Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse

January 2007

Legislative Counsel Bureau

Bulletin No. 07-3

LEGISLATIVE COMMITTEE ON HEALTH CARE
SUBCOMMITTEE TO STUDY SERVICES FOR THE TREATMENT AND PREVENTION OF SUBSTANCE ABUSE

(Assembly Bill 2 [Chapter 1, S*tatutes of Nevada 2005, 22nd Special Session*])

BULLETIN NO. 07-3

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Assembly Bill 2
(Chapter 1, *Statutes of Nevada 2005, 22nd Special Session*)

During the Subcommittee's final meeting on April 25, 2006, the members conducted a work session and voted to forward eight recommendations to the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) for consideration. The following recommendations were presented to the Committee at its May 9, 2006, meeting, and seven (items 1 through 6, and 8) were discussed during the Committee's August 10, 2006, work session. More information can be found in the meeting minutes of both the Subcommittee and Committee at www.leg.state.nv.us.

1. Request the drafting of a bill that creates the Licensed Professional Counselors (LPC) credential in Nevada. It was noted that Nevada is one of only two states that do not recognize the LPC credential. The Subcommittee heard testimony about the prevalence of co-occurring disorders and the problem of individuals needing to visit with more than one counselor to have all their needs met. Licensed Professional Counselors are trained and licensed to provide a broad range of services including substance abuse and mental health counseling, which may help the efficiency and effectiveness of treatment. Concern was raised about the creation of a new licensing board for this group, and the suggestion was made to expand the jurisdiction of the licensing boards that currently exist. The Subcommittee did not resolve the licensing board issue, preferring to leave such specific decisions for later discussion. Note: During the Legislative Committee on Health Care's work session, the Committee approved a bill draft request (BDR) that would consolidate three existing licensing boards into a new behavioral health board and create the LPC credential. **(BDR 308)**

2. Request the drafting of a bill that funds a pilot program that provides a long-term residential treatment facility for substance abusers, with an emphasis on providing comprehensive prevention and treatment services and programs. The program would provide intensive case management and wrap-around services to be administered by a community-based or faith-based organization. It is the Subcommittee's expectation that such a pilot program will provide outcomes that will help establish "best practices" for residential treatment and prevention services in the State. **(Supported by the Legislative Committee on Health Care.)**

3. Request the drafting of a bill that funds comprehensive post-incarceration treatment programs to enable non-violent offenders to successfully transition back into society. The bill would provide the opportunity for more individuals to receive treatment during the transition process by providing the opportunity to be paroled sooner and receive treatment

while on parole. Funding mechanisms that can be used in Nevada's Department of Correction's budget to increase funding for treatment should be explored so that cost savings will be maximized. For example, the bill could require Nevada's Department of Corrections to determine the savings by releasing offenders into treatment, including money saved from not housing them in prison and any reduction in recidivism. The savings could be redistributed to pay for post-incarceration treatment for a greater number of inmates. **(Supported by the Legislative Committee on Health Care.)**

4. Send a letter to the Department of Health and Human Services (DHHS) to encourage the funding of Nevada's two community triage centers in its budget for the Division of Mental Health and Developmental Services. The letter will express the Committee's support for ongoing State funding of community triage centers at least at the current level (adjusted for inflation). If triage centers are not included in the DHHS budget, the Committee should request the drafting of a bill that would continue the State's contribution of matching funds using the same formula followed during the 2005-2007 biennium pursuant to Assembly Bill 175 (Chapter 446, *Statutes of Nevada 2005*). Note: During the Legislative Committee on Health Care's work session, the recommendation was changed to appropriate $1,505,000 in Fiscal Year (FY) 2008, and $1,608,845 in FY 2009 to fund the two existing community triage centers. **(Appropriation supported by the Legislative Committee on Health Care.)**

5. Send a letter to the following medical groups: The Medical School at the University of Nevada, Reno; residency programs in Family Practice, Pediatrics, and Obstetrics/Gynecology in Nevada; the Clark County Medical Society, the Washoe County Medical Society, the Nevada State Medical Association; entities offering continuing education credits; and other relevant groups. The letter will: (1) emphasize the Committee's strong support for children to have access to diagnosis and therapy for fetal alcohol spectrum disorders (FASD); (2) highlight the need for additional professionals qualified to diagnose FASD in Nevada; (3) emphasize the importance of prevention; and (4) encourage the groups to educate their members how to diagnose FASD so doctors in Nevada will be knowledgeable and comfortable diagnosing the disorder. **(Supported by the Legislative Committee on Health Care.)**

6. Send a letter to the DHHS recommending that the budget request for Bureau of Alcohol and Drug Abuse (BADA) include a formula for case load growth in funding substance abuse treatment and prevention programs. The Subcommittee heard testimony that treatment programs are not able to grow with the demand for services because funding for substance abuse treatment through BADA has never included a formula for caseload growth. **(Supported by the Legislative Committee on Health Care.)**

7. Send a letter to the Legislative Commission's Subcommittee to Study Sentencing and Pardons, and Parole and Probation (Assembly Concurrent Resolution No. 17, File No. 98, Statutes of Nevada 2005) emphasizing the Committee's concerns related to substance abuse treatment services for incarcerated persons. The letter will emphasize the Committee's

concern for the health of inmates and acknowledge that related issues fall within the jurisdiction of the judiciary committees. The letter will encourage the A.C.R. 17 Subcommittee to examine the following concerns: (1) treatment programs for incarcerated persons have lost federal funding; (2) treatment needs to be comprehensive and of adequate time to include both in-custody and transitional services; (3) the number of inmates that receive treatment should be increased to better serve the growing number in need; (4) the system of corrections should make the treatment of substance abuse a priority; and (5) the need to expand comprehensive post-incarceration treatment and explore funding options that consider cost savings. **(Approved by the Legislative Committee on Health Care at the May 9, 2006, meeting.)**

8. Send a letter to members of the 2007 Legislature in both houses to encourage their support of and participation in substance abuse prevention coalitions in their communities. The Subcommittee heard extensive testimony about the dedicated community coalitions that are fighting methamphetamine and substance abuse throughout the State and believes the coalitions' efforts should be supported. **(Supported by the Legislative Committee on Health Care.)**

REPORT BY THE LEGISLATIVE COMMITTEE ON HEALTH CARE SUBCOMMITTEE TO STUDY SERVICES FOR THE TREATMENT AND PREVENTION OF SUBSTANCE ABUSE

I. INTRODUCTION

During the 22nd Special Session, the Nevada State Legislature passed Assembly Bill 2 (Chapter 1, *Statutes of Nevada 2005*), which in section 211.5, directed the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) to conduct an interim study of the organizational and delivery structure of services for the treatment and prevention of substance abuse in Nevada (see Appendix A). In response, the Chairman of the Legislative Committee on Health Care, Senator Maurice E. Washington, appointed a four-member Subcommittee, chaired by Assemblywoman Sheila Leslie, to conduct the study.

Members

Assemblywoman Sheila Leslie, Chair
Senator Joe Heck
Senator Steven A. Horsford
Assemblyman Joe Hardy

Staff

The following Legislative Counsel Bureau staff members provided support for the Subcommittee:

Amber J. Joiner, Senior Research Analyst, Research Division
Leslie K. Hamner, Principal Deputy Legislative Counsel, Legal Division
Andrew K. Min, Deputy Legislative Counsel, Legal Division
Ricka Benum, Senior Research Secretary, Research Division

II. REVIEW OF ASSEMBLY BILL 2

Section 211.5 of Assembly Bill 2 of the 22nd Special Session requires the Legislative Committee on Health Care to conduct an interim study of the organizational and delivery structure of services for the treatment and prevention of substance abuse in Nevada.

Assembly Bill 2 requires that the study include, without limitation:

(a) An evaluation of the manner in which the organizational and delivery structure of services for the treatment and prevention of substance abuse in this State may be improved so that the services are provided in the most effective manner for the residents of this State;

(b) An analysis of the services for the treatment and prevention of substance abuse that are currently funded or provided by public agencies in this State to determine whether any of these services are overlapping or duplicative, and whether any of these services could successfully be integrated; and

(c) An analysis of the utilization of services for the treatment and prevention of substance abuse in this State and of projections for the future needs for such services in this State, including, without limitation:

(1) An examination of the barriers that persons diagnosed with both a mental illness and a substance abuse problem encounter in attempting to receive appropriate services for the treatment of substance abuse in this State;

(2) An examination of the barriers that pregnant women encounter in attempting to receive appropriate services for the treatment of substance abuse in this State;

(3) An examination of the collaboration of the different divisions of the Department of Health and Human Services in the provision of services to persons with substance abuse problems in this State, and an examination of whether that collaboration is focused on the best interests of the persons receiving the services; and

(4) An examination of the provision of services for the prevention of substance abuse in this State, and an examination of whether these services are effective at preventing or reducing the incidence of substance abuse problems in this State.

Additionally, the Legislative Committee on Health Care must ensure that the persons and entities that provide services for the treatment or prevention of mental illness or substance abuse in the State are involved in the study. Finally, the Legislative Committee on Health Care is required to submit a report of the results of the study and any recommendations for legislation to the 74th Session of the Nevada State Legislature.

III. BACKGROUND

The legislative study required by A.B. 2 was proposed during the regular Legislative Session in 2005 in conjunction with the proposed transfer of the Bureau of Alcohol and Drug Abuse (BADA) from the Health Division in the Department of Health and Human Services (DHHS) to the Division of Mental Health and Developmental Services in DHHS. The transfer of services and interim study were proposed as amendments to Senate Bill 462; however, S.B. 462 failed to pass both houses of the Legislature.

Assembly Bill 2 from the 22nd Special Session includes many provisions from S.B. 462 of the regular 2005 Legislative Session. In addition to the study, A.B. 2 provides that on July 1, 2007, BADA will be transferred to the DHHS. The Department is required to develop a plan for the transfer of services and submit the plan to the Governor and the Legislative Committee on Health Care on or before March 31, 2006, for review and approval. This marks BADA's second move; the Bureau was previously located in the Department of Employment, Training and Rehabilitation, and was transferred to the Department of Human Resources (now DHHS) in 1999.

