opportunities to improve. We have seen a decrease in mental health services in the last year in Washoe County—I think that is statewide. In Washoe County, we have been hit particularly hard, most notably with the closure of one of our two acute psychiatric hospital facilities. Assembly Bill 387 (2019), which is called Collaborative Pathways, came about last session with the goal of keeping children from coming into child welfare care, unnecessarily, to get services. It is taking us some time to get off the ground and to implement. Reimbursement rates for mental health and behavioral health services have continued to be low, which resulted in a decrease in service options for children and child welfare; this includes foster care rates as well. We had some court activity that was backlogged and slowed down multiple processes, mostly in part due to COVID-19. Fortunately, that is starting to resolve itself as we continue to move through and past COVID-19. Finally, in Washoe County we have some significant transportation issues that continue to grow, particularly within the school district, creating difficulties keeping children in their schools when they come into care—we all know it is important to keep kids in their home schools. Transportation around the County has been exceptionally difficult over the last year in particular.

I will send it over to Clark County, I think we have some representation down there to take on the next section.

Timothy Burch, Administrator of Human Services, Clark County Department of Family Services:

Our format will echo that of Mr. Gustafson in Washoe County (Agenda Item VII). We want to keep this succinct for you and give you an opportunity to ask us questions, but we also want to highlight the enormous efforts of our staff and the things they have accomplished in dealing with these difficult situations.

Our Southern Nevada Children's Advocacy Center (SNCAC), which received a National Association of Counties (NACo) award in 2019, has continued its efforts by serving 1,848 children. These are young people who have been experiencing sexual assault and have come through our system to receive forensic interviews in conjunction with law enforcement. The SNCAC's foundation raised money to continue making sure those young people get mental health care services at the center, free of charge to those families.

Earlier, you heard a lot about homelessness and its impacts specifically in southern Nevada. We have been able to work with our partners on the adult side of the service continuum and social service to house 72 families in emergency hotel/motel situations, which has kept over 193 children, since December, out of the child welfare system. Those children would have otherwise come into our emergency shelter at Child Haven and then brought into the child welfare system. Additionally, we used those beds to reunify 12 children and families back together. We have had to use those because the family unification program—those vouchers you heard about earlier—has done a good job with our local housing authority maintaining 100 percent lease up on those. We need more vouchers, and we need more housing opportunities for our families.

Prior to the pandemic, we worked with the Legal Aid Center of Southern Nevada and other community partners to implement a sibling bill of rights to make sure siblings are placed together whenever possible. We can report that less than 3 percent of our sibling groups right now are placed separately due to the lack of placement homes; those are primarily due to the treatment needs of those individual children.

Additionally, you have heard about the importance of placing with family. Forty-seven percent of Clark County's placements are with kinship providers, which far exceeds the national average. Our Kinship Guardianship Assistance Program (KinGAP) and guardianships make sure those relationships are supported financially. We doubled the amount of KinGAP guardianships in 2021 over 2020.

Commercially sexually exploited children (CSEC) are transitioning from a justice model to that of a victim model, and that is rolling over to child welfare. We assessed this last year; over 398 children were at risk of being trafficked, and 93 of those unaccompanied minors were returned safely home. We have begun to fund some local partners to stand up beds. They are in the process of recruiting training staff to open those beds for these young people.

You heard earlier about the FFPSA and prevention services. We recognize that children under the age of three are disproportionately the ones most likely to experience fatalities in our system. We started a program a few years ago called Thrive By Five, where we take low-level interactions with our call center and refer those out to community partners to try to offer services early in that engagement process. This last year had over 17 percent of those 800 families enroll in voluntary services that otherwise would not have been available to them, in an effort to try to keep them out of our systems.

On the far end of the spectrum, where children have come into and become wards of our system, over 550 adoptions were finalized in Clark County this last year, which exceeded our five-year average, despite the pandemic.

I want to recognize the efforts our staff have done around the aged-out foster youth. You heard that alarming number around unaccompanied homeless youth 18 to 24 years of age in our community. About a decade ago, the Department of Social Services took over the aged-out foster youth program. We just completed a ten-year look-back study with UNLV. It showed that through the support services we offered, less than 2 percent of that population has become homeless over that time frame, which is in stark contrast to the national average of about 25 percent.

Regarding opportunities for improvement and growth, years ago the system was debifurcated and pushed down an opportunity for Clark County and Washoe County to be able to provide both ends—investigation and permanency services—to adoption and the block grant was formulated at that time to make the counties whole. We have grown

dramatically since that time; I believe we have had one bump in about 2015 in that block grant. We anticipate this coming fiscal year to have to deal with the $29 million structural deficit to keep up with growth of our system and make sure that our families and children are safe.

We talked about the foster care rates earlier. I do not want to gloss over our child welfare responsibility for the CSEC. Right now, we have a $115 day rate for a higher level of care for specialized foster care agencies. When we talk to other communities who are working with the CSEC youth, they can require up to three times as many resources invested in them to have successful outcomes.

The transition from a justice community to a child welfare model has not yet been funded. It stands as an unfunded mandate for us, and we seek some conversation assistance with that.

Mental health has framed the last several years for us, not just because of the pandemic, but because of the lack of available resources in our community. One of the earlier questions asked why there are so many neglect cases in Nevada compared to the national average. When a child has been removed from an adult caregiver, who is not receiving mental health treatment and is unable to care for the child, that goes into our system as a neglect. So that is one of the contributing factors there.

During the last session, we were charged with beginning to track the number of children who were surrendered into our system through AB 387, the Collaborative Pathways Program. This year, we have already had over 80 young people where parents have brought them into our system and surrendered them because they were unable to provide for the child's mental health. It puts us on track right now for well over 120 for the entire year if this keeps pace. We desperately need more assistance, mental health treatment, and wraparound services for the children in our community so they do not wind up in deep end systems such as child welfare.

We do want to thank the Interim Finance Committee (IFC) for $1.9 million from the American Rescue Plan Act of 2021 (H.R.1319 of the 117th Congress) that helped us fund an Interim Care Facility for Intellectually Developmentally Delayed Children (ICF for IDD). The Board of County Commissioners just ratified the contract with the provider at Tuesday morning's meeting and we look to stand that program up in May. We are thankful for the support of the Division staff, as well in helping us move that project through. This facility will move children out of our emergency shelter who are lingering there because of their autism and other types of developmental delays that make them more difficult to place, especially when we are lacking the appropriate foster care homes in the community.

Medicaid rates were the main topic of conversation at the governor's health care conference earlier this week. We challenged providers to help step in and work with us to expand the systems of care for our families and children. Medicaid rates, obviously, were a major speaking point from them and that the reimbursement system needs to be reexamined.

Again, we want to make sure we highlight the efforts that all the teams have done around the FFPSA; it has been several years of planning and moving that ball down the field. One of the things we are concerned about is the front-end investment. A lot of our providers have built their service models around the system as is, and the ability to pivot and wait to get reimbursed is a business cost they are not yet able to undertake. We are worried about the service provider community not being able to keep pace with the change in our government service provider model.

Those are the big things for Clark County. I would like to now introduce one of our community advocates, Kimberly Abbott from the Legal Aid Center of Southern Nevada.

Kimberly Abbott, J.D., C.W.L.S., Team Chief, Children's Attorneys Project, Legal Aid Center of Southern Nevada:

I am a certified child welfare specialist. I would be remiss if I did not thank Dr. Pitlock for encouraging a collaborative approach to today's presentation. We appreciate the extension of the offer to come to the table and be part of today's presentation (Agenda Item VII).

The Legal Aid Center of Southern Nevada is a nonprofit organization providing free legal services to low-income Nevadans and we have been doing that since 1958. We serve Clark County residents in a wide variety of areas. However, one of our largest programs—which is the most relevant to today's discussion—is our Children's Attorneys Project. It is now more than 20 years old. We have 29 staff attorneys and a small army of several hundred pro bono volunteers. With that, we represent every child coming into foster care in Clark County. A legislative change in 2019 clarified that children are parties in these dependency actions and entitled to counsel. We provide direct client representation to the children; we are different from court-appointed special advocates (CASAs) or guardian ad litems (GALs) who represent the best interests of the children.

Our education advocacy program is an important component of the work we do. They help to ensure that children with disabilities in our system are getting appropriate education services. We are grateful that the IFC recently approved a funding increase that, we believe, will allow us to triple the number of children served through that program. We are excited about that opportunity as we move forward.

One of the things we are proud of is that we have four certified child welfare law specialists on staff. We only have a handful in Nevada, maybe seven or eight total, so we are excited to be able to provide that expertise to the clients that we serve.

One of our big accomplishments—in coordination with the Clark County Step Up program and thanks to contributions from AT&T—was to launch an innovative app for our older and aging out clients that provides access to community resources at the palm of their hand.

I want to highlight a couple of our future goals. We hope to continue collaborating with our stakeholders to make improvements to our system. Areas where we would like to see some improvements are having a more trauma-informed system, a more family-centric system, and as Mr. Burch talked about, a more robust and fully developed array of mental health services for our youth. I know this is a topic the Committee spent hours hearing about last month, but we cannot underscore the importance of fixing our gaps and further developing the system because the needs of our youth are not being met as we currently sit here. We were grateful to be part of the governor's summit earlier this week, but we certainly still have a lot of work to collaborate and do together.

Lastly, I would like to talk to you about the human face of the foster care system. My colleagues have done an excellent job talking to you about policies, statistics, and programs, but I would like to give you a little perspective of child welfare from the children who are the users of our system.

If you will indulge me, if you can imagine—just for a moment—that you are a newborn coming into this incredible world, taking your first few breaths of life, and with those breaths, you are met with pain and discomfort because you are in withdrawal because your mom used heroin during her pregnancy. You spend your first few days on morphine in the

pediatric intensive care unit (PICU) and hopefully, we can find a foster family to come start visiting you and forming a bond with you.

Now imagine you are a three-year-old. You are found cold, dirty, hungry, and barefoot wandering around an apartment complex on Boulder Highway. Your parents are passed out drunk and they are about to be arrested for child endangerment. You go to Child Haven, our shelter, while the Department is looking to locate some relatives.

Now imagine you are six years old; it is the middle of the night, and you are with the CPS worker who is desperately trying to reach grandma to come get you. Your mom is in the back of an ambulance. Your dad is in the back of a police car. They were fighting again, and it got really bad this time.

Imagine now you are an eleven-year-old and along with your eight-year-old and five-year-old siblings, you were just delivered to a foster home. Your mom died of COVID-19 last night and you have no idea who is going to take care of you.

Now imagine you are 16 years old and sadly, you are back in the foster care system for a second time. Your aunt adopted you when you were just two years old, but as you have gotten older, she struggled to meet your mental health needs and to help control your behaviors. You just spent the night in juvenile detention because you pushed her during an argument and now she is refusing to come pick you up.

I tell you these stories not to depress you, but because these are the realities of the children who we are dealing with in the foster care system. For the lucky ones, approximately half were able to locate relatives and fictive kin so they could go somewhere known to them, but for approximately the other half, they go to foster care and that means they are going to live with strangers. I ask you to imagine, for just a minute, what that feels like for them. They are in a new, unfamiliar place, where the rules and the whole setup may be very different than anything they have ever experienced. The rest of the family may not look like you. They may speak a different language than you. They may practice a different religion then you were raised in. They may cook food that is very different from what you like, or what you are used to. Pretty much life, as you know it, has been turned on its head. For kids in foster care, uncertainty and instability are often the only certainty.

At the Children's Attorneys Project, it is our honor and privilege to walk this path with these youth as they move through the system. To be a constant and consistent force in their lives, trying to explain to them along the way what is happening, and to give them a little bit of agency, a little bit of power, knowing they have a voice that is being heard as these life-altering decisions are being made for them, and about them, in a system that often feels to them like they do not have a say or any control.

Sometimes this path is straight and short, but too many times it is long, winding, and full of bumps, detours, twists, and turns. As you make decisions and consider policies that may potentially impact the lives of these children, we offer our organization to provide feedback, answer questions, inform you in any way we can from the perspective of the children we serve because after all, they are the intended beneficiaries of our system. Thank you very much.

Chair Peters:

Thank you all for the presentation. That was touching, Ms. Abbott. The description of the cases you see and the scenarios that children are put into are the worst nightmares for a lot of parents. I have some questions related to the audits done by the LCB on your divisions

and the foster facilities that we have seen either close or have been on conditional actions. First, I want to see if the Committee members have questions. Assemblyman Orentlicher, please go ahead with your question.

Assemblyman Orentlicher:

The challenges you face and the needs out there are enormous, and I am grateful for all you do. I wanted to pick up on one thing that Ms. Abbott mentioned about the desire for a more family-centric approach. Is that more family-centric in the sense that when you do a placement, you try to place with a relative? Or is it family-centric in the sense to do more to keep the kids with the family? I read some jurisdictions are criticized for being too quick to remove a child from a family and that maybe we need to be more family-centric in that way. Then, other jurisdictions are too slow to remove children from their families. If you could elaborate on the more family-centric approach, I would appreciate it.

Ms. Abbott:

I meant it in both and in a variety of ways. You will see from some of the information that Mr. Burch presented, I think we are making strides on some of these things. The increase in kinship placements and the high number we have compared to other states in the country is a fantastic development.

Additionally, we now can do our KinGap guardianships, which are paid guardianships and give families other options. They have been fantastic and have been catching on; we have been turning to them more. For so long, we looked at the option of either we get a parent help, and they step up and do what they need to do, or we terminate their rights. It was an either or. Guardianship gives us something that is a little bit in the middle, because it allows the family to decide if that is a better legal mechanism for them. Sometimes grandma wants to be grandma and not mom, or an aunt wants to be an aunt and not mom; guardianship provides another avenue for that.

We are happy to see a shift that we are exploring other alternatives. I think when we remove a child from a parent, although that may be necessary sometimes, it does not mean they have to be removed or disconnected from their entire family and the entire ecosystem that they knew. I think we do a good job at acknowledging our responsibilities to look for family. I think the problem is when we find them, we are desperate to find a placement, so we ask if they could take the child. If they have reason, and they say no, we move on to the next person; we do not stop and say, "But how can you still be a support to this family? How can you still be a connection to this child? Do you grandma, still want visits even though you cannot necessarily take placement?" It happens in some cases, but I do not think systematically it happens enough.

As you referenced with Families First, we try to keep the family together if we can. We have always worked to get upstream and provide additional services and support to the families, so we can have less removals because we all agree that when we remove a child from the home, it is traumatic and detrimental. Although it may be necessary it does not change the fact that it is traumatic and detrimental to the child.

I also think supporting kin placements is important. We can get them licensed, but it takes time to get them licensed. Other states have moved to situations where they pay first, license later. We do not start payments until after they are licensed. When we take a grandma—who is on a fixed income—and we drop two teenage boys in her lap, who are going to eat her out of house and home in the first five minutes there, plus they are going to outgrow their shoes every five minutes, that is a huge financial burden that she is taking

on. Then we say make time to go take classes and jump through these hoops and go through this process; that is something I hope we can look at moving forward as well.

Chair Peters:

I hear you about the reimbursement rates and that is across the board. I was listening to the radio on my way in today and increasing pay is being seen as one of the best ways to fight some of the losses we have seen over the last couple of years. With licensing and outreach, what are some things that we can be doing to make it easier or more inviting for the public and private interests to participate in those community-based support services?

Ms. Jackson:

I believe one of the ways is, and it was in some of our presentations, to look at the Medicaid rates, the rates of reimbursement, and the timelines. We hear that compared to other states, it is relatively low and many companies or facilities have to wait a long time to be reimbursed. I think that is also something that could be looked at to entice more agencies and more outreach to come to Nevada. It is beautiful here and to experience opening homes and services here.

Mr. Gustafson:

To add to Ms. Jackson's comments, we try to keep kids in state obviously, but there are not many in-state residential programs in Nevada. I can probably count them on one hand, as far as residential treatment programs. Some of the out-of-state facilities have actually notified us that they will not work with Nevada Medicaid because of timeliness issues and reimbursement issues.

To add to your original question, I think it is important to look at the rates for foster families, because I can imagine the rate probably does not cover the meals right now for the kids, let alone anything else. I think finding additional ways to support foster families and to, obviously, get additional foster families. I know within Washoe County, we try to do as much marketing as we can. We try to partner with community agencies, such as University of Nevada, Reno (UNR), or whomever we can, to try and get the word out there that we need families and individuals to foster, mentor, and adopt. It is what we preach, but a lot of these kids go into homes, and they need additional services.

It is traumatic for kids to come into care and when they do, oftentimes, that can come with some weight—the loss of not being with mom and dad or the difficulties of going in with strangers if it happens to be foster care. Some of those kids might need clinical or therapeutic services and those are very lacking. I referenced that we lost one of our two psychiatric hospitals, so when kids become acute, they are now going to medical hospitals where they are waiting to get a bed in the one psychiatric hospital we have left and that creates backlogs, difficulties, and undo stressors for kids and families. Getting kids involved in therapy and community-based providers is important, but it is hard to do because many of them are backlogged and have caps on how many Medicaid clients they will see because they can get more money when they see third-party liability insurance clients or cash payers. So, that creates difficulties.

