MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Fifth Session
February 25, 2009

The Committee on Health and Human Services was called to order by Chair Debbie Smith at 1:38 p.m. on Wednesday, February 25, 2009, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Debbie Smith, Chairwoman
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Ty Cobb
Assemblyman Mo Denis
Assemblyman John Hambrick
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman April Mastroluca
Assemblywoman Bonnie Parnell
Assemblywoman Ellen B. Spiegel
Assemblyman Lynn D. Stewart

COMMITTEE MEMBERS ABSENT:

Assemblywoman Sheila Leslie

GUEST LEGISLATORS PRESENT:

Assemblyman Aizley, Clark County Assembly District No. 41

CMB47

STAFF MEMBERS PRESENT:

Amber Joiner, Committee Policy Analyst
Darlene Rubin, Committee Secretary
Chris Kanowitz, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Jane Gruner, M.A., Associate Administrator for Developmental Services, Division of Mental Health and Developmental Services, Department of Health and Human Services
Deborah McBride, Bureau Chief II, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services
Misty Vaughan Allen, M.A., State Suicide Prevention Coordinator, Office of Suicide Prevention, Department of Health and Human Services
Katherine Unthank, Ph.D., representing Nevada Mental Health Counseling Association and the Nevada Counselors Association, Reno, Nevada
Rebecca Gasca, Public Advocate, American Civil Liberties Union, Reno, Nevada
Helen Foley, representing the Nevada Association of Marriage and Family Therapy, Las Vegas, Nevada
Michael Alonso, representing West Hills Hospital, Reno, Nevada
Steven Zuchowski, M.D., representing the Nevada Psychiatric Association, Reno, Nevada
Jeanette Belz, representing Nevada Psychiatric Association, Reno, Nevada
Bill Welch, President/CEO, Nevada Hospital Association, Reno, Nevada

Chairwoman Smith:
We have two presentations today and one bill that we will be hearing afterwards. I would like to welcome our first presenter, Dr. Harold Cook.

Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services:
I would like to introduce Jane Gruner, the Administrator for Sierra Regional Center, and Deborah McBride, Administrator for the Substance Abuse Prevention and Treatment Program. I want to thank you for the opportunity to provide you with some information about our division. We have a very large

and complicated organization, and I hope we can leave you with some semblance of a coherent story.

You have a packet (Exhibit C) and I will be following along on the first tab to some extent, but I will be talking rather than reading the materials.

The Division of Mental Health and Developmental Services (MHDS) is a large agency, larger than many other departments in the state. Currently, we have approximately 1,900 positions and a budget approaching $700 million for the biennium, which includes state and federal funds. The division is responsible for the operation of state-funded mental health programs, developmental services programs, and contracted substance abuse and prevention programs. We work throughout the state in multiple settings, including some of the smaller rural counties, to the largest urban center, Las Vegas, where we have multiple clinics and sites.

The division is located within the Department of Health and Human Services (DHHS), which is also a very large organization. Associated with the division is the Governor's Commission on Mental Health Developmental Services, which has some regulatory oversight of the division and meets on a regular basis to review the division operations. We have our next meeting scheduled in about two weeks. On the third page of the presentation is the budget that was legislatively approved for the 2008-2009 biennium. For General Fund we were approved for approximately $514 million, as the next page will show. With federal funds, we were approved for $720 million. This Legislature will probably see a little reduction in that. Page 5 shows a very complicated organizational chart. The division is organized into three regions; south, north, and rural. Within these regions there are five mental health agencies.

Assemblywoman Pierce:
Referring to your organizational chart, how many clinics are eliminated in the rural counties in the Governor's Budget?

Harold Cook:
Up to last year, MHDS had 21 rural clinics. Two—Fernley and Dayton—have already closed, another nine are scheduled to be closed in the Governor's Budget.

Assemblywoman Pierce:
Can you tell me which locations are closing?

Harold Cook:
Those locations are Battle Mountain, Silver Springs, Hawthorne, Lovelock, Tonopah, and a smaller clinic in Moapa. MHDS has five mental health agencies, three developmental services agencies, and the Substance Abuse Prevention and Treatment Agency (SAPTA). The administrative offices are located in Carson City. In Fiscal Year 2007, we served almost 30,000. Mental health programs are situated throughout the state. Some of the services we provide include medications. Although I have been doing this work for more than 30 years, there are many people who, when they think of mental health services, still think of the old psychiatrist's couch and psychotherapy—talk therapy sort of treatment—as being the essence of mental health treatment. The essence of mental health treatment right now is providing medication to people. That is what is done in the great majority of cases and that is what we do. We provide state-of-the-art psychotropic and anti-depressant medications to most of the clients we see in mental health. The newer, anti-psychotic, anti-depressant medications have been shown to be very effective; they have reduced hospital stays, and although they are more expensive than the older medications, in some ways they save us money in terms of the other services that we might have to provide. But, it is essential, in terms of the mental health treatment that we provide, that people are provided these medications in order to reduce the symptoms they have, which often can be so intractable that no amount of other treatment could be effective.

Among the other programs are forensic services. Lakes Crossing Center provides forensic mental health services for the entire state. That is a facility in Sparks, Nevada, which currently has 76 beds and provides assessment and treatment of criminally-adjudicated individuals who may or may not be incompetent to stand trial. If they are incompetent to stand trial, the facility will provide treatment to competency. In addition, the center provides treatment for people who are adjudicated not guilty by reason of insanity, or guilty but insane. We have only a few people in the facility at this time with that diagnosis. Anyone who has criminal charges and requires mental health treatment to become adjudicated goes through Lakes Crossing or is in some way treated by Lakes Crossing staff.

We have a variety of out-patient programs: The Program of Assertive Community Treatment (PACT) is probably the most effective and popular out patient program that we have. It is an intensive and team-concept of service coordination, psychiatry, psychology, counseling, and nursing. These people receive hospital-level care, but they live at home and they see their clinicians on a weekly, if not daily, basis. We recently looked at some statistics and found that people in the PACT program in the north had an average of

58 hospital days per year prior to being in the program, and after being in the program for awhile, their average psychiatric hospital days decreased to 12.

We provide Service Coordination, which is a program to assist people to access whatever services they need. For people with severe and persistent mental illness, this is an essential program. We have Mental Health Court, a highly-effective program to assist people with criminal charges against them to stay out of jail. We work with local courts in Washoe, Clark, and Carson to help individuals who have mental illness and criminal charges avoid their criminal charges. Our medication clinics are where we provide the medication. We have out-patient counseling and psycho-social rehab, a service designed to assist people to develop the skills they need to address their symptoms, to address their living situations, and other skills such as getting jobs, keeping jobs, and so on. It is one of my favorite programs.

The recipients of mental health services are people with severe and persistent mental illness, which is, almost invariably, a chronic, lifelong illness. It is a little like diabetes. It is treated largely with medication and, like diabetes, it also requires some additional things the individual must do to manage his disease. A diabetic must take insulin and also watch his weight, his diet, and so on. For people with severe and persistent mental illness, getting rid of the symptoms of the mental illness is the first step; getting rid of the voices in the head, the delusions, the hallucinations, and the severe and crippling depression. These are things that prevent people from doing almost anything productive. These are the sorts of things that put people into the hospital. Once the medication either reduces or eliminates those symptoms, then we provide services to help people with the psycho-social rehabilitation to get on with their lives; to live in independent settings, apartments and houses, to get jobs, if that is a reasonable goal for them. That is the recovery movement: to assist people in achieving this level of community integration and independence which, if we are successful and they are successful, gets them freed up from the services we provide. Often these are very ill individuals; they require a lot of support, a lot of services. That is our goal, and it is what we do in mental health. Although it is often said that we do not have enough services, I can tell you that what is available in the State of Nevada is something to be proud of and an excellent program of services.

Assemblywoman Parnell:
You commented that treatment of most mental illnesses now relies heavily on medication. As part of a coalition that has worked with rural mental clinics, one of the biggest concerns has been the loss of psychiatrists. As they are the ones writing the prescriptions, could you update us on that? The concern in Carson, in particular, was that if people needed this medication and could not get it

through one of the clinics, they were walking around our streets suffering, which sometimes means intervention by law enforcement.