IV. SUBCOMMITTEE ACTIVITIES

In order to meet the requirements of Assembly Bill 2, the Subcommittee met three times. The first meeting was held in Las Vegas, Nevada, on February 2, 2006; the second in Carson City, Nevada, on March 14, 2006; and the third in Las Vegas on April 25, 2006. All three meetings were broadcast live on the Internet and videoconferenced between the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City, which allowed testimony from both locations.

During the course of the study, testimony from federal, State, and local agencies; businesses; community groups; medical experts; nonprofit organizations; and the public was provided on a wide range of topics related to substance abuse. The following are brief summaries of the Subcommittee's activities at each of the three meetings. For more complete summaries of testimony and exhibits, please refer to the *Summary Minutes and Action Report* of the meetings, available at http://www.leg.state.nv.us/73rd/Interim/StatCom/HealthCareTreat/.

FEBRUARY 2, 2006, MEETING

The first meeting of the Legislative Committee on Health Care Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse began with an overview of the Subcommittee's activities, responsibilities, and work plan. The Subcommittee also heard the following testimony:

- Presentations from divisions within the DHHS that examined: (1) the transfer plan for the BADA from the Health Division to the Division of Mental Health and Developmental Services; (2) the organizational and delivery structure of the services the divisions provide for the prevention and treatment of substance abuse; and (3) the collaboration among the different divisions to provide substance abuse services;

- Presentations that examined the provision of services for the *prevention* of substance abuse by: The Juvenile Justice Programs Office, Division of Child and Family Services, DHHS; the Safe and Drug-Free Schools and Communities Program, Nevada Department of Education; the Office of Criminal Justice Assistance, Nevada's Department of Public Safety; the Statewide Coalition Partnership, Dayton, Nevada; and the Nevada Substance Abuse Prevention Council, Las Vegas, Nevada;

- Presentations that examined the provision of services for the *treatment* of substance abuse by: The Juvenile Justice Programs Office, Division of Child and Family Services, DHHS; Nevada's Department of Corrections; the Office of Criminal Justice Assistance, Nevada's Department of Public Safety; the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (Nevada AADAPTS); and the Center for the Application of Substance Abuse Technologies, University of Nevada, Reno; and

- Presentations that examined the barriers that people who are diagnosed with both a mental illness and a substance abuse problem face in receiving appropriate services by: the Carson City Justice and Municipal Court; the Eighth Judicial District Mental Health Court, Clark County, Nevada; the Second Judicial District Mental Health Court, Washoe County, Nevada; the Division of Mental Health and Developmental Services, DHHS; NAMI (the National Alliance on Mental Illness) of Southern Nevada; and Nevada AADAPTS.

MARCH 14, 2006, MEETING

The second meeting of the Legislative Committee on Health Care Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse included a presentation by Carol L. Chervenak, M.D., Medical Director of the ABC House for the Linn and Benton Counties Child Victim Assessment Center in Albany, Oregon. Dr. Chervenak provided an extensive discussion of the devastating effects of methamphetamine use on individuals and families. The Subcommittee also heard the following testimony:

- Presentations that examined the issues surrounding methamphetamine abuse in Nevada by: Join Together Northern Nevada; the Carson City Drug Abuse Coalition; Partnership of Community Resources; Douglas County's Substance Abuse Prevention Coalition; Goshen Community Development Coalition; and the Investigation Division of Nevada's Department of Public Safety;

- Presentations that examined the adequacy of services available in Nevada for incarcerated persons with substance abuse problems by: the Eighth Judicial District Drug Court, Clark County, Nevada; the Second Judicial District Drug Court, Washoe County, Nevada; the Las Vegas Metropolitan Police Department; the Washoe County Sheriff's Office; Nevada's Department of Corrections; and Vitality Unlimited, Elko, Nevada; and

- Presentations that examined the issues concerning children receiving county and family services because their parents or guardians have substance abuse problems by: the Washoe County Department of Social Services; the Clark County Department of Family Services; and the Division of Child and Family Services, DHHS.

APRIL 25, 2006, MEETING

The third meeting of the Legislative Committee on Health Care Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse included a work session and the following testimony:

- Presentations that examined the barriers pregnant women encounter in attempting to receive appropriate services for the treatment of substance abuse by: STEP 2, Inc.; the Washoe County Public Defender's Office; CASA of Carson City; and the Perinatal Substance Abuse Prevention Subcommittee (PSAP);

- A presentation that examined the connection between methamphetamine use and technological crimes by the Advisory Board for the Nevada Task Force for Technological Crime; and

- Presentations that examined the role of faith-based organizations in the treatment and prevention of substance abuse by: the Salvation Army Adult Rehabilitation Programs in Las Vegas and Reno, Nevada; The Ridge House; and LDS Family Services.

V. DISCUSSION OF RECOMMENDATIONS

During the Subcommittee's final meeting on April 25, 2006, the members conducted a work session and voted to forward eight recommendations to the Legislative Committee on Health Care for consideration. The following recommendations were presented to the Committee at its May 9, 2006, meeting, and seven (items 1 through 6, and 8) were discussed during the Committee's August 10, 2006, work session. More information can be found in the meeting minutes of both the Subcommittee and Committee at www.leg.state.nv.us.

A. SUBSTANCE ABUSE TREATMENT AND PREVENTION

Funding

At the February 2, 2006, meeting, the Subcommittee heard testimony from Frank Parenti, Executive Director of Nevada AADAPTS, that the need for adequate funding of treatment programs in Nevada is considerable. Citing BADA reports, Mr. Parenti testified that in 2004, 1,767 clients were placed on waiting lists for an average of 27 days before accessing treatment. Additionally, Mr. Parenti stated that according to BADA in 2005 there was an unmet need for treatment of 13,720 adolescents and 117,476 adults (see Appendix B). One reason for the long waiting lists and unmet need is that treatment programs are not able to grow with the demand for services because funding for substance abuse treatment through BADA has never included a formula for caseload growth.

During the February 2, 2006, meeting, Alexander Haartz, Administrator, Health Division, DHHS, explained that national estimates, percentages, and population modifiers are often used to develop funding formulas for other social programs, such as those for children with developmental delays or HIV-AIDS (human immunodeficiency virus or acquired immunodeficiency syndrome) patients. He said that another often-used formula is the basic calculation comparison between the number of persons who visit or call a provider and the number of persons turned away and placed on waiting lists. Mr. Haartz testified that although BADA has never developed a caseload methodology for substance abuse funding in the past, the plan for the future is to include specific caseload budgeting strategies in the Division's budget requests to the Governor.

Recognizing the need for caseload growth considerations in budgeting, the Subcommittee made the following Recommendation:

> **Send a letter to the DHHS recommending that the budget request for BADA include a formula for case load growth in funding substance abuse treatment and prevention programs. (Recommendation No. 6, supported by the Legislative Committee on Health Care.)**

Methamphetamine

The Subcommittee heard extensive testimony about the problem of drug abuse, and especially methamphetamine use, in Nevada. According to the *Bureau of Alcohol and Drug Abuse 2004 Annual Report*, presented at the February 2, 2006, meeting, over 29 percent of admissions to BADA funded treatment facilities were for methamphetamine in 2004, second only to alcohol as the drug of choice. Additionally, the report indicated that in the last five years, the percentage of methamphetamine admissions has increased by 28.6 percent (see Appendix C). Several experts provided testimony about the devastating affects and prevalence of methamphetamine use in Nevada.

At the March 14, 2006, meeting, Carol L. Chervenak, M.D., Medical Director, ABC House, Linn and Benton Counties Child Victim Assessment Center, Albany, Oregon, provided an extensive presentation describing the effects of methamphetamine use on the abuser's body, the impacts on children and families, and the importance of treatment and prevention. At the same meeting, Belinda Thompson, Executive Director of the Goshen Community Development Coalition and Chair of the Nevada Substance Abuse Prevention Council, presented a report called *Nevada and the State of Methamphetamine*, which provided many statistics revealing the prevalence and impact of methamphetamine use in the State (See Appendix D).

The Subcommittee also heard testimony from the dedicated community coalitions that are fighting methamphetamine and substance abuse throughout the State. Christie McGill, Chair of the Statewide Coalition Partnership, Dayton, Nevada, informed the Subcommittee of success stories associated with Nevada's community coalitions. The State's coalitions are comprised, in part, of county social services personnel, law enforcement representatives, school districts, parents, prevention agencies, and faith-based organizations. A total of 1,833 agencies, citizens, and local leaders have worked together to plan multiple prevention strategies utilizing various sectors with common goals (see list of prevention coalitions in Appendix B and Appendix E).

Acknowledging the community coalitions' efforts to fight methamphetamine and drug abuse in Nevada, the Subcommittee made the following Recommendation:

> **Send a letter to members of the 2007 Legislature in both houses to encourage their support of and participation in substance abuse prevention coalitions in their communities. (Recommendation No. 8, supported by the Legislative Committee on Health Care.)**

Residential Treatment Facilities

Diaz Dixon, Chief Executive Officer of STEP2, Inc., Reno, testified at the April 25, 2006, meeting about his substance abuse rehabilitation program for chemically dependent women. The non profit organization provides rehabilitation services for clients as a referral program offered by Nevada drug courts. Often, the clients are pregnant and services must include

consideration for the needs of additional children and family members. Mr. Dixon identified some barriers pregnant women encounter during substance abuse treatment, including safe and structured childcare environments, housing, and limited job opportunities for gainful and suitable employment during and after treatment. Subcommittee members commended the Light House facility in Reno for its work to keep children with their mothers and its reputation for being known as a successful long-term transition program.

Recognizing the need to identify "best practice" programs, such as Light House, that can be evaluated, replicated, and established statewide, the Subcommittee made the following recommendation:

> **Request the drafting of a bill that funds a pilot program that provides a long-term residential treatment facility for substance abusers, with an emphasis on providing comprehensive prevention and treatment services and programs. (Recommendation No. 2, supported by the Legislative Committee on Health Care.)**

The program will provide intensive case management and wrap-around services to be administered by a community-based or faith-based organization. It is the Subcommittee's expectation that such a pilot program will provide outcomes that will help establish "best practices" for residential treatment and prevention services in the State.