In October 2017, we opened up our family engagement center, which was radical and new countrywide. One of the reasons we did that is we wanted our foster parents and our biological parents to be able to be in a home-like environment that is conducive to visiting and building relationships. We have come to the realization that it is more beneficial for the biological parents to have a good relationship with the foster parents because they can

teach each other a lot. When we can be part of that process, as the child welfare agency, it becomes a three-pronged system where everybody works together. Then you are in a homey, friendly environment where you can play games, cook together, and eat together. If you can find new and unique community-based support and ideas to bolster the foster parents and the biological parents, who are working hard to get their children back, that is key to making the system successful.

Mr. Burch:

We work with community service agencies such as Foster Kinship, which is homegrown, and with the assistance and leadership of Dr. Ali Caliendo, it has grown into a national model and is under review to land in that national clearinghouse for FFPSA. The investments do work when we are able to make them. I think we beat the drum on needing more investment quite thoroughly.

We are always looking for businesses to come in and help incentivize. A lot of times we hear that potential foster parents have difficulty taking time off work to go to all the hearings and things that they need to be a foster parent because they usually happen during business hours. Asking employers to incentivize, in some way, such as leave banks for their employees to get involved, is a meaningful thing and something we mention to our partners.

I would be remiss if I did not thank some of the major local partners, like the Las Vegas Raiders and the Vegas Golden Knights, that have stepped in and done things as small as show up at community events to as large as recording welcome videos for our virtual foster parent trainings out of relationships with some players who they themselves have gone through foster care. I think the willingness to support is there.

There have been great statewide campaigns for Home Means Nevada and other things. A statewide demonstrated commitment to foster parent recruitment through that level of campaign and messaging helps. As agencies, we are dependent upon the niceties of strangers and community partners to help us with a lot of that marketing and messaging because it is just not something that is built into our budgets.

Ms. Abbott:

Dr. Pitlock reminded me of an important support; we spent a long time talking about this at the provider summit earlier this week. One way that we can support families, both foster parents and relative caregivers, is to have a robust respite system. It is important that our caregivers take care of themselves and have a chance to take a break so they do not get burnt out, so they do not turn away from this work. Supporting a robust system to ensure they have access to appropriate respite is another way to ensure that we have quality caregivers.

Chair Peters:

I have to agree. The thing that came up for me, even after reading the audit, was what do we do about ensuring access. Therapy is one thing because that is a medical service—but what about cooking, laundry service, or general cleaning services for these families to make sure they are getting those basic needs met while they are caring for the kids and their emotional needs during the time they are in those families? How do we market that? It is not really foster parents we are looking for but rather a foster community. It is a community to support the families. It is a community to support the children and getting them to school, getting to therapy sessions, and making sure the households are taken care of.

Those are things that we could get behind and find ways to bring the community in on. Assemblywoman Titus has a question, please go ahead.

Assemblywoman Titus:

I have been on this Health Care Committee now for four sessions and foster care has been an issue the entire time. One of the bills that was passed several years ago—that I was very concerned about—was the amount of training that a foster parent had to go through and some of the sensitivity training. I was concerned at the time that it may put further barriers into getting more foster families willing to step up, especially in the rural areas. I am glad to hear there is some virtual training so folks out in Fallon or Dyer can get that training, because it is not just related to our urban areas, it is throughout the state. Have we seen any decrease in the number of families willing to be foster parents since we added the amount of requirements for training?

Ms. Jackson:

I have not specifically seen decreases because of training. Usually, our families are asking for additional trainings around things like trauma or how to truly understand this child's needs, or mental health, because they have not experienced these mental health needs.

What we have seen in the model home standards that were passed was a requirement for a flu shot, and I believe we still have a requirement for tuberculosis; it is those little things that are a little bit intrusive. In our rural communities, who are not always onboard with getting specific immunizations, the flu shots seemed to be somewhat of a barrier. I think that was seen throughout our jurisdictions that it was one more mandate.

I have not seen that the training requirement has been a barrier to getting families. If anything, I think they enjoy it; they make connections to other families. In the rural areas, we are actually looking to increase our post training. Once you are licensed, we want to give you very specific trainings for the children you want placed in your home and give you some guidance on what those trainings need to look like other than just saying, you have to have four hours, so go find four hours. We are looking at making it more specific to our current population that has more specific needs.

Assemblywoman Titus:

Is there some leeway when there is a crisis and the child has to get out of the home and be placed with a family member who has not been trained? Do you allow for that because they have not looked at the foster system yet, but they need a place for this child?

Ms. Jackson:

We prefer to place with family members, whether they are licensed or not. We do offer licensing to them once placement has occurred. We go to the homes where we take the child to see the home and we have some safety measures in place so that we are just not sending a child to a family member. We talk to that family member; we explain our process to them and what is going on. It may be a lengthier process than what they are anticipating. They think things can be solved in a couple of weeks and that it not always the case.

That is our first response, but we do refer them. There was a joint program that came out with the Division of Child and Family Services, DHHS that if a family member or fictive kin takes a child and they meet the income level, they can get some payment while they are going through the licensing process.

Just to clarify, I do not think that I was clear, we also changed our format to an online platform so that we have panels, guest speakers, and training in a format that everyone can access no matter where you are in Nevada.

Chair Peters:

Are there any other questions from the Committee? I am not seeing any. I continue to have audit-related questions, but I think we could probably go over those when we meet during session and talk about the status of those issues and the status of things like your actuarial study on rates, which will be interesting to hear about. I think Medicaid is going through some actuarial analysis as well. Hopefully, this next session we will have some robust conversations about what actual payments look like over the coming biennium. Thank you for coming and we appreciate you all being here.

AGENDA ITEM VIII—OVERVIEW OF COMMERCIALLY SEXUALLY EXPLOITED CHILDREN IN NEVADA

Chair Peters:

We are going to move on to Agenda Item VIII, which is the overview of commercially sexually exploited children in Nevada. We have Brigid Duffy to present on this issue. Please go ahead and introduce yourself and begin when you are ready.

Brigid Duffy, Chief Deputy District Attorney, Director, Juvenile Division, Clark County Office of the District Attorney:

I am presenting to you today an overview of the evolution of our state's policy for the commercial sexual exploitation of children in Nevada, presenting it as our past, our present, and our potential future (Agenda Item VIII).

My professional title may make you wonder why I am presenting today. I run the Division of the Clark County District Attorney's Office that oversees children who are in foster care and the juvenile justice system. These children often fall within this realm of being our sexually exploited children. I am an active part of our statewide commission regarding the treatment and prevention and services to these children. I have been doing that since 2015 and I have been an active part of the legislation. I was selected, despite the fact that it is odd that the prosecutor is presenting this, because I have that very long extensive history of our past, our present, and now going into our future.

I am not going to go too far in depth on this because you heard a lot about the FFPSA earlier today. Our treatment of children that fall within this sexual exploitation has a lot to do with the federal laws that have come about. In 2014, the Preventing Sex Trafficking and Strengthening Families Act (H.R.4980 of the 113th Congress) was a real big catalyst that required states to develop policies and procedures to identify, document, screen, and service children through the child welfare agency. In Nevada, prior to 2014, that was not occurring for all children in the State of Nevada and was only occurring for children that were in the foster care system at some level. In 2014, the federal act came out and said we needed to start transitioning all children who fall within this category to the child welfare system.

Where were we pre-2015 Session? There were a lot of children who were identified by the police for solicitation of prostitution, and they were arrested, detained, charged, and adjudicated for those offenses in the delinquency system. In Clark County, under Judge William O. Voy, we were running a specialty court specific to the population of

children who were being arrested, detained, and charged. The specialty court had service providers to help wrap the child into services, but at that time, we were still treating them as delinquents. Unless there was a parent or a person responsible for the welfare of the child—like a guardian or other person found in the home—the child welfare agencies were not the primary agency providing those services. In 2015, there was a constant conversation around our need for safe houses in order to get the appropriate treatment and services for these children.

Then, the 2015 Session came and we had AB 153, it was our version in Nevada of a safe harbor law. It ended up being codified as NRS 62C.240. At that time, a collaboration of community partners came together and determined we were ready as a state to ensure that we were not adjudicating—for those who are not familiar with that term, in criminal we call it finding guilty, and in juvenile, we call it adjudication—for solicitation of prostitution or for prostitution. Our version of the safe harbor law then would allow the district attorney's office to still file the charge. It allowed for the child to still be arrested and detained for the charge, but we were not able to formally adjudicate the child for the charge, so they were not found guilty of it. We were only allowed to supervise and provide services at that point and only for those two acts. The court could still order out-of-home services and out-of-community placements in the best interest of the child. The court may still issue all orders for the compliance with recommended services meaning he or she could still order the child—you have to do this and if you do not do it, then your consequences could become greater. Then at 18 years old, there was an automatic dismissal, so it was not on the juvenile record. At the age of 18, if the young adult was in completed services, the young adult could agree to stay under court jurisdiction longer, but, again, that was up to that young adult who turned 18 years old. At the end of the 2015 Session, there was still no funding for safe and appropriate housing for these victims.

Then in the 2015–2016 Interim, the conversation that was sparked by AB 153 brought us to the Nevada Coalition to Prevent the Commercial Sexual Exploitation of Children and that was established by the State of Nevada Executive Order 2016-14.

That takes us over to the 2019 Session, where there were two significant pieces of legislation, SB 293 and AB 151. These bills highlighted the movement toward implementation of the federal requirements that had child welfare agencies as the primary agencies that were identifying, screening, and servicing the CSEC.

Senate Bill 293 was again the product of collaboration and compromise to take steps in moving toward the creation of safe housing and safe harbors. The bill created a contract position within for a statewide coordinator. Interim meetings were conducted in order to assess gaps in services, housing needs, and evaluating incentives needed to recruit providers of these safe houses that we need. At that time, SB 293 took safe harbor one step closer to a true safe harbor law stating that anybody who had reasonable cause to believe a child is a CSEC is prohibited from arresting, detaining, and adjudicating the children for solicitation of prostitution and prostitution, curfew, jaywalking, or loitering for the purposes of prostitution. In the 2019 Session, that was to become effective in July 2022. When we moved that effective date to July 2022, it was because we still did not have that housing option. If we remove the housing option of detention, which is absolutely not appropriate for this population of victims, we still did not have the build up of what was truly needed within our state.

Assembly Bill 151 is very special to me because it was one that I drafted out of my own brain concept. It created its first standalone statutory section to address the identification and needs of our CSEC. We now have what is codified as Chapter 432C of NRS, the Protection of Children from Sexual Exploitation. Over the past few years leading up to 2019,

across the country states were aggressively passing legislation to transition the identification and care coordination of CSEC to child welfare agencies. However, states were cramming those laws into traditional child abuse and neglect statutes—statutes that were really designed to identify and treat children who were abused and neglected by parents or guardians, not by traffickers, and in most CSEC cases, the parents are not the ones exploiting the child. To cram into our child abuse and neglect statutes, people who are not persons responsible for a child's welfare through parent or guardianship, it was a little odd. It also seemed, in some cases, to be punishing parents, even though they were not really involved in it. We were successful in addressing the Legislature and the LCB to create this standalone statute that you all now have to put anything you would like to with regard to our child victims of sex trafficking.

Assembly Bill 151 has mandated reporting requirements. Now, if anybody who is a mandated reporter of child abuse and neglect has reasonable cause to believe that a child is a victim of commercial sexual exploitation, they are required to call in a report to the intake unit of the child welfare agency. When that intake call is received, child welfare agencies will screen them, assess for risk, and assign for assessment if deemed necessary. Child welfare agencies are able to provide services directly, or they may refer out for service-to-service providers. Again, it does not require the parent to be the perpetrator of the sexual exploitation. It requires a cross report to law enforcement so we can hopefully identify the trafficker. Once again, there was no funding to support this new responsibility on child welfare agencies, but they are doing it. We heard Administrator Burch mentioned that they have a case load of about 398 children since the child welfare agency has taken on this role in Clark County.

After the passing of those two pieces of legislation, we move into the 2019–2020 Interim. At that time, the governor directed DCFS to establish a statewide coalition. The focus of that coalition was to ensure, implement, and develop the recommendations for services, legislation, and best practices. In 2019, when we go back to SB 293, it started out as a very aggressive bill that mandated what type of housing we needed, mandated that housing lay in the responsibility of the child welfare agency. Ultimately, with the stakeholders discussing it, it was determined we really needed to make sure we were building up the correct housing for these victims. In the 2019–2020 Interim, we started this statewide coalition that discussed all these needs involving housing, as well as services, and potential legislation.

That coalition started three subcommittees: (1) our local task force and multidisciplinary team (MDT); (2) external engagement; and (3) funding, data, and sustainability. I have a little bit on each of those subcommittees.

The local task force and MDT subcommittee coordinated the interagency approach to assessment, service planning, and case management. It is in the best interest of our children if we are all working together at one table, talking about the same child rather than in various silos, retraumatizing that victim. Our local task force and MDT group looked at making sure we have smooth services entering for that child.

External engagement was the review of our rapid indicator tool. This is our screening tool that is used statewide and by community partners including juvenile justice services here in Clark County. Also, in external engagement we are making recommended changes to Nevada 211 for more accessibility for survivors, families, and providers and that met a requirement found within the 2021 Session with SB 143. Regarding funding and sustainability, we developed a comprehensive statewide CSEC database. We are working now with UNLV partners and looking at other management information systems to connect with our CSEC case management systems.

During the 2021 Session, we had SB 274. It took the work from the 2019–2020 Interim and recognized that we needed a continuum of care for our victims and survivors. It is not just that we need one thing, there are different levels of trauma and treatment throughout this victim's journey to being a survivor and we needed to make sure that we were implementing that continuum of care. One very significant piece that was determined to be within that continuum of care, was creating the foundation for a receiving center. The receiving center is modeled after one in the State of Georgia, operating fully right now. It would be a secured facility that operates 24/7 to provide appropriate inpatient and outpatient services. It is not a detention facility or a group foster home. It focuses on complex trauma and the needs of our victims and survivors. It moves the implementation of SB 293, which I just talked about earlier. The no detainment, no adjudication section of SB 293 was moved to July 1, 2023.

Once again, at the end of the 2021 Session, we did not receive any funding towards any housing or staffing the needs of the child welfare agencies to screen and assess these victims for services.

Now, where do we need to go? These legislative recommendations come from discussion among stakeholders on the Statewide Coalition. These recommendations were also presented to the Joint Interim Standing Committee on Judiciary, and they are not vetted for fiscal impacts on agencies. Many of them are recommendations from the Shared Hope International report card.

For those of you who are not familiar with the Shared Hope International report card, it is a national organization that looks at each state and grades it an A through F on their response and treatment of child sex trafficking victims. Nevada got an F for the 2021 report card. The statewide coordinator, Esther Rodriguez Brown, and I reached out to Shared Hope International to talk to them about our F. We went line by line as to what we saw, and some of the things that we are already doing, they just misinterpreted. I think we moved up to a pretty solid D from the F because they did not understand our statutes. Again, this is a national organization, and they are not trained in understanding how we interpret our statutes. I will say we have come a long way and further than a D if you look back at where we started to where we are going now with my presentation. After the fact, we learned that Shared Hope changed the goal line. There was a Shared Hope report card years ago and all the states started getting A's and B's and moving up. Then they moved the goal line out and said we can do better and of course we can do better, we can always do better. We did well, but now they have moved it and we need to progress.

Some of the recommendations are from the Shared Hope report card for legislative changes, and the stakeholders among these coalition groups have decided that they would like me to present these to you. Possible legislation—mandate the creation of multidisciplinary teams to collaborate and prevent additional trauma for our victims and survivors. We are actively working right now on the shell of that legislation within a legislative subcommittee. There are foundations within statute already for multidisciplinary teams around issues that impact our children and families within our statute. We are hoping that will be an easy fix to mandate that team.

The second one is to mandate that child welfare agencies and juvenile justice agencies screen children to see how they are experiencing commercial sexual exploitation. Right now, in Clark County, we are already screening children who are coming into the system, either juvenile justice or child welfare; it is not statutorily mandated that we do so. I am unfamiliar with what the rest of the state is currently doing. I know we have talked about everybody in the state using the same screening tool and hopefully that will be rolled out.

The next one is to create stronger safe harbor statutes. There are so many versions of safe harbor statutes across the country. It would definitely be a policy decision among members to decide where they wanted to take the State of Nevada.

Ensure the extension of foster care to cover young adults to age 21. In 2019 and 2021, there were two bills (AB 150 [2019] and SB 397 [2021]) that addressed this very issue. I think we are moving in that direction; we just need a little more technical assistance in the state.

Extend the ability to testify by alternative means to all victims under the age of 18. A child who is a victim of sex trafficking right now who is 16 years old or above does not have the ability to testify by alternative means, it does not apply to them. There is a recommendation that we do extend it to 16 years old and above.

