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

Seventy-Sixth Session
April 11, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 2:55 p.m. on Monday, April 11, 2011, 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/76th2011/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 April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Lynn D. Stewart, Clark County Assembly District No. 22

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Linda Whimple, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada
M. Frances Barron, R.N., CEO, Mental Health West, Las Vegas, Nevada; and Chair, State Board of Health
Lesley Dickson, M.D., State Legislative Representative, Nevada Psychiatric Association; and Chair, Governor's Committee on Co-Occurring Disorders
Frank Reagan, Chairman, Southern Nevada Mental Health Coalition; and Lieutenant, Clark County Detention Center, Las Vegas Metropolitan Police Department
A. J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department; and representing Nevada Sheriffs' and Chiefs' Association
Connie Cox, L.S.W., Private Citizen, Las Vegas, Nevada
Marjorie Bull, Private Citizen, Las Vegas, Nevada
Coni Kalinowski, Medical Director, Mojave Mental Health, University of Nevada School of Medicine
John W. Griffin, representing Nevada Justice Association
Jack Mayes, Executive Director, Nevada Disability Advocacy & Law Center
Christina Remmes, Private Citizen, Las Vegas, Nevada
Rebecca Gasca, Legislative and Policy Director, American Civil Liberties Union of Nevada
David Mandzak, Private Citizen, Las Vegas, Nevada
Thomas Newman, Private Citizen, Las Vegas, Nevada
Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Tierra D. Jones, representing Office of the Clark County Public Defender
Alex Ortiz, representing Clark County

Chair Mastroluca:
[Roll was called.] We are going to start with a presentation from University Medical Center of Southern Nevada (UMC). We have had a couple of bills on where UMC is going. There seemed to be a little bit of confusion amongst the Committee, so I asked Ms. Silver to come and talk about the bigger picture of where they are headed in the hopes that we can figure out how those bills fit in and be able to move things along, so that UMC can become the most successful that they can.

Kathleen Silver, Chief Executive Officer, University Medical Center of Southern Nevada:
I appreciate the opportunity to inform the Committee about UMC and its plans for an academic health center concept. You have a PowerPoint presentation in support of my talk (Exhibit C).

For the benefit of those who are from the north and not familiar with UMC, let me tell you a little bit about us—a brief overview—and the role that we play in the community. University Medical Center is an integral part of southern Nevada and has a reach that stretches well beyond the entire state and into the surrounding states of Utah, Arizona, and California, as well as supporting an excess of 40 million visitors a year. We have served the community since 1931. Some of the main services that we provide to the community include:

- The only level I trauma center.
- The only level II pediatric trauma center.
- The only burn center.
- The only transplant program.
- The only children's hospital that is fully recognized and accredited by the National Association of Children's Hospitals and Related Institutions.
- A level III neonatal intensive care unit.
- An award-winning cardiology program.
- The only hospital in the state to have received the very prestigious American Heart Association's Get With The Guidelines Gold awards in heart care and stroke.
- A network of primary care and urgent care centers around the valley that help unload some of the burden in the emergency rooms across the valley.

Let us speak to our concept about the academic health center. This was an initiative that was announced in January 2010 by then Commissioner Rory Reid and former Chancellor Jim Rogers. The idea was to create a public-private partnership and to form a top flight teaching hospital. The goal is to improve the quality of care, advance medical research, and to enhance our philanthropic

efforts. Training future doctors for the state of Nevada is obviously one of our primary interests, working to build and elevate the level of health care in southern Nevada, and to discuss current academic partnerships with the University of Nevada School of Medicine. As I think many of you know, we are the primary clinical campus for the residency programs in the state. We have residencies in family practice, internal medicine, pediatrics, psychiatry, emergency medicine, obstetrics-gynecology, and general surgery. We have fellowships in critical care medicine and oncology, and are looking to develop even more fellowship opportunities.

There has been a lot of discussion over the last few months about a study that was done to help ensure that UMC can remain sustainable. We, in association with the School of Medicine, commissioned a study that looked at two things. Specifically it looked at our governance structure and what would be the best option for us to pursue, and it assessed our operational efficiencies. The discussion of academic partnership or an academic health center was very much a part of this same FTI Consulting study, and FTI Consulting made some observations about that model.