B. CO-OCCURRING DISORDERS

The Subcommittee heard testimony about the prevalence of co-occurring disorders and the problem of individuals needing to visit with more than one counselor to have all their mental health and substance abuse treatment needs met. Workforce shortages, including an insufficient number of dually licensed counselors, contribute to the lack of ample treatment for those with co-occurring disorders. Frank Parenti testified that, according to BADA, approximately 10 percent of people seeking substance abuse treatment in Nevada also have mental health issues (see Appendix B). Vic Davis, President of the National Alliance on Mental Illness of Southern Nevada, presented testimony that an even larger number of people are affected: 37 percent of alcohol abusers and 53 percent of drug abusers have at least one serious mental illness (see Appendix F).

In response to concerns related to mental health and co-occurring disorders, the Subcommittee made the following recommendations:

> **Request the drafting of a bill that creates the Licensed Professional Counselors (LPC) credential in Nevada. (Recommendation No. 1) (BDR 308)**

It was noted that Nevada is one of only two states that do not recognize the LPC credential. Licensed Professional Counselors are trained and licensed to provide a broad range of services, including substance abuse and mental health counseling, which may help the efficiency and

effectiveness of treatment. Concern was raised about the creation of a new licensing board for this group, and the suggestion was made to expand the jurisdiction of the licensing boards that currently exist. The Subcommittee did not resolve the licensing board issue, preferring to leave such specific decisions for later discussion. During the Legislative Committee on Health Care's work session, the Committee approved a BDR that would consolidate three existing licensing boards into a new behavioral health board and create the LPC credential.

> **Send a letter to the DHHS to encourage the funding of Nevada's two community triage centers in its budget for the Division of Mental Health and Developmental Services. (Recommendation No. 4, appropriation supported by the Legislative Committee on Health Care.)**

Section 449.0031 of the *Nevada Revised Statutes* defines a triage center as "a facility that provides on a 24-hour basis medical assessments of and short-term monitoring services for mentally ill persons and abusers of alcohol or drugs in a manner which does not require that the assessments and services be provided in a licensed hospital." The letter in Recommendation No. 4 will express the Committee's support for ongoing State funding of community triage centers at least at the current level (adjusted for inflation). If triage centers are not included in the DHHS budget, the Subcommittee recommends that the Committee request the drafting of a bill that would continue the State's contribution of matching funds using the same formula followed during the 2005-2007 biennium pursuant to Assembly Bill 175 (Chapter 446, *Statutes of Nevada 2005*). Note: During the Legislative Committee on Health Care's work session, the recommendation was changed to appropriate $1,505,000 in Fiscal Year (FY) 2008, and $1,608,845 in FY 2009 to fund the two existing community triage centers.

C. INCARCERATED PERSONS

The Subcommittee heard testimony from several entities about substance abuse treatment services provided to incarcerated persons in Nevada. Jay Terrell, Substance Abuse Program Director in Nevada's Department of Corrections, testified at the February 2, 2006, meeting that 70 to 85 percent of the offenders in the criminal justice system in Nevada have committed substance abuse-related crimes or have addictions. At the March 14, 2006, meeting, Judge Jack Lehman, Senior Judge, Drug Court, Eighth Judicial District, Clark County, Nevada, recommended the expansion of correctional programs like the Offenders Acting in Solidarity to Insure Sobriety (OASIS), and other closely supervised re-entry programs for inmates with drug problems.

Judge Lehman testified that the Clark County Drug Court oversees a successful re-entry program associated with Nevada State Prison inmates. The program has a 60 to 70 percent graduation rate, and only approximately 10 percent of the inmates have failed and been sent back to prison. At the same meeting, Judge Peter I. Breen, Senior Judge, Drug Court, Second Judicial District, Washoe County, Nevada, testified that Washoe County's

success statistics mirror those of Clark County, illustrating that treatment programs within the court system are effective. He said that Washoe County's Drug Court was recently augmented with a six-month aftercare program, following the initial treatment period of 18 months.

Acknowledging the success of re-entry programs currently in Nevada, and the need for additional services, the Subcommittee made the following recommendations:

> **Request the drafting of a bill that funds comprehensive post-incarceration treatment programs to enable non-violent offenders to successfully transition back into society. (Recommendation No. 3, supported by the Legislative Committee on Health Care.)**

This bill will provide the opportunity for more individuals to receive treatment during the transition process by providing the opportunity to be paroled sooner and receive treatment while on parole. The Subcommittee emphasized that funding mechanisms that can be used in Nevada's Department of Corrections' budget to increase funding for treatment should also be explored so that cost savings will be maximized. For example, the bill could require Nevada's Department of Corrections to determine the savings by releasing offenders into treatment, including money saved from not housing them in prison and any reduction in recidivism. The savings could be redistributed to pay for post-incarceration treatment for a greater number of inmates.

> **Send a letter to the Legislative Commission's Subcommittee to Study Sentencing and Pardons, and Parole and Probation (Assembly Concurrent Resolution No. 17, File No. 98, *Statutes of Nevada 2005*) emphasizing the Committee's concerns related to substance abuse treatment services for incarcerated persons. (Recommendation No. 7, approved by the Legislative Committee on Health Care at the May 9, 2006, meeting.)**

The letter will emphasize the Committee's concern for the health of inmates and acknowledge that related issues fall within the jurisdiction of the judiciary committees. The letter will encourage the A.C.R. 17 Subcommittee to examine the following concerns: (1) treatment programs for incarcerated persons have lost federal funding; (2) treatment needs to be comprehensive and of adequate time to include both in-custody and transitional services; (3) the number of inmates that receive treatment should be increased to better serve the growing number in need; (4) the system of corrections should make the treatment of substance abuse a priority; and (5) the need to expand comprehensive post-incarceration treatment and explore funding options that consider cost savings.

D. FETAL ALCOHOL SPECTRUM DISORDER

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe a spectrum of diagnosable disorders affecting individuals who were prenatally exposed to alcohol. Such disorders may include behavioral, learning, mental, and physical disabilities. At the April 25, 2006, meeting, Cynthia Huth, the Perinatal and Women's Health Nurse Consultant for Nevada's Health Division's Bureau of Family Health Services, testified that FASD is 100 percent preventable, and that Nevada's FASD rate has increased to ten times the national average in case reports. Ms. Huth also discussed the dilemma that there is only one geneticist in the entire State qualified and trained to diagnose FASD. She identified Colleen Morris, M.D., University of Nevada, Las Vegas (UNLV), Nevada System of Higher Education, and emphasized the need for additional and properly trained professionals who can diagnose FASD (see Appendix G).

Recognizing the importance of FASD prevention and the lack of professionals able to diagnose FASD in Nevada, the Subcommittee made the following recommendation:

> **Send a letter to the following medical groups: The Medical School at the University of Nevada, Reno; residency programs in Family Practice, Pediatrics, and Obstetrics/Gynecology in Nevada; the Clark County Medical Society, the Washoe County Medical Society, the Nevada State Medical Association; entities offering continuing education credits; and other relevant groups. (Recommendation No. 5, supported by the Legislative Committee on Health Care.)**

The letter will: (1) emphasize the Committee's strong support for children to have access to diagnosis and therapy for FASD; (2) highlight the need for additional professionals qualified to diagnose FASD in Nevada; (3) emphasize the importance of prevention; and (4) encourage the groups to educate their members how to diagnose FASD so doctors in Nevada will be knowledgeable and comfortable diagnosing the disorder.

VI. ISSUES OF CONCERN

In addition to the list of recommendations previously discussed, at the final meeting, members voiced concern about a number of issues that warrant further discussion and reporting to the Legislative Committee on Health Care:

1. The Subcommittee members expressed concern regarding the lack of waiting list data and the uncertainty inherent in calculating the unmet need for substance abuse treatment in the State. Currently, publicly supported providers in Nevada are required to report waiting list data only for their priority populations (pregnant women and intravenous drug users). Public providers are not required to report on non-priority populations, and private providers are not required to report any waiting list information. The Bureau of Alcohol and Drug Abuse is planning to distribute an annual, voluntary survey to treatment providers in the State, beginning in July 2006, to gather more information about services in Nevada. The Subcommittee voted to sign a letter, jointly with BADA, that will accompany the survey. The letter will request voluntary submission of data related to people seeking substance abuse treatment services in order to gain more information about the unmet need in Nevada.

2. The Subcommittee members heard testimony about the need for more professionals licensed to practice substance abuse treatment in Nevada and recognize this as an important issue. As in other health fields in the State, reciprocity provisions for substance abuse counselors make it difficult for professionals who are licensed in other states to become licensed in Nevada. Members expressed interest in working with the other members of the Legislative Committee on Health Care and relevant groups to change licensing provisions to make it easier for qualified professionals to be licensed. Members also recognize the importance of protecting the health and welfare of citizens when changing licensing requirements.

3. The Subcommittee members recognize the importance of substance abuse prevention strategies in the State and are concerned about the recent and anticipated losses of federal funds for prevention programs. Specifically, in FY 2008-2009, Nevada is expected to lose the following federal funding: $150,445 due to cuts in the Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA); $3 million due to the expiration of the three-year State Incentive Grant from the Center for Substance Abuse Prevention, SAMHSA; and $171,818 due to cuts in the Safe and Drug Free Schools program from the U.S. Department of Education.

4. The Subcommittee members expressed concern about the need for appropriate State funding for long-term programs that provide integrated treatment for persons with co-occurring disorders. Many current programs offer parallel treatment requiring the client to visit one counselor for their substance abuse problem and another for mental

health services. The ideal treatment would integrate both mental health and substance abuse counseling to treat the whole person at once.

5. The Subcommittee heard testimony about the special cognitive and long-term treatment needs that are specific to methamphetamine users and consider it essential that current, appropriate practices for methamphetamine treatment be utilized by entities providing treatment in Nevada. Members expressed concern that the most recent research on "best practices" for methamphetamine treatment may not be distributed to providers and used in practice as effectively as it could be. Additionally, members believe that methamphetamine use is a public health issue and that all entities that provide public health education in the State should disseminate information about methamphetamine prevention and treatment in the correspondence they already distribute to the community.