Harold Cook:
If the question is specific to rural clinics, historically we have had difficulty recruiting and retaining psychiatrists. We have not lost any positions, but the turnover has been fairly high. At this point we are doing reasonably well, and we have new management in rural clinics who have taken on the function of recruiting more psychiatrists as aggressively as possible. I agree it has been a problem, but we are working as hard as we can to resolve it.

Assemblywoman Pierce:
Is the PACT program for people with severe and persistent mental illness?

Harold Cook:
All mental health programs are for people with severe and persistent mental illness. The PACT program is for those people who have extraordinarily severe and persistent mental illness. When we first started the PACT in Washoe County there were people who came into that program who had been hospitalized for decades. That is how ill they were.

Assemblywoman Pierce:
Is that program available to them for their entire life, as long as they need it?

Harold Cook:
That is one of the downsides of the PACT. People do not get discharged from the PACT. We are dealing with a chronic illness, one that we do not have the means to cure, so people who are referred to the PACT will often stay there until they move out of the area or, when they get older, move into a nursing home. People stay in the PACT for many years.

Assemblywoman Pierce:
How many people do you serve in the PACT?

Harold Cook:
Each PACT serves 72 individuals. We have two in the south, and one in the north.

Jane Gruner, M.A., Associate Administrator for Developmental Services, Division of Mental Health and Developmental Services, Department of Health and Human Services:
I support the Developmental Services of MHDS and SAPTA. We have three regional centers that make up Developmental Services; one in Las Vegas, one in

Carson City that covers the rural areas, and one in Sparks. We support 4,855 individuals with developmental disabilities throughout the state. Developmental Services supports individuals of all ages with intellectual disabilities to learn, play, and work in their own communities. In the presentation booklet (Exhibit C), I have listed all the office locations and the intake numbers.

Developmental Services supports individuals who have lifelong needs and will most likely be supported throughout their lifetimes. Our regional centers have all received a four-year accreditation through the Council on Quality and Leadership, which is a nationally recognized organization that focuses on quality and organizational values. Developmental Services is committed to the philosophy that choice leads to self-respect and empowerment, and empowerment is necessary for people to develop their own capabilities. With that belief, we have developed five parts of our program: Family support, jobs and day training programs, supported living arrangements, family preservation program, and, in Las Vegas, we have an intermediate care facility. Sierra Regional Center recently closed its intermediate care facility, and as we work through our Olmstead Plan, that is a big issue. There are about 15 states that have closed all of their intermediate care facilities. What we have done is develop programs within the community to support the individuals who had been living on the campus program.

Developmental Services begin with eligibility. To be eligible, one needs to reside in Nevada, have a confirmed diagnosis of mental retardation or a related condition, and have that manifest in mental retardation before the age of 18, and for related conditions before the age of 22.

Assemblywoman Spiegel:
I am confused. I see that autism is included. Could you clarify? Is that related to mental retardation?

Jane Gruner:
It can be. Autism has a wide spectrum. It could be in the catchment area of developmental disabilities, and we do have a specialized program for autistic children. Once accepted for services, it is life-long, and a service coordinator is assigned who will work with the individual and the family, friends, and others they want in his life, to develop a life plan. It is rather like a roadmap to achieve the opportunities that the individual would like to see in his life. It could be school-related, work-related, or leisure time-related and the team will help the individual come up with goals and objectives and ways to reach them. The service coordinator helps the individual explore different areas that he may not have had an opportunity to explore, and help him or her develop treatment goals and objectives and select from the array of services that we offer. In the

handout (Exhibit C) there is a list of available services that one could choose in the developmental services area. A typical example might be a child, aged three, with a diagnosis of autism for whom the self-directed autism program was selected. This program option gives a family a set monthly budget from which they can purchase needed services; such as, behavioral services, speech, a recreation program, social skills, things that would help this family and the child develop and to be as productive as possible as they all get older.

Another example would be our jobs and day training programs, which allow people to obtain work in a community placement. That might be a young woman who is ready to graduate from high school but not yet ready to leave home, who does not really want to have a supported living arrangement, however, she would like to work outside of the home. With her service coordinator's help, she could visit different work locations, talk about what type of work she would like to do, and then select from the different provider groups that work with us the type of work that she would like to do. She would be supported in that while she lives at home.

In our family support area, families are assisted to obtain general services from their community, as well as to receive vouchers for respite care that allow the family to hire a provider to come in and support their child so they can get away for a rest from the daily duties of parenting. In addition, if funds are available, they could choose to have a set monthly amount from which they could purchase those kinds of services, like a recreation program or someone to come in and help their child learn how to brush her teeth, or do the types of day-to-day living activities that their child may have difficulty learning.

Chairwoman Smith:
It may be more of a budget issue, but I think it is important for this Committee to know that many of these services, if not all, have a limit. For example, on the autism services, only so many people are able to be served in our budget, right?

Jane Gruner:
Correct.

Assemblyman Stewart:
On the satellite offices, it seems like they are all grouped on the west side of the Las Vegas valley, except one in Henderson. Do you have any on the east side?

Jane Gruner:
I will have to get back to you on that.

Assemblyman Stewart:
I know you have group homes where mentally disabled people live under supervision, and they are able to go out and work. Under what category does that fall?

Jane Gruner:
That would be under supported living arrangements.

Assemblyman Stewart:
How many such homes are there in the Las Vegas valley?

Jane Gruner:
There are 972 people who are in a supported living arrangement, with three or four in each home.

Assemblywoman Pierce:
You said that about 15 states had done away with intermediate care facilities. Is that entirely a budget consideration, or is there some kind of new thought on care?

Jane Gruner:
There is the Olmstead plan from 2007 that has helped states come up with plans for helping individuals live in the least restrictive environment. The intermediate care facility is considered an institutional placement, and we are trying very hard to build programs within communities that allow individuals to live in a neighborhood versus in an institutional setting.

Assemblywoman Parnell:
I am on the board of directors of Retired and Senior Volunteer Program (RSVP) which offer services for our senior citizens. Is there any kind of volunteer program that works with this particular population?

Jane Gruner:
Special Olympics.

Assemblywoman Parnell:
But not a program where care givers go into the home on a volunteer basis?

Jane Gruner:
No. Probably the best answer to that is that service coordinators help families develop circles of friends they can rely on, and they offer training for families if they want volunteers to help them. For example, a church group. The family

could talk to our service coordinator and use our clinical staff to do training. It would be individualized.

Deborah McBride, Bureau Chief II, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services:

I will give a brief overview of SAPTA. NRS Chapter 458 is the agency's authorizing legislation. The primary mission of SAPTA is to identify the alcohol and drug abuse needs of Nevadans, and to support a continuum of services to address those needs, including prevention, early intervention, treatment, and recovery support services. The agency plans and coordinates statewide substance abuse service delivery and provides technical assistance to programs in other state agencies to insure that our resources are used in a manner which best serves the citizens of Nevada.

NRS Chapter 458 also requires that any alcohol and drug abuse program that receives state and/or federal funds through SAPTA must be certified by SAPTA. State certification determines whether a program has met minimum requirements related to service delivery. With the exception of the Driving under the Influence (DUI) Evaluation Centers, certification is optional for programs that do not receive SAPTA funding, and certification determines whether a program has the necessary organizational infrastructure to provide a specified service. In State Fiscal Year 2008, there were 22 private nonprofit or governmental certified substance abuse treatment providers which had services available at 71 sites throughout Nevada. Additionally, SAPTA certified another 45 treatment programs that were not funded. The prevention program certified 84 funded programs and 8 programs that were not funded throughout the state. A separate listing of the certified prevention treatment programs and locations is included in the presentation booklet (Exhibit C).

The agency has one advisory board and one advisory committee, each made up of volunteers who advise on program policy. The SAPTA Advisory Board advises the Mental Health and Developmental Services Division Administrator and the Agency Director. Members represent both treatment and prevention providers statewide. On page 5 of the presentation booklet is an organization chart. The advisory committee is the State Incentive Grant (SIG) Advisory Committee and its members are appointed by the Governor. It advises SAPTA on its prevention infrastructure grant and is chaired by the Division Administrator.

SAPTA is funded by a number of sources, including the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA); the Strategic Prevention

Framework State Incentive Grant (SPF SIG), also a grant program from SAMHSA; and the federal Department of Education's Safe and Drug Free Schools Program. We also have two federal data contracts with Synectics, state liquor tax and state general funds. The State General Fund supports prevention programs, methamphetamine public education and awareness, and the state prevention infrastructure program. Treatment funding covers the Co-Occurring Disorders Pilot Project in Nevada and the Wait List Reduction.