Two of our more controversial recommendations would be: (1) eliminate licensed houses of prostitution; and (2) create tougher penalties for buyers of a child.

That is my past, present, and hopeful future for you all. I am ready to take any questions you may have.

Chair Peters:

Thank you for the presentation. I have a question from Assemblywoman Gorelow; please go ahead with your question.

Assemblywoman Gorelow:

I received an email a couple of weeks ago from somebody who was requesting that we add child sex trafficking to the state statutory definition of *child abuse* and *neglect* under Chapter 432B of NRS. I was also talking with some people who work with the county, and they stated that would be a problem because it would require CPS to work with pimps and potentially even the family members who were actually selling the child. Could you elaborate or explain a little more about that?

Ms. Duffy:

Actually, that is not a difficult fix. Currently, in the court improvement realm through the Nevada Supreme Court, we are working on legislation. One of those pieces of legislation is to add to the definition of *sexual exploitation* within Chapter 432B of NRS, *commercial sexual exploitation*. It would then apply to parents, guardians, or persons responsible for a child's welfare who commercially sexually exploit a child—only to them, and sometimes parents are responsible for those things. It is something that we are missing within Chapter 432B of NRS and something that was also brought out by Shared Hope. We do have sexual exploitation listed as a definition of *child abuse* in Chapter 432B of NRS, but there are some who believe that it does not go far enough to capture commercial sexual exploitation of a child. We still have Chapter 432C of NRS where we can service and help children outside of a parent who is doing that exploitation.

Assemblywoman Gorelow:

Thank you, that confused me a little bit more, but we will have more conversations.

Chair Peters:

I think that would be an interesting bill draft request, potentially, if we do see it is necessary. I have another question from Dr. Titus; please go ahead.

Assemblywoman Titus:

Your continual advocacy for the youth in Nevada is so much appreciated. I have to go back to your last statement on some ways to improve where you mentioned legalized prostitution. Did you say eliminating legalized prostitution in Nevada was one of your goals or one of your solutions?

Ms. Duffy:

Yes, it would be eliminating licensed houses of prostitution. I know that has been a very difficult …

Assemblywoman Titus:

I just want to focus on that for a little bit. As the county health officer in Lyon County, which has legalized prostitution, I have inspected the brothels in our County. I am wondering what data you have that there are children in our legal brothels in the State of Nevada.

Ms. Duffy:

I am going to do my best. I wish I had my partners from Awaken Reno with me because this has been a long conversation with them over the years. One of the recommendations from Shared Hope included that elimination because of the message it sends, and it is bleeding over into our illegal prostitution. It is starting with our children who are being trafficked in the streets, then bringing them up into the legal houses of prostitution. If we can get rid of the stigma that it is okay to buy sex, then we would be assisting our children who are being picked up on the streets. I am not the best one to talk about the specific issues as this is one from our advocates in the collaborations across the state, although I do agree, and I agreed to put it in as one of the bold recommendations the group has coming forward.

Assemblywoman Titus:

I would argue that perhaps in Clark County and Washoe County you see that more. I am concerned that by the broad statement to eliminate all, there may actually be an increase in illegal trafficking. I have some concerns and there is further dialogue that has to happen. The statement caught me by surprise.

Chair Peters:

I also was curious about where that came from; thank you for the explanation. It sounds like there will be more conversations on that information and data. Are there any other questions from the Committee on this issue? I do not see any. Thank you, Ms. Duffy, we appreciate you being here and for your presentation.

AGENDA ITEM IX—THE INTERSECTION BETWEEN HOMELESSNESS AND COMMERCIALLY SEXUALLY EXPLOITED CHILDREN

Chair Peters:

Our next presentation is Agenda Item IX, the intersection between homelessness and commercially sexually exploited children. We have some folks from Rite of Passage to present. Please introduce yourself and proceed when you are ready.

Lawrence Howell, Chief Administrative Officer, Rite of Passage:

We are going to talk about the intersection between homelessness and commercially sexually exploited children (Agenda Item IX).

Rite of Passage is a longstanding Nevada nonprofit that has been working with kids for over 35 years. We provide shelter, outpatient foster care, and residential treatment to teenage youths who are victims of commercial sexual exploitation. We currently have programs specifically for this population in Nevada, Hawaii, California, Utah, and Arizona.

I am humbled by everybody who came before us today and spoke on this issue and other issues. We consider them partners and collaborate with every single one of them from DCFS to Clark County and members of the committees and the commissions. We sit on these committees and commissions with them, and it is clear we are one part of a very big issue. We are happy to be here and happy to answer any questions that you may have. I am going to do the introduction and then hand it over to the director of our Las Vegas program to present a few things and then we will answer questions.

In Las Vegas, we serve youth CSEC victims in a shelter, an outpatient environment, drop-in center, and we do have a safe house. There was a lot of discussion earlier about funding and why there is not more of these services in Nevada. We applied for and received a grant to open the safe house from the Office for Victims of Crime of the U.S. Department of Justice. We have a safe house for six youth in Clark County, but we went to Washington, D.C. for the funding. We are the only youth program in the State of Nevada selected to receive funding for that. The facility opened about a year ago and it is going well.

We are going to transition now to Makaya Swain, who is the director of The Embracing Project. The Embracing Project is our Las Vegas hub of services for homeless and sexually exploited youth. She is a longtime advocate on the streets in the community, with the kids fighting for sexually exploited youth, homeless youth, and everything that we are talking about today. With that, I will hand it over to Makaya.

Makaya Swain, Program Director, The Embracing Project, Rite of Passage:

I will start with an overview of some of the services and then we will get into the topic at hand. We offer wraparound trauma-informed services for the youth victims and survivors of interpersonal violence—not just sex trafficking—also sexual assault, molestation, domestic violence, and any other interpersonal violence the kids may have experienced. We have three sides to our program: (1) our sexually exploited youth program, which is focused on the sexual exploitation of children; (2) our mentoring program, which functions more as a prevention program, focusing on connecting teens—any kids between the ages of 12 and 18—with either individual mentoring or group mentoring; and (3) our housing program for six youth, who are CSEC specific. We focus a lot on court advocacy, court accompaniment when kids are going to testify, and individual advocacy in the community. As you can imagine, the children who have been exploited have difficulty advocating for themselves and

their needs and being taken seriously by adults around them because of their age and some of the things in their history.

In our drop-in center, we are central to Las Vegas in the downtown area. We picked this location purposefully, because before we had our first drop-in center, the youth were traveling all around Clark County to receive services. They would receive some things in North Las Vegas, some things in the east, and some things in the middle. They were getting around primarily on the bus, as they lack supportive adult figures in their life who will help them with transportation.

We offer individual therapy, group therapy, and family therapy. We do a lot of family support because it is a total family issue. For us to have the best outcomes, we need to identify support systems—that might be blood-related family or their chosen family—to make sure once they exit our program, as they are finished with services here, they have people around them who are going to support them in their needs.

We have a Clark County School District approved school here. We operate through the adult education program, which has been absolutely fantastic.

You will see that a lot of the services we provide to kids, were born out of need. Originally, we started with basic skills training and psychosocial rehabilitation services, but as we got more kids in the program, we noticed more needs coming up. As the needs grew and as we struggled to find other service providers to fulfill those needs, we expanded our programming and adjusted to meet the needs of the kids that we work with. I will say kids a lot, but they are ages 12 to 21, so you know big kids, but I will refer to them as kids.

Our school started because we were noticing a lot of the kids in the program were at our drop-in center during the day, when they were supposed to be in school. We addressed the issue with them, asked what was going on in school, and they were having a lot of trouble functioning in a traditional school environment. A lot of the kids we work with have mental health issues, post-traumatic stress disorder (PTSD), or a lot of triggers. As you can imagine, putting all of those things together in one child does not necessarily make the ideal student. They were struggling. Some of the kids were still on the streets, some of the kids were still under the hands of the traffickers, so they would sleep in class or get in trouble. Things would happen in school; there was fighting. They lacked the internal and external resources to be successful in a traditional school, so we brought the school into our program.

We have seen about 25 kids graduate through our school and we should have some more graduates this year as well, which would be fantastic. It is a great environment for them to be in because they can attend school, but if they need a break, if they need a nap, if they are having a bad day and they need to cry, they can do that. We have great teachers; we are always assigned special education teachers. For the most part, the majority of the kids we work with would qualify for an individualized education program (IEP); however, they are not in school long enough to actually get assessed for an IEP. The school has been fantastic. We have school today, so it might get a little bit loud behind me.

We also have basic necessities such as clothing, hygiene, food, and things that kids need just to survive, because if we can provide them here, it saves them from having to go out and look elsewhere for those basic necessities. At the end of the day, when we are speaking about kids from families that do not have extensive resources when it comes to things like hygiene products, clothing, or school supplies. When they are given the choice to provide a roof over their heads and food or get things like hygiene items, clothing, and school

supplies, they are going to choose the things like shelter and food. We have those basic needs here.

We also do a lot of job readiness, whether that is resumé building or interview skills. We are helping to educate the kids on how they can function in a world—jobs and working in establishments and filing taxes. Those things are not necessarily taught in school, and they are certainly not taught on the streets. We help transition kids from where they were before and how they think about money and working into looking at careers and things they can do to get qualified for jobs here in Las Vegas or elsewhere, if they choose to move.

We do a lot of life skills education, that is, working on communication skills or social skills. We must do a lot of work on identifying toxic or violent relationships or relationships that are very unhealthy. In 2020, we served 121 sexually exploited youth. At the time of the intake, which is their first day, we take them through a comprehensive intake and ask them about their lives. At that time, 49 percent of those kids identified as either having witnessed or experienced domestic violence. In addition to that, another quarter of the kids had experienced dating violence in intimate relationships, outside of the relationship with the trafficker. When we speak about kids who are surrounded by violence or violent families, or just chaotic families and relationships, they have a lot of difficulty identifying a healthy relationship, not just within the family unit or dating relationships, but also within support systems. It can be uncomfortable sometimes for kids when they first start the program because we are a building full of supportive adults who are looking for healthy relationships with our clients. When we are modeling those behaviors, it is a very unfamiliar thing that can be uncomfortable for the kids because they are learning something new for the first time.

We do a lot of mentoring and modeling of social behaviors. We have kids who bring their kids here, we assist them with that and make sure we get them connected with the proper parent education.

If the kids have a need that we cannot fulfill, we reach out to our fantastic partners. We have partnered with Signs of Hope, formerly the Rape Crisis Center, and the Family and Child Treatment of Southern Nevada. We have an extensive range of partners that come together to support the kids as best as we can.

As I mentioned, we also work with the whole family. We have a support group for parents who have sexually exploited children, and we also do parent education.

To connect between homelessness and sexual exploitation, at the time of intake, 79 percent of the kids we worked with in 2020, identified that they had run away at least once. That ranged from three days to one young lady who, at the age of 15, had been a runaway for two years—she had lived in California in a tent city. It is unsafe for children to be on the streets looking for shelter; that is when a lot of sexual exploitation can occur. One of the underreported forms of sexual exploitation is youth who are engaging in "survival sex." Survival sex means exchanging sex for basic necessities that every child should have such as food or a place to stay. When the adults around them know they do not have those, the child can fall into exploitative relationships where they are exchanging sex for those basic necessities. Survival sex is not always classified as trafficking. However, survival sex can progress into a trafficking situation just because these basic necessities are the things the child needs to survive, so it creates a large imbalance of power.

Trafficking itself is already underreported because some victims and survivors have difficulty identifying themselves as being victimized and reaching out and letting other people know that things that are happening to them could be considered victimization. There is still a lot

of stigma, shame, and victim blaming with trafficking, despite all the education, documentaries, and things that we as a community and the public have access to. This shaming of victims creates a situation where they may not feel safe or that they can trust anyone to report the crimes that are occurring.

Trafficking in general encompasses a lot of different issues. There is domestic violence. We see teen pregnancy, which then creates another basic necessity because now they are not only trying to provide for themselves but also for their children. We also see substance abuse, gang activity, and mental health issues. All of these things are happening in one child at one time. If you can imagine putting all of these issues into one child, the push and pull factors for trafficking are just tremendous.

As I said, our programs were born out of need. When we established the safe house for CSEC children, it was out of need. We had youth in our program who were maybe being kicked out or maybe running away from a situation where there was violence in the home. In 2020, about 60 percent of the kids identified as experiencing sexual assault or molestation, either in the home or on the streets. These are the situations they are trying to get away from, and sometimes these are the situations they end up back in when they do not have safe shelter. When we created the house, it was an extension of the programming that was already working for the kids. It was to surround them with comfort, help make them feel safe, let them know it was okay to be their own individual selves, to be accepted by people in the community, and to let them know there is still a really big place for them in the community.

Right now, we have four young ladies in the house. We have had approximately 11 kids go through the house, many of whom have transitioned over into their own independent living situation, whether that is an apartment of their own or into a more permanent housing program. We also work with Nevada Partnership for Homeless Youth and a lot of homeless youth programs because we have a program of only six beds—six beds are not enough.

When you heard Ms. Duffy talk about funding, the funding is not there, and it is needed. We have four kids in the house right now and we have identified many more who need housing. We have children who are currently receiving services from us who are in Child Haven or in the homeless youth shelters. We have young adults who are currently in the adult shelters. There is a large need for this, so one of our objectives is to increase our capacity for providing that safe and stable transitional housing for the children.

Of course, our goal is to always provide services that meet the individual needs of the youth. Everything that we do is tailored to the individual. Although, we have kids who might have been in similar situations and even children who might have been exploited by the same person, their needs are very different. It requires us to adapt to each individual and that is the care they deserve.

As I said, we have individual group and family therapy. We currently have four therapists who are all well-versed in trauma as well as CSEC, substance abuse, domestic violence, and a host of other issues.

We do a lot of crisis intervention. A lot of crisis situations come up with the kids who we work with. They do not have a lot of the coping skills as we think about them in the traditional sense. Unfortunately, they do have a high threshold for suffering and violence at the hands of adults, usually, but they do not have a lot of coping or de-escalation skills to deal with the issues that come up in regular teen life such as relationships or disagreements with their parents.

We also partner with Signs of Hope to operate a 24/7 human trafficking hotline, which is an in-person response to identify the victims of human trafficking. Again, this is crisis intervention. We interact with the victims and survivors on what could be possibly one of the worst nights of their life. It takes a lot of de-escalation and just being with them in the moment and, of course, the follow-up that comes from that as well.

We have a school program that we are doing two days a week, which is working for a lot of the kids, but we will eventually need to expand that to more availability. We will need some more nights and early mornings because we are working with teens who have kids, jobs, or other responsibilities and they need the expansion of that school program.

Material resources, anything kids might need that are basic necessities we try to have on hand here at our drop-in center. Everything we have that is material is donated. We have some great partners in the community—kind individuals who see the need of the kids and donate as much as they can to us. They have been fantastic.

Our girls' circle program is part of our prevention programs. That is group mentoring for kids who are just starting to get into trouble, starting to become system-involved, or people are noticing that they are having difficulties.

We adapt to the time and create a lot of empowering classes around healthy relationships, budgeting, managing money, and what money means to the kids we work with. We also have photography classes; and try to find things that them joy. Unfortunately, when we ask the kids about the things they enjoy, they do not have a lot of the regular teen experiences when we talk about hobbies, sports, and things like that. We try to introduce them to as many things as possible. They definitely do not like every one of them, but it gives them an opportunity to see some different things and find something that they like. Sometimes it is odd things for teens, we have one girl who really likes to crochet. We try to introduce them to as many positive activities as possible.

Regarding employment support, the children who do not have extensive resources or come from families with significant resources are looking for jobs at 15 and 16 years old and getting into the workforce. We support them in that. We do a lot of resumé building, and we practice interview skills. We even go with them and stand outside the store while they go inside to ask for the hiring manager. We help them with clothing once they find a job, and we help them with their taxes. As I said, everything we have was born out of need and what the kids we are requesting. If anyone has any questions, please let me know.

Mr. Howell:

The best example I can give on where youth homelessness and CSEC collide is, last year we had a young lady who was constantly asking for bus passes, which we provided through The Embracing Project. We finally dug into why she needed a bus pass, and it was because she was being exploited. She did not feel safe in the shelters that were offered to her, so she was sleeping on the bus at night. She would get on the bus and tell the bus driver she would be in the back sleeping. The bus drivers had an agreement to just leave her alone. It was so sad and disheartening when we found out. She was surviving; she was doing everything she could to survive because she had no place to live; she was homeless. Once we found out, we connected her with other community resources that were safe. It really motivated us to get the safe house started for situations like that, where you discover something today and you need to deal with it tonight. Now we have the house—Canyon View Shelter—for that type of situation, while we work on something more permanent.

Like I said before, we partner and collaborate with just about everybody who has spoken today and who is going to speak. It is a big issue, and we are proud to be part of this group that is doing something about it. With that, we will answer any questions.

Chair Peters:

Thank you for the presentation. How many nights, on average, does a person stay in your safe house? What does the average stay look like because you said it has six beds?