On financial performance, if uninterrupted, expenses and negative trends could lead to an operating deficit in excess of $100 million by 2014. The impact on Clark County's budget is significant, and future support is very limited from Clark County. University Medical Center must be able to improve revenue and reduce costs to sustain any future operations. Sustainable improvements of $44 million per year would be achievable by 2014 if we implement all the recommendations made by the consultants. We are currently working on a plan to do just that.

FTI Consulting looked at the current relationship between UMC and the School of Medicine, and outlined some recommendations for the creation of an academic health center. University Medical Center and the University of Nevada School of Medicine leadership must work together to create a hybrid culture of both community and academic physicians. In other words, we cannot become a Johns Hopkins Hospital look-alike or anything close to that for a period of time. We have to develop, along with the community positions, a model to actually help develop certain centers of excellence in various programs.

We need to expand the School of Medicine faculty so that it is aligned with and accountable to UMC and plays a larger role in the hospital's activities. This would be done through recruitment of outstanding clinicians; recruitment of community physicians who support the academic health center concept and can contribute to the mission of UMC; and recruitment of a group that will build and

develop centers of excellence, increase the quality of care, and link inpatient and outpatient care.

The challenges come from the economic times that we currently face, but in the long term, an expanded School of Medicine faculty through an academic health center helps change the payer mix and provides a foundation for ongoing fiscal stability in addition to improving quality.

Several models were discussed, but FTI Consulting recommended that we pursue what is referred to as a 501(c)(3) public benefit corporation. This would allow the flexibility to meet the needs of the community and the hospital. Under this model, the county commission would transfer direct management of the public hospital to an independent selfperpetuating board. The county also retains specific powers to ensure the public service mission is met. This may include powers such as approving an annual health service plan; approving and appointing a chief executive officer; requiring certain services via a funding agreement based on what finances the government can support; and requiring quarterly or annual reports on the level of services, costs, quality, and patient satisfaction. Under a revised governance structure, there is potential for significant philanthropic support to help support UMC, the academic health center, and the School of Medicine. The governance model is still being discussed by the Clark County Board of Commissioners and the UMC Hospital Advisory Board.

Although many of these issues are in the discussion and planning stages, we are moving forward in this direction to raise the quality of care through the creation of an academic health center. The benefits of this will not only be in southern Nevada, but will benefit the whole state as well. We seek to raise the bar in health care to support not only the academic mission through the School of Medicine, but for the community while looking to increase fiscal sustainability. This will be achieved through performance enhancements to increase revenue by changing the payer mix. With that, I am happy to answer any questions that the Committee might have.

Chair Mastroluca:
Would you explain how the hospital and the School of Medicine are all going to work together to better UMC?

Kathleen Silver:
The bills that you have heard thus far—and it is my understanding you have not heard anything on the medical district yet—bills specifically that we brought to you that addressed the compensation of the advisory board as well as the credentialing of physicians who are on UMC's medical staff, all of this is

designed to move us along this path. In other words, in the beginning we would need a collaboration between School of Medicine physicians and community physicians all headed in the same direction, and all supportive of the academic mission. We think that will raise the level of awareness of what types of services and what level of quality is available at the hospital, and bring in recognized clinicians who can actually give the community some comfort in the level of care that is being prepared there. So for us, we think that sustainability has two necessities. One of them is that we address the operational deficiencies that have been identified by FTI Consulting. The other is to implement the governance model in conjunction with the academic medical center's reach. The School of Medicine will have to expand to be able to do this and we want to help.

Chair Mastroluca:
Do you anticipate the School of Medicine leading the charge as far as the type of medicine that is being pursued, or will UMC lead that charge?

Kathleen Silver:
I think it has to be an absolute partnership. I think that has to be done in a collaborative way. I do not think it is appropriate for the hospital to give that direction, and I do not think it is appropriate for the School of Medicine to direct the hospital in that direction. I think it needs to be a working partnership.