VII. CONCLUDING REMARKS

The Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse fulfilled all of the requirements of Assembly Bill 2 by examining the following: the organizational and delivery structure of services for the treatment and prevention of substance abuse; the provision of services for the prevention of substance abuse; the provision of services for the treatment of substance abuse; the barriers that persons diagnosed with co-occurring disorders encounter in receiving appropriate services; and the barriers that pregnant women encounter in attempting to receive appropriate substance abuse services. In addition to the issues specifically outlined in A.B. 2, the Subcommittee also examined other substance abuse problems facing Nevada, including: the adequacy of services available for incarcerated persons with substance abuse problems; the issues concerning children receiving county and family services because their parents or guardians have substance abuse problems; and the issues surrounding methamphetamine abuse in Nevada.

The Subcommittee would like to thank all of the federal, State, and local agencies; elected officials; businesses; community groups; national and local experts; nonprofit organizations; and the public for their contributions to this study. The members sincerely appreciate the time, expertise, and recommendations these people volunteered to make the study as comprehensive and thorough as possible. This study would not have been possible without their assistance and cooperation.

VIII. APPENDICES

APPENDIX A

Assembly Bill 2
Chapter 1, *Statutes of Nevada 2005, 22nd Special Session*

Sec. 211.5. 1. The Legislative Committee on Health Care shall conduct an interim study of the organizational and delivery structure of services for the treatment and prevention of substance abuse in this State.

2. The study must include, without limitation:

(a) An evaluation of the manner in which the organizational and delivery structure of services for the treatment and prevention of substance abuse in this State may be improved so that the services are provided in the most effective manner for the residents of this State;

(b) An analysis of the services for the treatment and prevention of substance abuse that are currently funded or provided by public agencies in this State to determine whether any of these services are overlapping or duplicative, and whether any of these services could successfully be integrated; and

(c) An analysis of the utilization of services for the treatment and prevention of substance abuse in this State and of projections for the future needs for such services in this State, including, without limitation:

(1) An examination of the barriers that persons diagnosed with both a mental illness and a substance abuse problem encounter in attempting to receive appropriate services for the treatment of substance abuse in this State;

(2) An examination of the barriers that pregnant women encounter in attempting to receive appropriate services for the treatment of substance abuse in this State;

(3) An examination of the collaboration of the different divisions of the Department of Human Resources in the provision of services to persons with substance abuse problems in this State, and an examination of whether that collaboration is focused on the best interests of the persons receiving the services; and

(4) An examination of the provision of services for the prevention of substance abuse in this State, and an examination of whether these services are effective at preventing or reducing the incidence of substance abuse problems in this State.

3. The Legislative Committee on Health Care shall ensure that the persons and entities which provide services for the treatment or prevention of mental illness or substance abuse in this State are involved in the study.

4. The Legislative Committee on Health Care shall submit a report of the results of the study and any recommendations for legislation to the 74th Session of the Nevada Legislature.

APPENDIX B

The testimony of Frank Parenti, Executive Director
Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services
(Nevada AADAPTS)

Legislative Committee on Health Care
Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse
February 2, 2006
Frank Parenti, Executive Director
NEVADA AADAPTS

NEVADA AADAPTS is a statewide organization comprised of and representing non-profit human service organizations concerned with addictive disorders, prevention, intervention and treatment.

We are committed to improving the quality and quantity of services by impacting public policy regarding addiction issues and by advancing professionalism in the field.

NEVADA AADPTS represents 18 substance abuse treatment and prevention providers in the north, south and rural areas of Nevada.

- **Waiting List**

Addiction is a public health crisis impacting Nevada. The need for adequately funded substance abuse treatment services is compelling. According to The Bureau of Alcohol and Drug Abuse (BADA) the number of clients placed on a waiting list during SFY 2004 was **1,767 clients annually. In 2005 this number has increased to 1,864**. The average wait time to access services was **27 days**. These figures do not reflect the thousands of individuals who do not access service as a result of extended waiting periods for an initial assessment. The unfortunate truth is these individuals simply hang up the phone without scheduling an appointment or adding their name to a waiting list. Research clearly demonstrates timely access to services is crucial to engaging a client in the treatment process. People are ready to access services and we are missing the opportunity due to lack of adequate funding.

- **Unmet Need**

BADA, using a federal methodology, has established that there was an unmet need for treatment services in SFY 2005 of; **13,720 Adolescents and 117,476 Adults.** Many of these individuals are reaching out for treatment but we can't reach them due to our waiting lists.

- **Funding Issues**

Currently the primary source for funding substance abuse programs is the Federal Substance Abuse, Prevention and Treatment Block Grant. This accounts for approximately $12 million dollars for treatment services. As a requirement for Federal funding, State general funds must match $500,000. Additional State general funds account for approximately $3 million dollars total.

A major concern is the lack of case load adjustments for BADA. The growth in Nevada's population is producing an increase need for treatment services. The assumption in the BADA budget that caseloads are not increasing is simply unrealistic given the need. How are we to continue to provide the needed services when our caseload projections in the budget are assumed to be stagnant?

- **What works?**
  How do we reach as many people as we can ... given limited resources?

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT supports a variety of activities aimed at fulfilling its mission:

To improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation.

CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.

This process is mirrored in the philosophy of BADA and the promotion of the public/private partnerships to facilitate services. The ability of BADA to advance exceptional quantity and quality of services to individuals in need has been made evident since it was moved from the Department of Employment, Training, and Rehabilitation (DETR) in 1999.

- **The Challenges**

It is not where BADA is housed ... it is how we can secure adequate funding to allow continued services to the thousands in need.

The questions that need to be addressed are:

How do we reduce waiting list numbers and address the overwhelming unmet need?

How can we continue to demonstrate success and avoid losing ground every year while assuring funding is directed to the population we have been serving?

Legislative Committee on Health Care
Subcommittee to Study Services for the Treatment and Prevention of Substance Abuse
February 2, 2006
Frank Parenti, Executive Director
NEVADA AADAPTS

- **Mental Health Challenges**

Recently the term co-occurring disorder has become more prevalent in the addiction and mental health treatment systems. As you know often times the same term may have different meaning to different people.

According to the Bureau of Alcohol and Drug Abuse during SFY 2004 10% of the total treatment admissions also identified a mental health issue. (BADA Client Data System)

NEVADA AADAPTS has identified a segment of the addiction treatment population suffering from co-occurring disorders. Primarily this is a substance abuse issue and also a secondary mental health issue such as an adjustment disorders related to the consequences of substance use (situational depression and anxiety). This definition of a co-occurring disorder can be treated by the majority of providers who have dual licensed staff.

Many of our providers also face the challenge of coordinating treatment for the Severely Mentally Ill (SMI) who also has a secondary addiction issue. The SMI population may also require psychiatric medication to function. When attempting to treat an individual who is classified as SMI our first effort is to coordinate psychiatric services. The mental health system is also overwhelmed with referrals and clients often must wait 4-6 weeks for services. This creates a "Catch 22" where a treatment provider will need to stabilize the psychiatric issue first prior to treating the substance abuse issue. The mental health system may require a client to be drug free for 4-6 weeks as many substance abuse withdrawal symptoms mimic mental health issues.

The challenges facing the addiction and mental health field are related to workforce issues, the staffing shortages are substantial. For addiction providers limited funding for services presents difficulties when attempting to recruit dual licensed staff. Attempts to coordinate services are difficult as both sides face staffing issues.

How can we improve the services when our resources are limited?

Can we offer incentives for individuals willing to enter our workforce?

NV AADAPTS MEMBERSHIP LIST

Salvation Army
Adult Rehabilitation Program
211 Judson Ave.
Las Vegas, NV 89030

Bridge Counseling Associates
1701 W. Charleston #400
Las Vegas, NV 89102

Bristlecone Family Resource
1725 S. McCarran Blvd.
Reno, NV 89502

Center for Alcohol and Substance Abuse Technologies (CASAT)
UNR
800 Haskell
Reno, NV 89509

Community Counseling Center
1120 Almond Tree Lane Suite 207
Las Vegas, NV 89104

EOB Addiction Treatment Services
522 W. Washington
Las Vegas, NV 89106

Family and Child Treatment
1050 S Rainbow Blvd
Las Vegas, NV

Join Together Northern Nevada
1325 Airmotive Way Suite 205
Reno, NV 89502

Las Vegas Indian Center
2300 W. Bonanza Road
Las Vegas, NV 89106

Lyon County Council on Substance Abuse
215 W. Bridge St. #8
Yerington, NV 89447

Nevada Treatment Center
1721 E. Charleston Blvd.
Las Vegas, NV 89030

New Frontier
165 N. Carson St.
Fallon, NV 89406

Ridge House
275 Hill St. Suite 281
Reno, NV 89501

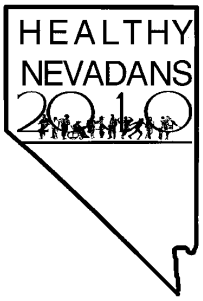
Sierra Recovery Center
972-B Tallac Ave.
S. Lake Tahoe, CA 96150

Step2/Lighthouse of the Sierra
3695 Kings Row
Reno, NV 89503

Westcare of Nevada
5659 Duncan Drive.
Las Vegas, NV 89130

APPENDIX C

Bureau of Alcohol and Drug Abuse 2004 Annual Report
State Health Division
Department of Human Resources
(now the DHHS)



Bureau of Alcohol and Drug Abuse
2004 Annual Report

State Health Division
Department of Human Resources

Maria D. Canfield, M.S., Chief

Kenny C. Guinn, Governor
Michael J. Willden, Director
Department of Human Resources
December 2004

Alex Haartz, Administrator
Bradford Lee, MD, State Health Officer
State Health Division

State Health Division
Department of Human Resources

Bureau of Alcohol and Drug Abuse 2004 Annual Report

Brad Towle, M.A., M.P.A., Supervising Health Program Specialist
William Bailey Jr., B.S., Health Program Specialist
Jim Gibbs, B.S., Management Analyst