Mr. Howell:

It does have six beds. The stay varies depending on the needs of the individual child. One young lady has been there for five months; we have had some kids there for five days; and we had one child who was there less than five hours.

Chair Peters:

It sounds like your look to the future is to expand and offer more beds and maybe more community partnerships to ensure we have long-term places for these kids. If you come up with a way in which we can help, please let us know. Are there any questions from the Committee on this issue? Assemblywoman Titus has a question.

Assemblywoman Titus:

Rite of Passage has been in my community and the Mason Valley for decades. Are you going to continue the school you have in Mason Valley?

Mr. Howell:

We have 26 sexually exploited youth girls in that program right now; it is under a Nevada psychological residential treatment facility (PRTF) license because there was no real place to put it, so last year we got a license as a PRTF. We are trying to build a continuum. We have the drop-in center, then we have the safe house, and now we have a PRTF for the girls who are traumatized and in need of intensive therapy. It is very effective considering the remote location of Mason Valley. With 30 or less girls there, we can provide a lot of intensive services, and then, hopefully, transition them back to the community through the drop-in center or to a whole new community, depending on their individual needs.

Assemblywoman Titus:

In the past you have taken students from El Dorado County and California areas. Are you still doing that or are all these kids from Nevada?

Mr. Howell:

They are mostly Nevada girls right now. We have a program for sexually exploited youth in Hawaii and one in the Los Angeles County area; sometimes the victims need to get away from the people who are exploiting them. We have two girls from Hawaii in Yerington, and there are a couple of girls from California who we sent to Hawaii to create some distance between them and the situation while we work on their trauma and individual needs before we decide where they are going to go.

Assemblywoman Titus:

You said you have 26 girls in the Mason Valley facility now; what is your capacity?

Mr. Howell:

It is licensed for 50, but we are very selective on who we take and the services they need. Right now, we have a waiting list of the youth who need to get in. We are at 26 because right now that it what the milieu can safely handle.

Assemblywoman Titus:

How many people are on the waiting list?

Mr. Howell:

I did not look this morning, but yesterday it was about eight girls.

Chair Peters:

Are there any other questions on this particular item? I do not see any. Thank you for being here today and for your work in Nevada.

AGENDA ITEM X—PRESENTATION ON FOSTER CARE SERVICES FOR CHILDREN WITH SEVERE BEHAVIORAL, EMOTIONAL, AND MEDICAL DISORDERS

Chair Peters:

Our next agenda item is a presentation on foster care services for children with severe behavioral, emotional, and medical disorders. We have Laurie Jackson who will be presenting. Please introduce yourself and proceed when you are ready.

Ms. Jackson:

I am going to provide a quick overview of the services for specialized foster care (Agenda Item X). We are going to talk about a higher level of care—its criteria, training, and challenges.

Specialized foster care can also be known as treatment foster care. Specialized foster care, or advanced foster care, is the rural child welfare's version of specialized foster care. It is a treatment system designed to provide behavioral supports to children who have not been able to maintain regular home foster care or relative placements, as they have mental health or behavioral needs. These homes are the stepping-stones before we would look at residential treatment or psychiatric treatment facilities.

We use a system of care approach in these specialized foster homes with specialized training. The specialized training, Together Facing the Challenge, is a specific program developed by Duke University and The Pennsylvania State University.

Criteria for admission into a specialized foster home must be met. Before a child is placed into a more restrictive setting, the child must have: (1) a comprehensive biopsychosocial assessment; (2) a severe emotional disturbance designation; (3) failed prior less restrictive placements, whether that was family, kin, or family foster care placements; and (4) a child and adolescent services intensity instrument (CASII) score of 18 or higher.

Specialized foster care and the staff in specialized foster care are provided the Together Facing the Challenge training, which is geared toward the foster care provider. It has an ancillary benefit to the child because the foster care provider works with a coach; it is a

supportive and involved relationship between the coach and the foster parent. The training model uses effective behavior management strategies, and it is a supportive and involved relationship between foster parents and the youth in their care. We have found that it limits, or helps to stop, the youth from disrupting those homes and having to look at a higher, more restrictive, level of care, which may be a residential treatment either in state or out of state.

Currently, Clark County has the majority of these children enrolled, simply because of its population. The rural areas have about 31 children who fall into that designation.

I will not go over the challenges and strategies again since I went over them in the last presentation, and you have heard it about three times now.

The specialized foster homes were a little more immune than family foster homes at loss. We did not lose as many of them, but we do not have enough of them. In my first presentation, I talked a little bit about how there were less calls, but those calls were much more severe and there was more trauma involved. These children are coming into care and requiring these specialized homes and like everything else, there are not enough of them. We are working to try dual licensing, and we are looking forward to the actuarial study. We do consult regularly with our agency homes that reside mostly in our urban areas to see about opening homes in some of our more rural areas.

I am open for questions, should the Committee have any.

Chair Peters:

Are there any questions from the Committee on the brief presentation on this issue? I am not seeing any questions. Thank you for being here; we appreciate what you do and your program for these kids.

AGENDA ITEM XI—THE DEMARCATION BETWEEN YOUTH AND YOUNG ADULT SERVICES, GAPS, AND CHALLENGES IN CONTINUATION OF CARE AND ITS IMPACT ON YOUTH IN THE CHILD WELFARE AND JUVENILE JUSTICE SYSTEMS

Chair Peters:

Next is Agenda Item XI, the demarcation between youth and young adult services, gaps and challenges in continuation of care, and its impact on youth in the child welfare and juvenile justice system. We have quite a few people to either present or answer questions; please go ahead and introduce yourself and proceed.

JoAnne Malay, Deputy Administrator, Clinical Services and Mental Health, DPBH, DHHS:

With me today is Ellen Richardson-Adams, who will be presenting. Young adults in transition is an important milestone that we all experience. Youth in systems of care oftentimes need additional services and systems of support to help make this process successful and smooth. Our presentation today will provide information on the ways DPBH wraps young adults for this transition (Agenda Item XI). I will hand it over to Ms. Richardson-Adams.

Ellen Richardson-Adams, Agency Manager, Southern Nevada Adult Mental Health Services (SNAMHS) Outpatient/Rural Clinics, DPBH, DHHS:

I will start with a broad overview of DPBH with clinical services. We serve the rural and frontier areas, along with urban Clark County and Washoe County. There are 16 outpatient clinics across the 12 Nevada counties in which we serve children, adolescents, and adults. In the urban areas, SNAMHS serves ages 18 and over, but in Mesquite and Laughlin, we serve youth, adolescents, and adults. Northern Nevada Adult Mental Health Services (NNAMHS) serves ages 18 and over.

The services offered include the following: medication management, counseling, case management, basic skills training, psychosocial rehabilitation, and psychological testing. We have some co-occurring programs for those who have substance abuse and mental health. We provide benefit enrollments such as insurance, food assistance, social security disability, and other outside resources that are helpful. We have drop-in centers across some of the different clinics. We also provide crisis stabilization team support in the rural counties; there is a program for youth and a separate program for adults. All services are individualized and applicable for a particular person.

We provide targeted case management as outlined in Chapter 2500 of the *Medicaid Services Manual*. What that means is we provide linkage and referral to community resources. It might include making an appointment for an individual with the primary care provider, setting them up for their dental appointments and making sure their mouth is healthy for oral hygiene, gynecology appointments, or any other specialists that would be applicable, including vision.

We offer assistance with enrollment into education programs. We help them if they are still eligible for educational services through an IEP. We can connect them for adult education and any type of vocational rehab or job training programs. In addition, there might be referrals to speech, music, and art therapy, along with occupational and physical therapy. Again, what is applicable for that person and what would be helpful for their success in the community.

As Ms. Malay mentioned earlier, we recognize the importance of young adults. Turning 18 years old is an important time and can be scary. We focus on that age group to help make it a true transition for the individuals who are hitting that big milestone. Oftentimes, the youth that come into our services have been in involuntary programs. There have been decision makers on their behalf to tell them what they are going to do, what counseling they will take, what program they will go to, et cetera. Then, suddenly, they turn 18 years of age and have decisions to make on their own. Services can be voluntary unless they are court ordered. Sometimes we have youth who say, "Thanks, but no thanks." We work out a process with them so when they are interested in services they know who to contact, how to come back in, and that they are welcome at any time.

The SNAMHS and NNAMHS both have legislatively approved young adult and transition caseloads. For the case management side, it is a 15:1 caseload ratio. Part of the reason why that ratio is so low is because of the need for intensive services and access to their case manager to help with any type of services they are seeking or for guidance.

Young adults in transition for the urban areas is a little different than the young adults in transition for the rural areas. I am going to take a minute to talk through the difference. For the urban areas, we begin that process about six months prior to them turning age 18. We join as a partner with their child-family team meetings. We participate with other youth providers for their multidisciplinary teams, or MDTs.

We set up a series of face-to-face meetings with those youth because we know that relationship building is going to be the piece that it going to help them want to be in services. It takes away from, "I have to go to this institution place or this building" to "I get to see Miss Ellen" or "I get to see Miss Tiffany." It makes it more personalized, and we find that the more relationship building time we have, the smoother the transition goes. We value that piece and continue that engagement even after they turn 18 years old. We try to keep those primary points of contacts in place for them so it sustains their energy of wanting to be in services. We invite them to come see our place and take a tour so they do not have to enter the building by themselves. They have somebody to guide them through the process, to show them what the doctor's office looks like, or what the counseling room looks like. They can come see the drop-in center where they can get onto the computer and check social media or apply for a job. If, for whatever reason, they are not able to come and see what one of the residential homes looks like, we take pictures to them; that way, they can see and are part of the decision-making process regarding what their future home may look like. Oftentimes, the young adults transition into our state financial supported living.

If they are out of state or, again, if they are not able to meet face-to-face, we have different videoconference options available so that relationship building can begin and they can start meeting their providers. We provide information on what adult services are and how we can help them fulfill their dreams and future things they may want to do. It is a series of bridging for that age and to hold their hand and help them through that process.

It is slightly different for the rural areas. One of the positive pieces is because we serve youth adolescents and adults, oftentimes they can stay with the same provider. If they are 17 years old, 11 months, and have Ms. Smith as their counselor, next month, when they turn 18 years old, Ms. Smith can still be their counselor. It helps them because there is that relationship and the counselor is helping them through that process.

If they are already in the child welfare system, the team continues to participate in the child-family team meetings. We cooperate with different educational settings, so if they are in high school, we work with the local school they attend and help bridge those pieces.

If somebody has an IEP, there is a component that talks about educational or vocational plans for those age 14 and over. We participate in that piece and we can carry that forward; it is not just a document or a process that ends at age 18.

There are supportive services that help with transitioning from youth to adulthood and with a life plan, continuing to be forward thinking. We help them discover who they are and what they want to be help and then set out paths to help them get there. Again, the key piece is they can maintain that behavioral health service provider and team, they are not starting over. They really work on decision-making and practice those decision-making pieces. Now that they are an adult and everything falls to them, they can have a guide and somebody to help them through that decision-making process.

It is important that SNAMHS has bridge programs in place for the youth who are aging into adult systems. Those programs provide an introduction and a discussion opportunity for the next steps, making it not so scary that they are turning 18 and becoming an adult. It helps to establish that familiarity of people, environments, and processes. It creates that warm handoff and helps to improve engagement. Our goal is we want them to continue in services; we do not want them to end and just say, "I am 18, I am grown, you cannot tell me what to do. Thanks, but no thanks." We want them to say, "I am going to be 18 next week. Can I come by?" Yes, at age 18, 19, 20, 21, and 30 we are here for you. Those bridge programs help to establish that.

The bridge programs have set up three primary pieces. The National Association of State Mental Health Program Directors offered a Transformation Transfer Initiative (TTI) grant. The purpose of this grant is to create motivations and incentives for individuals to come in for their appointments. We look at items that are specific for that age group that will incentivize them to want to come and follow up with their appointments. It is a great program as a whole. They come to their appointment and do what they are supposed to do and then say, "I get this backpack? Is this for me?" I see them from my office window. It is pretty cool; they strut and there is this excitement about them. We have found the TTI piece has been a great option.

We participate with Clark County's Department of Juvenile Justice Services. We are a partner for The Harbor and have staff assigned there. We can also provide services and supports for families with resources.

The Clark County School District has Mission High School, and we have two staff assigned there as well. For individual youth who have co-occurring disorders and are in active recovery, this high school helps them to maintain their recovery. Having two of our staff stationed there helps bridge into adult services so we can continue the post-18 piece for their co-occurring and continued recovery.

Turning 18 provides a lot of challenges and opportunities. There are some limited step-up or step-down programs for young adults in transition. There are some limitations with community living transition. If you are 18 or 19 years old, oftentimes the available housing has 30-, 40-, 50-, 60-, or 80-year-olds living there, and they are not necessarily seen as fun. They may not connect with the young adults or understand their lives; sometimes it is hard to engage. We look at how we can make it specific—almost like going to college and living in a dorm with a resident advisor—where there are opportunities for them to learn how to do chores and have people in their same age group with whom they can connect, build a relationship, and socialize.

The licensing for adult residential types begins at age 18—you are not eligible at age 17 and 364 days. You are not eligible to enter adult housing based on licensing until you are truly 18 years old. Sometimes there is a bit of an overlap when somebody is turning 18, and I talked already about what those opportunities would look like. It would be some type of young adult housing that would focus on that age group where they can build friends and relationships; learn how to do those adult things like cooking, cleaning, and managing their money; and making those independent decisions.

There are some limitations. When an individual is coming from an acute inpatient or PRTF, usually they can only stay there until their eighteenth birthday when they no longer meet eligibility criteria, as I spoke about earlier. You cannot enter the adult world until you are 18 years old, so there is this 24- to-48-hour gap around their birthday where there is a state of limbo. We do our best to work through that on an individualized basis, but it is a challenge. With that, I am open to any questions. Thank you for the opportunity.

Chair Peters:

Are there any questions from the Committee? I am not seeing any. I would like you to expand on some of the things the legislative process may be able to help you with at this time—whether that is developing these bridge programs or whether there are any barriers to bridge programs that you have identified specifically. It looks like there are some ideas in here from the challenges and opportunities around licensing and making sure those handoffs at the eighteenth birthday are not so disruptive. Could you discuss that more?

Ms. Richardson-Adams:

Some opportunities would be for us to look at whether there is another licensing type that we could add into statute—possibly for ages 16 or 17 through 22, something that would help bridge that piece and make the opportunity smoother and more seamless for the individuals. With that, we could talk about what programming could look like and what opportunities are there for them to begin in adult services even slightly earlier, if it is appropriate for that particular youth.

Chair Peters:

I think it is definitely worth exploring what it might look like. We consistently see that age group, 16 to 24, not having the bridge, but we have services on either side. Even in our homeless discussions and our LGBT youth discussions, this is the age range where we have not built out effective services or at least not effective enough across the state to capture those kids. I think it is a great idea to look into.

Just as a side note, I could imagine retiring and becoming one of these people who helps teach them how to clean a kitchen, how to maintain their pots and pans, or how to balance a checkbook. I think there is a lot of opportunity within the community to tap into resources and people who would love to come in and participate in a smaller setting with this age range of kids.

Assemblywoman Titus has a question.

Assemblywoman Titus:

Just a comment along the same lines. In high school, we had a class called home economics and somehow or another we did away with that class. I took it, and your gender did not matter. Maybe another class on home economics would be good to do.

Chair Peters:

I think about that class frequently now that I have kids—my cupboards being open and the way you put pans on your stove—things I learned in home economics in middle school. It stuck with me. I would have to talk to the school districts about how we teach that these days.

I am not seeing any other questions, so we will go ahead and close out this agenda item. Thank you for being here and please be in touch with these ideas and how we can work through some of these issues together.

AGENDA ITEM XII—PRESENTATION ON SUCCESSES AND CHALLENGES IN ADDRESSING HOMELESSNESS AMONG YOUNG ADULTS IN NEVADA BY EDDY HOUSE—A DROP-IN RESOURCE CENTER IN NORTHERN NEVADA

Chair Peters:

We are ready to move on to Agenda Item XII, which is our presentation on successes and challenges in addressing homelessness among youth and young adults in Nevada by the Eddy House, a drop-in resource center in northern Nevada. As a side note to my colleagues in southern Nevada, if you are ever in northern Nevada, come in and talk to the folks at Eddy House and tour their facility. It is wonderful what they have been able to do and how quickly they have been able to grow into a foundational resource for our community. Please introduce yourself and go ahead.

Trevor Macaluso, Chief Executive Officer (CEO), Eddy House:

I want to thank you Chair for inviting us and thank you to Dr. Pitlock and her team for recommending this presentation (Agenda Item XII). Eddy House is a 501(c)(3) nonprofit in Reno. Our mission is to work with homeless and at-risk youth to help them develop the job and life skills necessary for sustainable independence. Our essential goal is to help end youth homelessness in northern Nevada. Our current target population is 18- to 24-year-olds, that transitional age youth as defined by the U.S. Department of Housing and Urban Development.

