MINUTES OF THE
BEHAVIORAL HEALTH PLANNING AND ADVISORY COUNCIL
BLOCK GRANT MEETING
JULY 14, 2015

The Behavioral Health Planning and Advisory Council (BHPAC) Block Grant Meeting was called to order by Mike McMahon at 7:48 a.m. on Tuesday, July 14, 2015, in the Legislative Building, Room 2134, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer Building, 555 E. Washington, Las Vegas, NV. Offsite attendees accessed the meeting through a conference call number.

BHPAC MEMBERS PRESENT:

Alyce Thomas
Rene Norris
Ali Jai Faison
Elizabeth Burcio
Hilary Jones
Katherine Mayhew
Mechelle Merrill
Denise Everett
Sharon Wilson
William "Bill" Kirby
Heather Kuhn

OTHERS PRESENT:

Denna Atkinson, Foundation for Recovery
Michelle Berry, Center for the Application of Substance Abuse Technologies (CASAT)
Patrick Bozarth, Community Counseling
Cheryl Bricker, Partnership for Community Resources
Steve Burt, RidgeHouse
Michael Corti, Nevada Community Prevention Coalition
Trey Delap, Group Six Partners
Diaz Dixon, Step 2
Marissa Duke, PACT Coalition
Kari Earle, Social Entrepreneurs Incorporated (SEI)
Chris Empey, Washoe County, Department of Social Services
Charlene Frost, Nevada PEP
Evelyn Grippaldi, Clark County, Department of Juvenile Justice Services
Heidi Gustafson, Foundation for Recovery
Sara Hunt, University of Nevada, Las Vegas
Mari Hutchinson, Step 2
Terri Keene, Clark County, Department of Family Services
Linda Lang, Nevada Statewide Coalition Partnership
Ron Lawrence, Community Counseling
Lisa Leathram-Vonail, WestCare
Sheila Leslie, Washoe County, Department of Social Services
Barry Lovgren, Private Citizen
Kelly Marschall, SEI
Jan Marson, Nevada Rural Children's Mental Health Consortium
Kelly McDermott, Central Recovery Treatment
Jeff Munk, Frontier Community Center
Jim Osti, Southern Nevada Health District
Frank Parenti, HELP of Southern Nevada
Claranna Petrie, Clark County, Department of Juvenile Justice Services
Allison Ramsey, Partnership for Community Resources
Lana Robards, New Frontier
David Robeck, Bridge Counseling Associates
Jamie Ross, PACT Coalition
David Sanchez, Southern Nevada Children First
Tenea Smith, Rural Nevada Counseling

STATE STAFF PRESENT:
Betsy Fedor, SAPTA
Kendra Furlong, SAPTA
Melanie Harrill, SAPTA
Charlene Howard, SAPTA
Auralie Jensen, SAPTA
Kevin Quint, SAPTA
Sneha Ravikumar, SAPTA
Stephanie Robbins, SAPTA
Nancy Sirkin, Division of Child & Family Services
Martie Washington, SAPTA
Sara Weaver, SAPTA
Curtis Wiersma, SAPTA

Mike McMahon:
The meeting is open. We will take public comments.

Barry Lovgren:
I will read my written testimony:

> I'm a private citizen, and I've been following the Block Grant applications since 2009. That's when I found that the number of pregnant women receiving substance abuse treatment in the course of a year had fallen by half to just 200. By July 2014 it had fallen to just 139 in the course of a year.
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> I've focused most of my attention on one of the 17 federal Substance Abuse Prevention and Treatment priorities, the one that addresses the Block Grant requirement that the State publicize the availability of treatment and admission priority for pregnant women at treatment programs funded by the grant. It doesn't do much good to offer something if nobody knows about it.
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> The State also sets Block Grant priorities of its own. Nevada set 18 in the last application. I followed one of them because the State Plan for it provided for substance abuse screening and referral project for pregnant women. Unfortunately, that project seems to have pretty much died.
>
> My understanding is that the substance abuse portion of this year's application will largely be driven by needs assessment. In 2009 SAPTA published its White Paper on Estimating Need, establishing a 3-step process for needs assessment for substance abuse that's much the same as that for needs assessment for any other disease. First, survey prevalence data to determine the total need for services to deal with the disease, in this instance substance abuse. Second, determine the extent to which that need is being met by the services currently being provided. Third, determine unmet needs the gap between the services that are needed and the services that are being provided. That's actually pretty straightforward: A data-driven process for figuring out what's needed, what's provided, and the difference between the two.
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> The Nevada Substance Abuse, Mental health and Suicide Prevention Needs Assessment Report doesn't follow this 3-step process. It has no prevalence data to determine total need for substance abuse services. It has some information on what services are being provided. And instead of determining the gap between total need for services and the services provided, it has an extensive survey of the opinions held by service providers, consumers, and focus groups on what they think the unmet needs are. An opinion poll is not a needs assessment.
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> Here's an example of what got missed. Hospitals in Nevada are required to report certain neonatal disorders to the Division. This provides prevalence data for Neonatal Drug Withdrawal, a disorder caused only by addiction to heroin and other opiates during pregnancy. This prevalence data shows a steady increase since 2008. In 2012 there were 203 cases of this disorder reported to the Division,

203 newborn babies going through opiate withdrawal in a single year. This increase in addiction among pregnant women is consistent with reports of increased heroin use in Nevada.