Chairwoman Smith:
Where is the methamphetamine funding in the Governor's Recommended Budget? Are we going to be able to continue funding? Can you give us an update on where we are since the last session? It seemed like the methamphetamine issue was so huge in the last session, and it is not in the forefront of the news anymore.

Deborah McBride:
We have had a slight reduction in the funding; we plan for a budget of $100,000 each year, and we are mostly level with that funding, and we hope to have that continue. We are doing fairly well with methamphetamine programs throughout the state; the SAPTA's Prevention Coalitions worked on the "Most of Us" campaign reaching a lot of people, there are many community activities on methamphetamine awareness and education, and according to the last Youth Risk Behavioral Survey (YRBS) we are seeing first-time use of methamphetamine among high school students has declined. We feel positive that we are making an impact through the combined efforts of many organizations and community partners throughout the state, in addition to SAPTA and law enforcement.

Chairwoman Smith:
Do you know if the change in the law regarding Sudafed purchases has had an impact?

Deborah McBride:
There has been a decrease in methamphetamine-related admissions to SAPTA.

Chairwoman Smith:
If you have access to that information, it would be good for this Committee to know. When people complain about their inability to buy Sudafed, it is nice to be able to respond that the law is working.

Deborah McBride:
A full continuum of care for adults and adolescents is supported through the treatment program, including comprehensive evaluations, early intervention, detoxification, residential inpatient/outpatient, transitional housing, and more, as shown on the listing within the presentation booklet (Exhibit C). The block grant also includes set-aside provisions for pregnant women and women with dependant children, HIV, and tuberculosis services. As mentioned earlier, as a result of SAPTA receiving State General Funds, the wait list reduction decreased from 22 average days in state Fiscal Year 2007 to 19 in state Fiscal Year 2008. Moreover, the Co-Occurring Disorders Pilot Project has served 295 individuals since its inception in 2007. The Co-Occurring Disorders Program is for those who have a substance abuse problem as well as a mental health problem.

The SAPTA block grant is also the primary source of funding for Substance Abuse Prevention Activities in Nevada. Beginning in state Fiscal Year 2009, all substance abuse prevention services were contracted out through 12 coalitions throughout the state, the coalitions in turn allocate funding out to community organizations. SAMHSA recognized that as a "Notable Practice," and we were one of the first in the nation to be so acknowledged. Prevention programs support activities including substance use, education and early intervention, technical assistance to community programs, mentoring programs for young adults, and parenting programs.

Assemblyman Hambrick:
Dr. Cook, I am impressed with the number of services being provided. Could you give me an overview of the level of competency of the staff involved? For example, are the psychiatrists and psychologists board-certified and current in their certification? Are the group home residents supervised, and what is the level of competency of the supervisors?

Harold Cook:
In general terms, if we have a position which requires a license, everyone is licensed—nurses, social workers, psychiatrists, psychologists—at that very basic level, everyone is licensed. If someone loses a license, he loses his job. We have many psychiatrists who are board-certified; not all of them are. We hire a number of psychiatrists just out of residency, and it takes a while to get board-certified. State law requires that all state psychologists achieve board certification within 5 years of employment. In terms of direct care staff, all of the direct care staff in the community homes is contracted. They work for the contractors that we hire to provide that care. We provide quality assurance and oversight for the homes. Because of a number of issues, there is some variability in how good they are, but we do monitor that, and if there are problems with the staff, we will work with the contractor to address that.

Over the years we have had a great deal of success in maintaining people in these community homes, and we have a lot of very good providers who work diligently with us.

Chairwoman Smith:
Our next presenter is Misty Vaughan Allen. She is the coordinator of the Office of Suicide Prevention in the Department of Health and Human Services. Welcome, we look forward to having an update from you. This has been a passion of mine for many years, as you know, and I am anxious to hear your report.

Misty Vaughan Allen, M.A., State Suicide Prevention Coordinator, Office of Suicide Prevention, Department of Health and Human Services:
I cannot thank you enough for the opportunity to talk about a subject that is often kept in the shadows, and I am realizing that more and more people want to hear about it because we cannot deny that it is an issue affecting our communities, our schools, and our tribes in Nevada. It was very challenging to come up with the key points on this topic, so I have an overview as well as a few programs I would like to highlight for you. [Ms. Allen gave a Power Point presentation accompanied by a handout (Exhibit D).]

The Office of Suicide Prevention is very different from MHDS. We have two full-time staff, one is in Clark County, and I get the other 16 counties. We have one part-time employee in training who is grant-funded through a Youth Suicide Prevention Program grant which we are now winding down. As you can see, we were funded and established in 2005, and the Las Vegas office was established in 2006. While the Youth Suicide Prevention Program for the state is winding down, the State of Nevada has received a Tribal Youth Suicide Prevention grant through the Inter-Tribal Council, and the Office of Suicide Prevention is looking to be a partner in that. We are beginning that and currently seeking a project director.

The Nevada Suicide Prevention Plan was released in May 2007 with 11 goals and 35 objectives, and we are up-to-date on our timelines. The plan is posted on the website. Some of our goals have been realized sooner than I imagined, and it is exciting because people finally understand the need for this prevention effort. To highlight some of our accomplishments: a lot of what we do is training in the communities, in agencies, and since 2006, we have trained over 5,000 Nevada residents, with only two full-time employees. Some of our primary partners with whom we continue to work and train are the Aging Services Division and the Department of Employment, Training and Rehabilitation (DETR) that just recently mandated that their staff statewide be trained, which we completed in December 2008/January 2009. We also work

closely with the Child Death Review teams, as well as the Children's Mental Health Consortium in Clark, Washoe, and rural counties. We continue to provide this training through funding from the Garrett Lee Smith Memorial Act which was $1.2 million for three years. That has supported our travel and some of our major trainings. We have many partners, including the Nevada Coalition for Suicide Prevention and the Clark County Children's Mental Health Consortium that are helping us in the youth prevention efforts.

Generally, about 32,000 people die from suicide in the United States every year—that is like a jet liner with 90 people aboard crashing every single day—that is an incredible number of people. That is the number we know about, not those who are undetermined or unspecified. There are 4 males for every female in the United States who commit suicide. About 80 percent of all suicide deaths are male, and firearms are involved in about 60 percent of the cases nationwide. In Nevada it is about 58 percent, and that is true year after year. Every 16 minutes someone dies by suicide. The map is very telling; the red states are those with the highest rates of suicide and usually are in the top ten. A rate is death per 100,000 people. The national average rate is about 11. The 2005 statistics are the most current. Nevada had the highest rate for decades, but we have been number two for many years. Nevertheless, Nevada has double the national average suicides. Specific to Nevada, it is the sixth leading cause of death for our state; nationally suicide is the 11th leading cause of death. For our young people age 15 to 34, it is the 2nd leading cause of death. Older Nevadans have twice the national average of suicide deaths and that is compared to equal age groups, so technically older adults have almost three times the national average. Nevada also has more suicide than homicide deaths, AIDS-related deaths and automobile accident deaths.

I recently received updated statistics from the state, but I want to emphasize that this is preliminary data, numbers are still coming in and, this data does not include in 2006 and 2007 the Nevadans who died out of state, so those numbers will most likely go up in 2006 and 2007.

Chairwoman Smith:
When we had the Interim Study several years ago, one of the things that came as a surprise to the Committee was that it is not tourists who influence our high suicide rate. I think there was always that idea that was the reason our rate was so high, and in fact that is not true. Is that still the truth?

Misty Vaughan Allen:
That is absolutely the truth. I went back over 20 years and amazingly over the two decades it averaged 10 percent every year. What we do not know is how many came to Nevada and had been here six months or a year, but they are not tourists.

Chairwoman Smith:
The other thing that was very interesting, and we talked about it in one of our Subcommittees, was the high percentage of suicides in rural Nevada. You see that in other states, and that seems to be the common denominator; the rural nature of the states with high rates.

Misty Vaughan Allen:
As you saw on the map with all the red, a big part of that comes with the rural lifestyle. The Health Division gave me some rates for Clark, Washoe, and other, which would include all the rural counties. Because suicide is still somewhat rare, we do not show data on each county, because it would not be a fair representation of what is actually happening. The rate would be extremely high, so we combined those. But, as you can see, they are still higher than the other counties. I will keep you up to date as these become formalized tables and the data is closed.