Chair Mastroluca:
Am I correct in assuming that the hospital sees the potential for future funding coming from having this academic partnership and being able to basically have a product, which is better health care for the community?

Kathleen Silver:
That is correct. Part of the sustainability from the revenue side, or to increase revenues, would be to make us a destination for health care, to have the community recognize us as the place to go if you want the best health care in the community.

Chair Mastroluca:
I know you do not have a firm timeline, but are we talking 5 years or 20 years?

Kathleen Silver:
You are probably talking about somewhere between a five- and ten-year time horizon, the biggest component of which is the need to recruit additional faculty and staff for the School of Medicine, in addition to the School of Medicine being able to expand certain teaching programs which currently are not in place. Schools of medicine evolve. They develop residencies in more specialty

programs. That does two things. For example, if you have an internist—we have residencies in internal medicine—and he wants to go into cardiology or gastroenterology, we cannot currently do that. We lose those residents to other states with other programs. So by keeping them and making those programs available within Nevada, we believe that we could not only improve the care here, but we could improve the School of Medicine's ability to make those services available.

Assemblyman Livermore:
While I probably do not possess a background for the complexity of what UMC is going through with the teaching hospital, I do have a little bit of involvement in transition. Originally I was an elected hospital trustee at a community hospital and we did open meeting laws, et cetera. One of the things a 501(c)(3) requires is to have a fiduciary responsibility. The first and utmost role is the fiduciary responsibility of that facility that you agree to serve. How do you see that role—working together to make sure that the commission that UMC currently serves is retained with that fiduciary responsibility of making sure that the hospital has enough resources to sustain itself? It will not receive any potential property taxes or other things like that once it converts to being a 501(c)(3).

Kathleen Silver:
One of the best parts of the model that is being proposed by FTI Consulting in this 501(c)(3) public benefit corporation is that it allows the county to make it imperative for us to retain the hospital's mission. In addition, it allows us to keep some of the things that are very positive about being a public entity, or quasi-public entity. Specifically, part of our funding mechanism comes through what we call intergovernmental transfers that are made on behalf of the county to the state, matched with federal monies, and then come back to UMC in the form of disproportionate share dollars and upper payment limit dollars. So we get to keep what is very positive about being the community's hospital, about being a quasi-public entity, but yet we get to drop some of the things that make it challenging to operate in a highly competitive business environment.

Assemblyman Livermore:
That is exactly what I was referencing. You get to drop what is challenging. Now will the hospital that I was part of—and just for your information, still am—one of the things the county did because it is a sole source hospital, is the purchase of the hospital went along with the agreement that indigent care would be served for the life of the hospital. But you come from a valley that has eight or nine for-profit hospitals and I do not know how everyone shares in indigent care down there, but there are going to be some tough decisions made

by the governance body. I just say that and put it on the table as you develop this model and move forward. Those are decisions that may be unpopular.

Kathleen Silver:
I think that is why it is an important discussion to have. The county would negotiate with the public benefit corporation for the services that it actually would mandate us to provide. While we would not have worked through all of those discussions at this point, looking at other models across the country where this has been done, the county typically requires of the former county hospital to maintain its mission, and to have a responsibility for a portion of the indigent care. In southern Nevada, all the hospitals participate in indigent care. Clearly it is easy to say that we have the largest amount of indigent care, and when we refer to indigent care we are talking about the care delivered under the eligibility requirements of the Clark County Social Service Department. So all of the hospitals are eligible to participate. What happens, however, is because Clark County Social Service does not pay for professional fees, indigent patients are not as welcomed, perhaps, in some of the other hospitals because it is hard to get physicians to take care of them. All of this would be negotiated between the county and the new entity as to what needs to be retained by the hospital. There would be no ability to eliminate services, for example, without the permission of the county.

Assemblyman Livermore:
Best of luck.