Treatment of choice for heroin-addicted pregnant women is Methadone maintenance. The only program the Division funds for this is the Adelson Clinic in Las Vegas. There is not a funded Methadone maintenance program anywhere else in Nevada. Clearly there's an unmet need for Methadone maintenance services.

I'm hoping that one of the State priorities established for this year's application will be substance abuse treatment for pregnant women, and that the State Plan for that priority will provide for expanding the availability of funded Methadone maintenance for pregnant addicts.

Stephanie Woodard:
I will start with the introduction of the Block Grant and meta-analysis process. The meta-analysis was completed taking into consideration of a multitude of needs assessments conducted since 2012.

SEI [Social Entrepreneurs Incorporated] reviewed the results of the meta-analysis and placed recommendations under the six strategic initiatives for the Block Grant. Our goal is to join the needs assessments and data to help inform our decisions to develop priorities for this Block Grant. We recognize this is a fundamental shift from how we have developed the Block Grant in past years. We are very excited about the opportunity to join with the Behavioral Health Planning and Advisory Council in this endeavor.

Kelly Marschall:
I am going to start with the methodology and a summary of what data was collected and used in the meta-analysis. In looking at an integrated model, integration implies caring for the entire person in terms of physical or primary health care, behavioral health, mental health, and substance abuse prevention and treatment needs. We created an inventory of summary reports, needs assessments, and analyses that had not been developed in the State since 2012. We identified that there were some needs assessments that spoke to a particular priority population, such as children's behavioral health, that were not updated since 2012. We went as far back as 2010. On the back of the meta-analysis, you will see a list of all the reports that we consulted and reviewed. Many individuals participated in one or more of these report summaries since 2010.

One of the strengths of the meta-analysis is that it includes the opinions about the unmet needs and priorities for the Council to consider in establishing priorities for the Block Grant. We reviewed all the reports and found commonalities. These were identified in multiple reports related to a priority population, unmet needs, or a recommendation. Some reports had goals that were determined as recommendations to develop a summary, which rolls up more than 20 reports into 1 document. The Block Grant asks for information and recommendations that are related to evidence-based practice or a particular framework. One of the limitations of the report is that it does not capture the richness of the depth or articulation of thoughts offered by the consumers in a manner that would link it back to evidence-based practice.

Another limitation of the report is timing. It does not take into account changes that have already occurred, such as legislation and policy changes. The third limitation is terminology. There were multiple authors for these numerous reports, and recommendations and summaries were changed in some cases. Finally, planning initiative work is dynamic, additional data or recommendations may have been developed since the time the meta-analysis was completed.

The strength of the report is that it represents over 1,000 consumers and advocates. It builds on best practices, and looks at evidence-based efforts and tries to link recommendations. This process promotes an opportunity for integration, which has long been something desired but not quite realized.

One of the things we looked for in a prioritization process was to leverage some of the practices that have been utilized in the public health arena for a number of years, and currently public health entities across the country are undergoing a process to achieve accreditation as part of the Affordable Care Act. Part of that includes a community health assessment in a prioritization process.

The tool that was selected for the prioritization process was from the State of Illinois. We used the tool to prioritize issues as outlined in the meta-analysis summary and quantified in the behavioral health barometer. We will be rating the prioritizations as high, medium, or low. We believe that this process would aid the Council to determine where Council Members are of a similar opinion about an issue and where they may vary. The components that we are looking to evaluate include how important the issue or the unmet need is to the community and what the seriousness would be of not addressing that issue. We want a sense of the size of the problem, the number of people affected in Nevada, and the resources and time to address the need.

We took into account what SAMHSA [Substance Abuse and Mental Health Services Administration] was looking for in the Block Grant. SAMHSA made suggestions regarding where data should be pulled. SAMHSA has now published a behavioral health barometer nationwide and by state. Many of the needs assessments and reports we summarized used varied methodology to quantify the size and scope of a variety of issues. Because the results of this prioritization process will be used for the Block Grant, we opted to provide Council Members with a copy of the barometer as one way to think about the size of the problem.

What we are looking at is data related to the number of adults age 18 or older in Nevada and in the U.S. who had serious thoughts of suicide in the past year. The bars on the left represent Nevada and the bars on the right represent the U.S. You can see in 2009 and 2010 the percentage for Nevada was higher than across the nation, 4.2 percent compared to 3.8 percent, respectively. When you look at the number on the bottom, 4.3 percent in Nevada (approximately 85,000 adults) in 2009 through 2013 had serious thoughts of suicide within the past year. The footnote at the bottom of the barometer notes that estimates are based on combined data for multiple years of the National Survey on Drug Abuse and Health Data. Estimates in the accompanying figure are from an estimation figure that uses two consecutive years of National Survey of Drug Abuse and Health Data.