I wanted to highlight something that is coming up quite often now—the relationship to the economy, foreclosures, and suicide—because I think it is a very dangerous issue that the media are reporting, and they sensationalize it. I want to emphasize that the economy and home foreclosures do increase the risk for suicide, but it is not imminent; we can do a lot to decrease that risk. What it does is increase the risk for vulnerable people. Suicide does not typically, only in rare occasions, happen because of one event. It is a chain of adversity leading to this risk increase; someone loses his job, stress occurs in a relationship, someone might fall back on payments. It is not just one event. So, when the media says that more people are dying by suicide due to home foreclosures, I stick to the fact that the risk increases, but if we can improve support systems and help with resiliency and perhaps increase services for these vulnerable people, suicide does not have to occur.

Assemblyman Stewart:
Have there been any studies as to why the male suicide rate is almost four times that of females?

Misty Vaughan Allen:
They do study it. There is a lot of speculation on socialization, help-seeking behaviors, and so on, and men are not reaching out for help in time. Access to

lethal means is believed to be a determining factor; men typically have greater access to firearms. I do believe that is changing. Nevertheless, the more lethal the means, the more typical a completion will occur. However, China, for example, has a higher female suicide rate, and the belief there is possibly the access to means through pesticides because women are the ones in the field. India, too, is showing something similar.

Another wonderful program that is described in my packet (Exhibit D) is a pilot project, which Clark County Children's Mental Health Consortium is piloting and the Office of Suicide Prevention is supporting, to really help with early identification and screening. We believe that this is crucial; most children are not identified, and 80 percent of those who have mental health disorders are not getting help. One in five young people in Nevada have mental health disorders. In the first two years of this grant, we were working with a school-based screening program in southern Nevada. That is no longer part of our project, but it is continuing with the Center for Health and Learning. We felt that to accompany a school-based program, multiple layers were needed, and what better way to see more youth than through their pediatric/primary care physician because technically, they can go on an annual basis up to age 18. We hope to determine if this is beneficial and cost-effective and if people are really accessing the services of their doctors and then being connected to mental health services. This pilot was carried out in December, and I will highlight a couple of the benefits. The physician with the Nevada Health Centers in Las Vegas saw one client who had brought her teenager in, and after the interview and screenings, she said, "Please, can I bring back my other children? This is really important." The physician did not expect that. Another girl who, because she had multiple health issues, he did not screen, said before she left, "I need you to know I am suicidal." This physician always screened his clients from then on. We are looking forward to seeing what will come out of this, but the interest is growing across Nevada; from what was meant to be a small project in Henderson is now going out to the rurals. Hopefully it will be a part of the tribal grant as well. Nationally we know the earlier we identify young people with mental health concerns, the better off they and their families will be.

Part of the data to help emphasize the Youth Suicide Prevention Projects, the Youth Risk Behavior Survey, which will be run next month for 2009, is statewide data. Twenty-six percent of our young people of high school age feel seriously hopeless and depressed; 14 percent seriously think about suicide; and 9 percent make the attempt. In Washoe County, 14 percent of our young people actually made a plan. This is a huge problem. They are feeling pain, and they are thinking about this.

Assemblyman Denis:
We tend to think that teen suicide is more prevalent among the "fringe" kids. But I have seen some research that it happens with the football stars, the cheerleaders, the popular kids, is that true?

Misty Vaughan Allen:
Actually, suicide can touch anyone, all types of youth. I spoke to someone recently who works in the juvenile justice field, and he said the kids in juvenile justice, who you would think are high-risk, are getting screened. They do that on a regular basis, so they catch them and get help. It is the ones who are falling through the cracks, not part of the system, unknown to the mental health system, that we are missing. I just read research that talked about the type you mention; the good students and athletes are not asking for help. They are not reaching out for help when they know they have problems.

Assemblyman Denis:
So how do we reach out to those kids? We tend to think those kids are okay because they are good students, or they excel at sports.

Misty Vaughan Allen:
I think the best answer is a comprehensive multi-level prevention program in which we do the screenings with physicians, and screenings in school-based programs all the way down to elementary school. We can focus on mental health and resiliency in coping, but we also need to educate adults at all levels who work with teens, including those in juvenile justice, the teachers, the administrators, and the parents, so they know what to look for. I think we quite often miss the signs, and until, unfortunately, a tragic completion of suicide occurs, the signs are not put together. We wait until we have a whole bunch of evidence, instead of having a depression or falling grades—just one warning sign—to be enough to ask, "what is going on here?" That is the early intervention identification.

There are protective factors. This is preventable, but not 100 percent of the time, unfortunately. I want to highlight what does work: restricted access to lethal means. You read about the young man who shot his pregnant girlfriend; they knew about this, there were warning signs. That access could have prevented a tragedy. The same with suicide; if we are worried about someone and think there is a risk for suicide, perhaps upon being discharged from a mental health facility or from a juvenile justice facility, or even an over-stressed athlete going to college. If we are worried, we need to get those lethal means out of the house or locked up. Medications should be locked up and distributed by an adult. That is something we can do today. Effective clinical care and resources are sometimes more difficult to access in rural areas. Strong

connections can be built in elementary school and beyond and we can help children build healthy relationships. Seeking help can make a difference. When you see someone you are worried about, or even yourself, do not be afraid to talk about it. We are trying to break down that stigma.

We have multiple levels of training that are important parts of a comprehensive suicide prevention program, and we are building our resources of trainers throughout the state, which is definitely helping. There is a training going on today in Elko with the tribes.

Chairwoman Smith:
Do you connect with Nevada 2-1-1 line and network for referrals?

Misty Vaughan Allen:
Absolutely. Nevada 2-1-1 goes into the Crisis Call Center and Help of Southern Nevada. The Crisis Call Center runs the 24-hour Suicide Prevention Hotline, so they are very well trained and an excellent resource. Nevada 2-1-1, unfortunately, is not 24/7 at this point, so it is not typically given out as a prevention hotline. The hope down the road is it will become 24/7 statewide because that would be an easy number to remember. The National Lifeline is 1-800-273-TALK, a link to 200 other centers around the nation, and if someone calls for himself or others, he gets a person, not a machine. I tested it at midnight the other night, and it does work. The 1-800-273-TALK is also a link to the Veterans Administration. We know a lot of our young men and women returning from war are at risk for suicide, and there is a separate branch—the only branch on that hotline—but it is a wonderful resource.

Chairwoman Smith:
What is happening with your funding in this recommended budget?

Misty Vaughan Allen:
At this point it is a small budget, and the impact would most likely be on travel to the rurals, but we will find a way. We keep seeking grant funding through SAMHSA. Another opportunity has come up today for similar funding.

Assemblywoman Spiegel:
I think it is really impressive that you get so much done with so few resources. You are to be commended for that. Do you make use of volunteer resources?

Misty Vaughan Allen:
I am trying. I had the privilege of traveling with those who work in rural clinics earlier in the fall as they were going out to their communities, to let them get to know me. A lot of people do not know this program exists or do not want to

talk about it unless there is a tragedy. I am trying to get out there before the tragedy happens. Rural clinics have always been a wonderful link for me to get into the communities in a positive, non-tragic way. A goal would be to develop a corps of volunteers in each community that could be on call for someone at risk, because one of our trainings is suicide first-aid. It is two-day training, and it changes how you hear and see the warning signs of someone at risk. One option would be to get a corps trained to be on a rotating call basis.

Assemblyman Hambrick:
Do you have any data available on clustered or epidemic suicide by youth, or do you track the locations and frequency or type of suicide?

Misty Vaughan Allen:
Because our data is so delayed, tracking is very challenging. As you can see, 2005 is my most solid data. But I do hear about events going on because someone from a community will call and say something is happening. And if a cluster occurs, and I believe there are potentials currently, we have protocol and guides to get in and help the school or the community prevent future suicides. There are protocols that can keep people safe in that situation, but I do not have collected data. It is a great idea to track.

Chairwoman Smith:
So why do we not have that data, and why is there such a delay? Where is the breakdown?