A little bit about our history, we were founded by Lynette Eddy in 2011. She was a master of social work student at the University and through an internship at a shelter in Reno, discovered that the youth homeless population in our community was the fastest growing subpopulation of homeless in the area. Upon graduation, she was able to put together and start our organization. In 2015, we opened a drop-in center that was located on East Sixth Street in Reno. It was a Monday through Friday drop-in center, from 9 a.m. to 5 p.m., for youth aged 12 to 21 to access day services. In 2020, we expanded to our current facility in downtown Reno on Willow Street and, with that, expanded our drop-in center, added an emergency shelter, a community living program, and our transitional housing program. The 17,000-square foot facility is where we currently operate. It is a fully owned facility that we have; we do not have any debt. We were able to purchase that facility thanks to a loan from the Housing Division, Department of Business and Industry, for $2 million that was given to us in 2018. In July 2020, we were able to fully pay off that loan, which is amazing, thanks to a lot of the community support and foundations in the northern Nevada community. We appreciate the state for the funding to help us begin that process.

In 2020, we were recognized as an "envision center" by the U.S. Department of Housing and Urban Development. An envision center is an identified central hub for resources and support. We were the first in Nevada, and we are 1 of only 100 in the country. We were able to survive, keep going, and expand our services throughout the pandemic, which I think is very exciting. In 2021, we expanded our street outreach program, and I am going to cover a little bit more of these programs in detail shortly.

This year all of our programming is based in research done by UNR that was funded by the Nell J. Redfield Foundation. We have opened our diversion programming and are hoping to pilot an independent living home with the Human Services Agency of Washoe County.

Our continuum of services at Eddy House has entry points with exit points being both diversion and independence. For anybody who encounters us directly through our outreach activities, drop-in center, or emergency shelter, our priority is diversion to prevent them from accessing the shelter long term; get them into permanent housing; or prevent them from becoming homeless or maintaining their homeless situation long term. However, clients tend to skip around based on their needs. We want to make sure we are serving each and every client right where their needs are. While it is like a step stool or a ladder towards independence, we recognize that every client will be served, based upon their specific needs.

Our outreach program is primarily street outreach to encampments, motels, and apartments. We identify homeless youth in our community and provide them with resources, essential things—like fruit, snacks, warm clothing, hand warmers, and information about Eddy House and our services—so we can become a hub for them and a service to them in their time of need. We also do partner outreach at other shelters, for example, the Nevada Cares Campus, different juvenile justice court systems, and we

identify other partnering shelters where we can do outreach. Again, as you have heard in previous presentations, when it comes to housing—but obviously for shelters—we are dedicated towards youth, and we are a more appropriate facility than the Cares Campus. While it is a great resource for the northern Nevada community, the average age there is 55 years and older. Our outreach team also does a lot of community awareness about our services so any individual is aware of what we are doing and can make referrals to any youth they encounter. Our outreach primarily focuses on those diversion efforts I mentioned previously.

Our drop-in center is open 24 hours a day. We offer basic essential services like mail service, therapy, laundry vouchers, basically any essential service that a youth who is homeless or at-risk might need at the time. Essential supplies are things like Narcan for those who might have an opioid addiction; it could also include first aid kits, anything we need to make sure we are providing anything of substance to the clients we serve.

Our emergency shelter is an overnight shelter. Cots and beds are reserved daily. We have no sobriety requirement. We have on-call support from our therapist and our case management team 24 hours a day, 7 days a week, so any youth facing crisis has a support system available to them. Our capacity is currently approved for 27 men and 4 women. Over the course of our history, we tend to serve about 60 to 65 percent men over women, although, we have seen our female numbers grow over the last eight to nine months. We always have additional cots; we have never turned anybody away and that is a great thing about the dynamic building that we currently operate in.

Our community living program is the next step after the emergency shelter. This is a temporary housing program that we also operate at the same facility. It has the capacity currently for 23 men and 6 women. It is a six-month program that has a higher expectation of the clients and a higher level of commitment from them. It is a sober living environment. We say it is a six-month program, but some clients move through it much faster, and some take a little bit longer.

As you have heard a lot today—and you will see some more statistics from us here shortly—our clients have faced a lot of trauma. They come from a lot of different backgrounds, and they have a lot of different needs. Essential documents take a long time to get—which means you cannot get a job without essential documents. It can take a while to get our homeless youth, who are in transition, on their feet and on a path towards independence. We have a much higher level of case management and have put together, in collaboration with those clients, Client Success Plans.

We have a holistic approach when it comes to our community living program. The goal of every shelter should be trying to house people as fast as possible—you often hear that defined as the housing first model and what most shelters across the country will say is the standard. While we do not disagree, we do disagree that for transitional age youth, just giving them a job and an apartment by themselves is not going to fix the problem. I am not aware of many 18- to 24-yearf-olds who are employed and able to afford to live on their own, have the life skills, the mental health awareness, or know of the resources in the community to be successful independently. We focus on a holistic approach through our programming in our community living program around five areas identified by UNR's Dr. Kenneth Coll and the counseling education program, and this is the basis for how we conduct our programming at the Eddy House. We believe when a client has a broader knowledge of: (1) careers and finance; (2) housing and transportation; (3) their essential documents; (4) community; and (5) self care, they are more likely to be successful living independently and less likely to return to homelessness or needing services in the future.

We do a lot of these things through groups and strategic partnerships with government agencies, other nonprofits, companies, and volunteers in the community. Altogether, they provide about 80 percent of the programming groups we teach throughout the week, with the remaining balance being taught in house by our own staff. A lot of the plans the research is based on comes from foster youth transition plans and the Foster Youth Connect Network in the Washington area.

Following their graduation from the community living program, our clients are eligible to move into our transitional living program. This is transitional housing that these clients are able to access for up to two years by paying a small program service fee. They are required to check in with case management on a weekly basis, with a face-to-face at least once a month. Once they are employed, most youth at this age are not eligible for a lot of the affordable housing vouchers that we have around town. It is no secret there is an affordable housing crisis, not only throughout the state, but especially in northern Nevada and the Reno/Truckee Meadows area. There are only 15 Foster Youth for Independence vouchers, or FYIs, available, and those 15 vouchers are only available to youth who have exited foster care, as in they have aged out at 18 from foster care, and that is not enough for what we have in the community. Eddy House's solution is to provide transitional housing as a stopgap where we capture those youth who are ready for independence but are not quite ready to financially live independently, as there are no other options available. We have a capacity of ten between our two homes. Neither of our homes are owned by Eddy House, so we are at the will of those owners for us to even maintain those programs. One of them is at the Kids Kottage campus, a Washoe County facility, and one is a home owned by Renown Health.

Our independent living home is an independent living program; you heard DCFS talk about it earlier today. We have proposed a pilot program to the Human Services Agency of Washoe County for us to open a home and become a provider to capture six residents who are aging out foster youth. This would be less than a 12-month program where Eddy House would handle all of the programming, life skills, and everything we currently offer to our in-house residents, and they would have specific case management. We consider this a homeless prevention program. There are a lot of foster youth who when they exit, do not have a place to go, and they end up in our shelter. We would rather they not end up in a shelter and not face that additional trauma of becoming homeless. These are the kinds of programs that are needed to prevent long-term homelessness amongst our youth.

In 2021, Eddy House served 374 unique individuals over the course of the year; of those, 216 accessed our services for the first time. Both numbers represent an approximate 10 percent increase of those we served in 2020. Of the clients we served in 2021, 99 percent self-identified as homeless. We provided over 5,000 showers and 12,000 bed nights—a bed night is every night that a single bed is filled; it is not representative of a specific number of youths, just how many beds we filled over the course of the year. We provide other services, such as bus passes and meals.

In 2022, we have had a 71 percent success exit rate from our community living program into either a transitional living program, an independent program, or permanent housing situation; that is up from 45 percent in 2021. Already in the first quarter of 2022, those who have exited from our transitional homes have 100 percent exited into a permanent housing situation, whereas last year, that number was only 70 percent. We attribute this to our new research-based model on how we handle programming and development with the youth we serve. However, in the first quarter of this year, we have identified and served 43 new homeless or at-risk youth in the northern Nevada community and have served a total of 136 youth.

I cannot speak to all homeless youth; I can only speak to the youth we have served at Eddy House. These numbers come from those who are self-identified: 44 percent were homeless before they turned 18; 48 percent became homeless between the ages of 18 and 21; and only 8 percent became homeless after the age of 22. I think this indicates why this transitional age is so important. The presentations we have seen today indicate there is something happening when young people are turning 18 years old and are in that age range of what is causing their situation. Forty-eight percent of our clients attest that the previous situation they were living in was unsafe, which is why they are at the Eddy House shelter. When clients come and they stay in our shelter, we ask them where they slept the previous night, and I think this demonstrates the transient nature of our youth, which you heard earlier in one of the first presentations. It is very hard to get a solid number of how many homeless youths there are because of how they move around. Thirty-one percent of the clients we serve were couch surfing the night before, 23 percent were in a home of some sort, and 31 percent slept on the street the night before. Thirty-six percent of our clients also are members of the LGBTQ community.

One thing that is interesting for many of the homeless shelters across the country is the statistics show their capacities or numbers tend to increase over the winter and decrease over the summer. For homeless youth, we have identified that it is the opposite, at least with the Eddy House. Many of the youth, even though the previous living situation was unsafe, are willing to stay there during the winter and in the summer when it is nicer, they would rather sleep outside; that is usually how they end up finding Eddy House, through our outreach programs.

Some of the self-reported challenges that the youth we serve have faced include:

- 59 percent were abused, neglected, or assaulted as a child;
- 55 percent were physically or sexually assaulted as an adult;
- 10 percent reported being trafficked, but in conversations with them in case management, the reality is closer to 20 percent. Many of them do not know the definition of trafficking. We have had clients say they did not get any money, so they were not being trafficked; there is a lot of education or miseducation around the issue;
- 35 percent of our clients had been in foster care at some point in their life; and
- 64 percent have their diploma or high school equivalency.

The foster care number is why we believe that an independent living home and these independent living programs are so important because again, it is contributing to one-third of the clients we see.

Eighty-five percent of our clients have self-reported that they use substances. Of those who used substances: 95 percent use marijuana; 90 percent use alcohol; 20 percent use methamphetamine; 10 percent use opioids by choice; and 5 percent use other substances. The truth is, the longer an individual is homeless, the likelihood of substance misuse increases, which is why it is so important that we have these early interventions and the work that we do at Eddy House. While our clients are using, and some might be addicted, we are able to do some early intervention. We are not dealing with folks who have been using for years and years, so it is a little easier and more obvious to handle those situations when it comes to youth.

Regarding mental and behavioral health, 40 percent of our clients self-report a mental health disability. Our in-house therapist would estimate that the actual number is about 75 percent of the clients whom we serve. About 8 percent of our clients receive psychiatric referrals, half of whom will need permanent supportive housing. They have a mental health diagnosis that will require permanent support over the course of their lifetime. They either do not have the self awareness or insight to recognize they have a disability. Because of their mental health diagnosis, they are unwilling to become medicated, or they are just unable to take care of themselves—basic things like taking a shower, turning off the stove, things that are essential to safe living. Ten percent of our clients receive medication referrals, which include some of the psychiatric referrals, but also things like antidepressants. Most of our clients show signs of trauma, and we would argue that being homeless in and of itself is a form of trauma.

We have identified a few policy and funding needs that are important to us as an organization that the Legislature could consider. One is to increase the number of mental health providers by easing the licensing and reciprocity that is seen in other states to increase the likelihood that other providers might move into our state, and another is to incentivize mental health providers to work in the nonprofit areas. Working in homeless and youth homelessness, you are often working with more high-acuity clients than you might in a private practice. It is very difficult for mental health providers with their own secondhand trauma, boundaries, and the things they have to live through when it comes to their work and professional life. They are less likely to work at a nonprofit organization like ours; incentives for those who would do so would be wonderful.

More transitional housing for homeless and foster youth is needed along with increased funding for independent living programs. More vouchers are needed so we can prevent clients from falling off a cliff after going through programs like ours. Again, we appreciate, what the IFC and the Housing Division are going to do with affordable housing and increasing availability, but transitional housing is huge. We need a middle ground for our clients before affordable housing is an option. Because of the situation they are currently in, their background and level of income makes it difficult to compete with everybody else on a housing voucher when it comes to the local housing authorities in our state.

An increase in public transportation is needed. Many of the youth we work with rely on public transportation, which is not widely available in the northern Nevada community and quite frankly, the same thing in the southern Nevada community. Reliable public transportation is important not only for getting to work, but also finding viable housing options. Even some of the great housing options that exist across the community may not be as close to public transportation as they need to be or, again, a viable job for the youth to begin their career. It creates a large challenge for them.

More permanent supportive housing is needed for those clients who have mental health diagnoses and are going to need long-term supportive care.

Easier access to essential documents is important. You cannot get a job without some combination of a state identification, birth certificate, and social security card. You also cannot get any of those documents without having one to start with. Our clients show up on our door without any of them, so it takes a long time to secure a birth certificate and then receive their social security card and finally the Nevada identification. Easier access for homeless youth and the homeless community, in general, to essential documents would allow them to be on an easier and quicker path to finding work.

Finally, ending legal brothels and adopting an equality model are important. We have research, that we have read and are willing to share, that shows the presence of legalized prostitution does not substitute demand, it increases demand, which has a direct effect on the clients whom we serve.

Eddy House applied for one of the Nevada Recovers Nonprofit Grants through the Office of the Governor. We understand that a lot of those have now been passed through to the appropriate agencies. We intend to go before the Housing Division to ask for $3 to $6 million for a transitional living construction project that we plan to begin this year. That is all I have for you all.

Chair Peters:

Thank you for the presentation and for outlining some of the work that is being done at Eddy House. It has been awesome to see Eddy House come into the vision; I first learned about it in 2017 or 2018. I wanted to take a point of personal privilege and share that between the ages of 19 and 21 or 22, I was homeless, twice, and depended on friends and couches to get myself on my feet and figure out what to do next. Eddy House did not exist then; we did not have a lot of options in northern Nevada at the time. I had family, which was great, but they did not have the space for me to be a permanent resident. I wanted to share that as part of the destigmatizing piece.

Are there any questions from the Committee before I begin with some of my questions? Dr. Hardy, please go ahead with your question.

Senator Hardy:

I am curious about the reciprocity for providers. Do we have an idea what other states have done that helps them? How long does it take us now to get a person licensed or credentialed in the State of Nevada versus the reciprocity or the compact that other people are doing?

Mr. Macaluso:

We will pull some more specific data on that for you. A lot of the mental health providers we have spoken to have expressed that increasing the availability of providers is a concern for them as well. We will send that answer to staff.

Chair Peters:

How do you assist clients in obtaining the central documents and what are some of the barriers? What is your process around our LGBT and trans or nonbinary youth and potential name changes that are requested?

Mr. Macaluso:

The process to get the essential documents takes a long time. Oftentimes, if there is family, they may be unwilling to help attain those essential documents, which is the obstacle for our youth. We use a few different websites that cost us sometimes in the hundreds of dollars to obtain an essential document and a birth certificate, because not all of the youth were born here in the community. They may have been born in other states, so it is navigating other counties and other institutions even though that client has been living in Reno for many years. It is a lot of waiting. Then, we must send the birth certificate to Social Security in order to get the Social Security card. We have one client, who after

three months of us submitting the application, learned the birth certificate was lost, which caused the process to start over. Cleaning up those processes and returning to in-person appointments for the homeless youth population and some sort of expedition in getting appointments would benefit our clients. Our case managers walk through each of the processes and help them fill out every application so we can get those things done.

We have not had to deal with a name change or anything for our transgender or LGBT community as far as the essential documents are concerned. We are aware of the processes and are prepared to walk through them. Again, with a large number of that community that we serve, most of them are on the streets because they were removed from their home because of that lifestyle.

Chair Peters:

Regarding your LGBT clients, how do you handle cots and your specific capacity? You broke it down into men and women, but how do you fit in your LGBT youth?

Mr. Macaluso:

For those who are nonbinary, or do not identify as either male or female, we allow them to choose the cot room that best suits them. The clients we serve, at this point, have not had any issue with it, so it has not been a problem. However, with an expansion, we would also be able to offer more private rooms, especially for our community living program and other transitional programs, to become more accommodating. We have nongender-specific bathrooms as well as gender-specific bathrooms. We want to do everything we can to accommodate anybody, no matter what their identity is.

Chair Peters:

I love and appreciate that. Can you talk about the capacity of your transitional housing and limitations; you broke that down well for us, but what does that capacity mean for your wait list? Do you have a list of youth who are waiting to be a part of that program?

Mr. Macaluso:

It causes a big problem for us. We have a great front door in our outreach program, in our shelter, and we have a community living program that works. Then, we have a full transitional housing program currently, which means there is no room for them. Because it is a two-year program, it can sometimes take a long time. We explore other options that are available in the community. We may have to refer them to other group homes or push harder than is ideal for a client to live with roommates or in an independent situation knowing that their likelihood of success might not be as great as if we could offer them a transitional housing spot. The hope with our construction project is to open a minimum of 20 to 25 doors so we could make sure we have an exit strategy that is equal to our entry and programming.