Assemblyman Hambrick:
You have spoken several times about the need to increase staffing and education. A lot of us are used to competition in sports, but it is nothing compared to the medical community, and the recruiting of research people. You mentioned several subspecialties. We have Phoenix and the Mayo Clinic on one side of us, and the Los Angeles basin and San Francisco on the other side of us. I understand you have a plan and you mentioned the community several times, and we hope at some point to have medical tourism, but what plans do you have to recruit the best of the best? We have a lot of benefits in this community, but we have some drawbacks, as we all know. How will you address trying to get these people away from where they are now? They are going to try to hang onto those people as best they can, and they may have some incentives we may not have. Would you address that, please?

Kathleen Silver:
You are right. It is a very competitive environment to recruit physicians, and it is not always easy to recruit physicians to southern Nevada. In certain specialties that are highly competitive, we would perhaps collaborate with the

community group that has an ability to recruit and attract some of those specialists. We have a community group right now that is interested in a partnership, a tripartite way of doing business between the group, the School of Medicine, and the hospital, where they would develop a residency program in urology. It would be almost impossible to do this from scratch without that collaboration, because you would have to hire four or five urologists to be able to develop a significant program within the School of Medicine itself. So what we would envision is there would be some physicians who would be hired by the School of Medicine and some physicians who would be hired by the group.

There are other markets around the country which, believe it or not, still make us look pretty darn attractive. In Los Angeles—the Los Angeles basin which you mentioned—orthopedic surgeons, particularly in academics, probably earn in the neighborhood of $250,000 per year. An orthopedist in our community in southern Nevada can certainly make double or triple that. So we are still pretty attractive to certain specialties by comparison. It would have to be some kind of a hybrid model that would allow us to expand in conjunction with the community and with the School of Medicine to make that happen and to grow that type of program as quickly as we would like to.

Assemblyman Brooks:
Thank you, Ms. Silver, for that presentation. You mentioned going to a nonprofit model and then you mentioned the ability of dropping or eliminating some services. Can you expand on what those services might be? What type of issues do you foresee with taking a hospital that has been a quasi-public hospital to being a total nonprofit entity? What are the benefits and the risks? One of the things I know we have been worried about is accountability. So if an elected official gives up that accountability, who is to hold the hospital responsible? Would you elaborate on that?

Kathleen Silver:
I think that maybe part of what I said was misunderstood. We are not talking about the ability to eliminate services. What we are really talking about here is dropping some of the things that make us less agile as a public entity, specifically the adherence to state procurement and open meeting laws and things of that nature—not with any disregard to the need for transparency. I think most of you know that we have been on the front edge of transparency, particularly as it relates to our performance measures, in southern Nevada. We are not afraid of doing that. It was a little humbling at first, but it is growing on us, and we are getting used to it. We are actually a nonprofit now because we are a public nonprofit hospital. This 501(c)(3) public benefit corporation is a different model, and it is the public benefit corporation that ensures that the

needs of the community and the needs of the public are still being met by the new entity. The accountability for the behavior and the activities of the hospital would come from a new board, but there would be a plan that would have to be developed between the county and the new board. For purposes of this discussion, we will call it a health services plan, and it would outline what the expectations are for the new entity and what services would be expected to be provided by the hospital on an ongoing basis. Any discussion of elimination of services would have to still be approved by the county commission, that would still own the hospital. They would lease the property, if you will, to the public benefit corporation. So the county still maintains an ownership role. It would lease the asset to the new corporation.

Assemblyman Brooks:
What liability will that leave Clark County officials? We have all witnessed things that have occurred over the last couple of years, and that has been with more or less intense oversight of the Clark County Commission. Would this allow that nonprofit to veer off and be a little more autonomous? How long would it take before the county can recognize financial problems that we have encountered over the past?

Kathleen Silver:
What we would expect to see is a regular accounting back to the Clark County Commissioners for whatever financial performance, patient satisfaction measures, or performance measures that the county would like to see from us. I would not presume that there would be any less accountability back to the elected officials.

We are one of only five county hospitals left in the nation that operate under this current governance structure. Most county hospitals have gone to a different model. The benefit is that the county gets to keep the things that are positive for the hospital and does not have to adhere to state procurement and open meeting laws. It is very difficult in our highly competitive market in southern Nevada. For us to discuss our plans, our business options and plans in an open meeting where our competitors can come and basically hear what our opportunities are and where we are headed, it is not typically the way you would like to do business. Did I answer all your questions? I think there was a third question that I might not have answered.

