Brian Sandoval
Governor

Joel A. Dvoskin, Ph.D.
Chair

Hon. Jackie Glass, Ret.
Vice-Chair

Behavioral Health and Wellness Council

Behavioral Health and Wellness Council
Meeting Action Minutes
February 27, 2014

Meeting Location
Grant Sawyer State Office Building
555 East Washington Avenue, Room 4412
Las Vegas, NV 89101

Videoconference Location
Legislative Building
401 South Carson Street, Room 2134
Carson City, NV 89701

Members Present	Members Absent	Assisting Staff
Joel Dvoskin, Chair	Michael Kelley-Babbitt	Melissa Slayden
Jackie Glass, Vice-Chair		
Susan Roske		
Richard Whitley		
Mike Willden		
Pat Hickey		
Tim Burch		
Katherine Miller		
Steven Wolfson		
Dale Carrison		
Monte Miller		
Sue Gaines		
Dick Steinberg		
Randolph Townsend		
Debbie Smith		
Doug Gillespie (left at 11:30)		
Marilyn Kirkpatrick		
Karla Perez		
Michael Roberson		

I. Call to Order, Welcome, Roll Call, Announcements

A. Chair Joel Dvoskin called the meeting to order at 9:32 AM. Melissa Slayden called roll and a quorum was noted. Dr. Dale Carrison made an announcement: "People were wondering why we [UMC and other area hospitals] were closed yesterday [to traffic]. This is fairly routine, is not an unusual event, and occurs at least once a week in the Valley. I had no ulterior motives in not telling this body [the Council]. Friday UMC was closed and Tuesday UMC and four area hospitals were closed because they were at capacity."

B. Joel suggested that Council members look for succinct materials pertaining to emergent issues and he would ensure the Council as a whole would receive those materials.

II. Public Comment

A. The Chair asked for public comment, there were none.

III. Panel presentation regarding Housing

A. Tim Burch, Director, Clark County Department of Social Services:

The regional response to homelessness in Southern Nevada is what makes this successful. The Southern Nevada Regional Planning Coalition (mid-2000s) convened a committee on homelessness of stakeholders from all local municipalities to change the way we do business concerning homelessness in Las Vegas. The federal strategic plan to prevent and end homelessness, Opening Doors, changed the way we do business and wrap services. Now it is a "Housing First" model, moving people from homelessness, to stabilization, and into permanent supportive housing (and change the funding streams around the individual as they gain sufficiency). Permanent supportive housing is open to a person as long as they can maintain housing; based on HUD fair market rate standards and the individual's ability to pay for it should they get long-term benefits. It is not a group living situation.

In 2007 we were higher than the national average in veteran homelessness. Veteran Assisted Supportive Housing (VASH) vouchers were created by the federal government. LVV was an underperforming community; it took more than 120 days to get a homeless veteran housed. This has been moved down to 30 days. Now Las Vegas is an over-performing community. There are 880 VASH vouchers in use and a waiting list. This means we can ask for vouchers from underperforming communities. There are over 250 beds for transitional housing, and emergency shelter beds. Also, we are looking for rapid housing dollars. The number of homeless veterans in the Las Vegas community has decreased 35% in the last 6 years; over 85 % success rate over for staying housed 18 months or longer. HUD requires point-in-time surveys every other year, survey was taken in 2013. It is a sight count which includes unaccompanied youth (16-24). There will also be one in 2014 because Veteran's Administration is so focused on ending veteran homelessness. That data will be available in April. Social Services recognizes a person if they have ever served in armed forces. The VA recognizes them as eligible for services if they had an honorable or general discharge. 10% of the street population is classified as having an "other than" honorable or general discharge and as such have barriers to accessing benefits through the VA.

"Chronically homeless," as defined by HUD is: homeless for one year or longer *or* four episodes of homelessness in a three year period *and* have a disability (either physical or mental illness, including addiction).