Misty Vaughan Allen:
I ask myself that every day. We reach out to our county coroners for data. My office has 2007 data from Clark County Coroner. The counties are sometimes more challenging to get because of who is tracking it, and with the tribes, it varies as well. With the grant, we are trying to work with Health Services to improve that system of collection. After the county, the State Health Division would tabulate that based on their registry. The State Health Division sends it to Centers for Disease Control (CDC), and technically we are waiting until the CDC releases the official data.

Chairwoman Smith:
In today's world, with all the technology we have, this is the kind of thing that just makes me crazy. We just have to figure out if we can do something differently. Regarding the national statistics you were giving us, is everyone else in the same boat, and is there a slow-down getting data back from the CDC, or are other states having better luck with how they track?

Misty Vaughan Allen:
There are 17 states that are part of a National Violent Death Registry, and they have very up-to-date and in-depth data related to suicide and homicide. I have tried to become a part of that and am unable to at this time.

Chairwoman Smith:
Why is that?

Misty Vaughan Allen:
It is a lack of funding. The available funding went to other states. I think communication needs to be developed to become a part of that system. Multiple agencies need to be involved, which poses confidentiality issues. But a part of the suicide data tracking is that it is such a challenging form of death. There are many undetermined deaths and sometimes it can take months for a coroner to determine the cause, and I can understand if one is in a smaller community and might know the family. That is part of the slow backlog on suicide deaths.

Chairwoman Smith:
I get all of that, but on the ones that are known, not to get data for three years is problematic. We will keep working on that.

Assemblyman Stewart:
I suggest you contact our Controller, Kim Wallin, and talk to her about the XBRL Program, a method of accessing data quickly.

Assemblyman Hambrick:
When I was more involved with this issue, training in the coroner's office revealed that many times alcohol poisoning as a cause of death in young people was accidental. Two or three youths who had died in a car accident would be seen as accidental, but those investigating the case overlooked some of the signs and sometimes did not have the funding, or the time, or the inclination to look into the causes, and those were some of the problems I ran into.

Misty Vaughan Allen:
Working with the Child Death Review teams I found they have the ability to more deeply explore some of those questions. Nationally, 32,000 people die by overdose. Most people do not leave notes, only 1 in 10, so it is very difficult to determine the cause, and if people are not seeing the warning signs, I can see how that misinformation could occur.

Assemblywoman Parnell:
When the bill was first written, I remember there was a section that really encouraged groups—and Assemblyman Denis might be interested in this—such as the Nevada Parent Teachers Association (PTA), and I believe it stayed in the bill. I am wondering if you have had much communication with, or if you have ever done a presentation for the PTA? We need to get to parents, too, and I wonder how far along we are in that effort.

Misty Vaughan Allen:
The PTA is a difficult population to address, first, in getting the group together, and, second, dealing with subject matter they do not readily want to discuss. We are working with foster families and the agencies that support them. I think it is a matter of time, but also a matter of opportunity. I can put up posters and say we are doing training and no one shows up. So it is having the right avenue to speak to groups, and parents would be so crucial.

Assemblywoman Parnell:
I remember saying four or six years ago that the Nevada PTA has a state convention every year, and they have workshops. It is a start; it certainly is not going to reach a huge audience, but I think it is so important, as is working with school counselors.

Misty Vaughan Allen:
Our school counselors are a huge focus.

Chairwoman Smith:
I think my colleague is absolutely correct. I think one of the things we find is that it is one of those discussion topics that most parents do not want to hear about until they are in crisis, so it makes it difficult to reach the populations that we so often need. Just wrapping this up, what is your biggest challenge?

Misty Vaughan Allen:
One of my biggest challenges is reaching all of the populations I would like to reach. Speaking to the children, developing school-based programs—that is frightening to administrators and schools to think about comprehensive suicide prevention. However, we have the tools; it is having the doors opened before the crisis occurs, that is the biggest challenge. I do want to thank Dr. Cook and his people. The rural clinic directors have been a wonderful avenue into those isolated communities. I was born and raised in Reno, Nevada, and to many that may seem like the "big city," so being accepted into some of the smaller, isolated communities has been a challenge. However, I know that once I am accepted and can train others, we can start to build the prevention program.

Chairwoman Smith:
And so we closed the rural clinics and there goes your connection to the people out in those rural communities that are so isolated.

Misty Vaughan Allen:
But it also increases my need to keep going out there and work with the volunteer people. It takes the community; that is the basis of the protection.

Chairwoman Smith:
Regarding schools, one of the things that I know we have talked about is training for teachers, administrators, and counselors, and that it is so difficult because in the K-12 environment we have tried to stay focused on professional development for the core subjects and to stay focused on student achievement. Once the door is opened to other subjects, it is a floodgate. This is such a critical issue, and I know it has been hard not to have access to those professional development programs. I guess you are just doing the training outside of the normal hours and in the separate programs.

Misty Vaughan Allen:
We just had four counselors in the Clark County School District trained in the suicide first-aid so that they could take it internally, and their plan at elementary, middle, and high school is to reach, first and foremost, the counselors throughout the district. After they do that, they would probably reach out to the administrators and teachers, and hopefully the Office of Suicide Prevention can work toward getting to the parents in a team effort because it will take the multiple-level effort.

Chairwoman Smith:
So they are doing a sort of train-the-trainer program?

Misty Vaughan Allen:
They just finished.

Assemblyman Hardy:
I have been intrigued by the conversation. When Dr. Cook presented, he said basically that what we do is treat with medicines. We no longer lie on the couch, no longer talk about your mother and your dog; we treat you with medicine. When I look at suicide prevention, I am looking at the treatment of depression. That is where we need to be. If we wait for the person to say, "I'm suicidal," we are way behind. The people who commit suicide do it for a biochemical reason, for lack of a better way to say it, whether it is post-traumatic stress disorder, or pick a reason that you think we have a depression for, but the chemistry—like brown eyes or blue eyes—can run in

families as well, so there is an increased risk. If we focus on suicide, we are just a little late. We have to focus on the concept of what is depression. It is fairly easy to notice that someone is not his "normal" self, and there are some simple questions that you can ask on depression. When we treat with medicines, they work, in spite of the stigma or reluctance to take them. So, in line with advancing our common goals, what is the phone number that we are going to call if we worry about suicide?

Misty Vaughan Allen:
I apologize, I put it on a slide and I think it was a different version of this PowerPoint. The number is 1-800-273-8255 (273-TALK).

Assemblyman Hardy:
Nevada 2-1-1, that somehow Chairwoman Smith is going to rescue from this process, will be available for people to call for different reasons. One of the links they can make is to a suicide hotline. When 2-1-1 is done for the day—10:00 P.M. or 8:00 P.M. in the rurals—is there a message that will say "If you are suicidal, push this button and you will be connected to the suicide hotline," is that feasible?

Misty Vaughan Allen:
Yes, that is what happens currently. But I think the concern of Chairwoman Smith is that if one is in that level of crisis and he dials 2-1-1, it could be just frustrating enough to not reach out again. So it is never ideal if it is not 24/7. That was the benefit of the National Lifeline Network; no matter what, it will bounce to a human voice. Ideally, 2-1-1 on a 24/7 schedule would cure that issue. But there is a message currently that would guide them to the lifeline.

Assemblyman Hardy:
Is it a message that says you have to call a certain number, or is it "push 2" like other programmed systems do?

Misty Vaughan Allen:
I have not tested 2-1-1. I called the Lifeline. Regarding what you said earlier about medication, and, as Dr. Cook stated, medication is really important, and depression is a huge part of suicidality, but I must emphasize it is not just depression that leads people to be at risk for suicide, and if we can build protective factors throughout the community along with quality mental health care and access to medications, it will safeguard many more people. The majority of people with mental illnesses do not go on to be at risk for suicide. It is still a multi-level prevention including help-seeking, relationships, and resiliency.

Assemblywoman Parnell:
My youngest son, who lives in Phoenix, and his wife are on the board of Teen Lifeline, and they have just done some amazing things. It is made up of young professionals in their 20s and 30s, and they raise millions of dollars. Do we have anything in the state similar to that? If not, maybe we should try to start something.

Misty Vaughan Allen:
We do not have a Teenline currently. That has been attempted with the Crisis Call Center many times, but we found it was not being utilized enough. They even had it where the teens were answering. What we are looking at right now with the potential help of the Youth Suicide Grant and the Crisis Call Center is to develop a text messaging intervention system, which would be cutting edge, where teens could text in when in crisis, and the volunteers answering the hotline would use computers and would have been trained in text language to intervene in a suicide.