Assemblyman Brooks:
It was in regard to the accountability factor. How do we manage that?

Kathleen Silver:
I would envision the county would continue to require a regular financial reporting back to the commission for how the hospital is performing in the categories of finance, patient satisfaction, and performance measures. I think that is the way most of these entities are structured today, with that kind of connection back to the governing body.

Assemblyman Livermore:
You are completely right. You get your competitors out of your boardroom. Not only do they get a copy of your open meeting, they get a copy of every financial statement you have, every business plan that you make, and every strategic plan because they are there listening to what you say. I cannot agree with you more. Washoe Medical Center went through this thing about ten years before Carson City did. We had two hospitals in northern Nevada that basically possessed this type of model. So it has been done successfully, and I think you are probably moving in the right direction. As always, the devil is in the details. I think you are going to operate in a business environment that is going to allow you to make the right choices that you need to make.

Assemblyman Frierson:
I heard several examples of areas of specialty, but I wonder if you have a comprehensive number. Do you have the total number of specialties, just so we can get an idea of the bulk of it?

Kathleen Silver:
Right now we really have no specialty residencies or fellowships, other than the couple that I mentioned, which are oncology, surgery, and critical care medicine. What we would like to see are programs in ENT (ear, nose, and throat), urology, gastroenterology, cardiology, pathology, and radiology. The list is probably as long as your arm, but that would be the plan. When you look at fully evolved and developed medical schools, you would expect to see a panoply of residency programs. You would not be limited to primary areas of medicine.

Assemblyman Brooks:
Will this new model allow you to receive grants, scholarships, and other types of funding? Is that one of the motivations for changing the model?

Kathleen Silver:
It is very challenging to get philanthropic support for a tax-supported institution. A lot of times people who might be willing to write a check to a foundation or a 501(c)(3) nonprofit do not want to write it to what they see as a government entity. It is kind of like sending a check to the Internal Revenue Service (IRS)

when you do not have to. I think it is a way for the hospital to attract more research dollars and more philanthropy by changing the model. I think the research dollars come from the expansion of the School of Medicine and its programs. The philanthropic support would come from the acknowledgement by the community that we are a different model.

Assemblywoman Pierce:
You might have touched on this, but can you explain the whole medical district part of this?

Kathleen Silver:
The discussion—which you probably know as Assembly Bill 54—has not been heard yet by this Committee. The medical district is really a parallel idea to move the hospital in a slightly different direction, and I think would probably happen if the governance structure did not change. So if the Clark County Commission decided, for example, not to follow the recommendation of looking at a 501(c)(3) public benefit corporation, it may be able to evolve the hospital into a medical district that would allow certain other benefits.

Assemblywoman Pierce:
Actually, we have heard that bill. So these are not two different tracks?

Kathleen Silver:
There are two different paths, both with the same ending, but just a different way to get there. Both have the idea of academic health center in mind, but a different approach.

Assemblywoman Benitez-Thompson:
This is obviously a big project and you folks have a lot of years ahead of you. Can you give me an idea of what the next big steps are? I know applying for a 501(c)(3) can sometimes take years, especially with the IRS going through the financials. Is there an initial 5-year, 10-year, or 15-year plan?

Kathleen Silver:
It is probably going to be predicated on the commission's decision to send us down the path of a 501(c)(3) or to send us down a different path. I think that the time frames will change depending on the direction we get from the commission related to governance. I do not mean to be vague about that, but it is just the reality of circumstances that we are in right now.

Chair Mastroluca:
Are there any other questions? [There were none.] Thank you, Ms. Silver.

We are going to open the hearing on Assembly Bill 94, which authorizes involuntary court-ordered admission of certain persons with mental illness to programs of community-based or outpatient services.