We provided the barometer to Council Members as a resource to utilize in trying to understand the seriousness of particular issues related to Nevada's population as a whole. The barometer also measures adolescents, age 12 to 17, in Nevada compared to the U.S. in the past month. Nevada's numbers were higher than the nation as a whole. The estimate is approximately 25,000 adolescents per year reported using illicit drugs. Regarding initiation of substance abuse among that same population, 12 percent initiated alcohol use, 6 percent initiated marijuana use within the year prior. Regarding alcohol dependent or abuse among individuals age 12 or older, Nevada's numbers are greater than a nation as a whole, with an estimate of over 2,000 individuals. According to the barometer, those who perceived there was no great risk of having 5 or more drinks once or twice a week was 6 in 10 adolescents in 2012-2013. Those who perceived no great risk from smoking marijuana once a month about 8 in 10 adolescents in 2012-2013. Of those who had a major depressive episode, 29.9 percent received treatment, leaving 70 percent who did not receive treatment.

Looking at the past year of alcohol abuse treatment, 4.6 percent received treatment in 2009-2013. When we think about mental health treatment or counseling, looking at adults age 18 or older with any mental illness, 31 percent received treatment. In Nevada, approximately 114,000 adults received treatment within the prior year. Substance abuse treatment in 2013, 361.5 percent were in treatment, 19.5 percent were in treatment for alcohol use only, and 44 percent were in treatment for both drug and alcohol use. Illicit drug use treatment for age 12 or older is 13.2 percent received treatment and over 86 percent did not receive treatment. Of adult mental health consumers in Nevada by age 15, 0.9 percent were employed, 40.9 percent

were unemployed, and 43.3 percent were not in the labor force when receiving treatment. In 2013, 3,659 children and adolescents were served in Nevada's Public Mental Health System.

When considering individuals enrolled in opioid treatment programs in Nevada who received methadone, a single day count showed the numbers of 800 was up to 1,491. In 2009 and 2013, the numbers were similar. In 2010, there was a decrease, a slight increase in 2011, and a dip in 2012. Individuals who received buprenorphine as a substance abuse treatment on a single day count increased from 2009 to 2013. In 2013, that count was 1,471, with 75 who were receiving buprenorphine.

Rene Norris:
I am seeing data of adults 18 and older. Do you have any data on children? I believe there is a Suicide Prevention Program from which you could obtain some data.

Ms. Marschall:
The behavioral health barometer does not include all of the data that would be available for Nevada. I believe SAMHSA is trying to create a comparison for the purpose of the Block Grant to direct the State towards a tool to which to refer. The Council could definitely make a suggestion to Division of Public and Behavioral Health (DPBH) as part of the Block Grant to pull particular data sources they feel are not reflected in the barometer.

Alyce Thomas:
Do we have any information on the services that are being provided to the children? The Block Grant is for children and adults, and I do not think we can look at it in its entirety if we do not have information about adults and children.

Ms. Marschall:
The behavioral health system in Nevada is comprised of federal, state, and local resources. They operate under a variety of funding sources, priorities, and mandates. The expenditures are actually separated into five categories: the Director's Office, Aging and Disability Services Division, Division of Health Care Financing and Policy, DPBH, and Division of Child and Family Services. When looking at Nevada as a whole, it is critical to look at the importance of integration with a number of the plans reinforced for the need of a "no wrong door" approach as a process for people receiving services throughout the State.

Kari Earle:
The reports that were reviewed to inform the meta-analysis had some degree of guiding principles as to how services should be delivered and what should drive decision making and policy development. We took SAMHSA's language and Nevada's specific language in those reports and married them.

The guiding principles for recovery are: it emerges from hope; it is person and family driven; it occurs giving many pathways; it is holistic; it is supported by peers and allies; it is supported through relationships and social networks; it is culturally based and influenced; it is supported by addressing trauma; it involves individual family and community strengths and responsibilities; and it is based on respect.

These are the core values of the System-of-Care Model, which has been adopted by and used in Nevada. What we would encourage the Council to consider, as you are thinking about integration, is adopting shared language.

Ali Jai Faison:
Is there a way we could get a dollar figure? Many times the information that is being shared is good, but the monetary effect of support and services prevents many people from pursuing it.

Ms. Earle:
I believe that will be part of the development of the Block Grant in understanding the cost per service for a variety of services across the continuum of care.

Mr. McMahon:
I cannot answer dollar amounts at this time. We are hoping to get more of a global perspective as to where the resources need to be allocated. We need to determine where to invest the Block Grant money so that it makes the biggest impact possible.