Assemblywoman Parnell:
Bringing our attention back to the need for financial support, it would be helpful to have a group of people who are engaged in raising money. It would be wonderful to have a group that could sponsor golf tournaments, or other fund raising events, so that you are assured of having a constant stream of funding and we do not have to worry about some of the issues that have been brought up today.

Chairwoman Smith:
Thank you for the presentation, Misty, and for the good work you have been doing. It has only been a short time since your office was funded, and you have made a lot of progress. We appreciate that because it is a very important issue in this state that needs more attention and more opportunity, but we will stay the course.

We are going to open the hearing on Assembly Bill 6.

Assembly Bill 6: Revises provisions governing certain emergency admissions to mental health facilities and hospitals. (BDR 39-211)

This was a bill that came out of interim from the Legislative Committee on Health chaired by Assemblywoman Leslie, who is not available today, so Dr. Hardy, as a member of that Interim Committee, is going to present the bill today, and then we will take some testimony.

Assemblyman Joseph (Joe) P. Hardy, Clark County Assembly District No. 20:
Assembly Bill 6 came out of the Interim Health Committee and, as you are aware, there has been an over-crowding of the emergency rooms in Clark County and elsewhere in Nevada, and the Interim Committee heard much testimony from many people about that over-crowding. Part of that over-crowding was from the alleged mentally ill occupying the emergency room beds. This measure would improve admission and release procedures of an allegedly mentally ill person to a mental health facility or hospital, and is an attempt to reduce the number of emergency room beds occupied by allegedly mentally ill patients.

There are two significant changes; the first provides a procedure to expedite the release of people held under emergency admission by allowing a range of professionals to sign a certificate authorizing release. The second changes the point in time at which a medical examination must be conducted on a person, from before transportation of the person to a mental health facility to before admission to a mental health facility. This would allow people who are allegedly mentally ill to be transported directly to mental health facilities more quickly and receive their medical clearance there instead of in an emergency room.

Regarding the first change, current law provides that a person who allegedly has a mental illness may be held involuntarily for evaluation, observation, and treatment under an emergency admission for up to 72 hours. If a petition is not made to the court to involuntarily retain the person, or the person does not voluntarily remain in the facility, then the person must be released within 72 hours. This bill retains the 72-hour limit but requires the immediate release of a person who is admitted under an emergency admission if the administrative officer of the mental health facility or hospital receives a certificate signed by certain professionals stating that the professional has personally examined the person and the person should be released. Those who can sign a certificate of release in this bill include a psychiatrist, a licensed psychologist, a licensed physician, a licensed clinical social worker, or a registered nurse who holds a master's or doctorate degree in psychiatric nursing.

As for the second provision in A.B. 6, the current law provides that before a person can be transported to a public or private mental health facility, he has to be medically cleared. This results in people being taken first to the emergency room to be examined for any physical ailments, and then transported to the mental health facility. This measure would change the point at which the medical clearance can occur from before a person is transported to a mental health facility to before they are admitted to a mental health facility. This would allow a person suspected of having a mental illness to be taken directly to a mental health facility and be examined for medical problems there. This

would result in fewer people being taken to the emergency room if it is suspected that the primary ailment is an issue of mental health rather than physical health.

In conclusion, I realize that there are some groups who may not be able to support A.B. 6 as it is written. I may be one of them. But it was our best attempt during the interim and through the bill drafting process to try to address this very important issue. I welcome suggestions from the other professionals and anyone on how we can improve the bill, and I hope that during this session we can find a way to improve these procedures and free up some emergency room beds. For the record, I have had four stakeholder representatives approach me today about trying to clarify and/or improve the bill, including putting in family therapists, looking at the liability, and who is on the list of professionals. So I would welcome the people to come before the Committee and express their concerns because I think there probably will be many reasonable concerns, though with the intent of helping us do something good.

Chairwoman Smith:
Thank you for that presentation. I have to say that Ms. Leslie warned me that this bill would be difficult in nature, but that is not why she left today and left you with this job, Dr. Hardy.

It appears that the goal is to have the patients released from the emergency room to reduce crowding in the emergency room and to have them released to a mental health facility. Right?

Assemblyman Hardy:
Yes, and if you go into an emergency room in Clark County on a given day you will find there will be people on gurneys in the hall. I am not going to say they are all allegedly mentally ill, but what the staff do is watch patients so that they can determine that the reason the patients are there is not for a medical reason, it is for a mental health reason, and then have a disposition for those patients. So that disposition may or may not be admission to a mental health facility. One of the things that happens, is that if you are in the emergency room and you do not have a psychiatrist on staff who happens to be in the hospital, then you make a call to get a trained team from a local mental health facility who assesses the patients to determine if they are okay. Usually that team is under the direction of a psychiatrist. The psychiatrist, usually over the phone, agrees with their assessment. Then what this would allow us to do is to say, Okay, these people have evaluated the patient, they know what they are doing and that allows someone to be able to say, Yes, this person is okay to go, either home with the appropriate follow up, or to a mental health facility and be transported. So that is not a quick process, but, nonetheless, it is a necessary

process to go through, either in the emergency room or the mental health facility. It gives some flexibility, and I think that is the key word that we have to look at. How can we flexibly take care of people, protect people, so that they do not end up being one of the statistics that we heard about earlier? But not everyone needs to be admitted, either to the hospital or to the mental health facility. Does that help?

Chairwoman Smith:
It does. Regarding the statistics, which is the bigger problem? And I apologize because I am sure that all of this was discussed and hammered out in the Interim Committee, but we have a pretty new group here.

Assemblyman Hardy:
The bigger problem is the person. What can we do for the person, the patient, the one who has the crisis? That problem comes to the emergency room because we do not know what to do with him, or the police pick him up and bring him to the emergency room because he has to be screened somewhere medically to make sure that it is not a medical problem but a mental health problem. If you go to a hammer, then you are by definition a nail. So if you go to the psychiatrist or you go to the physician, then that physician is more likely to treat you with medication. You are looking at how this person could be either behaviorally treated or medically treated, even though he does not have a medical problem. And most of the things we see in the emergency room are going to be treated medically, meaning with medication, and the patient will go out of the emergency room with a script for some medicine, or he will be admitted somewhere to be cared for until he becomes stable.

Assemblyman Denis:
Do we know if a patient goes directly to the mental health facility, and do they have the ability to handle that?

Assemblyman Hardy:
The facility has the ability to handle something, and Dr. Cook will probably come up here and say, Yes, we can do everything.

Assemblyman Denis:
If we have the ability to take people out of the emergency rooms to avoid over-crowding, and they go to the mental health facility directly, do you have the ability to handle that without over-crowding?

Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services:
Would this be an appropriate time for me to offer my testimony on this bill? It may address Assemblyman Denis's question.

Chairwoman Smith:
It would.

Harold Cook:
I hesitate to offer this testimony because unlike Dr. Hardy's statement a minute ago, I am going to say, "No, we cannot do everything."

On behalf of the Division of Mental Health and Developmental Services (MHDS), this testimony is submitted to oppose the bill as written. There are two major changes to existing law represented by this bill, one of which is an improvement, while the other represents a possible enormous increase in costs to state psychiatric facilities. Assembly Bill 6 would expand the array of advanced practice clinicians who are authorized to release a person believed to have a mental illness from a legal 2000 emergency hold. This change we are in agreement with.

The change in existing law that would no longer require medical clearance before transport to a psychiatric facility, but only before admission, could result in patients being transported to a psychiatric facility without medical clearance. That was what Dr. Hardy was testifying to a minute ago. If the psychiatric facility does not have the capability of performing medical clearance, then the patient would have to be put back into the ambulance, or a new ambulance would have to be called, and the patient would have to be transported to a medical facility. Currently the two psychiatric facilities that the state operates—Dini-Townsend Hospital in the north, and Rawson-Neal in the south—do have extremely limited capabilities to perform medical clearance. A version of this bill was brought forward as Assembly Bill No. 225 of the 74th Legislative Session, and it recommended the same single word change in the statute. I believe, although I was not in this position at that time, that MHDS put a fairly substantial fiscal note to that bill. If this bill were to pass, what I am testifying to is that MHDS would either have to turn people away at the front door for medical clearance, or there would be an approximately $2.5 million fiscal note to ramp up Dini-Townsend Hospital and Rawson-Neal Hospital to be able to do medical clearance.