Chair Peters:

I look forward to seeing that buildout construction. Are there any other questions from the Committee for the Eddy House? I do not see any. Thank you so much for your presentation; we really appreciate learning more about Eddy House.

AGENDA ITEM XIII—OVERVIEW OF PUBLIC ASSISTANCE PROGRAMS THAT PROVIDE ECONOMIC RELIEF TO FAMILIES

Chair Peters:

That puts us at Agenda Item XIII, an overview of public assistance programs that provide economic relief for families. We have some folks from the Division of Welfare and Supportive Services (DWSS), DHHS. Please introduce yourself and proceed when you are ready.

Robert Thompson, Administrator, DWSS, DHHS:

The Division of Welfare and Supportive Services administers several programs that receive federal funding. In the interest of time, we will not be able to get deep into every single one of our programs, but we want to give a high-level overview of each one of these programs, as all of our programs are designed to move children, families, and individuals out of poverty (Agenda Item XIII).

The first program we wanted to talk about was our Childcare and Development Program. The Childcare and Development Program has grown just beyond what we could have imagined using an influx of federal funds in March 2020. The Childcare and Development Program provides financial assistance to income-eligible families to access childcare and help all families find quality childcare via The Children's Cabinet and the Las Vegas Urban League. We have issued over $99 million paid to providers since April 1, 2022. We have expanded the income eligibility to 85 percent of the state median income to serve more children and families. Since that expansion, the Las Vegas Urban League processed 244 new applications in the first month the change was implemented. While the total caseload has dropped slightly, we are anticipating a 50 percent increase of eligible children. I was notified the drop in the number of children being served is actually due to workforce. The childcare centers are having difficulty onboarding staff, but we are working with them and currently 77 percent of licensed providers are participating in the childcare program.

We want to talk about our Child Support Enforcement Program. The Child Support Enforcement Program is designed to engage both parents to make sure they are part of the child's life, but also to bring financial support to the parents that are caring for the child. In 2021, we collected over $206 million dollars for children in Nevada. We wanted to point out that in 2012, Nevada was 37th in the nation in the measurable categories by the federal government. Those measurable categories are based on collections, cases with orders established, current child support arrearages, and payments on arrearages. In 2021 and 2020, we increased our ratings to seventh and ninth in the nation. I was informed two days ago that we are maintaining seventh, so we are happy about that. We have rolled out a new child support computer system that went live this month and went out with few problems.

The next program I want to talk about is our Medicaid Program. In the State of Nevada, DWSS does the eligibility and completes the applications for persons applying to receive Medicaid. Once approved, the Division of Health Care Financing and Policy, DHHS, takes over for the billing and patient management. We are currently serving over 900,000 Nevadans on Medicaid, including Nevada Checkup. I think it is notable to point out that Medicaid pays for 56 percent of all Nevada births.

The next program I want to talk about is our Supplemental Nutrition Assistance Program (SNAP), also known as food stamps. Currently, Nevada's food stamp program serves 438,000 individuals. Of those, 177,000—or approximately 40 percent—are children between

the ages of 0 to 18. There are multiple programs within SNAP. It provides a monthly benefit, but it also provides employment and training, outreach services, and SNAP education, which we will talk about.

Next, we will talk about the SNAP Education Program (SNAP-Ed) which receives a grant and is 100 percent federally funded. We use that grant to connect with children. I toured a school where we were teaching children to grow fresh fruits and vegetables. Then, they partnered with a junior high school, and the junior high school helped those children who grew the fruits and vegetables cook the fruits and vegetables. Then they sat down and had a banquet together. We also work with child physical activity classes targeting school-aged children. The SNAP Education Program complements SNAP.

The SNAP provides federal funds for SNAP Outreach. We partner with community partners. We have 12 community partners covering all 16 counties and one independent city to reach those families who are not able to apply for SNAP through the traditional sources of calling in, coming to our offices, or applying online.

Next, we will talk about our Temporary Assistance for Needy Families (TANF), the cash assistance program commonly referred to as the Welfare Program. The Welfare Program has multiple aspects to it also. The Welfare Program provides a monthly check to those who qualify but is tied to a work program. Those work programs come with many support services including childcare, transportation, work cards, counseling, and vocational training. We are currently kicking off a specialized unit to focus on individuals who are dealing with substance abuse disorders who can and are able to work at the same time they are dealing with those disorders.

We wanted to talk about the community programs that come along with SNAP. We use part of The SNAP block grant to provide direct assistance to our customers. We also use part of that block grant to assist our communities in areas such as childcare and we provide assistance to the county child welfare agencies that we have heard from today—autism treatment assistance program, family preservation program, workforce development, and benefits to families with young children. Those benefits can be something as simple as a diaper program that we kicked off. We received additional funding from the federal government during the pandemic and we used part of it to send additional money to our TANF customers so they had a one-time assistance to help buy school clothes.

There are successes in the TANF program. Some of you on this Committee may have heard in our other committees that DWSS struggled with meeting some of the work participation rates at the measurement of the federal government for many years. We were facing penalties in the all-family work participation rate. We are required to have so many of these families engaged, and we could not reach the benchmarks of the federal government. We have reached those all-family work participation rates. We have met the corrective compliance plan. Last week we were notified that for the first time since the TANF Program went into effect, we are not facing a penalty for not meeting the two-parent work participation rate. That is for the first time on record.

The next program I want to talk about is the Energy Assistance Program (EAP), which is also administered through DWSS. Through our Division, the EAP assists families who are under a certain percent of poverty. We can provide them with assistance to reduce the energy burden of their household, with the goal of them not spending a higher percentage of their income on energy bills than the median in Nevada. During the pandemic, we received additional funds for this program also and we were able to send out additional money for this program.

The last program I want to talk about is our Targeted Outreach Program. This was the brainchild of Director Whitley. It started about eight to ten years ago when we asked one of our case managers to start connecting with community partners or individuals who were not able to get to our offices for whatever reason. In addition to the SNAP Outreach Program, the Targeted Outreach Program does outreach for all of our programs. We now have 42 case managers servicing 161 sites statewide. Some are full-time, but most of them are part-time. They go to mental health facilities and to correction facilities—anywhere we have identified a need for any of our programs, where people, for whatever reason, were not able to apply. One of the successes of this program is that there are 90 additional sites waiting to sign up for us. Along with the other agencies that spoke today, we have had some trouble onboarding staff and bringing our staffing levels up to where we like them. As we stabilize and move forward, we plan on continuing this program because the feedback from our community has been fantastic with the support we have been able to give our community partners.

In 2019, 28,000 applications were processed at those community partners, and we attended 120 special community events. Along with the partners that we visit every month, or every week, or some of them every day, we went out to community events. In 2020, as we dealt with the pandemic, we had to scale back our outreach because it cannot be done virtually at home, but we are now opening those doors again and getting back out into the community.

I have already talked about the Targeted Outreach successes, but the implementation of that was really an "office in a box." Our case managers have a rolling suitcase that holds their laptop, Wi-Fi, their telephones, printers, and everything they need to be able to go out and serve the community. We hope to continue growing that program. We would be open to any questions.

Chair Peters:

Thank you for the presentation; quite a bit of work goes on under the Division. Can you give us an idea of the number of people that you work with in the community under all these different programs, not individually under the programs, but generally?

Mr. Thompson:

On average, we process 69,000 applications per month, and we take approximately 30,000 phone calls per month. We measure what our workers do by task and that is called a "touch"—it can be an application, phone call, somebody moving in and out of a home, a child being born, or income change. There are about 250,000 touches per month on the cases we work. Our largest caseload is Medicaid, and it is over 900,000. Over one in four Nevadans are being served through our agency this time monthly.

Chair Peters:

It is interesting that crossover of Medicaid and your Division. When you say that you have 250,000 folks under the Medicaid program, can you talk about what your office does with that group of clients?

Mr. Thompson:

Just to quantify that, there are over 900,000 individuals receiving Medicaid per month. The 250,000 are how many touches we do per month for all of our big three programs: food stamps, Medicaid, and cash assistance. Just the updates and case management are a

250,000 touches per month. Now that I have clarified that, I am so sorry I missed the question.

Chair Peters:

I am glad you clarified that. What does your Division do within the Medicaid space? Eligibility is one piece. How long is your engagement with those clients through the Medicaid process?

Mr. Thompson:

When a person has the need for Medicaid, they can apply through DWSS by clicking in, calling in, or coming in. They can go through our website to apply for those services, they can come to one of our offices to apply for Medicaid, and Medicaid is the only program we have where a person can apply via telephone and attest to their signature—we can do everything verbally over the phone with them.

It is our job to verify their income depending on the type of program they are applying for. Medicaid has multiple programs and over 30 subprograms, and we have to determine what category a person is eligible for. Once we make that determination, we input it into our system. When we approve it, we transmit it to the DHCFP and that Division takes over the case management. Our constant engagement with those customers is that we must continually update if their income changes, which is very common in Nevada. We must complete an annual redetermination for federal guidelines. We must do the paperwork packet with them once a year or verbally over the phone. Some of our customers are living in an institution, and those cases require monthly touches to make sure the case is up to date and the institution is receiving the full benefit for customers who have additional benefits, such as waivers. There is more that goes on with the Medicaid program.

Fifty percent of our Medicaid customers also receive SNAP food stamps. Some states require an individual go to the food stamp office to apply for benefits and then they may have to go across town to apply for the Medicaid program. In the late 1980s or early 1990s, Nevada integrated those programs, so we do it all in one touch. However, that means we are training our case managers to work on three different federal programs, often with three different sets of guidelines in one computer system, so we engage those customers often. The TANF program is also integrated into the other two. The TANF program, which has a different set of guidelines, is one of our smallest programs and separate from those. The energy assistance, child support, and childcare are all standalone programs; they are not integrated with the other two. They will do referrals back and forth, and we will share information back and forth, but they are not integrated eligibility.

Chair Peters:

Thank you for that clarification and breakdown. It is an amazing feat to have that integration of your programs. It makes life much easier when you only have to touch one office to get a bunch of work done, to ensure you are getting the resources that are applicable for you, and not have to run around. We end up seeing people fall off when they have to go to multiple locations and talk to multiple people for their different services.

One of the reasons we asked you to present was to talk about some of those crossover services for children and parents, including the childcare subsidies. I have talked at length with your Division about how this works; would you mind explaining how you leverage some of the federal grant funds to offer those services and what those look like for parents in the

community? And how has COVID-19 changed the way you offer those services or the number of families who may have been impacted by those services?

Mr. Thompson:

Deputy Chappel is our subject matter expert on the childcare program, so I am going to turn it over to her.

Chair Peters:

Full disclosure—Deputy Chappel is my mother.

Margot Chappel, Deputy Administrator, Field Operations Support, DWSS, DHHS:

I am glad you asked because I wanted to chime in to say we were just recently awarded a technical assistance grant from the APHSA, the American Public Human Services Association. We are engaged in a six-month planning process to streamline and align our services for young families with parents who are 24 years old and younger. One of the mandatory requirements for this project is that we have a parent represented with that user experience. We have a gal who was 24 years old, she is older now, when she was using our services and she works for us. Our program chiefs, two deputies, and agency manager for childcare are looking at that because right now the childcare eligibility process is solely done by funded partners, such as The Children's Cabinet and the Las Vegas Urban League, which creates an unnatural barrier to services for those families. When we do the integrated application process, we see if they might be eligible for childcare and we refer them to The Children's Cabinet and the Las Vegas Urban League, and we get all the funding for that. We are looking at how we can integrate that and make it easier for the families that come in.

Chair Peters:

Yes. The only piece I would ask you to expand on is the COVID-19 funding that has come through your office and how that has been used in our communities to help with the dire need of childcare services in Nevada right now.

Ms. Chappel:

We have given two rounds of substantial amounts of funding to licensed childcare providers and our family, friends, and neighbors who are certified through our Childcare and Development Program. Those are individuals who have gone through a background check, their home is safe, they take care of a child for a family member who is eligible for subsidies. That person does not have a license, but we have gone in—or The Children's Cabinet or the Las Vegas Urban League has gone in—and checked to make sure they meet all of the standards for the federal program to receive that money.

We sent an initial smaller amount ranging from $7,000 to $600,000 in the first round of funding that we received. Coronavirus Relief Supplemental Funds were provided initially and—those of you on IFC may remember—there was a distinct and separate pot of money that came in for provider stabilization grants, which was a larger amount of money. We have distributed about half of that, at this point, through The Children's Cabinet and the Las Vegas Urban League and that is still in the process of going out.

The requests we received exceeded the amount of money we had, so we had to come up with a way to equitably complete that award process, which I think we did. We came up with a plan where we cut the highest request the most and the larger centers are going to

receive a little bit less. The people who applied for under $500,000 will see no cut at all, but anybody who applied for over $1 million will see a cut. We have given them a lot of money and we are also increasing the subsidy rates; that has not happened yet, but they are coming around May 1. Then, hopefully we will have more licensed childcare providers participating in that program.

Chair Peters:

I appreciate that; it has made a difference to our family. We have one child left in childcare, outside of the public school system, and we recently received a notice that because of those funds, they were able to offer a credit back to us for a week where the entire school was closed because of COVID-19. The credit was to ensure we were not harmed by the COVID-19 closure as we were trying to figure out childcare for ourselves, while I was still working, and we still had kids in the public school. Thank you for that breakdown. I think what you are doing is going to make a huge difference and has made a huge difference to families so far as we are in recovery. Are there any questions from the Committee members?

Senator Harris:

I have a quick question about the integrated services and the single application. Is Lifeline included in the assessment? If a person comes in applying for Medicaid, is Lifeline eligibility also assessed at that point?

Mr. Thompson:

The only programs that are integrated are Medicaid, SNAP, and TANF. We are working through several partners and through the Department of Health and Human Services towards a "No Wrong Door Platform" to be able to use our website to allow additional screenings for other programs to be done. That is a futuristic concept you brought up that we are working on, but at this time the only true integration we have are those three programs.

Senator Harris:

Let me just clarify, I think your answer is no, you do not currently do that.

Mr. Thompson:

Correct.

Senator Harris:

Okay. If there is anything we can do to help, let me know. Since COVID-19 happened, the power of communication has been thrown in our face, so if people can apply for Medicaid and get their Lifeline eligibility at the same time, it would be beneficial, as you have noted, which is why you have integrated the three programs.

Mr. Thompson:

If I may jump in, I missed one bullet point that I think is so important to throw out. Prior to COVID-19, we were issuing approximately $48 million a month in food stamps from our agency, and last month we issued $111 million in food stamps. We only had a 7 percent increase in the caseload for the SNAP Program prior to COVID-19, but the benefits we are

issuing right now are double what we were seeing prior to COVID-19, which is a huge benefit to our families.

Chair Peters:

Those are amazing numbers. I had questions—but we can take them offline—about how your agency plays into our food security networks and making sure we are identifying where there may be food deserts and how we uplift those communities in that way. Also, if there is a correlation between SNAP beneficiaries and food deserts. That is a broader conversation we can have another time but it speaks to the complexity of your Division.

Dr. Titus has a question.

Assemblywoman Titus:

I have a question regarding the fraud and accountability of these Coronavirus funds. Chair Peters mentioned a particular incident with her family and the preschool where her children go. Do you have a list of the childcare facilities that received those funds? If so, how much and when they received that money, did they offer rebates to the families who paid them by the month? For instance, in my family, I pay for a grandson to go to a preschool, and they shut down at various times. Certainly, I have not seen any reimbursement or did not expect any reimbursement, but I was wondering about the accountability and following these funds.

Ms. Chappel:

We are following it closely through The Children's Cabinet, who monitored the whole application process. We gave them half of the money up front that they requested. We had a formula for how much they could get based on how many children they were licensed to have. They are required to send us a report at three months about how they utilized the funds. We then determine the final payout based on the amount of funds remaining, as well as what they had done with it. There was a caveat, and I went back and forth with the feds on this one. In the first round, the providers had to pass the costs along to the families. In the second round, for the provider stabilization grants, the federal government told us that we could not require the providers to pass along savings to the families because it was meant to stabilize the provider program, not to support families. We have not gotten a lot of clarity from them yet. It may be that we discount them because we originally required the provider to pass on 20 percent of their total grant to families in savings. We are going back and forth on that right now.

Assemblywoman Titus:

Will you have a document available for public purview about where this money was sent?

Ms. Chappel:

We have a spreadsheet, but I am not certain about the rules on making it public or if we can put it up on a website for everyone to see. I will follow up and see if that is something we can legally do.

Chair Peters:

I had the same question when our schools shut down. I sent them the link to apply for this grant and suggested they apply for it, and I hoped they were paying their teachers while

the school was shut down. They followed up and said they were following the guidelines to ensure that they were meeting the criteria. This happened back in early January, and we just recently got a notice that they are extending the cost savings onto their clients.

Are there any other questions from the Committee on these topics? I do not see any more questions. Thank you for the presentation, and we look forward to working with you on some of these issues as we move forward into session.