Ms. Earle:
As we transition to discussion of identified needs and gaps, affordability of services is included in the content. Through this process, SAMHSA and the State have developed populations of focus to include: adults with serious mental illness; children with severe emotional disturbance in their families; pregnant women and women with dependent children; persons in need of primary substance abuse prevention; persons at risk or with tuberculosis who are in treatment for substance abuse; persons at risk or with HIV/AIDS and in treatment for substance abuse; and intravenous drug users.

In addition, to those primary populations of focus, there are also subpopulations that have been identified for Nevada's Block Grant development: at-risk and transition-age youth; children and adults who are affected by homelessness and substance use disorders; individuals with co-occurring disorders; individuals that are lesbian, gay, bisexual, transgender, or questioning; and residents living in rural and frontier communities.

On the mental health side, children's residential behavioral health is a missing piece that is underserved and includes crisis stabilization; acute intensive services, mobile crisis specifically; intensive home based services; and adult residential behavioral health treatment. The substance abuse continuum, which are reflected there as well but specific to substance abuse treatment, includes youth residential treatment; adult residential treatment; recovery supports; peer supports; community support; and specifically in the areas of education and employment. Also missing is the area of housing that is safe, stable, and affordable.

The six strategic initiatives that have been identified by SAMHSA are prevention of substance abuse and mental illness; health care and health systems integration; trauma and justice; planning and recovery supports; health information technology; and workforce development. These six initiatives are becoming drivers for how funding is allocated to discretionary funding from SAMHSA and how planning is occurring. It is important for Nevada to be able to work within the SAMHSA framework.

I will read the initiatives and explain the associated key observations.

<u>Initiative 1; Prevention of Substance Abuse and Mental Illness Key Observations</u>:
- Limited crisis intervention services
- Limited early intervention services
- Lack of early identification and intervention for at risk populations
- Lack of positive community-based activities for the prevention of substance abuse and primary prevention and early prevention

<u>Initiative 2; Health Care and Health Systems Integration Key Observations</u>:
- Over utilization of the emergency room
- Fragmentation of cross systems and lack of coordination
- Too many youth placed out of state
- Insufficient alternatives to hospitalization

- Lack of treatment facilities that serve pregnant women
- Long waiting list and lack of services and providers
- Distance and time to access the nearest available services
- Affordability of services
- Lack of insurance coverage for those services

Initiative 3; Trauma and Justice Key Observations:

- Minimal access to and options for jail diversions, particularly for black and Hispanic males
- Limited access to and options for community re-entry programs
- Lack of understanding how specialty courts function
- Limited legal avenues to address the abuse and misuse of prescription drugs
- Resistance of some judges and court masters to use alternative treatment options
- Lack of knowledge about behavioral health and substance abuse issues especially among first responders and law enforcement

Initiative 4; Planning and Recovery Supports Key Observations:

- Lack of affordable housing options
- Need for habilitated services and support
- Cultural or community stigma
- Lack of adequate transportation options and resources
- Need for peer support services

Initiative 5; Health Information Technology Key Observations:

- No current centralized repository for sharing exists
- No single standards for data collection or measures for our agencies to collect
- Lack of broad adoption of the health information exchange
- Lack of overall awareness of resources

Initiative 6; Workforce Development Key Observations:

- Poor workforce retention and high turnover
- Training programs that are not working together
- Low wages
- Frontline staff burnout
- Capacity building issues
- Practice issues and licensing and credential policies

Integration efforts need to look at increasing access to both the prevention services as well as the treatment and recovery and wellness services, and high quality services with evidence-based and outcome driven supports.

Katherine Mayhew:
Regarding the population with intellectual disorders or fetal alcohol syndrome or other developmental disorders and those who may have emotional disturbance, it is a very difficult population for which to find resources in Nevada. Many of those kids are adjudicated or sent to treatment centers out of state, and we do not have anything to keep them in the community. Many of them are not aware of what their offense is. When you talk about residential treatment, there is a big gap for that population.

Denise Everett:
Under strategic initiative number one, I assume we are looking at evidence-based best practices. We have a shortage of child and adolescent psychiatrists in Northern Nevada. Finding psychiatric treatment for this population is very difficult.

Ms. Earle:
That is a good point. When you look at all of the initiatives and all of the recommendations, it was emphatic in the reports that evidence-based practices and accountability were components of how services are designed and developed.

Hilary Jones:
Are the stakeholders from the public sector invited to the table like the hospitals and through the emergency rooms and the treatment centers that are paid for by private insurance? When you talk about integration, there are so many systems of care not being coordinated.

Ms. Earle:
Are you asking about the 20 reports reviewed from those various systems?

Ms. Jones:
Yes.

Ms. Earle:
I believe in a couple of cases they were taken into account, but that might also be something you provide as a recommendation.

Ms. Marschall:
I know that the Governor's Council on Behavioral Health and Wellness, which were reports 2A and 2B that were reviewed, included two sets of recommendations. That Council includes private sector and public sector representatives and specifically includes the hospitals. Their recommendations were woven into the report and considered. The Mental Health consortium reports, 6A through 6D, include some public and private providers. When we look at workforce shortages in particular, John Packham's work was reviewed and Nevada received "shortage area" designation for most specialty providers.