Chairwoman Smith:
We have not seen a fiscal note yet. Is that being developed?

Harold Cook:
I actually have a fiscal note, but I have not attached it to the bill because I do not want to kill the bill. I would like to recommend an amendment. The one provision for adding to the list of professional licensed staff who could deal with the medical clearance issue is a positive point, and I would like to see that go forward. But, the issue of having medical clearance performed at state psychiatric facilities—and I would even want to expand that to private psychiatric facilities, many of whom probably would not have the ability to do medical clearances—would be something I would have to oppose. If the bill goes forward as written, I would have to put in a fiscal note.

Chairwoman Smith:
Dr. Cook, is there any county involvement or county financial commitment to this, any obligation from the county in this situation for funding?

Harold Cook:
The *Nevada Revised Statutes* (NRS) stipulates that counties are responsible for funding indigent medical care services within those counties, so I do not know to what extent counties do provide funding to local hospitals for medical clearance. It probably varies across counties. It may be that many times hospitals just have to absorb the cost.

Chairwoman Smith:
I allowed you to testify first, even though you were not supporting the bill, because I felt with your agency role it was important for the Committee to understand your position before we went on. At this point we are going to back up and take testimony in support of A.B. 6.

Katherine Unthank, Ph.D., representing Nevada Mental Health Counseling Association and the Nevada Counselors Association, Reno Nevada:
We are here to respectfully request that "clinical professional counselor" be added to the list of licensed professionals in section 1 of A.B. 6. We are in support of this bill and, in support of our request, we would like to point out that our academic and post-graduate supervision requirements for licensed professional counselors in the State of Nevada are equal to the clinical social workers that are already included in that list.

Chairwoman Smith:
Did you bring a written amendment with you?

Katherine Unthank:
No, I did not.

Chairwoman Smith:
If you testify in the future, it is helpful if you bring us something in writing that details what your suggestion is, but we will take note of that, and we appreciate your testimony. It is pretty basic, so in this case, I think we can handle it.

Rebecca Gasca, Public Advocate, American Civil Liberties Union, Reno, Nevada:
We are here today to express our support for this bill, primarily because under NRS 433A.160 there are opportunities in which individuals can be involuntarily committed to mental health institutions. Commitment to a mental health institution or facility is by definition the very deprivation of the individual liberties that we seek to protect. As you heard from the good doctor earlier, there are instances in which people need not be involuntarily admitted into those institutions, and what this bill would do is allow a qualified individual who is not connected by blood or by marriage to that person, or to the financial interests of the mental health institution, to certify within 72 hours that a person need not be there. What that would do is give that person his individual liberty that we seek to protect.

Chairwoman Smith:
I have a couple of other people signed in, in support of this bill, but not to speak. Is there anyone else who wishes to speak in support of A.B. 6? I see that Helen Foley has amendments (Exhibit E), but if no one else wants to testify in support, do you want to speak, Helen, and offer an amendment?

Helen Foley, representing the Nevada Association of Marriage and Family Therapy, Las Vegas, Nevada:
Our amendment (Exhibit E) would conform to Dr. Unthank's amendment, and we would also want to include "marriage and family therapists" (MFTs). In NRS 433A.018, it spells out the persons professionally qualified in the field of psychiatric mental health, and it gives that laundry list of all of those people who are currently included in the bill with the two additions of MFTs and Licensed Professional Counselors (LPCs), so those two categories are the only ones that have been excluded from the legislation and we would request that they be included in this.

The only other concern I have is that the bill does not state that any of these mental health professionals would have to have privileges to work at the facilities where this person may be released. So, any MFT or even a clinical social worker would be able to come in and release a person from that facility under the strictest interpretation of the legislation, and I believe that it should be someone who is working at that facility, rather than anyone on the outside just

coming in. There are more than 600 MFTs in the State of Nevada and they work at almost every mental health facility, private and public, in the state.

Chairwoman Smith:
Did you bring a written amendment?

Helen Foley:
I will provide it within 10 minutes.

Assemblywoman Mastroluca:
If the professional licensed person that made the decision to release the individual did not have privileges at that facility, who would ultimately be responsible if something should happen?

Helen Foley:
That is a question on the minds of many of the mental health facilities, what type of liability they would have if someone from the outside came in and released someone. I do not have an answer for you, but it is a big question mark that causes concern.

Chairwoman Smith:
Is there anyone else who wants to speak, with or without amendments? [None.] I want to acknowledge our colleague Assemblyman Paul Aizley in the audience. Welcome to the Committee.

Now we will take testimony in opposition to A.B. 6.

Michael Alonso, representing West Hills Hospital, Reno, Nevada:
I signed in as opposed to the bill. However, I wanted to clarify that we are opposed only to section 5 of the bill. We understand the issue with the emergency rooms as Assemblyman Hardy presented to you, and we support that, in general, but we do not know that we could handle all that capacity. With respect to the rest of the bill, we are opposed to the language as written, and I have met with Assemblyman Hardy and with you, Madam Chair, and we would be happy to work with the Committee to try to come up with something, if that is the Committee's desire.

The main issue for us is the emergency hold statute. In the way it is intended to be used in this state, in order for someone to be involuntarily committed, it must be proven or shown, through a licensed psychiatrist that there is a clear and present danger of harm to the patient or others. So, if someone comes into our facility under those circumstances, and then another health care provider, who may or may not have privileges at our hospital, then says the patient needs

to be released, we have a conflict. We are put in the middle and are told we have to release the patient if the health care provider gives us the certificate. But, under the statutory scheme, we are working under the notion that there is a clear and present danger the patient may harm himself or others. There is a liability issue if that person is released when a licensed psychiatrist is telling us not to release that person. That is the main issue we have with the bill.

Assemblyman Hambrick:
Previously Dr. Cook offered a possible fiscal note on this. Would you care to estimate what you believe a fiscal note may be, at least for your facility?

Michael Alonso:
I do not have a fiscal note. We have no idea what that number would be. It is my understanding that the language in section 5 would allow a mental health facility to set up a triage to do the medical part of it, to help keep those people from going into the emergency room.

Steven Zuchowski, M.D. representing the Nevada Psychiatric Association, Reno, Nevada:
We are in opposition to the bill, as written. I should also mention my other affiliations and who I am not representing today. I am a full time employee of the University of Nevada School of Medicine as an Assistant Professor. I am also Chief of Staff at West Hills, Willow Springs Center, in Reno, and I also work at the PACT team that Dr. Cook described earlier today. While I represent the Nevada Psychiatric Association, I am also a daily user of the Legal 2000 process, and so I bring that experience to the table in opposing the bill as written.

I did provide a written amendment (Exhibit F) with suggestions. I will go through that and comment about why we think the suggestions would be better suited for the law. Similar to some of the other commentary regarding having someone other than the psychiatrist or physician releasing people from Legal 2000s, we are concerned about that, both from a liability perspective as well as just simply an unworkable situation. It creates a conflict, in terms of someone coming in and ordering the discharge of a patient who I, as the attending psychiatrist at West Hills, for instance, may not feel is ready for discharge and may be diametrically opposed to because I think the patient is dangerous to himself or others. It is a decision that should be left to physicians, because mostly we are going to bear the liability. We are taught in medical school that whoever signs the discharge is the one who is going to bear responsibility for what happens after discharge, to some extent.

Chairwoman Smith:
So what you are saying is your preference is that a staff physician could sign the certificate rather than the licensed psychiatrist, that it would free up some opportunity, but not broaden it?

Steven Zuchowski:
Also, the Nevada Psychiatric Association is very much interested in collaboration. We appreciate the input of psychologists, counselors, marriage and family therapists, and so on, so we would like this to be a collaborative process, but ultimately where the decision to discharge lies with us, we really have to have that final call. We have proposed an alternative under section 1.

Some additional ideas for amendments include some clarifications to the language. Just in the daily use of the Legal 2000 process, we have found some terms to be awkward or difficult. For instance, use of the word "Alzheimer's Disease" is too specific, basically. That is a very specific diagnosis, and we would suggest that be broadened to "dementia and delirium."