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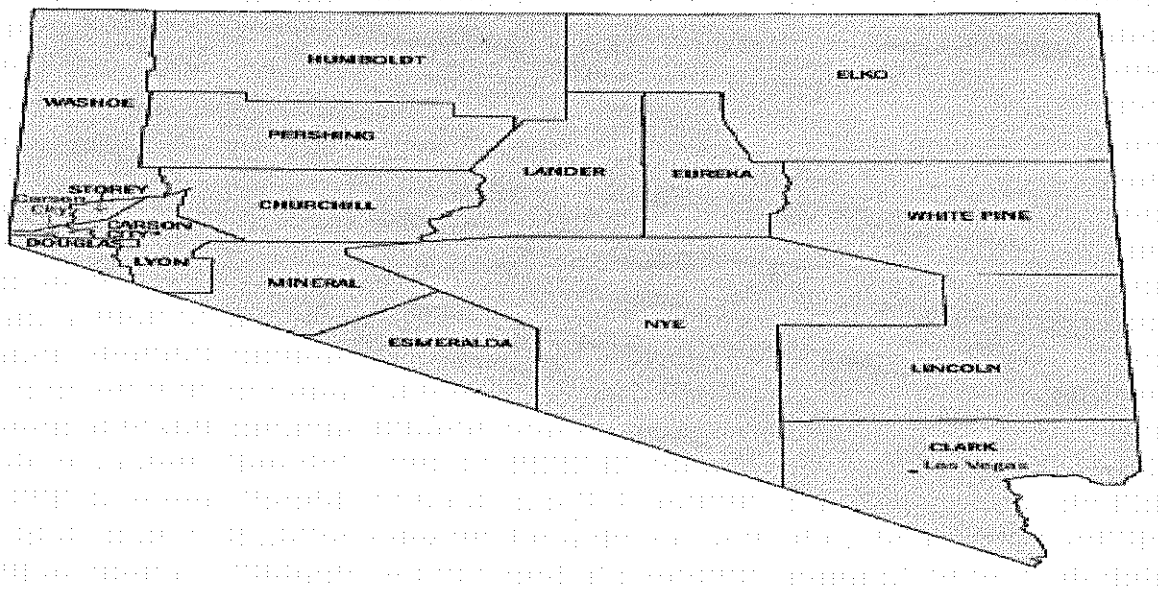
Nevada and the State of Methamphetamine
Report by the Substance Abuse Prevention Council

Nevada

and

The State of

Methamphetamine



March 14, 2006

Presented To: Nevada State Legislature
Health Care Subcommittee
By The- Nevada Substance Abuse Prevention Council

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APPENDIX E

Community Substance Abuse Prevention Coalitions
Testimony of Christy McGill, Statewide Coalition Partnership
and
Belinda Thompson, Nevada Substance Abuse Prevention Council

To: Legislative Committee on Health Care Subcommittee

My name is Christy McGill and I am honored to present to this committee on behalf of the Nevada Statewide Partnership of Coalitions. Prevention in Nevada is an upcoming success story that needs to be heard and sustained because it proactively plans for positive youth development. Prevention aims to reduce the risk factors involved with substance abuse while promoting the protective factors that have been shown to lead to positive youth development on individual, family, and community levels. Effective prevention occurs through multiple strategies across multiple sectors in a community.

In 2003, BADA, through the Statewide Incentive Grant, galvanized prevention efforts by supporting existing local coalition infrastructure to bring together citizens and existing agencies to collaborate and strategically plan for prevention focusing on local data based decision making on who, what and where the SIG prevention dollars should be spent. What happened was, when the coalitions brought agencies and citizens together the strategic planning process went beyond SIG funds and spilled over into other prevention dollars.

The common belief quickly spread that since prevention funds were precious and scarce this kind of local interagency and community collaboration was essential if prevention was going to make an impact in our local communities—in other words no one provider had enough resources to implement multiple prevention strategies across multiple sectors. Local coalition members from the schools, sheriff, youth organizations, health agencies, prevention agencies, and businesses planned how they as a community could work together in prevention. Each coalition was successful but only because local providers and community members were willing and ready to collaborate. The table below tells the story of the local collaboration that has occurred.

Coalition Name	Area Served	# of coalition members	Common Sectors represented
BEST Coalition	Las Vegas	184	1) Law enforcement 2) School District 3) County Human Services 4) Parents 5) Youth 6) Citizens 7) Prevention Agencies 8) Faith Based Organizations 9) Business 10) National Guard 11) Juvenile Justice 12) Media 13) DEA 14) Local officials
Churchill Community Coalition	Churchill County	120	
Community Council on Youth	Carson City	54	
Frontier Community Coalition	6th Judicial District	N/A	
Goshen Community Development Coalition	Las Vegas	357	
Healthy Communities Coalition	Lyon and Storey Counties	215	
Join Together Northern Nevada	Washoe County	167	
Nye Communities Coalition	Nye and Esmeralda Counties	116	
Partners Allied for Community Excellence	Elko County	327	
Partnership of Community Resources	Douglas County	250	
Walker River Community Coalition	Walker River Tribe	12	

So what does it mean for prevention when 1,833 local leaders, citizens, and agencies come together to plan? Multiple prevention strategies across multiple sectors and thus together coalitions and prevention service providers have served in 2005:

57,255 Nevada Youth
30 million citizens have viewed prevention media messages
150,000 Nevada citizens have received prevention information

Has all this effort made an impact? Recent data suggests that despite the many growth changes Nevada communities are experiencing, prevention is working! Below are just a few examples of local indicators that prevention is positively impacting Nevada's youth:

- In Churchill County, the number of High School Students who report never having used methamphetamine has increased 11.1% from 2001 to 2005. The number of Junior High students who report never having smoked a cigarette increased 11.2% from 2001 to 2005 (Youth Risk Behavior Survey)

- In Washoe County, lifetime use of marijuana by Middle School students decreased from 17.9% in 2003 to 15.2% in 2005. Current use of marijuana by High School students decreased from 23.5% in 2003 to 21.7% in 2005. In the last two years Join Together Northern Nevada and their partners implemented seven evidence based prevention programs.

- Prior to the SIG Coalition process there was no model prevention programming in Nye or Esmeralda counties and now there are five organizations across two counties that offer prevention programming that are state certified through BADA. Trend data from the Nevada YRBS for Nye County from the years 2001 to 2005 has shown significant decreases in substance abuse by Nye county Youth. Nye county Middle School youth show a 13% decrease in youth using cigarettes, 21.5% decrease of youth using alcohol and 7.8% decrease in youth using marijuana.

- According to No Child Left Behind Carson City school data, from 2003-2005 show a 53% drop in disciplinary incidents for possession/use of controlled substances.

- In Elko County, as a result of the SIG Coalition process seven new evidence based prevention programs were implemented and many community based strategies were implemented as well--resulting in a 79% decrease in Underage Drinking arrests at the Elko Motorcycle Jamboree, and a 11% increase of Elko High School students reporting that they did not smoke during the past 30 days and a 8.7% increase of students reporting that they did not drink alcohol in the past 30 days.

Above are just a few highlighted successes. Each coalition would be delighted to give this Committee a more detailed description of the prevention happenings and statistics in each of the communities.

We have learned that the collaboration of citizens and agencies does not just happen unless this effort is intentional and supported. Most of the mentioned coalitions do not directly serve clients and that is because their main goal is not to compete but bring citizens and agencies together to plan and support each other--each contributing an important piece of the prevention puzzle and ultimately creating healthier youth and communities. Research shows prevention affects positive community change when there are multiple strategies over multiple sectors and this takes coordination and the effort of service providers, schools, youth, law enforcement, parents, citizens, and businesses coming together in a local coalition that works proactively for the positive development of youth free, from the pitfalls and problems substance use and abuse can cause.

Our challenge is this system is not as simple as it seems, and both direct prevention providers and coalitions need to be sustained beyond the currant prevention funding. Prevention is just starting to work, but Nevada's permissive climate for drinking, gambling, and smoking demands that citizens and agencies proactively work together to ensure our youth remain healthy and substance free. The good news is that prevention strategies are much more cost efficient than intervention and treatment strategies.

As coalitions we not only work with our local community, but we also work together as the Nevada Statewide Coalition Partnership, and if you would like more information about prevention, the Partnership or the individual coalitions could provide that information for you. Attached is contact information.

Thank you.

Meeting Of
The Legislative Committee
On
Health Care Subcommittee
To Study Services For
The Treatment
And
Prevention Of Substance Abuse

(A.B. 2, 22nd Special Session)

Affiliated Prevention Services

The Nevada Substance Abuse Prevention Council (*NSAPC*) was formed in 2001 to address the issues of Substance Abuse Prevention Providers, Preventionist, and Treatment Providers throughout the State of Nevada as an educational resource for information dissemination, policy review, national trends, and data and effective measures for the provision of services on a statewide basis.

The *NSAPC* membership is inclusive of members of multiple disciplines throughout the state with a primary interest in the development of youth, families and communities.

Our membership has expanded to include parents, educators, business and community leaders.

We are a grassroots organization whose primary forte is to address the needs of our communities and providers through networking opportunities, information dissemination, and access to data, outreach, direct services and environmental strategies.

Estimated Number of Nevadans Receiving and Accessing Services

During the last calendar year, members of the ***NSAPC*** have served a broad spectrum of our Nevada Communities with services inclusive of but not limited to:

- ✓ Mentoring Programs
- ✓ After School Academic Support
- ✓ Parenting Programs
- ✓ Sexual Abstinence
- ✓ Teen Pregnancy Prevention
- ✓ Tobacco Prevention Education
- ✓ Human Trafficking
- ✓ Say No To Weapons-Project Safe Neighborhoods
- ✓ Enforcing Underage Drinking Laws
- ✓ Prescription Drug Use
- ✓ Access to Treatment
- ✓ Provision of Services to Youth whose Parents are in Treatment

With the receipt of funds from the Nevada State Incentive Grant, members of the ***NSAPC*** also offer services to the residents of the State inclusive of but not limited to Model programs that specifically address the identified risk and protective factors of the communities served.

These programs also consist of both direct services and environmental strategies.

Challenging College Alcohol Abuse
FACE Truth and Clarity
Positive Action
Leadership In Resiliency
Clark County Department Of Family Services
Southern Nevada Area Health Education Center
WestCare Nevada, Inc
YMCA of Southern Nevada
Churchill County Juvenile Probation Department
New Frontier Treatment Center
Boys and Girls Club of Western Nevada
Community Council on Youth
Nevada Hispanic Services
Ron Woods Resource Center
Jewish Family Services
Virgin Valley Family Services
Boys and Girls Club of Mason Valley

Central Lyon Parks and Recreation
Community Partnership Seeking Solutions of Fernley
ACCEPT
Bristlecone Family Resources
Quest Counseling
Esmeralda County School District
Even Start
No To Abuse
Nye County School District
Boys and Girls Club of Elko
Elko Band Council
Family Resource Centers of Northeastern Nevada
Great Basin College
Family Support Council
Nevada Hispanic Services Carson City
Partnership of Community Resources
Washoe Tribe of Nevada and California

An additional benefit of the inclusion of the Resource Centers allows Community Providers and Community Partners to access information on a variety of issues pertaining to their communities, implementations, direct services and identified concerns.