Ms. Jones:
I know that under the health care and health system integration, the stigma of mental illness and substance abuse on people are not taken seriously at emergency rooms or doctor offices.

Ms. Earle:
A number of the reports considered raised the issue of stigma on both sides. First, how people are treated when they go for care but also how that becomes a barrier to even presenting for care. The meta-analysis includes two different bullet points related to that. This is one of those examples of how there is cross over that you are speaking about within the health care system and lack of training of health care providers for behavioral health issues and how they present. It will be important for you all as a Council to discuss how you want to see those in a shared way so that you are ranking them similarly.

Jan Marson:
I will read my written testimony:

> Good morning members of the Advisory Council.
> My name is Dr. Jan Marson and I am the Chair of the Nevada Rural Children's Mental Health Consortium. Integration of mental health and substance abuse prevention and treatment makes wonderful sense from a practical, neurobiological, and financial point of view. There a few gaps that I would like to briefly bring to your attention.
>
> Underserved populations of Hispanics and Native American need to be specifically addressed. The Hispanic population in the State of Nevada is growing and this group has been faced with barriers

to access and allocation of appropriate resources. Our Native American Communities may be small in population but are off the charts in terms of need and risk factors. The Rural Children's Mental Health Consortium has been working with Pyramid Lake Tribal Members to do a community needs assessment to identify concerns and strengths. This project is community driven.

In the rural communities, it would be beneficial to develop in home family-centered services for mental health and substance abuse treatment. Integration also needs to be within the family system and wider community.

Finally, our consortium in our work promoting school-based mental health services have identified another major barrier as the boards that govern mental health professionals.

Sheila Leslie:
I represent Washoe County Department of Social Services and Behavioral Health. Regarding the behavioral health barometer from SAMHSA on page 16, substance use treatment, alcohol for adults, 95.4 percent of the people in Nevada, 12 and older with alcohol dependence or abuse, did not receive treatment. If you go to the substance abuse page 18, for illicit drugs, 86.8 percent did not receive treatment. I have never seen that number so high. We can talk about why one has worked for us and one has not. People in Nevada are not getting treatment. I encourage you to keep this metric as part of your deliberation. We should be measuring our progress on this.

Ms. Earle:
The rating chart is influenced by the significance of the problem and the people affected. That is where the Council can take into account that information as a way to prioritize.

Ms. Marschall:
On page 2 of the prioritization considerations, under strategic initiative number 2, the statistical information shows:

- There are too many youth placed out of state.
- There are insufficient alternatives to hospitalization.
- There is a lack of treatment facilities to serve pregnant women.
- There are long waiting lists, lack of available services and providers.
- There is a lack of affordability of services.
- There is a lack of insurance coverage.

If elements of this worksheet are rated high, that strategic initiative may end up being priority number 1 compared to the other initiatives. The challenge will be that Nevada has so many needs that it is difficult to not set a number of priorities for the Block Grant.

Mr. Lovgren:
I have a question on health care and health systems integration. One of the needs and gaps identified is lack of treatment facilities that serve pregnant women. On the substance abuse side, each substance abuse treatment program receiving Block Grant dollars from SAPTA is required to provide admission and treatment priority to pregnant women. There are 50 of those treatment sites and only 1 of those serves men in Nevada. There is a problem with the State meeting the federal requirement to publish this information so that people know about that availability.

Because of the way this is structured, perhaps we are talking about mental health facilities not substance abuse facilities. Other mental health facilities will not treat pregnant women. Can you clarify this?

Ms. Earle:
That is a combination of mental health and substance abuse and is referenced in the plans from which it emerged. It could be a combination of perception and survey input.

Mr. Lovgren:
With regard to substance abuse treatment services for pregnant women, the problem is not lack of facilities that provide the service. The problem is nobody knows about it. There is a federal requirement to let people know about it and that is not being met right now.

Diaz Dixon:
I am a member of the SAPTA Advisory Board and Chief Executive Officer at Step 2. Step 2 is a treatment facility for pregnant and other women. There is a waiting list. There are not enough substance abuse providers. That is the biggest problem.

Coming into this meeting, I thought it would be a much more collaborative process. There are numerous resources that could be helpful. We need to look at the issues and problems and determine what we can do to solve these problems collectively for the State of Nevada.

Mr. McMahon:
This is a transitional process. To integrate fully, the SAPTA Block Grant and the Mental Health Block Grant is a new concept for the State. This is another transitional step to integrate and bring the SAPTA Advisory Board and the Behavioral Health Planning and Advisory Council together to be able to have a joint process. With time constraints, this did not happen this year.

Lana Robards:
I represent New Frontier Treatment Center. There are a lot of us who feel that we have a lot to offer in a process like this, and we are not being included in this process. Many voices and solutions have never been expressed.

Linda Lang:
I represent Nevada Statewide Coalition Partnership. Under strategic initiative number 1, I want to complement the process for screening and referral, the substance abuse prevention portion, and the combined efforts substance abuse and mental illness.