Chairwoman Smith:
And you do not think that is too broad?

Dr, Steven Zuchowski:
No. Actually, in practice that is how it is being interpreted now.

We also mentioned the simple change from "next proceeding" to "previous." We have seen some people confused by the language "next proceeding 30 days," as opposed to just saying "previous." It is simply to make things a little more user-friendly.

On the second page, it reads "amend section 3 to clarify the deadline for filing a petition." What we have here is a problem in the implementation of the law where we are held to sometimes an unreasonable deadline. If a hold expires at 8:01 a.m. on a weekday when the court is open, we are faced with the issue of having to present a petition for extension between 8:00 a.m. and 8:01 a.m. during the court hours. If the hold expired at 7:59 a.m. we would have until 5:00 p.m. to file that extension. This causes consternation and difficulty and has resulted in people who are, in our opinion, dangerous to self or others being released on this technicality. We even had a case where our courier presented a petition for an extension of a hold at the lunch hour, when the clerk was not there to accept it, and then the petition was rejected because it was late. We do not think it is the intent to nit-pick to that level and to release people who really need treatment, and who really do qualify under the statute. Therefore, we would suggest that the deadline be simply 5:00 p.m. on the next court day,

so whenever the court is open, the deadline would be 5:00 p.m. that day. That is covered twice in our amendments, once for the 48-hour hold, and once for the 72-hour hold.

On the third page, where it says "amend section 4," there is also another minor clarification that would make the law a lot friendlier and clearer. About midway down, it specifies when exactly the 72 hours begin and end. That is a matter for interpretation at this point. Different courts interpret it differently, and no one is quite sure what the answer really is. Everyone knows it is 72 hours, but you have to know the beginning and the end. What we have proposed is that the 72 hours begin when the final certification is done on the Legal 2000 form. We have proposed some language to clarify that.

We also mentioned, for the same reason as Dr. Cook, our opposition to change the language from "transported" to "admitted," and we would prefer it to remain "transported." We do not think that we have the infrastructure to be able to handle those medical clearances and that we would end up with lines of ambulances coming to pick people up and take them to the medical hospital from the psychiatric hospital. We do not think that solves anything, and it creates more problems.

Finally, on the last page, we have addressed the situation where a patient is placed on a Legal 2000 and sent for medical clearance. Perhaps they are found to have had a serious overdose and have stopped breathing, and they become intubated and are admitted to the ICU. One problem we find in implementing this, is that the Legal 2000 at that point becomes quite vague as to what the status is. The person was initially on a Legal 2000 72-hour hold, now he is comatose in the ICU, and certainly not asking to leave at that point. But we need to have some mechanism for continuing to hold that person after he wakes up and begins to recover from his acute medical illness, a mechanism to trigger another psychiatric evaluation. We have proposed some language at the top of the last page that would address those issues and keep the court informed of a person who is on an "open" Legal 2000, meaning the 72 hours is not yet ticking because the person is receiving acute medical care, but yet he will need to be evaluated at some point for psychiatric clearance.

Chairwoman Smith:
Thank you for bringing the amendment to us today. Did you work on this in the interim with the Legislative Committee on Health Care, and did your association testify then?

Steven Zuchowski:
I do not think so.

Chairwoman Smith:
Do you think there is a need for this? To change what is currently being done?

Steven Zuchowski:
Certainly there is a problem, particularly in Las Vegas, in how things flow there. Sure, there is definitely a need to change how that flow occurs. We do not think this is the answer.

Jeanette Belz, representing the Nevada Psychiatric Association, Reno, Nevada:
We have been involved in this issue for several sessions, so Dr. Dickson, the President of the Nevada Psychiatric Association, did testify in the Interim Health Committee, and we were involved in bills relating to this last session as well.

Chairwoman Smith:
I wondered if you had offered this language previously.

Jeanette Belz:
There really was no specific language to present, but certainly conceptually we have worked with Assemblywoman Leslie and the Committee on it.

Bill Welch, President/CEO Nevada Hospital Association, Reno, Nevada:
I will speak on behalf of Mr. Jesse Wadhams who was going to testify for us, but I want to try to clarify some of the background work that has been done on initiating this legislation, at least in part. We concur with Mr. Alonso on the comments that have been made with regard to the authorizing and releasing of a patient who is on hold. There needs to be further clarification that there are legal issues that need to be addressed. We also have solicited input from the hospitals on how the credentialing would work regarding someone from outside the organization having authorization to come in. Accordingly, we would be happy to work with the Committee on that particular section.

With regard to section 5, regarding changing the word "transport" to "admit," this has been an issue debated going back to the 2005 Legislature, and possibly before then. There has been a lot of work done on it and that is why, in the 2007 Legislature, as Dr. Cook presented, there was a specific bill, specific to section 5, that was brought before the Committee, but unfortunately did not move forward. I want to make a couple of points. First, the mental health facilities indicate that they cannot consider alternatives on whether they would be willing to do some level of medical clearance because the law clearly today does not allow for a patient to be transported. So, there is a need to allow for it; it does not mandate that will happen. It would allow for it to happen only so that the medical community could work together in the future to create an environment where that may be an appropriate opportunity. The objective is to

insure that the patient is taken as quickly as possible to the location at which he needs care. Currently, mental health patients who are alleged to have mental health conditions, and who are picked up by an emergency transport service, have to be taken to a hospital. Through the last interim, and the interim before that, many studies have been presented. Assemblywoman Leslie chaired the 2000 Interim Health Committee, and she appointed a Committee of representatives in Clark County to look specifically at the mental health situation, but it is similar around the entire state. In those studies and through those work sessions, bringing all the players together, it became apparent that 93 to 97 percent of the patients who are transported by ambulance for need of potential mental health services, do not require medical care. If they are transported to the hospital, we must then hold those patients until we can make arrangements to transport them to a mental health location. The objective of this is understanding that those 93 to 97 percent do not need medical care, they need mental health care. We need to get those patients to that facility as soon as possible. The opportunity that a mental health facility has, if a patient in need of medical care is presented to them, and if the facility has the ability to do a medical screening, is that they can call for an ambulance immediately and that transport can occur very quickly. We do not have that same opportunity to insure that a patient presented to us who needs no medical care, can be transported immediately to a mental health facility. We think that it is important to allow for that provision to go forward in this legislation.

With regard to the cost of paying for this, Clark County and Washoe County—and I cannot speak for the rural counties—will provide limited payment; I believe Clark County is $72 or $75. In the past, the fiscal note that has been presented for medical clearance has been based upon the need to establish a full diagnostic center within the mental health facility. That is not a necessity, and that was clearly determined during the interims as we studied this. A medical clearance process, I believe, was somewhere around $100 to $125, and there was a whole concept developed that would allow for that to happen. Again, not mandating that a private mental health hospital or a state mental hospital would do it, but a process was developed to do a medical clearance, to meet the needs of that patient, and to determine whether that patient needed to be transported to an acute care facility to first be stabilized or needed to be maintained there to start receiving mental health treatment immediately.

I just want to add about the clarification on "admission" versus "transport." issue. I would encourage this Committee to take a look at least at one report that I know of because I served on that Committee that worked for months during the Interim and made recommendations on this issue.

Chairwoman Smith:
This is really an important issue that has been going on for a number of years. We may be inching closer to a resolution, it sounds like from the testimony and the amendments offered. I will put this in a Subcommittee and ask Dr. Hardy to chair that Subcommittee with Ms. Spiegel and Mr. Denis, and see if we have come close enough to reach some resolutions. I will also ask all the parties to follow this issue and offer your input. I am very interested in knowing with the amendments offered, and the limited staffing in the amendment offered, would the liability issue be different? That is a lingering question for everyone. I will have the staff work with you, Dr. Hardy, and we will get moving on that.

I will close the hearing on A.B. 6. Is there any general comment to come before the Committee? [None.] The meeting is adjourned [at 3:43 p.m.].

RESPECTFULLY SUBMITTED:

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Darlene Rubin
Committee Secretary

APPROVED BY:

_____
Assemblywoman Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 25, 2009 Time of Meeting: 1:30 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Harold Cook	Presentation Booklet, Division of Mental Health and Developmental Services
	D	Misty Vaughan Allen	Power Point Presentation printout and statistics
A.B. 6	E	Helen Foley	Amendment
A.B. 6	F	Steven Zuchowski	Amendment