Direct Services and or Environmental Strategies

The estimated number of recipients accessing and or receiving services is as follows:	
Direct Services and or Implementation of an Environmental /Strategy	58,552
Media Campaigns	29,686,064
Number of Citizens Affiliated	2,033
Information Dissemination	150,000 Weekly TV Show

Sectors Represented
by
Coalitions, Substance Abuse Preventionists and Community Providers

Education	Service Clubs
Law Enforcement	Public Schools
DEA	Military
Youth	Foundations
Parents	Casinos
Public Health	Private Therapists
Mental Health Treatment	Fire Department
State Government	Arts
Local Government	Hispanic Services
Tribal	Human Trafficking
Juvenile Justice	Abstinence Programs
Alcohol and Other Drug Prevention	Teen Pregnancy Associations And Organizations
Alcohol and Other Drug Treatment	National Conference Of Black Mayors
Media	Elected Officials
Universities	Recovery Community
Courts	Health Care
Social Services	Legislative
Community Based Organizations	Public Defender
Business Community	Faith Based Community
Seniors	Poets

Effectiveness of Efforts/Does Prevention Work?

Information reported by Coalition Partners and the 2003-2005 Youth Risk Behavior Survey.

As reported by Join Together Northern Nevada
Lifetime use of marijuana by middle school students decreased from 17.9 % in 2003 to 15.2% in 2005 (YRBS)
Current use of marijuana by high school students decreased from 23.5% in 2003 to 21.7% in 2005 YRBS
JTNN has implemented 7 evidence based prevention programs in the Washoe County Community in the last two years.
As reported by Partnership of Community Resources
Three (3) new non profits are in various stages of offering prevention programming to youth
Binge drinking among 12-18 year olds was down by 13.8% as per 2001-2005 YRBS
Lifetime prevalence of alcohol among youth 12-18 years old down 14.8% as per 2001-2005 YRBS
Use before age 13 down 8.8% as per 2001-2005 YRBS
As reported by Churchill
The number of High School Students who reported never having used methamphetamine has increased 11.1% from 2001 to 2005
The number of students who report having never smoked a whole cigarette increased 11.2% from 2001 to 2005
As reported by Community Council On Youth
As per the YRBS the percentage of youth abstaining from alcohol use went up by 4.7%
As reported by Nye
Nye county middle schools report a significant decrease in the percentage of change for youth cigarette use by 13.3%, alcohol use 21.3% and marijuana use 7.8%
As reported by Healthy Communities Lyon and Storey Counties
Formation of two (2) new prevention agencies
According to the Lyon County YRBS, In 2003, 42.7% of middle school youth reported having "their first drink of alcohol other than a few sips" before the age of 13 but in 2005 34.9% of middle school youth reported having "their first drink of alcohol other than a few sips" before the age of 13.
As reported by PACE-Elko
7 new evidence based Substance Abuse Prevention programs
79% decrease in Underage Drinking arrests at Elko Motorcycle Jamboree (implemented age identifying wrist band machines);
HS students (01-05 YRBS) reported that they did not smoke during past 30 days increased 11.8%
HS students(01-05 YRBS) reporting they don't drink alcohol has increased 8.7%

As reported by BEST
2,044 Partnership For a Drug Free America Public Service Announcements were run (pro bono) on local television stations with a value of over $250,000.00
As reported by Goshen
Mentored two (2) new Prevention Coalitions-Luz Southern Nevada Latino Coalition serving Clark County and surrounding areas and the and Seventh Judicial District Coalition serving Eureka, Lincoln and White Pine Counties.
Initiated and facilitated the organization of the community to address Human Trafficking
Clark County specific YRBS data below.
As reported by Frontier Community Coalition
Partnered with the Battle Mountain Family Resource Center to retain, leverage and expand existing services to serve the residents of Battle Mountain and surrounding areas.

Does Prevention Work?

GOAL: Prevent the onset of substance abuse.

While there are many issues related to early onset of substance use, people who begin drinking before age 15 are four times more likely to develop alcohol dependence at some time in their lives compared with those who have their first drink at age 20 or older.

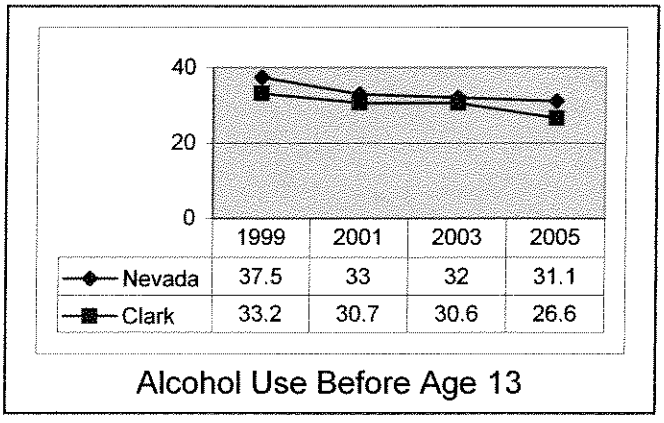
Grant, B.F., and Dawson, D.A. Age of onset of alcohol use and its association with DSM–IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. Journal of Substance Abuse 9:103–110, 1997.

Prevention Works

Clark County (1999): In a typical high school classroom of 30, approximately 10 students reported having their first drink of alcohol before their 13th birthday.

Clark County (2005): The number of students who reported having their first drink of alcohol before the age of 13 was reduced by approximately 2 students per classroom; down to approximately 8.

Youth Risk Behavior Survey.



Alcohol Use Before Age 13

GOAL: Reduce substance abuse.

The cost of substance abuse is measured in terms of human as well as economic costs.

One in four US deaths can be attributed to alcohol, tobacco, or illicit drug use.

Tobacco users run the biggest risk of harm, since the majority of those deaths (430,700 annually) are associated with smoking.

Illicit drug users make over 527,000 costly emergency room visits each year for drug related problems.

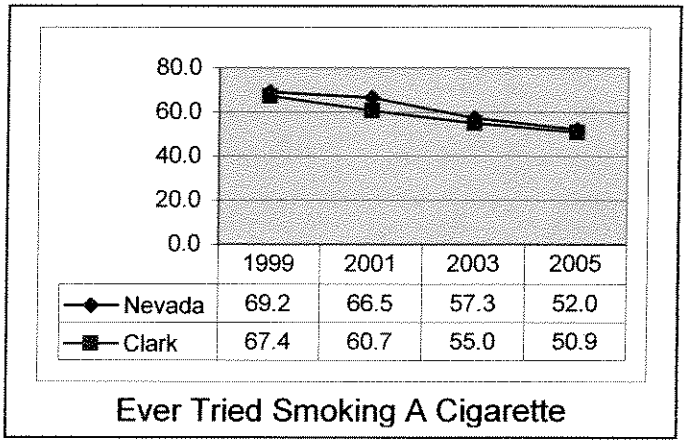
http://www.innovatorsawards.org/facts *The Johns Hopkins University. Baltimore, Maryland.*

Prevention Works

Nevada (1999): In a typical high school classroom of 30, approximately 21 students reported that they had tried smoking a cigarette.

Nevada (2005): The number of students reporting they had ever tried smoking a cigarette was reduced by approximately 5 students per classroom; down to approximately 16.

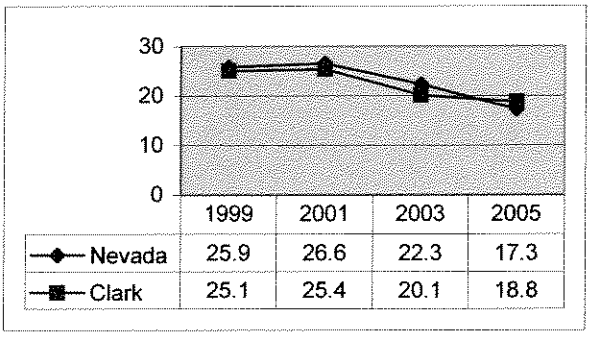
Youth Risk Behavior Survey



Ever Tried Smoking A Cigarette

GOAL: Reduce substance abuse related problems in our communities.
Although our communities struggle with many substance abuse related problems, we know that children from families with substance-abusing parents are more likely to have problems with delinquency, poor school performance, and emotional difficulties than their peers from homes without substance abuse. Additionally, more than 75 percent of domestic violence victims report that their assailant had been drinking or using illicit drugs at the time of the incident.
http://www.innovatorsawards.org/facts *The Johns Hopkins University. Baltimore, Maryland.*

Prevention Works
Nevada (1999): In a typical high school classroom of 30, approximately 8 students reported smoking marijuana during the past 30 days.
Nevada (2005): The number of students who reported smoking marijuana during the past 30 days was reduced by approximately 3 students per classroom; down to approximately 5.
Youth Risk Behavior Survey.



	1999	2001	2003	2005
Nevada	25.9	26.6	22.3	17.3
Clark	25.1	25.4	20.1	18.8

Marijuana Use During Past 30 Days

This data demonstrates substantial improvements in three (3) primary substance abuse prevention measurements including; age of first (1st) use, lifetime use of a substance and thirty(30) day use of a substance.

Many factors, including the efforts of Nevada's substance abuse prevention providers may be attributed to the improvements in this trend data. The field of substance abuse prevention has been enhanced and improved over the past 2-4 years with the establishment of a coordinated, statewide effort focused on prevention at the community level through community coalitions. Additional resources have been infused into prevention from multiple disciplines such as the State Incentive Grant which was successfully secured by the Bureau of Alcohol and Drug Abuse, and the multiple disciples that these funds have brought together.