AGENDA ITEM XIV—OVERVIEW OF THE NEVADA HOME VISITING PROGRAM, WHICH FUNDS COMMUNITY-BASED SERVICES SUPPORTING CHILDREN AND THEIR PARENTS FROM THE PRENATAL STAGE TO KINDERGARTEN ENTRY IN TARGETED AT-RISK COMMUNITIES

Chair Peters:

We are going to move on to Agenda Item XIV, an overview of the Nevada Home Visiting Program, which funds community-based services supporting children and their parents from the prenatal stage to kindergarten entry in targeted at-risk communities. I look forward to hearing how things are going. Please introduce yourself and proceed when you are ready.

Vickie Ives, M.A., Deputy Bureau Chief, Bureau of Child, Family and Community Wellness, DBPH, DHHS:

Thank you for the opportunity to give a brief overview of the Nevada Home Visiting Program (Agenda Item XIV). You will see it is an upstream intervention that has a lot of touchpoints with the prior presentations today. I will go ahead and turn it over to my colleague.

Tami Conn, Maternal, Child and Adolescent Health Section Manager, Bureau of Child, Family and Community Wellness, DBPH, DHHS:

What is the Nevada Home Visiting Program? The Program serves expectant persons and families with children up to age five, or kindergarten entry, through which trained professionals visit the families in their home, maintain a regular schedule of visits, and provide families with ongoing support, screenings, education, and referrals. I want to note that the Home Visiting Program is strictly voluntary; it is evidence-based, and the staff are held to model fidelity, and I will be going over those models.

The goals of home visiting are to encourage positive parenting, improve maternal and child health, prevent child abuse and neglect, and promote child development and school readiness. Nevada Home Visiting takes a two-generation approach to improve family circumstances in the present and improve outcomes for the future. The RAND Corporation research shows a $3 to $5 return on investment in service savings for every dollar spent and home visiting.

Who is eligible to receive Nevada Home Visiting services? The program supports families who meet at least one of the following eligibility criteria:

- Have an income at or below 100 percent federal poverty level;
- Are pregnant people who have not attained the age of 21;
- Have a history of child abuse or neglect or have had interactions with child welfare services;

- Have a history of substance use or need substance use treatment;
- Use tobacco products in the home;
- Have or have had children with low student achievement;
- Have children with developmental delays or disabilities; or
- Are in families, including individuals serving or formally serving in the armed forces, including families with members of the armed forces who have had multiple deployment outside the United States.

Again, they have to meet one of these criteria to be eligible for home visiting services.

The primary source of funding for home visiting is a federal Health Resources and Services Administration grant called the Maternal, Infant, and Early Childhood Home Visiting Program, also known as MIECHV. This Program funds most of the Nevada Home Visiting efforts.

The Program has 12 programs in seven counties, both urban and rural. The number of current enrolled families is 279, and the counties being served are Washoe, Storey, Lyon, Carson City, Mineral, Nye, and Clark Counties.

Nevada Home Visiting employs four evidence-based models. The first of the models is the nurse family partnership model, also known as NFP. This model serves first-time pregnant people and their child up to two years of age. The current agency using this model is the Southern Nevada Health District, which serves Clark County. The NFP model uses specially educated registered nurses to regularly visit their clients starting before 28 weeks of pregnancy and continuing through the child's second birthday. The goals of NFP are to improve pregnancy outcomes, improve child health and development, and improve the economic self-sufficiency of the family.

The next model is home instruction for parents of preschool youngsters, also known as HIPPY. This model serves families with children ages two to five years old until kindergarten entry. The current agencies utilizing this model are The Children's Cabinet, which serves Washoe County, and the Sunrise Children's Foundation serving Nye and Clark Counties. The HIPPY model focuses on parent-involved and parent-directed early learning with targeted outcomes of improving the parent-child relationship, promoting positive parent-child interaction, helping underserved children achieve long-term academic success, increasing parental involvement in the child's educational experience, and creating pathways for parents to access economic and educational opportunities in their communities.

The next model is the parents as teachers program, also known as PAT. This program serves pregnant people and families with children up to kindergarten entry. The current agencies using PAT are Community Chest in Lyon, Storey, and Mineral Counties; Lyon County Human Services in Lyon County; the Yerington Paiute Tribe; and The Children's Cabinet in Washoe County. The PAT program emphasizes parent-child interaction, development-centered parenting, and the family well-being with the primary goals of increasing parent knowledge of early childhood development, improving parenting practices, providing early detection of developmental delays or health issues, preventing child abuse and neglect, and increasing children's school readiness and school success.

The last of the four programs is the Early Head Start program, which serves pregnant people and families with children up to three years of age. The current agencies using the Early Head Start model are UNR, serving Washoe County, and the Sunrise Children's Foundation, serving Clark County. Early Head Start is its own program but it utilizes the PAT curriculum. The agencies have the opportunity to use the PAT curriculum, but still have access to Early Head Start specific resources. Early Head Start supports building cognitive self-regulation or executive functioning skills, such as focusing, maintaining attention, and controlling impulses.

That is a very brief overview of the Nevada Home Visiting Program. Are there any questions?

Chair Peters:

Are there any questions from the Committee on these programs? I do not see any questions. Thank you for this presentation; it looks like awesome work. I know a number of those agencies are doing great things with their programs for parents and families. Do you have anything else to present?

Ms. Ives:

It was just the brief overview of the models, but if any additional information such as performance measures, benchmarks, or anything else would be helpful, we would be happy to provide it.

Chair Peters:

We may be talking more about the maternal health and early childhood metrics at the next meeting, so I might reach out and ask for those.

AGENDA ITEM XV—OVERVIEW OF FORENSIC MENTAL HEALTH SERVICES IN NEVADA

Chair Peters:

I am going to go ahead and move on to Agenda Item XV, which is the overview of forensic mental health services in Nevada. We have folks from DPBH; please introduce yourself and proceed when you are ready.

Ms. Malay:

We are going to present our programs and primarily focus on our forensic services (Agenda Item XV). Our agenda today includes a brief overview of civil services for adults who are admitted to our hospitals under Chapter 433A of NRS. We will also give a brief overview of our misdemeanor program in our civil hospitals and outpatient clinics and an overview of forensic services to adults committed under Chapter 178 of NRS. We will also provide information on our programs, our growth, ensuring evidence-based practices, and future programming.

While we primarily focus on impatient services, our outpatient services play a crucial role in treatment, supervision of court-ordered individuals, and successful discharges of our inpatient clients. Our hospitals and outpatient clinics provide direct behavioral health care. Civil admissions can occur as emergency admissions due to a mental health crisis. The substantial likelihood of serious harm to him or herself or others due to mental illness is

commonly called a "legal hold," and it is a 72-hour admission. The next type of admission is an involuntary admission, which is court-ordered admission for observation, evaluation, and treatment. This can be up to a six-month admission.

When we look at our misdemeanor programs, we must understand that the criminal system is not the best option for individuals with mental illness who have committed a misdemeanor. The misdemeanor diversion programs are alternatives that safely divert people with behavioral health needs into treatment that produces better outcomes for the individual, the community, and the justice system. The Division has civil misdemeanor diversion programs that partner with our local justice systems, our health care facilities, and outpatient clinics in northern and southern Nevada. About 23 percent of our clients admitted to our psychiatric hospitals are through the misdemeanor program, through municipal and county courts.

The Division has secure psychiatric facilities providing comprehensive forensic mental health services—along with civil health services, we also provide forensic services. From around the state, individuals are court ordered to Lake's Crossing Center in northern Nevada and Muri Stein Hospital in southern Nevada for evaluation and/or treatment for restoration to legal competency. Individuals admitted to the facilities are facing serious charges, are considered to be a danger to self or others, and in need of security and structure for restoration to competency. Our forensic hospitals provide additional treatment and observation services to individuals who were unable to be treated to competencies, are facing certain category A or B felonies, and have been determined to be in need of the level of care provided by a secure forensic facility. Our hospitals also include defendants who have been found not guilty by reason of insanity. All admissions and discharges are by court order. It is important to note that individuals committed for restoration and who have a serious mental illness can be competent to stand trial. Over the past three years, 68 to 77 percent of all of our clients admitted for restoration were found competent to stand trial.

Over the past ten years, we have seen a national trend for increased forensic services. In 2014, a National Association of State Mental Health Program Directors Survey found that 78 percent of hospitals reported an increase in need, with 50 percent reporting that they have near or have been found in contempt of court for failing to admit court-ordered patients in a timely manner. This same survey found a 72 percent increase in incompetent to stand trials from 1999 to 2014. In 2007, NRS changes allowed the courts to commit certain defendants to the hospital for up to ten years if individuals could not be restored and needed to be treated in a secure facility.

Our bed capacity has increased. In December 2021, we had 164 filled beds; today we have 189 filled beds. This is how fast our commitments and census are growing.

To show our census growth statewide, I will give you a bit of our history. In 1976, Nevada's first forensic hospital—Lake's Crossing Center—opened in Sparks, Nevada. Between 2006 and 2014, 30 more beds were opened in Lake's annex. In 2015, the Muri Stein Hospital opened in Las Vegas. It started small in early 2015, but by the end of the year, we had quickly increased to 47 beds. In the last 15 years, there has been a percentage increase in bed capacity and census. In FY 2021–2022, we added additional beds by utilizing civil beds to meet our forensic needs.

Staffing shortages play a role in our ability to serve our clients. Nationally, many staff are leaving psychiatric units for much higher pay and less stressful conditions elsewhere. The departures have limited the capacity of state-run hospitals. Our evaluators, which are psychiatrists and psychologists, ensure evaluations are done on clients to adjudicate

through the system. Other staff, such as nursing and forensic services, ensure a safe and therapeutic environment. The Division has a shortage in state full-time equivalents, with a high reliance on contract staff.

Another factor impacting the number of available beds at our forensic hospitals is a growing number of clients who have been adjudicated under NRS 178.461. This population was added when the statute was passed in 2007. These individuals have completed their course of competency, restoration treatment, and still have been found incompetent to stand trial without probability that they can be brought to competency. These clients are determined to present an immediate risk to themselves and/or the public if released into the community. In these cases, the individual is ordered to remain in the care and custody of the administrator of the Division, or their designee, for a period of up to ten years, with the potential for a five-year expansion depending on charges. If a defendant is charged with a category A felony or certain category B felonies, and found permanently incompetent to stand trial, there is a motion for a hearing to determine whether to commit the incompetent defendant to the custody of the administrator. This decision is largely based on a risk assessment performed by evaluators at our forensic hospitals. At least once every 12 months, the court reviews the eligibility of the defendant for conditional release. These defendants, remanded to the custody of the administrator for observation, are known as 461 patients. The length of commitment of any of these patients must not exceed ten years, although—as I said earlier—certain charges qualify the individuals for additional five-year commitment increments. With that I am going to pass it over to Mr. Cross who will speak on conditional release.

Drew Cross, Interim Agency Manager, Lake's Crossing Center, DBPH, DHHS:

The Division carefully considers candidates for conditional release to determine what may be the least restrictive treatment alternative for the individual that is also consistent with the public safety and the welfare of the individual. This process includes a comprehensive evaluation that considers the individual's history, recent behavior, treatment compliance, and current mental status. If the evaluator considering these factors, in consultation with the individual's treatment team, opines the individual is a good candidate for conditional release, then the discharge planning process begins. This includes extensive collaboration between the individual's inpatient treatment team—the team that would work with the client in the community—and other resources to assure the individual would have wraparound services to assure theirs and other's safety. Prior to a final opinion and recommendation to the court, a Division psychologist completes a risk assessment identifying factors relevant to future risk.

In preparation of the conditional release hearing, the evaluation discharge plan and risk assessment are submitted to the court and distributed to the defense counsel and district attorney. A hearing is set with the committing court for review of the material and for testimony, if any. The final decision to release an individual on conditional release is made by the court. If the court decides the individual can be conditionally released, an order is prepared and final discharge arrangements made. If the court decides the client is not currently eligible for conditional release, the individual remains at the forensic facility and their case is reviewed again in 12 months. If an individual on conditional release violates any component of their conditional release plan, they can be returned to the forensic facility until a hearing is held to review the violation, and a determination will be made if they can remain on conditional release status.

Dr. Shera Bradley will now speak on opportunities and forensics with the statewide steering committee.

Shera D. Bradley, Ph.D., Director of Civil Forensic Psychology, SNAMHS, DBPH, DHHS:

The statewide forensic steering committee was formed in response to the opening of the Muri Stein Hospital in Las Vegas. The committee is a multidisciplinary team of professionals in both northern and southern Nevada. It allows us to have the opportunity to discuss various policies, procedures, and processes that were being developed at the Muri Stein Hospital, in consultation with our colleagues at Lake's Crossing Center, which had been established for many years. The committee allows us to share various successes at our hospitals and programming that we are developing and to consult with one another about various challenges. We have used the committee meetings to brainstorm solutions to meet the expanding need for forensic services. Each county and city jurisdiction approaches competency and forensic clinical issues differently, so the committee is a good place for us to come together and talk about that and develop strategies to respond. It also allows us to share information from professional conferences and trainings we attend to keep up to date with the state of forensic mental health.

Additionally, we are committed to providing evidence-based services. When we meet as a steering committee we are able to talk about things that are working in our hospitals and other programming that is being developed nationwide to respond to this growing need. We participate in a forensic task force meeting that is run through the Eighth Judicial District Court of Clark County. The steering committee discusses possible agenda items to put on the task force agenda and makes decisions about which ones we will bring to the court and jails that sit on the task force.

The Muri Stein Hospital has been in operation for nearly seven years now, and like many other places, we need to improve our recruitment, workforce development, and staffing. Finding enough staff to meet the growing need is a challenge, as many agencies have mentioned today. We would like to increase our visibility by developing web pages where people could access a list of our services, the various job opportunities, attract trainees to our professional training programs, and improve that workforce development pipeline. We also want to work on having web pages that improve our communication with the court system and families of patients. We will continue to review statutes and the various *Nevada Administrative Codes* that apply to us and make adjustments as the landscape of forensic mental health services changes in Nevada. Finally, we are striving to improve our data tracking by looking at trends over time, making predictions for things that we need to be doing in the future, and developing programs. We can talk about those things on a statewide basis and look at how things are working in both hospitals.

If there are no questions for me specifically, I will turn it back over to Ms. Malay.

Ms. Malay:

One last thing I wanted to mention about our opportunity. The Division acknowledges the growing needs for a forensic strategic plan due to our changing environment and rapid growth, so a proposal request for forensic strategic planning in Nevada was completed and awarded. The request for the contract approval goes before the Board of Examiners in June, with work to begin in July, if approved. The contract bid was awarded to a company that has done similar work in the State of Washington, Virginia, and Alaska. The company will review our current system in Nevada, our statutes, and out competency system; it will evaluate our data tracking and reporting to analyze and improve our outcomes. We are excited about that opportunity. We are open to any questions.

Chair Peters:

My first question has to do with the strategic plan. Do you think your review of the statutes will be available before our deadlines for the next legislative session or would that be pushed off to the following legislative session?

Ms. Malay:

This company that we hope to work was kind enough to give us their work from other states. This helped us with some of the statutes we would like to review to improve our process and have more up-to-date processes that are done nationally and are evidence-based. Yes, we will have some.

Chair Peters:

I have another question, but I am going to see if the Committee has questions before I jump into mine. Are there any questions from the Committee? Assemblywoman Gorelow, please go ahead.

Assemblywoman Gorelow:

I had a quick question regarding the staffing. We are hearing this as a theme, that we cannot fill positions. Are there certain credentials or educational requirements for these staff members and what are they? Are there any suggestions on what we can do to help people meet those credentials and requirements?

Ms. Malay:

Our licensed professionals are some of the hardest to recruit here in the state. Dr. Bradley has done a phenomenal job on a psychology internship program in multiple levels. Working with the universities to get those recruitments would be great for us as well. Mental health technicians have a higher turnover; although we do get more applicants, sometimes they do not always stay as there are opportunities, and they move on. Then, of course, our nursing staff is another one of our licensed professionals that are hard to find.

I know that Leon Ravin, M.D., our Statewide Psychiatric Medical Director, DHHS, has been working with multiple parties, but he could certainly use some help on how to recruit psychiatrists because they are in high demand, and our wages and salaries are not as competitive with other states and certainly private entities.

Nevada is rather unique in that we use forensic specialists, which are a Category 3 peace officer, in our forensic facilities. They are currently in high competition with our other law enforcement and correctional institutes.

Assemblywoman Gorelow:

You mentioned the mental health technicians. What kind of educational background does one need to be a mental health technician? I understand the doctor and those take a long time to grow. In my full-time job, we are looking for professionals in the autism realm, and I have been suggesting to our CEO to train someone from within who already has a certificate in one discipline who could take a year's worth of training to obtain a certificate in another discipline. Let us try to build the pipeline that way. I was just wondering what the mental health technician required.

