

**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 video conferenced to the Grant Sawyer Building, 555 E. Washington, and Las Vegas, NV. Offsite attendees accessed the meeting through a conference call number or the Internet.

BHPAC MEMBERS PRESENT:

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

OTHERS PRESENT:

Charlene Frost	Evelyn Grippaldi	Claranna Petrie	David Sanchez
Kelly McDermott	Tracy Delay	Patrick Bozarth	Marissa Duke
Terri Keene	Nancy Sirkin	Heidi Gustafson	Jim Osti
Denna Atkinson	Michael Corti	Sara hunt	Tenea Smith
Barry Lovgren	Chris Empey	Martie Washington	Auralie Jensen
Lisa Leathram-Vonail	Sneha Ravikuma	Allison Ramsey	Stephanie Robbins
Curtis Wiersma	Kendra Furlong	Cheryl Bricker	Mari Hutchinson
Betsy Fedor	Jan Marssey	Linda Lang	Sheila Leslie
Lana Robard	Kelly Marschall	Kari Earle	Steve Burt
Michelle Berry	Diaz Dixon	Jeff Munk	David Robeck

Mike McMahon:

The meeting is open. We will take public comment.

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.

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.

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.

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.

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 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 and this endeavor.

Ms. 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 assessment 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 behavior health, that were not updated to 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 have 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 of the unmet need 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 either a priority population or 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 matter that it would link 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 are multiple authors for these numerous reports, and recommendations and summaries were changed in some cases. Finally, planning an initiative work is dynamic, additional data or recommendations may have been developed since the time the meta-analysis was completed.

One of the strengths 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 accomplish addressing the need. Looking at the Block Grant is one or more populations affected particular need that targets for the Substance Abuse and Mental Health Services Administration (SAMHSA) application through this process. We took into account what SAMHSA was looking for in the Block Grant. SAMHSA made suggestions where data should be pulled. SAMHSA has now published a behavioral health barometer nationwide but also 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 aged 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 United States. 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, or 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 adolescent's ages 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 use 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 five or more drinks once or twice a week was six in ten adolescents in 2012-2013; Those who perceived no great risk from smoking marijuana once a month about eight in ten adolescents in 2012-2013. 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 alcohol abuse treatment, 4.6 percent received treatment in 2009-2013; when we think about mental health treatment or counselling, looking at adults age eighteen or older, with any mental illness, that is 31 percent received treatment. In Nevada about 114,000 adults received treatment within the prior year. Substance abuse treatment in 2013, 361 ½ 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 of age 12 or older is 13.2 percent received treatment and over 86 percent did not receive treatment, Adult mental health consumers in Nevada by age 15, .9 percent were employed, 40.9 percent were unemployed. 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 range from 800 was up to 1,491. In 2009 and 2013, the numbers were similar. In 2010, there was a decrease in 2010, 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.

Ms. Norris:

I am seeing data of adults 18 and older. Do you have any data on children? I believe they have a Suicide Prevention Program and you could obtain some data from that.

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 point State towards a tool that they could all refer to. 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 Service Division, Division of Health Care and Financing and Policy, Department of Public and Behavioral Health, and Division of Child and Family Service. 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.

Ms. Earle:

The reports that were reviewed to inform the meta-analysis had some degree of guiding principles on how services should be delivered and what should drive decision making and policy development. We took SAMHSA's language and the 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 from the people that I speak to, it is the monetary effect of support and services that 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 do not have any direct answers for you as far as specifics for dollars at this time. We are hoping to get more of a global perspective as to where the resources need to be allocated. Where to invest the Block Grant money so that it does make the biggest impact that we can.

Ms. Earle:

As we transition to discussion of identified needs and gaps, affordability of services is included in the content of the needs and gaps. Through this process both SAMHSA and Nevada have developed population of focus: 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, an intervenes 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, the 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; youth residential treatment; adult residential treatment; recovery supports; peer supports; community support; and specifically in the areas of education and employment. Also in the areas 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; persons enter 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.

Regarding prevention and substance abuse and mental illness, the key points are:

- 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 primary prevention and early prevention.

Health care and health systems integration:

- 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,
- the affordability of those services,
- lack of insurance coverage for those services.

Trauma and Justice and the needs and gaps in that initiative:

- 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.

Recovery Supports Initiative:

- lack of affordable housing options,
- need for habilitated services and support,
- cultural or community stigma,
- lack of adequate transportation option and resources,
- need for peer support services.

Health Information Technology:

- no current centralization suppository sharing currently 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.

Workforce Development:

- poor workforce retention and high turnover,
- training programs that are not working together,
- low wages,
- front line staff burnout,
- capacity building issues,
- practice issues and licensing and credential policies.

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

Ms. Mayhew:

The population with intellectual disorders or fetal alcohol syndrome or other developmental disorders and also have emotional disturbance, that population is a very difficult population to find resources for in Nevada. Many of those kids get 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, 6 A through 6 D, include some public and private providers. When we look at workforce shortage in particular, John Packhams' 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 stigmatism and 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.

Looking at the stigma piece on the meta-analysis and your prioritization. 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 are 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 is a project that 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.