Charlene Frost:
I represent Statewide Family Network Director for Nevada Public Employees Benefit Program. The priorities for family and children may look different from the priorities for the adults. We should not be treating our children like miniature adults because they are not.

Ms. Norris:
With past Block Grants, we have not had as much input as we have had at this point. In the past, they did not ask us what our priorities were or to rate them. We were told what they were going to put in the grant. This is a big step forward allowing us to have more input.

Ms. Thomas:
There are many services for recovery and it is not so much for children as it is for adults in mental health. I think this process is good. We have an opportunity to express how we feel.

Ms. Norris:
This is the way SAMHSA wants it now. For us to come together and meet needs of everyone. This Block Grant is about behavioral health, substance abuse, and mental health. We need to determine how people can be helped the most.

Ms. Earle:
The trauma and justice initiative asks for states to prioritize the development of trauma and informed screening and assessment tools, techniques, strategies, approaches and emphasizes the strengths-based approach. Recovery support is looking at person- and family-centered planning, promoting a partnership between those in recovery and their family members with service providers.

It fosters health and resilience, increases housing support, reduces barriers to employment, education and other life goals for individuals. This secures the necessary social supports that are available in every community. The supports are family driven, youth guided, and consistent with the principles of the system of care.

Ms. Marschall:
There is a limitation in the meta-analysis pertaining to vocabulary from consumers. This showed up when it came to trauma-informed approach. Many of the recommendations under trauma and justice speak specifically to the courts. There have been specialty courts and diversion programs, focus groups on surveys, that really spoke to how that was or was not working. There is a need and a gap between the reports that were reviewed, the evidence based, and the language people used.

Ms. Mayhew:
It is not a model, it is a philosophy of how you provide services and provide care for kids and families. Secondary trauma is for the workforce and is a big issue when it comes to retention. We do not address this much Statewide.

Sharon Wilson:
I am a Member of the Council, and I represent Department of Corrections. We have some good mental health programs in the prison, but, when people get out, they do not have many options. It is difficult when they go from the supportive environment we provide for them, to the homeless shelter. Some of them are not able to get into some of the housing that is available because they were former prisoners. Housing is a huge problem in our communities.

Ms. Norris:
If people cannot answer the questions due to trauma, does that mean it is going to be left out of the Block Grant application?

Ms. Marschall:
On the agenda, the idea is for you to rank the needs and gaps and then prioritize recommendations. The last agenda item is for you to shape an overarching recommendation that would include your rankings and would provide direction to DPBH on the Block Grant. The Council Members' expertise should be provided and have weight in your deliberations. We want to give both the public and the Council Members time to share their perspectives related to the strategic initiatives.

Ms. Norris:
In the future, can the survey be explained more clearly for those taking the survey?

Ms. Marschall:
The meta-analysis is unique since it draws from a variety of initiatives, needs assessments, and gaps. Going forward, a recommendation could be made to DPBH to conduct a comprehensive needs assessment in the future.

Ms. Earle:
In the Block Grant application, Nevada is required to respond to the strategic initiative pertaining to trauma and justice. You can make clearer recommendations that are currently reflected in the language if you chose to.

Mr. Faison:
Has there been any follow up on the presumptive Medicaid? Some of the problems we are seeing are people being released from prison and there is a gap between service, where they do not have the coverage and they only get three days of medication. They end up on the streets because there is no housing. They turn back to substance abuse as a means of coping with their problems. They cannot get a job, the services they need, or insurance coverage. This is why they end up in my office looking for help. Prior to being released, they should have the tools they need so they can re-enter society and use the services that are available to them.

Ms. Wilson:
I know we have a system for working with Social Security prior to people's release and Medicaid usually goes hand-in-hand with this. We do not have any way that I am aware of to do that. I have been told that in California, they can go on the insurance exchange and get their Medicaid started within a week. It seems like there should be some way to get their Medicaid started sooner in Nevada.

Steve Burt:
I represent Ridge house, and I am on the SAPTA Advisory Board. For our clients that come into our program, we connect with prior to release so we have all of their information. Day one of their release we go down to Medicaid or food stamp office and we get them enrolled. In the amount of time it takes for them to process their paperwork, I can bill retroactively to the issuance of the Medicaid card.

Ms. Wilson:
How long does that usually take?

Mr. Burt:
If I run it through the Medicaid office, it takes three weeks. If I run it through the food stamp office, it takes one week. If a client tries to do it on his or her own, it takes three months.

Mr. Faison:
Speaking to integration of services and sharing information across the board, one of the problems that my client had was, even though he had Medicaid, it was split between Amerigroup and Health Plan of Nevada (HPN). Now you are trying to work within the community of resources which providers are able to access for services. We sent the client to an HPN provider and the client was overlooked, as opposed to a Medicaid fee-for-service provider that could actually get it started immediately. This illustrates some of the problems we are encountering.