Safe Haven is housing geared toward individuals suffering from substance abuse or mental health issues. Communities can no longer seek this designation for a program; communities that have it are grandfathered in. The program was put into jeopardy last year when Salvation Army had to close part of the facility. SNAMHS helped seek out a vendor and WestCare took Safe Haven and folded it into the CTC services, keeping 25 specially designated beds in the community.

The total beds for the 7,500 people is 5,338. There is not enough capacity in the system for people who want housing. The more barriers there are, the more difficult it is to get into housing. The system is heavy with low-demand shelter beds. 5% of the 7,500 (375) individuals self-report going to the emergency room six or more times in the last year, indicating super-utilizers. HUD funding formula is rated on density of housing, age of housing, and number of houses built before 1960 or 1970. It is done in such a way to favor Boston and New York over Las Vegas. Rather, funding should be based on per population of homelessness. This issue requires federal advocacy, and Senator Donovan has twice broached the subject in the last two years.

We need to work more closely at tying systems together to wrap services around these individuals to

recapture them into treatment. Identification is a major barrier. The systems are there, we need to work at bridging them to make them work better together.

Homeless in Las Vegas underreport on mental illness and self-medication. We don't have adequate capture on substance abuse, co-occurring disorder, and mental health issue. A recommendation would be making sure our systems work to capture data accurately so we can provide targeted solutions. Systemic data capture drives federal funding. Data collection and use needs to be a part of the recommendations. The federal government is now looking for outcomes and we cannot provide that data, which means we lose out on funding opportunities.

The Gaps Analysis from Home Base told us we need to increase our mental health services, increase our substance abuse treatment services, develop 24 hour drop in programs for various crises, develop more permanent housing, expand our case management capacity, and expand our therapeutic courts models. The system needs capacity to help someone who needs services at any point in time.

There are landmark corporations in cities which recognize they are large part of the employment sector. That gap has not been bridged in Las Vegas because changes are government driven. It takes 15 contacts with a person to get them off the street, clinical outreach helps. There needs to be a teaming approach, much like the CIT process, which should be directly multidisciplinary. Clinicians, police, social worker, nurses, substance abuse counselors, and mental health techs coordinate their efforts as a team unit.

B. Ellen Richardson-Adams, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health
Chelsea Szklany, Agency Director, Southern Nevada Adult Mental Health Services
Housing inventory for Southern Nevada Adult Mental Health Services. This housing is individualized, person-centered planning, including assessment, support needs, skill sets, resources, history, vocational rehabilitation.

Mrs. Richardson-Adams presented on the different types of housing support and housing programs. Many of the programs include wraparound services based on the needs of the individual based on their ongoing assessments. She reviewed the service descriptions, regulatory oversight, annual budget, and total placements. The goal is to get individuals to live independently with the least amount of support.

The individuals who receive housing services from the State in Southern Nevada have had multiple contacts with the system who have expressed need. There are many doors into the services but not enough resources. The Legal 2000 forces people into the system when it is deemed necessary they go to SNAMHS for further evaluation. There are 148 people on the waiting list for housing.

IV. Discussion regarding presentation on Housing
Discussion took place during and after the presentation. This included medication clinic closures, enrolling newly eligible, and provider workforce (having people available to staff medication clinics). Senator Randolph Townsend asked what we need for housing, how much is needed, what is required, to develop a call to action. Tim Burch responded that family housing is an approach, independent living (single resident occupancy), and dispersed housing. It is about the money and business partnerships/community buy-in to accomplish the goals. SRO units are needed and hard to come by, and case management needs to be included.

Mike Willden suggested we have too much bifurcation in housing. Where does housing belong? It is about having the money in one place and having good case management over those funds. Then looking at how case management helps people in a more global way.

Joel Dvoskin noted that it is about decreasing waste (by having multiple case managers) and reducing caseload. When we increase our efficiency and still have homeless people then we know it is a product of a lack of capacity.