APPENDIX F

The testimony of Vic Davis, President
National Alliance on Mental Illness of Southern Nevada

February 2, 2006

Testimony to
Legislative Subcommittee to Study Substance Abuse
By Vic Davis
President, NAMI of Southern Nevada

Madam Chairman and members of the Committee, my name is Vic Davis with the National Alliance on Mental Illness of Southern Nevada. I appreciate this opportunity to address the serious subject of co-occurring disorders or dual diagnosis treatment of persons suffering from serious mental illness in the Nevada. I have attached a four page fact sheet that describes the scope of the problem and what is required to solve it. I would like to address the topic from the point of view of the consumers and family members who are trying to live with this two-edged sword.

One of the services that NAMI provides is support groups for both consumers and family members. It seems that about eight out of ten new people who attend our sessions describe situations where the consumer in crisis has both a mental illness and a substance abuse problem. The story is usually the same; the consumer has been diagnosed with a serious mental illness but has gone off their medicine and has resorted to alcohol or drugs as a form of self medication. The results are predictable in that they go into crisis causing havoc in the home and may end up homeless or in the judicial system. The next question is usually "Where can we get treatment to solve this problem?" The response is that there is nowhere in Southern Nevada where one can go to receive appropriate treatment. It just isn't available. There is a real need for dual-diagnosis treatment, but it is low on the priority list when compared to the lack of other services provided in the state.

We know that when a consumer is on their medication they begin to think more clearly. The question then is "What are they thinking about?" Many times the thoughts are about how bad their situation is and how they have no future. It follows then that they decide to get that drink or smoke that joint so they don't have to live with the reality of their life. And that begins the downward spiral of substance abuse that leads to going off their medicines with an eventual psychotic episode requiring hospitalization or worse.

In Nevada as in most other states, co-existing disorder services are separated by function and funding sources. Persons receiving services for substance

abuse are treated under a different set of rules that use methods different than those who receive mental health services. For example, a person who enters a substance abuse program may not be allowed to take any drugs including medicines. If the person is mentally ill, it is only a matter of time before they decompensate and go into crisis and get rejected from the program. The same is true for the mentally ill who try to participate in AA programs. On the other hand, if persons need mental health services and are found to be using drugs, they run the risk of being expelled from their program. There needs to be an integrated long-term approach that allows for the simultaneous treatment of both mental illness and substance abuse.

Unfortunately these integrated services are limited or not available in Nevada as far as I know. This is the single biggest barrier to receiving dual diagnosis services. The cycle for the mentally ill without these services is crisis to hospitalization to release to the community with no drug abuse treatment and limited counseling, then back eventually to another round starting with a new crisis. This is your "repeat offender" who is the primary consumer of mental health resources and a member of the group with the highest probability of incarceration and/or suicide. Every funeral of that I have attended of a person having a serious mental illness in Nevada also had a drug abuse problem. This is a reality that every family member knows exists and fears the most. The use of alcohol or drugs is the biggest issue that is raised within our organization and that is because we all know that necessary services are not available.

A major barrier to implementing dual-diagnosis treatment is the existence of artificial funding silos wherein mental health and substance abuse programs are supported with separate funding streams which in turn keeps the services separate and disjointed. The plans to move BADA into the division of Mental Health Services is a step in the right direction whereby the simultaneous administration of both activities can be focused on addressing the mutual problems.

Another barrier is the licensing restrictions that control the educational requirements of the providers. Substance abuse counselors and mental health counselors have different requirements, training, techniques and focus in their treatment of patients. There is a need to co-locate counselors as members of treatment teams and provide cross training of both professional categories with licensing changes to accommodate services.

Our current approach for treatment focuses on short term remedies such as hospitalization to achieve stabilization of the patient followed by minimal follow-up services. As I have stated earlier, many of those consumers who recycle to the hospital suffer from co-occurring disorders and require long term care. After the new hospital is completed, there will be beds available in the old building. It is time that the legislature takes positive action this next session and staff clinics with trained dual diagnosis providers to start the recovery process reduce the number of consumers who require hospitalization. The sooner that we get involved in the preventative mode, the better we will be in reducing the number of persons suffering from mental illness who decompensate into crisis and put a strain on the state's mental health resources.

I thank your for allowing me to speak today and would be glad to answer any questions that I can.

Attachment to February 2, 2006 testimony by Vic Davis

Facts About Mental Illness - Dual Diagnosis Services

Reprinted from National NAMI Website

What are dual diagnosis services?

Dual diagnosis services are treatments for people who suffer from co-occurring disorders -- mental illness and substance abuse. Research has strongly indicated that to recover fully, a consumer with co-occurring disorder needs treatment for both problems -- focusing on one does not ensure the other will go away. Dual diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.

Dual diagnosis services include different types of assistance that go beyond standard therapy or medication: assertive outreach, job and housing assistance, family counseling, even money and relationship management. The personalized treatment is viewed as long-term and can be begun at whatever stage of recovery the consumer is in. Positivity, hope and optimism are at the foundation of integrated treatment.

How often do people with severe mental illnesses also experience a co-occurring substance abuse problem?

There is a lack of information on the numbers of people with co-occurring disorders, but research has shown the disorders are very common. According to reports published in the *Journal of the American Medical Association (JAMA)*:
Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse. Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.

The best data available on the prevalence of co-occurring disorders are derived from two major surveys: the Epidemiologic Catchment Area (ECA) Survey (administered 1980-1984), and the National Comorbidity Survey (NCS), administered between 1990 and 1992.

Results of the NCS and the ECA Survey indicate high prevalence rates for co-occurring substance abuse disorders and mental disorders, as well as the increased risk for people with either a substance abuse disorder or mental disorder for developing a co-occurring disorder. For example, the NCS found that: 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder. 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.

The ECA Survey found that individuals with severe mental disorders were at significant

risk for developing a substance use disorder during their lifetime. Specifically: 47 percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population). 61 percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).
Continuing studies support these findings, that these disorders do appear to occur much more frequently then previously realized, and that appropriate integrated treatments must be developed.

What are the consequences of co-occurring severe mental illness and substance abuse?

For the consumer, the consequences are numerous and harsh. Persons with a co-occurring disorder have a statistically greater propensity for violence, medication noncompliance, and failure to respond to treatment than consumers with just substance abuse or a mental illness. These problems also extend out to these consumers' families, friends and co-workers. Purely healthwise, having a simultaneous mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. These consumers are in and out of hospitals and treatment programs without lasting success.

People with dual diagnoses also tend to have tardive dyskinesia (TD) and physical illnesses more often than those with a single disorder, and they experience more episodes of psychosis. In addition, physicians often don't recognize the presence of substance abuse disorders and mental disorders, especially in older adults.

Socially, people with mental illnesses often are susceptible to co-occurring disorders due to "downward drift." In other words, as a consequence of their mental illness they may find themselves living in marginal neighborhoods where drug use prevails. Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness.

Consumers with co-occurring disorders are also much more likely to be homeless or jailed. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder.

Consequences for society directly stem from the above. Just the back-and-forth treatment alone currently given to non-violent persons with dual diagnosis is costly. Moreover, violent or criminal consumers, no matter how unfairly afflicted, are dangerous and also costly. Those with co-occurring disorders are at high risk to contract AIDS, a disease that can affect society at large. Costs rise even higher when these persons, as those with co-occurring disorders have been shown to do, recycle through healthcare and criminal justice systems again and again. Without the establishment of more integrated treatment

programs, the cycle will continue.

Why is an integrated approach to treating severe mental illnesses and substance abuse problems so important?

Despite much research that supports its success, integrated treatment is still not made widely available to consumers. Those who struggle both with serious mental illness and substance abuse face problems of enormous proportions. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders.

Providing appropriate, integrated services for these consumers will not only allow for their recovery and improved overall health, but can ameliorate the effects their disorders have on their family, friends and society at large. By helping these consumers stay in treatment, find housing and jobs, and develop better social skills and judgment, we can potentially begin to substantially diminish some of the most sinister and costly societal problems: crime, HIV/AIDS, domestic violence and more.

There is much evidence that integrated treatment can be effective. For example:
Individuals with a substance abuse disorder are more likely to receive treatment if they have a co-occurring mental disorder.

Research shows that when consumers with dual diagnosis successfully overcome alcohol abuse, their response to treatment improves remarkably. With continued education on co-occurring disorders, hopefully, more treatments and better understanding are on the way.

What does effective integrated treatment entail?

Effective integrated treatment consists of the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion. The caregivers see to it that interventions are bundled together; the consumers, therefore, receive consistent treatment, with no division between mental health or substance abuse assistance. The approach, philosophy and recommendations are seamless, and the need to consult with separate teams and programs is eliminated.

Integrated treatment also requires the recognition that substance abuse counseling and traditional mental health counseling are different approaches that must be reconciled to treat co-occurring disorders. It is not enough merely to teach relationship skills to a person with bipolar disorder. They must also learn to explore how to avoid the relationships that are intertwined with their substance abuse.

Providers should recognize that denial is an inherent part of the problem. Patients often do not have insight as to the seriousness and scope of the problem. Abstinence may be a goal of the program but should not be a precondition for entering treatment. If dually

diagnosed clients do not fit into local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, special peer groups based on AA principles might be developed. Clients with a dual diagnosis have to proceed at their own pace in treatment.

An illness model of the problem should be used rather than a moralistic one. Providers need to convey understanding of how hard it is to end an addiction problem and give credit for any accomplishments. Attention should be given to social networks that can serve as important reinforcers. Clients should be given opportunities to socialize, have access to recreational activities, and develop peer relationships. Their families should be offered support and education, while learning not to react with guilt or blame but to learn to cope with two interacting illnesses.

What are the key factors in effective integrated treatment?

There are a number of key factors in an integrated treatment program. Treatment must be approached in **stages.** First, a *trust* is established between the consumer and the caregiver. This helps *motivate* the consumer to learn the skills for *actively controlling* their illnesses and focus on goals. This helps keep the consumer on track, *preventing relapse*. Treatment can begin at any one of these stages; the program is tailored to the individual.

Assertive outreach has been shown to engage and retain clients at a high rate, while those that fail to include outreach lose clients. Therefore, effective programs, through intensive case management, meeting at the consumer's residence, and other methods of developing a dependable relationship with the client, ensure that more consumers are consistently monitored and counseled. Effective treatment includes **motivational interventions**, which, through education, support and counseling, help empower deeply demoralized clients to recognize the importance of their goals and illness self-management. Of course, counseling is a fundamental component of dual diagnosis services.