Mr. Burt:
That is an urban-rural issue in Nevada. The providers who are enrolling with all of the managed care organizations have access to both. HPN is a little more challenging because they retain some of their own

clients within their HBI group. When I fill out the forms for my clients, I fill them out in a way that it is beneficial to the client and the providers. This way, the services of which they receive can be billed.

In looking at trauma and justice, trauma-informed care developed out of the criminal justice system. Incarceration creates trauma in it of itself, and I am not seeing this anywhere. As long as Nevada Department of Corrections does provide supportive services, treatment, therapy and re-entry services for all 13,000 inmates, with 5,000 of them getting out every year, there is going to be lots of trauma-informed care to provide to them. We believe that the peer leadership certification through the Peer Leadership Council would go a long way in the SAMHSA Block Grant application, which is a SAMHSA-based approach.

Mr. Faison:
Can you share your information?

Mr. Burt:
Yes.

Heidi Gustafson:
I will read my written testimony:

> In support of funding for Peer Services, I am with the Foundation for Recovery; Foundation for Recovery is one of two Recovery Community Organizations in Nevada.
>
> We provide a wide range of services free of charge that include Peer Recovery Services, mental health First Aid, GED, Veteran Services and many more.
>
> We have provided peer services for more than two years in Southern Nevada.
>
> FFR currently sees 200 to 300 people per month who want to sustain their very fragile early recovery and abstinence. These services are supplied by a volunteer coaching staff at no charge.
>
> We have per head data of the costs need to provide these services with infrastructure development and overhead costs and would like to invite anyone to come to our facility for a tour.
>
> We supply the 40 hours of education that is required to become a volunteer Peer Recovery Coach. In addition coaches are required to attend the 16 hour Mental Health First Aid Trainings. At this writing, we have trained more than 200 coaches. Also free of charge.
>
> Following the ten guiding principles as set forth by SAMHSA on page 17 and 18 of the *Gaps and Recommendations* handout; our services are person centered and available to the entire behavioral health community.
>
> We provide these services to anyone, regardless of their chosen pathway. There is a high volume of people with co-occurring disorders and PTSD using our coach services. This addresses integrated health care needs and also embraces Parity.
>
> To see the SAMHSA Block Grant Draft that supports Peer Recovery please refer to the 2016-17 Draft Application, page 65 and 66. This will allow you to see the Federal Government focus on peer Services.

We have never received money from SAPTA for our program and have relied on donations, local grants, and fundraising.

Long-term sustainability and growth are at risk without the future funding and backing of SAPTA to maintain and grow this SAMHSA supported model of recovery in Nevada.

FFR asks that you consider that our state currently treats addiction acutely instead of the chronic disease that it is. Acute treatment, while important, does not provide the long-term continuum of care necessary to achieve long-term recovery. This peer services model supported by SAMHSA provides this long-term support at a very low cost to the community.

I would ask you to prioritize the Recovery Community so as to provide the financial ability to not only continue our services but also to grow and expand Recovery Services thru the Peer Support Model throughout our state.

I would like to make a mention of something that has been a barrier to many of our peers. Individuals on medically assisted treatment are not employable. They will not pass a drug test. Being unemployable and therefore unemployed is an almost insurmountable obstacle to anyone looking to sustain his or her recovery.

I would like to thank SAPTA for allowing the Recovery Community to participate in this process.

I am a person in long-term recovery. What this means is that I have not used any alcohol or other drugs for more than 11 years.

When you think about a client, or patient or statistic, remember me. I am that person. I am that number. I am an example of what someone can achieve given the much needed support and services in early recovery.

Ms. Thomas:
There is 25 percent for substance abuse from SAPTA's Block Grant. What about mental health for our peer support? I think this is something we need to consider. Peer support for the substance abuse side as well as the mental health side.

Michael Corti:
I would like to address strategic initiative number 3 and 4. Working with the male population being incarcerated, you see fear in their eyes. Without a plan, support, direction, or education when they get out, they are going to end up back in prison.

Ms. Earle:
Within each of these strategic initiatives, there are a number of strategies. On the last page of the report, there are a number of policy regulations. These were lifted out of the main report because they were outside of the scope of the Block Grant.

The strategic initiative for health information technology is focused on ensuring that the behavioral health system is fully participating in electronic health records. It is necessary for behavioral health system to catch up for integration to occur, and other kinds of resources like electronic training, assessment, treatment, monitoring, and recovery support tools to serve remote populations.

The workforce development initiative pertains to building the capacity of the State to deliver competent organized behavioral health services, as well as using tools like training, technical assistance, and other focused efforts to promote an integrated, aligned and competent workforce.

Ms. Jones:
I believe that education needs to be provided to those who are performing medical detoxification. Some providers are prescribing them as an ongoing medication for recovering individuals.

Elizabeth Burcio:
I am a consumer of Behavioral Health. I think we need more programs to educate individuals with mental health illnesses. Are these programs available throughout the State through multiple mental health clinics?