Marilyn Kirkpatrick asked about liability to the State or business owners when housing is donated. She expressed her concern for homeless people in the system becoming stagnant because it can be very difficult to become independent once meeting the criteria and earning little from work. Tim Burch explained he would have to get back to the Council on information about housing donations. Joel asked for clarification on permanent housing. Tim Burch responded that when a person gets to the point where they can live independently they do not have to leave their housing because it was initially leased in that person's name.

Monte Miller mentioned that the homeless discussed have the potential to become very good citizens and clarified that Sen. Randolph Townsend had mentioned soliciting the business community to find the 2,500 needed housing units. Tim Burch let the Council know that it would be both the units and the funding. Current agreements are property by property, negotiated individually. If the funding was provided negotiations would have to occur at a higher level.

Sen. Randolph Townsend asked if it is absolutely crucial that housing exists in the eight different mental health budget accounts. He suggested speaking with the Governor, Mr. Willden, and Legislature to see if it is crucial. He asked for a ballpark of all the money that comes in for housing and all the silos it goes into to show how complex the matter truly is. He suggested there be one housing silo.

Joel Dvoskin explained that Case Managers are the one thing where you don't have trouble finding people to hire. There is success in hiring consumers as peer support counselors as they often share the same cultural background.

Debbie Smith shared her concerns that Washoe County also has a homeless problem which has not been presented or discussed. She asked that the data be presented to the Council.

V. Presentation regarding Children's Mental Health

Joel Dvoskin introduced the presentation as a starting point and introductory session to the issue of children's mental health and that he did not expect it to cover every issue the Council would need to discuss. It is expected that the issue would be explored in more depth in the future. He reiterated that the small changes (rather than system overhaul) the Council members see as solutions could be submitted as brief write-ups which he would then submit to the whole Council. Also, any "band-aids" for the system must be consistent with the long-term vision of what the system will look like. He described two stages of recommendations, one for May 31st aimed at alleviating emergencies and short-term payback. Debbie Smith's suggestion of three stages made more sense to the Chair. Funding, expansion/creation of resources, things that require legislation, and the fundamental "way we do business." Jackie Glass asked if the dropping of Medicaid services for incarcerated individuals and eligibility on release is a legislative issue or otherwise. Joel Dvoskin explained that in other states the Sheriff or other law enforcement take the lead in negotiating with Social Security Administration to reach an agreement to stop ending benefits. Marilyn Kirkpatrick mentioned it is an IT issue to see what the cost is to work on the issue. Richard Whitley explained that Laurie Squartsoff is working on the issue with Clark County and Washoe County detention centers. Joel Dvoskin asked that Laurie Squartsoff return to the Council with what is needed by IT to make this work. Sue Gaines spoke to the NDALC and that they are also working on the issue.

A. Kelly Wooldridge Deputy Administrator, Children's Mental Health, Division of Child and Family Services
   Cara Paoli, Chair Washoe Co. CMH Consortium
   Carol Broersma, Rural CMH Consortium
   Janelle Kraft Pearce, Chair Clark Co. CMH Consortium

In Nevada, 19% of children will have a mental health or behavioral health disorder. Nevada has a disproportionally higher rate of teen suicide than other states. Our state funding is lower than other states. We are spending the most amount of our money on high cost inpatient and out of state residential treatment. The least amount of our money is being spent on prevention. Joel Dvoskin asked how many children are housed out of state. Kelly Wooldridge said that it is a hard number to arrive at because juvenile justice services, child welfare services, and kids in parental custody can all result in out of state placement. The state has a few residential treatment centers: Desert Willow Treatment Center and Willow Springs Center and four acute treatment centers. It is difficult to get children placed and there is a lack of service providers.

Richard Whitley explained that the State has identified the lack of state licensure for facility types. It is being rectified with a change in regulation. Joel Dvoskin asked when the State anticipates that regulation change to be ready and any expectations for the Council.