Counseling helps develop positive coping patterns, as well as promotes cognitive and behavioral skills. Counseling can be in the form of individual, group, or family therapy or a combination of these. A consumer's **social support** is critical. Their immediate environment has a direct impact on their choices and moods; therefore consumers need help strengthening positive relationships and jettisoning those that encourage negative behavior.

Effective integrated treatment programs **view recovery as a long-term, community-based process**, one that can take months or, more likely, years to undergo. Improvement is slow even with a consistent treatment program. However, such an approach prevents relapses and enhances a consumer's gains.

To be effective, a dual diagnosis program must be **comprehensive**, taking into account a number of life's aspects: stress management, social networks, jobs, housing and activities. These programs view substance abuse as intertwined with mental illness, not a separate issue, and therefore provide solutions to both illnesses together at the same time.

Finally, effective integrated treatment programs must contain elements of **cultural sensitivity and competence** to even lure consumers, much less retain them. Various groups such as African-Americans, homeless, women with children, Hispanics and others can benefit from services tailored to their particular racial and cultural needs.

APPENDIX G

The testimony of Cynthia Huth
Perinatal and Women's Health Nurse Consultant
Nevada's Health Division
Bureau of Family Health Services
Fetal Alcohol Spectrum Disorder

Good Morning. My name is Cynthia Huth. I am the Perinatal & Women's Health Nurse Consultant for the Nevada State Health Division, Bureau of Family Health Services. As part of my position, I am staff to the Perinatal Substance Abuse Prevention Subcommittee of the Maternal and Child Health Advisory Board. The Subcommittee has asked me to speak on their behalf about Fetal Alcohol Spectrum Disorders (FASD); it's prevention and treatment.

In January 2006, the Perinatal Substance Abuse Prevention Subcommittee of the Maternal and Child Health Advisory Board coordinated and hosted two Town Hall Meetings dedicated to the issue of FASD. The testimony heard in Las Vegas and in Reno led to a report that will be published in the next few weeks.

My presentation is based on the summary and recommendations in that report. The report suggests some barriers to services for individuals with an FASD and some communities in need of training and outreach; and concludes with recommendations for addressing these issues.

Under NRS442.133, the Maternal and Child Health Advisory Board was appointed by the Governor to advise the Administration of the Health Division on matters concerning perinatal care to enhance the health and survivability of infants and mothers, and on matters concerning programs designed to improve the health of children.

Specific provisions are made within this statute to reduce the incidence of preventable diseases and handicapping conditions among children, which is addressed specifically by the Perinatal Substance Abuse Prevention Subcommittee of the board.

Statutory changes to NRS 442.137 now include language mandating:

- The identification of the most effective methods of preventing fetal alcohol syndrome (FAS). *Multiple agencies, including federal, state and private, have faced this problem. Fetal alcohol syndrome is 100% preventable – a pregnant woman must abstain from alcohol intake. Continuous public education about the dangers of alcohol use during pregnancy seems to be a key element in preventing FAS.*

- Collecting information relating to the incidence of fetal alcohol syndrome in this state. *In 2001, the prevalence of FAS in the United States was estimated to be between 0.5 and 2 per 1,000 births. Nevada may be at heightened risk for resident children born with an FASD. Dr. Colleen Morris, a Nevada geneticist, commented that as a medical student she was taught that FAS was rare, occurring in 1 of every 600 live births (equivalent to Down Syndrome). When she began her work in Nevada in 1988, she saw FAS at three times that rate; she now sees the occurrence of FAS at ten times that rate.*
- Prevention of the consumption of alcohol by women during pregnancy. *In the 2000 Cristman Associates Report for Nevada, 8% of all pregnant women drank alcohol during pregnancy. Prevalence data from the 2004 Behavioral Risk Factor Surveillance System for Nevada shows that 9.1% of all females engaged in binge drinking. Heavy drinking was engaged in by 7.7% of all women of childbearing age.*
- Assisting the Health Division to develop and carry out a program of public education to increase public awareness about the dangers of fetal alcohol syndrome and other adverse effects on a fetus that may result from the consumption of alcohol during pregnancy. *Warning signs were sent to over 1,000 drinking establishments in the past few years. A bus advertisement campaign about drinking during pregnancy recently ended after running for 1 ½ years.*
- And, assisting the University of Nevada School of Medicine in their development of guidelines that will assist health care providers serving pregnant women who are at a high risk of consuming alcohol during pregnancy; and children who are suffering from fetal alcohol syndrome. *This has not been accomplished due to lack of personnel (by both UNSOM and the Health Division) and lack of funds.*

Fetal Alcohol Spectrum Disorder is an umbrella term, used to describe a spectrum of diagnosable disorders effecting individuals who were prenatally exposed to alcohol.

Often "invisible" to the public, these may be physical, mental, behavioral, and learning disabilities.

FASD refers to conditions such as:

- Fetal Alcohol Syndrome (FAS),
- Partial Fetal Alcohol Syndrome (PFAS),
- Fetal Alcohol Effects (FAE),
- Alcohol-Related Birth Defects (ARBD) and,
- Alcohol-Related Neurodevelopmental Disorder (ARND).

The Town Hall Meetings were attended by seventy-eight participants; eighteen provided testimony.
Participants included:

- Seven parents (all either foster- or adoptive parents), and one adolescent with an FASD,
- Twenty-one health care professionals,
- Eleven social workers,
- One representative from a Nevada school district,
- And, three state leaders from the Senate and/or judiciary.

State agencies and organizations represented include: The Bureau of Family Health Services, Court Appointed Special Advocates, Friends of Special Children, Washoe County Social Services, Division of Mental Health and Developmental Services, the University of Nevada School of Medicine, Washoe County District Health Department, Nevada State Welfare Division, Clark County School District, Nevada Early Intervention Services, the Division of Child and Family Services, and the Nevada State Senate.

As a result of these town hall meetings, the Perinatal Substance Abuse Prevention Subcommittee has agreed on the following policy recommendations and priorities based on issues raised in public testimony:

- Implement Training and Outreach Programs, and provide "Best Practice" recommendations to Nevada's Health Care Community, School Districts, Bureau of Early Intervention Services, Criminal Justice systems, state-funded child care providers, and transitional, vocational, residential and social service programs serving the disability community.
- Create, train, and support an FASD advocacy corps in efforts to enter a variety of systems (at the request of parents/individuals with an FASD) to advocate for informed, lawful, and appropriate system's responses to individuals with an FASD. Systems

advocacy and influence should include school districts, Early Intervention, criminal justice, transitional and vocational programs, and social service programs.

- Fund and train social workers to function within Welfare, Medicaid, and judicial systems as FASD case managers.
- Pass amended statutes requiring child welfare agencies and other licensed child placement agencies to investigate the likelihood of prenatal exposure to alcohol and other drugs. At this time we do have statutes mandating that all agencies with adoptive or foster care services who are removing a child from the home (voluntarily or involuntarily), must ask one of the natural parents about drug/alcohol use during pregnancy. If the mother did use alcohol, tobacco or drugs during the pregnancy with the child, a perinatal substance abuse maternal report form must then be completed by an agency representative and sent to the Bureau of Family Health Services (BFHS) within thirty days. However, this statute does not cover child welfare agencies that are working with children that have not been removed from the home. If agencies are mandated to investigate the likelihood of prenatal exposure to alcohol or drugs, and find it likely, the caseworker should automatically have to create a plan for obtaining a diagnosis and a care plan for that child.
- Create fellowships for geneticists, pediatricians, and child- and adolescent-psychologists to do rotations with Special Needs children; hire and support the community work (diagnostic assessment) and research of geneticists.
- Encourage or require state systems of care across the life span to recognize FASD as a disability.

Promote legislative allocations of seed monies for the following separate projects:

- Creation and support of a statewide non-profit whose mission would be to establish an advocacy and education center;
- A pilot project, with outcome measures, which creates a "center" for FASD Family Services, including assessment and diagnosis, prevention campaigns, referrals and family parenting plans, and training and technical assistance to Para-professionals;

- Create, fund, and support (through training and technical assistance) a pilot program which works purposefully with children with an FASD, and whose outcomes and experience can be used in the creation and mentoring of other child care programs.
- And, the creation and support of FASD Campus for Adolescents and Adults where individuals with an FASD have opportunities to learn, in an appropriate environment, life- and job-skills that allow them to move toward self-sufficiency, and simultaneously allows their care-takers respite.

Funding is also needed to coordinate a continuing prevention campaign, which includes women of childbearing age, the health care community, family-planning organizations, pharmacies (where contraception is sold), and high-risk populations (including mothers who've already given birth to children with an FASD).

In addition to these recommendations and priorities, many parents mentioned the inequities between the supports available to foster- and adoption families.

Nevada Revised Statute127.186 does make provisions for providing financial assistance to families adopting children with special needs. By law, the agency which provides child welfare services or licensed child-placement is required to schedule any evaluations necessary to identify any special needs the child may have. Upon determining that the child has special needs, the agency is to notify the proposed adoptive parents that they may be eligible for financial assistance and assist the proposed adoptive parents in applying for and satisfying any other prerequisites necessary to obtain a grant of financial assistance. However, the grant of financial assistance must be limited, both in amount and duration. And, all financial assistance provided under this section ceases immediately when the child attains majority, becomes self-supporting, is emancipated or dies, whichever occurs first.

Even so, children with an FASD are not consistently considered "Special Needs," and so adoptive parents are eligible for none of this support. An adoption social worker testifying at the Reno Town Hall Meeting spoke of how discouraging her work often was, knowing that

the foster parents she works with will lose so many support services upon successful adoption, and that there are so few resources for children with this disability.

As a result, the PSAP Subcommittee recommends that the legislature deem FASD's suitable to "Special Needs" status within Child Welfare agencies, and consider passing amended statutes requiring child welfare agencies and other licensed child placement agencies to investigate the likelihood of prenatal exposure to alcohol and other drugs.

Thank you very much for your time and consideration.

APPENDIX H

Suggested Legislation

The following Bill Draft Requests will be available during the 2007 Legislation Session, or can be accessed after "Introduction" at the following Web site: http://www.leg.state.nv.us/74th/BDRList/page.cfm?showAll=1.

BDR 54-308 Makes Various Changes Concerning Counseling.