Ms. Malay:

We received help from legislators with nursing apprentice programs, and we just started those with approval. We are bringing in nurses who are in the later years of their training program and will be compensated to work alongside the trained, experienced nurses in our facilities. We already have nurses who are in school in their clinical rotation, but are working a shift alongside of us. It is very helpful, and more of those programs would be great.

The mental health technicians only require a high school education. They have to take some College of Southern Nevada classes in mental health and behavioral health, but those are the only requirements they need to work in our facilities.

Senator Harris:

I sit on the Joint Interim Standing Committee on Judiciary (Section 6 of AB 443 [2021]) and we have been looking at corrections issues. One of the things I hear time and time again is they have too many folks with mental health issues in their jails who are sitting there for, let us say, 90 days on something where they maybe should only serve two or three days, but they cannot get a competency hearing to see the judge until three months or so out. At that point, they have been held for much longer than whatever the offense may be. It seems to me that this is a staffing issue. How do we fix that? I am sure we need to recruit more folks, but in the meantime, is there anything we can do to get that number down?

Ms. Malay:

Oregon Advocacy Center v. Mink, 322 F.3d 1101, 1122 n.13 (9th Cir. 2003) is the federal case law that requires we get clients into our facilities for competency restoration to stand trial within seven days. They have gone through multiple judicial processes and that takes months, but we have to admit within seven days. Seven days is a quick turnaround time, so that is going to be a challenge.

Staffing is absolutely an issue. Those evaluators have to be able to evaluate the clients in order to move them along, but we also have to keep a safe environment, so we cannot keep constantly admitting people. We have to ensure that we have enough beds. The challenge is we need civil beds, and we need forensic beds, but one is required by federal law and statute and the other is not required. Forensic has been our priority due to the federal law. Staffing and more beds would help greatly beds. We only have so many beds and after they are filled, what do you do?

Senator Harris:

Can you tell me a little bit about what the assessment process looks like? Is it absolutely necessary that someone be admitted? Could we station someone at our most populous jails, and could they do an assessment at that point of contact? Is that too simplistic of a solution?

Ms. Malay:

One of the statutes we looked at has not garnished a lot of support for those jail-based competencies because it brings evaluators right into the jails to evaluate if someone needs commitment to a facility or if they can just stay on their medication. It is a process that has to be approved by the courts and the jails. Any help you could provide there would be great.

As an evaluator, Dr. Bradley could probably explain a little better. In 1960, the U.S. Supreme Court had a landmark case, *Dusky v. United States*, 362 U.S. 402 (1960), that required a defendant to have a competency evaluation prior to proceeding to trial. The same court case also outlined those standards to determine evaluation for competency. The Dusky Standard has a few elements. Dr. Bradley could explain the Dusky Standard and why those assessments take the length of time that they do because I think it is really important.

Dr. Bradley:

There are two points in time where evaluations are done. They have evaluations in the jail, or in the community if they are not incarcerated; we call them precommitment evaluations. They have those evaluations, then the judge makes a decision about whether the person requires restoration and whether that would be inpatient or outpatient. After they come to our programs, whether it is inpatient or outpatient, they require evaluations to move forward from there—whether they are found competent or incompetent, whether they need more treatment, whether they are able to be restored to competence. If they just have the two precommitment evaluations and then the three on the other end, that makes five evaluations that need to be done on any given patient or defendant.

The Dusky Standard outlines that we have to look at whether the person understands the court process. Do they have a rational and factual understanding of their charges? Do they have the ability to aid and assist the attorney with their defense in a rational way? How each evaluator determines that may be a little different—certainly through interviewing; review of records; sometimes psychological testing is done; collateral interviews, if needed, to understand the person's history or history of treatment if they are not able to give that information to us. If they are inpatient, we also use observations from the staff who see them 24/7—the mental health technicians, forensic specialist, or nurses who are seeing them day in and day out on the units. They can be relatively involved and time-consuming depending on each particular case.

Senator Harris:

I appreciate your responses. I will offer myself as a resource if I can to see how we can get these folks evaluated a bit quicker to save us some money from keeping them in jail. Then we will work on the real problem—why they are in jail in the first place.

Chair Peters:

Thank you for that offer, Senator Harris. Are there any other questions from the Committee before I ask my questions? I am not seeing any. How are your services funded; what are your funding mechanisms?

Ms. Malay:

We are 100 percent generally funded. As Ms. Richardson-Adams mentioned, we receive a small grant for incentives for some of the civil and outpatient clients, but our forensic facilities are 100 percent State General Funds.

Chair Peters:

Is there any potential for Medicaid coverage for these patients?

Ms. Malay:

When our civil population is in the hospital, we enroll them in Medicaid or the managed care organization programming for which they are eligible, and that is successful. It was a good, helpful program implemented by Director Whitley, and it continues today. Our federal law does not allow us to get reimbursement for hospital stays for those forensic clients because they are termed "incarcerated," so we do not get reimbursement for those clients. We are the only hospitals that take those clients under Chapter 178 of NRS, so it makes us very dependent upon the state funding.

Chair Peters:

Very interesting. This is not a money committee, but I think it is important to understand how the programs interplay with each other and some of the limitations that exist. What are some of the contributing factors to the national trend of the increased need for forensic services?

Ms. Malay:

Part of the trend, I think, is more people are being recognized as mentally ill and being screened for mental illness. I do not know if the agenda was prophetic or not, but it was interesting that there were so many interventions mentioned for the children. They are all so important, because at the other end of the spectrum are adult forensic clients, who unfortunately have become criminally involved. Prevention is probably one of the best interventions earlier in life. The other is the court system and jails have recognized mental illness and they will bring those clients in more readily now. We are seeing more involvement through the criminal systems.

Dr. Bradley:

That is a complicated question. I do not think we have the full answer to that. Some people have looked at the number of civil beds that are available and as those have decreased, the number of forensic beds has increased. That may be a part of it. I am sure you have heard of the term "criminalization of the mentally ill." If you have people who are not receiving services that encompass all of their needs, they sometimes end up getting themselves into situations where they get arrested. I think that is a piece of it. I agree with what Ms. Malay said about people recognizing mental illness and recognizing the need for competency evaluations. Convictions have been overturned because of the failure to recognize competency or have a competency hearing. I think sometimes the threshold to refer is pretty low and attorneys rely on those precommitment evaluators to tell them what is going on with the person. There are probably lots of other pieces that connect to it.

Mr. Cross:

I agree with both Ms. Malay and Dr. Bradley. Another contributing factor I would mention would be substance use.

Chair Peters:

Thank you for the response. As Senator Harris suggested, part of the solution may be to work towards unwinding these indicators and get a handle on populations before the increase starts or the need gets out of hand. It would be great to not have to build more facilities if we can get it from the beginning.

I do not see any other questions. Thank you for the presentation and the information; we look forward to working with you on these issues.

AGENDA ITEM XVI—UPDATE ON THE CORONAVIRUS DISEASE OF 2019 HEALTH CRISIS INTERIM STUDY PURSUANT TO SENATE BILL 209 (2021)

Chair Peters:

We are going to move on to our last presentation, Agenda Item XVI, our update on the COVID-19 health crisis interim study pursuant to SB 209. Vice Chair Doñate has been spearheading this effort and will be making the presentation. Please proceed when you are ready.

Fabian Doñate, Senate District 10:

Today I am presenting an update on the COVID-19 health crisis interim study pursuant to SB 209, which was passed last legislative session (Agenda Item XVI). Before we begin, I would like to note that a handout should be available on the Committee's website, and our Committee staff have been instrumental in crafting these documents for you. They helped coordinate a lot of these stakeholder engagements. I strongly recommend that you look at some of the information we have collected so far from this study.

As you recall, Chair Peters appointed me to lead the SB 209 interim study efforts during the January 20, 2022, Joint Interim Standing Committee on Health and Human Services meeting. At that point, I decided to hold various roundtable discussions with relevant stakeholders for each of the interim study requirements. Also, I will provide several updates, like this one, during the Committee meetings over the coming months to keep you informed about the progress of the interim study and to give you an opportunity to ask questions and provide comments.

We held our first roundtable on March 15, 2022. I invited several stakeholders to the first virtual roundtable discussion and this one focused on the study requirements related to the COVID-19 pandemic and Nevada's public health infrastructure. Specifically, we looked at strengths and weaknesses of the public health infrastructure. We took an analysis on state and local governments, how they responded, how they delineated duties and jurisdictions, and how they coordinated between one another. We looked at how these items can be improved for future public health crises. Then we also talked about public health funding recommendations.

Prior to the roundtable, stakeholders received an 11-question survey. The purpose of that was to ask them to be forward-looking and solution-oriented on what they felt was most important to prioritize moving forward from COVID-19 and for any future public health emergencies. In the document that the Committee staff prepared for you, a list of stakeholders who received the survey and participated in a roundtable is provided. Many of them, including Carson City Health and Human Services, DBPH, and Southern Nevada and Washoe County Health Districts, were a part of it.

Policy recommendations are probably the most impactful part of the things we are collecting from each of these stakeholder engagements. On page two of the handout, a summary of the high-level discussion and themes is provided to you, including the strength and challenges or weaknesses of our public health system. A few highlights for you. First, the greatest strengths that were identified from our public health entities and staff, were

their resilience and resolve despite many barriers and limitations and, of course, their coordination abilities.

Second, the greatest challenge identified was limited and lack of funding for public health programs across all levels of the system and a reliance on inconsistent federal grant funding to sustain the system. A common example exhibited between the different folks was, as you all know, there are different processes to request funding. It is not just receiving federal grants. They must go through IFC approval and then, once they receive the approval, they must go through internal channels to hire the folks needed to do the work. By the time you get the funds to do something, we have already surpassed a few months; that takes away from our public health response to the challenges that we have.

Additionally, other policy recommendations for both the COVID-19 response and the Nevada's public health infrastructure were also summarized on page two. We received many different policy considerations related to the COVID-19 response. Therefore, we outlined the specific recommendations in the addendum, which you can find on pages three and four of the handout. We have endless amounts of notes already collected just from the first stakeholder engagement and more, of course, will come as we move forward.

I will quickly summarize the four stakeholder conversations. The first one, that we just completed, was on government coordination. The second one is going to bring business entities and employees together to share what we have learned from the business sector. The third one focuses on public health infrastructure and public health workforce, not to be confused with the health care workforce. The fourth and final one will be everything else, the special topics, and health equity.

Chair Peters and Committee members, this concludes my remarks, and I am available to answer any questions you may have.

Chair Peters:

Thank you, Vice Chair, for the information and this robust report. I look forward to reading through these recommendations and suggestions and to hearing, at the end of your engagements, what you come up with as priorities. Are there any questions or comments from the Committee on this report? Dr. Titus, please go ahead.

Assemblywoman Titus:

Thank you for the report. Are going to look into some of the basic health care outcomes? I have been seeing some articles that look back on where Nevada ranks on deaths, treatments, and vaccinations. I see you are addressing infrastructure, staffing, and some of those issues, but I wondered about outcomes.

Senator Doñate:

That will be part of the special topics we will focus on in the last roundtable, health equity. It will focus on outcomes and special populations that were disproportionately affected from the COVID-19 crisis. If you have any recommendations, or if you would like to attend, you are more than welcome to answer any questions or even provide questions to the stakeholders as part of our survey. I am happy to have that as part of the final report, if that it something that you are looking for.

Assemblywoman Titus:

Great, thank you. I can send you some information I have been getting about where Nevada stands, and it is not very pretty on outcomes. I will forward that to you.

Chair Peters:

Are there any other questions from the Committee related to this report? I am not seeing any. Thank you again, Vice Chair, for the presentation and for your work on this study. We appreciate your effort and the effort of staff to complete this study for us.

AGENDA ITEM XVII—PUBLIC COMMENT

Chair Peters:

I am going to move on to our final agenda item for the day, which is our second public comment.

[Chair Peters repeated the protocol for public comment.]

There is nobody in the room in Carson City. If there is anybody in Las Vegas to provide public comment, please come to the table. I am not seeing anyone.

Broadcast and Production Services, please open the public comment line and add the first caller to the meeting.

Tiffany Tyler-Gardner, Ph.D., Executive Director, Children's Advocacy Alliance:

I am calling on behalf of the Children's Advocacy Alliance to thank you for prioritizing and understanding the systems impacting children and families in Nevada (Agenda Item XVII). Today you have heard about a number of challenges and opportunities to intervene on behalf of Nevada's children. While we are deeply appreciative of recent investments, we implore you to consider the needs yet unmet, the work undone, and the growing challenges faced by children and families. Whether it is the number of former foster youth experiencing homelessness, the parents surrendering children in hopes of care, the growing mental health crisis, the lack of support for those undertaking guardianship, or the historically, pervasively low reimbursement rates that have gutted our systems of care, it is clear that more investment is needed. Accordingly, we implore you to fully leverage your role as legislative leaders and changemakers to pull Nevada's children out of peril. Please take the next important step of investing in these systems and programs that were mentioned today, whether it is home visiting or support for children or families impacted by our systems like the child welfare system. You can have a hand in the change that we want to see and ensure a recovery for Nevada's children and families. Thank you for your leadership.

Chair Peters:

Thank you for the call; I appreciate the feedback. Are there any other callers on the public comment line?

BPS:

Chair, there are no more callers to public comment at this time.

Chair Peters:

Thank you so much. I am going to go ahead and close public comment.

Our next meeting will be held on May 19, 2022, at 9 a.m. This is planned to be an in-person meeting, so we will likely have the similar scenario with folks in the north and south, and we will have the virtual option as well. Thank you for being here today and for the robust conversation. I appreciate all the expertise and curiosity that you bring, Committee members, and of course, thank you, staff, for all the work you put in to help make this agenda so robust and phenomenal. I appreciate all your work.

AGENDA ITEM XVIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:47 p.m.

Respectfully submitted,

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Crystal Rowe
Research Policy Assistant

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Patrick B. Ashton
Senior Policy Analyst

APPROVED BY:

_____

Assemblywoman Sarah Peters, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IV A	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R007-21 of the State Board of Pharmacy
Agenda Item IV B	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R062-21 of the State Board of Health
Agenda Item IV C	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R064-21 of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board
Agenda Item IV D	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R028-22 of the Board of Medical Examiners
Agenda Item V	Cameron Rifkin, Policy Specialist, Children and Families Program, National Conference of State Legislatures (NSCL); Heather Wilson, Senior Policy Specialist, Children and Families Program, NCSL; and Jill Yordy, Senior Policy Specialist, Children and Families Program, NCSL	PowerPoint Presentation
Agenda Item VI	Domonique Rice, Ph.D., M.S., B.S., Deputy Administrator of Quality and Oversight, Division of Child and Family Services (DCFS), Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item VII	Kimberly Abbott, J.D., C.W.L.S., Team Chief, Children's Attorneys Project, Legal Aid Center of Southern Nevada; Timothy Burch, Administrator of Human Services, Clark County Department of Family	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Services; Ryan Gustafson, Division Director, Child Protective Services, Human Services Agency of Washoe County; and Laurie Jackson, Rural Regional Manager, DCFS, DHHS	
Agenda Item VIII	Brigid Duffy, Chief Deputy District Attorney, Director, Juvenile Division, Clark County Office of the District Attorney	PowerPoint Presentation
Agenda Item IX	Lawrence Howell, Chief Administrative Officer, Rite of Passage (ROP); and Makaya Swain, Program Director, The Embracing Project, ROP	PowerPoint Presentation
Agenda Item X	Laurie Jackson, Rural Regional Manager, DCFS, DHHS	PowerPoint Presentation
Agenda Item XI	JoAnne Malay, Deputy Administrator, Clinical Services and Mental Health, DPBH, DHHS; and Ellen Richardson-Adams, Agency Manager, Southern Nevada Adult Mental Health Services (SNAMHS) Outpatient/Rural Clinics, Department of Public and Behavioral Health (DPBH), DHHS	PowerPoint Presentation
Agenda Item XII	Trevor Macaluso, Chief Executive Officer, Eddy House	PowerPoint Presentation
Agenda Item XIII	Robert Thompson, Administrator, Division of Welfare and Supportive Services, DHHS	PowerPoint Presentation
Agenda Item XIV	Tami Conn, Maternal, Child and Adolescent Health Section Manager, Bureau of Child, Family and	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Community Wellness, DBPH, DHHS; and Vickie Ives, M.A., Deputy Bureau Chief, Bureau of Child, Family and Community Wellness, DBPH, DHHS	
Agenda Item XV	Shera D. Bradley, Ph.D., Director of Civil Forensic Psychology, SNAMHS, DPBH, DHHS; Drew Cross, Interim Agency Manager, Lake's Crossing Center, DBPH, DHHS; JoAnne Malay, Deputy Administrator, Clinical Services and Mental Health, DPBH, DHHS; and Ellen Richardson-Adams, Agency Manager, SNAMHS Outpatient/Rural Clinics, DPBH, DHHS	PowerPoint Presentation
Agenda Item XVI	Fabian Doñate, Senate District 10	Handout
Agenda Item XVII	Tiffany Tyler-Gardner, Ph.D., Executive Director, Children's Advocacy Alliance	Written Remarks