Kelly Wooldridge went on to speak to the Annual Plan Services Priorities for each of the Consortia present. Pilot programs and funding issues were briefly discussed. The Consortia and DCFS are working together to develop a strategic plan with three goals:

1. Implement policy, administrative, and regulatory change
2. Develop and expand services and supports (statewide mobile crisis) based on the system of care philosophy
3. Create or improve financing strategies by creating a strategic plan for blending funds in Nevada

DCFS provides community-based mental health services for infants through adolescents aged 18 or 19. Most of the funding for CMH from DCFS comes from fee for service Medicaid along with the State match. The unduplicated count of children served for FY13 is 2,865. Joel Dvoskin asked that the numbers of children served be given in more detail (amount of service) and matched with known need. Joel Dvoskin asked what the average length of stay is at Desert Willow. Kelly Wooldridge responded that for acute unit it is 20 days, 240 days for the Specialized Adolescent Treatment Program (SATP for moderate risk sex offenders), and for other residential treatment center units it is 154 days.

The largest amount of children served is aged 13 to 17, Caucasians followed by Hispanics.

VI. Discussion regarding presentation on Children's Mental Health

Karla Perez discussed that the reason we don't have RTCs in Southern Nevada is because of the Medicaid rates and the fact that they have to be licensed as a psychiatric hospital. Richard Whitley said that it might take 90 days to make the necessary changes in licensure. There are actually three facility types which do not occur here: psychiatric home health, psychiatric community health centers, and residential treatment centers. The State is working on all three of these. Dick Steinberg discussed that this has been an ongoing issue and that we need to look at drug treatment issues (and triage). We need to examine the systems we can set up so that we are not sending children out of state. Cara Paoli discussed co-occurring disorders have a gap in service treatment facilities won't take some of the kids with intellectual disabilities because they don't respond to treatment in the same way as other children; they are working on creative program. Again, children who need those services go out of state. Carol Broersma said that in the rural areas it is difficult to find the right door. Having one centralized place to call would help tremendously. Janelle Kraft-Pierce, added that funding streams and licensure as two of the biggest issues for Clark County. Jackie Glass asked about identifying the underserved or unidentified population. Kelly Wooldridge expressed that there are many wrong doors in the service delivery. Jackie Glass asked what is being done at the schools. Kelly Wooldridge explained that they are partnering with the Clark County School District. Janelle Kraft-Pierce wants the issues to be addressed earlier. One solution she suggested is having clinical people in the schools.

VII. Discussion and approval of Council's long- and short-term agenda and planning for March meeting
The Council discussed possible items for the March and April meetings. This included: firearms, governance issues, someone from the K-12 system join the next children's panel, suicide prevention, consumer success (both within and outside of the mental health court system), creation of a children's subcommittee, consideration of the budget timeframe, emergent problems, sex offender registry, Legal 2000 form changes and data share (A. J. Delap volunteered to make another presentation).

George Ross, Southern Nevada Legislative Forum, Healthcare Subcommittee
Mr. Ross spoke to the importance of mental health and the work of the SNLF. SNLF was invited to return and present. Dan Musgrove spoke to OSCaR in its historical context, the 1/3 rule, IFC, multiple entry points, and patient beds today. A.J. Delap came to the table to explain Scope, a criminal system which only law enforcement can access. It is entered and coded which allows law enforcement to understand why a person was formed with a Legal 2000.

VIII. Public Comment
Janelle Kraft-Pierce
If discussing children and suicide prevention, Office of Suicide Prevention has innovative programs. If there is extra money on behalf of children, we need mobile crisis.

Barry Lovgren, Private Citizen
Mr. Lovgren alleged a "decline in substance abuse treatment of pregnant women despite there being ample treatment services available," which he attributed to an alleged "failure to publicize the availability of this service."

IX. Adjournment
The Chair thanked the public for attending and adjourned the meeting at 4:16 PM.