Thank you for your time.

Sheila Leslie:

I represent Washoe County Department of Social Services and Behavioral Health. Regarding the behavioral health barometer from SAMHSA on page sixteen, substance use treatment, alcohol for adults, 95.4 percent of the people in Nevada. 12 and older with alcohol dependents or abuse did not receive treatment. If you go to the substance abuse page eighteen, 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, strategic initiative number six also. People in Nevada are not getting treatment. I encourage you to keep this metric as part of your deliberation and 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 Members 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:

- Two. three too many youth placed out of state;
- Two. four insufficient alternatives to hospitalization
- Two. Five lack of treatment facilities that will serve pregnant women;
- Two. Six long waiting lists, lack of available services and providers;
- looking at Rural Nevada, 2.7, the distance and time it takes to access the nearest available services;
- Two. Eight affordability of services;
- Two. Nine 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. The substance abuse side, each and every substance abuse treatment program which receives block grant money through SAPTA, is required to provide admission and treatment priority to pregnant women. There are 50 of those treatment sites and only 1 serve men in Nevada.

There is a problem with the State meeting the federal requirement that publicized 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; this is what I do not understand.

Ms. Earle:

That is a combination of mental health and substance abuse, and how it is referenced in the plans that it emerged from. It could be a combination of perception; some of it was 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 women 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 a large number of 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 that we are going through right now; to fully integrate the SAPTA Block Grant and the Mental Health Block Grant is a whole 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 the 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.

There are many voices and many solutions that were never heard.

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 NV Public Employee Benefit Program. The priorities for family and children may look a lot different than the priorities for the adults. We should not be treating our children like mini 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 so 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 everybody's needs. This is a Block Grant that is about behavioral health, substance abuse, mental health. How can we help these people the most?

Ms. Earle:

Trauma and Justice 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 center 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:

Just a note on the limitation in the meta-analysis about vocabulary from consumers that really showed up when it came to trauma informed approach. Many of the recommendations under trauma and justice, speaks specifically to the courts. There has been specialty courts and diversion programs, focus groups on surveys, that really spoke to how that was or was not working. This is where 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 too much to go to. 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 is expected to 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 initiative.

Ms. Norris:

In the future, can the survey be explained more clearly for who is taking the survey?

Ms. Marschall:

What is unique and the strength of the meta-analysis is it draws from a variety of initiatives, needs assessments and gaps. Going forward, recommending that a comprehensive needs assessment could be something that you could forward to DPBH.

Ms. Earle:

In the Block Grant application, Nevada is required to respond to the strategic initiative, trauma and justice. You can make clearer recommendations that are currently reflected in the language here, 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 at 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 computer on insurance exchange and get their Medicaid started within a week, it seems like there should be some way to get their Medicaid started here.

Steve Burt:

I represent Ridge house and I am on the SAPTA Advisory Board. 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 I have the client try and do it on their own it takes three months.

Mr. Faison:

If we speak to integration of services and share 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 take which insurance for services. We sent the client to a HPN provider and the client was overlooked, as opposed to a Medicaid fee for service provider that could actually get it going immediately. That is some of the problems we are finding, here in the South anyway.

Mr. Burt:

That is an urban-rural issue in Nevada. The providers that are enrolling in all of them do 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 2 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.

In closing,

I am Heidi Gustafson. 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:

The twenty five percent for substance abuse that is coming 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 number 4. Working with the male population being incarcerated, you see fear in their eye. Without a plan, support, a direction or education when they get out, they are going to end up right 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 were a number of policy regulations that were lifted out of the main report because they were outside of the scope of the Block Grant.

Health Information Technology: This strategic initiative for SAMHSA is focused on ensuring that the behavioral health system is fully participating in electronic health records. It is really 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.

- **Workforce Development:** This is looking at 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 work force.

Hilary Jones:

It seems that education needs to be provided to those who are doing medical detox. The providers that 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 the 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 depends on how they implement their therapeutic model. All therapeutic models are available to all clinicians throughout the state.

Ms. Burcio:

These lifelong changing tools should be offered by every clinic.

Sara Hunt:

I am the Director of the Mental and Behavioral Health Coalition at UNLV. I am here to encourage the Council Members on how you can use our training programs in our state, especially at the Universities and other schools, to help meet all of these initiatives. We are here to provide 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:

<http://dpbh.nv.gov/uploadedFiles/dpbhgov/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 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.

Hilary Jones:

Are there going to be five or six recommendations?

The strategic initiatives will be ranked. The Council will determine what to include in their recommendations.

Ms. Marschall:

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.

Denise 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.

Ms. Marschall:

These are important steps that are being taken.

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?

Ms. 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 PATH Coalition. Every dollar that is spent on prevention saves \$10 in treatment incarceration. I remind the Council that prevention is part of this Block Grant.

Ms. Merrill:

I make a motion that we include strategic initiatives 1, 2, 3, 4, and 6 in the recommendations.

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 to us 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 was adjourned at 2:47 p.m.

RESPECTFULLY SUBMITTED:

APPROVED BY:

DATE:

DRAFT