Mr. Faison:
Every agency is different. Depending on the level of their education, it depends on how they implement their therapeutic model. All therapeutic models are available to all clinicians throughout the state.

Ms. Burcio:
These life-changing tools should be offered by every clinic.

Sara Hunt:
I am the Director of the Mental and Behavioral Health Coalition at University of Nevada, Las Vegas. I encourage the Council Members to use our training programs in the State, especially at the universities and other schools, to help meet all of these initiatives. We are here to provide training to mental health professionals in all of these different initiatives.

Mr. McMahon:
Ms. Marschall and Ms. Earle, can you please walk us through the process that will happen next.

Ms. Marschall:
We started by reviewing the documents that were included in the meta-analysis and compared them to SAMHSA's six strategic initiatives. Next, we reviewed the needs and gaps that were key themes in multiple documents. There were extensive public comments. The Council Members took the barometer and they were provided a public health prioritization worksheet. They were asked to go through and respond to four sets of questions, ranking each one. They were asked to define the seriousness of not addressing the problem, the size of the problem, feasibility to address the problem, and the degree to which the problem impacted disparities in subpopulations.

The ranking of the strategic initiatives collected can be found at the following website:
http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalBHSP/Docs/Rating%20Analysis%20-%20Completed.pdf

Mr. Faison:
Realizing that the ratings are going to be ranked by what your career is or what has happened to you in the past, this can guide you on your personal experience and it can affect your ranking.

Ms. Earle:
On page 16 of the report, there are some things that floated to the top, these were fundamental to every recommendation.

Ms. Jones:
Are there going to be five or six recommendations?

Ms. Marschall:
The strategic initiatives will be ranked. The Council will determine what to include in their recommendations. Looking at the strategic initiatives by themselves may not provide enough information for the ranking of the analysis.

Ms. Wilson:
So there might be multiple recommendations on multiple initiatives.

Ms. Earle:
Yes. If the needs do not work with the scoring then we need to reconcile that matter. That is the goal.

Heather Kuhn:
I am a Council Member. When SAMHSA did a site visit in December, they were specific about mandating more pre- and post-assessment instruments for both prevention and treatment and overall recommendations to gathering data and measuring outcomes for prevention and treatment.

Ms. Everett:
I am an Executive Director of a non-profit that provides substance use disorder, mental health, and co-occurring disorder services to adolescents and adults. Looking at the charts, I cannot do any of these initiatives without the proper resources. Adequate resources are essential in order to use these initiatives.

Ms. Marschall:
You could bundle a multiple of needs and gaps together. That would address multiple issues.

Ms. Mayhew:
I noticed licensing and credentialing did not score very high. If we had more ease for licensing we would not have such a shortage on workforce.

Kevin Quint:
This is an important point to think about as a group. Are there ways to help the providers build capacity with this Block Grant?

Mechelle Merrill:
The graph illustrates how Nevada ranked. I believe we should move forward.

Mr. Faison:
We should look at the recommendations and narrow them down to the top five.

Ms. Thomas:
Have the Council Members' ranked their sheets?

Ms. Marschall:
The Chair will take input on the rankings from the public.

Jamie Ross:
I am the representative for PACT Coalition. Every dollar that is spent on prevention saves $10 in treatment and incarceration. I remind the Council that prevention is part of this Block Grant.

Ms. Merrill:
I motion that we include strategic initiatives 1, 2, 3, 4, and 6 in the recommendations. The strategic initiatives are as follows:

Strategic Initiative 1:
Increase the number and quality of behavioral health professionals in Nevada
Strategic Initiative 2:
Improve screening, assessment, and referral services for at-risk populations
Strategic Initiative 3:
Support earlier access to prevention and early intervention services (first episode psychosis)
Strategic Initiative 4:
Increase community-based services across systems of care
Strategic Initiative 6:
Provide community-based intervention in support to address trauma and prevent incarceration

Mr. Faison:
I second the motion.

Ms. Thomas:
The motion passed.

Ms. Mayhew:
I would like the Block Grant to address improving crisis management responses and resources.
Mr. Faison:
I think we all have selected what we want to see in the Block Grant application. I think we should go with the initiatives we have selected.

Ms. Jones:
I propose we stick with our graphs.

Mr. Lovgren:
When will the Block Grant application be posted? Is it going to be available for comments and/or concerns from the public and the SAPTA Advisory Board?

Mr. Quint:
The State Plan is due on July 31. Following the issuance of the State Plan, we will publish the Block Grant application and it will be available for public comment.

The SAPTA Advisory Board will meet again in mid-August and the Block Grant can be reviewed at that time. The Block Grant is due to SAMHSA on September 1.

Ms. Wilson:
The next BHPAC meeting is August 13. Will there be a means to submit comments online?

Mr. Quint:
I am sure we can arrange that with our website.

Ms. Wilson:
In the meta-analysis, it talks about specific ways to implement some of these recommendations. I recommend that interested parties take the opportunity to review the implementation recommendations.

Ms. Thomas:
Meeting is adjourned at 2:47 p.m.