Assembly Bill 94: Authorizes the involuntary court-ordered admission of certain persons with mental illness to programs of community-based or outpatient services under certain circumstances. (BDR 39-273)

Assemblyman Lynn D. Stewart, Clark County Assembly District No. 22:
Before I present the solution, let me present the problem. We have a significant group of mentally ill people who, on a regular basis—usually about a monthly basis—become irrational, violent, and are in need of medical mental care. Most of these people are on medication, do not take the medication, are picked up, are subject to a hearing, and are committed to Rawson-Neal Psychiatric Hospital, which costs approximately $850 per day. The average stay is about five days, so there is a very significant cost of over $4,000.

Forty-four states have come up with a solution similar to what we call Kendra's Law in New York. Other states have called it Arabella's Law. This was brought about by individuals with mental problems who acted violently and in some cases killed their own family members. I believe you have letters from various people that bring to light these various issues that have arisen. Our solution is twofold. One, we want to protect the general public and these individuals who have these mental problems from harming themselves or others. So our first concern is the safety of the individual and the safety of the public; the second is an economic factor in light of our economic conditions today. We would propose an order being issued by the court whereby these individuals, if they did not take their medication as they should, would be picked up and taken to an outpatient facility where they would be given their medication. Oftentimes it is a shot, which is an expensive shot somewhere around $800 to $1,000, but significantly cheaper than going to Rawson-Neal Psychiatric Hospital and spending several days there at $850 per day. So the intent of this bill is to provide for the safety of the individual who has this mental condition and the general public, and to provide a more economical solution to the problem.

I have witnesses down in Clark County. I very much appreciate them being there. They have been there for an extra couple of hours, and I would like to say that that is not the Chairwoman's or my fault; it is just the way the Legislature works sometimes. I have a number of people who have expressed concerns about civil rights, including law enforcement agencies, the American Civil Liberties Union, the Department of Health and Human Services, and the public defender. I have worked with all of them to try to come up with

solutions. Some of them have proposed amendments, which I am agreeable to. But this is a very, very serious problem and I am willing to work with them to reach solutions so that their concerns are alleviated. With that, Madam Chair, and with your permission, I would like to turn it over to witnesses in Las Vegas.

M. Frances Barron, R.N., CEO, Mental Health West, Las Vegas, Nevada; and Chair, State Board of Health:

I am a registered nurse of 44 years, and I am the Chair of the State Board of Health. I am also on the Southern Nevada Mental Health Coalition, which is a group of folks in southern Nevada who come together once a month to try and resolve the issues related to the mentally ill. I also represent a company called Mental Health West, which is a group of psychiatrists who own and operate a mental health system of care.

I am very, very concerned about Assembly Bill 94, and I see that as a real turning point in something we can do from a grassroots level to improve the care of the mentally ill. As I see it, the problem is wasted lives and ill-spent resources (Exhibit D). The severely mentally ill are crowding Nevada's emergency rooms to overflow. The same most severe mentally ill are circulated and recirculated from jail to emergency room to outpatient facility to state-paid inpatient facility over and over and over again, using and reusing the scarce resources available for the mentally ill. In the first quarter of 2011, 340 inpatients were readmitted to Rawson-Neal Psychiatric Hospital less than 30 days after a discharge from Rawson-Neal Psychiatric Hospital. With the average length of stay at Rawson-Neal Psychiatric Hospital at five days and a cost to the state of $850 per day, that is a cost of nearly $1.5 million just in one quarter. These same nonproductive folks are leading lives dependent on Nevada's shrinking social services without a treatment plan that addresses their primary problem.

What is the solution? I honestly believe it is mandatory outpatient treatment. Mandatory outpatient treatment has been enacted in 44 states. Mandatory outpatient treatment has been proven to lower the risk of violent behavior, reduce suicides, and enhance the capacity to function, despite problems with mental illness. Mandatory outpatient treatment saves lives and saves money.

How would it work? That is a question that I am asked and have discussed with Assemblyman Stewart. The answer is an integrated community approach. First, pass this legislation. Then allow the existing community capacity to integrate and develop the current resources in geographic regions to put together an initial plan. We are not saying that mandatory outpatient treatment is the panacea that is going to cure all mental health problems. We are saying

we need to address this and do what 44 other states have done and have this available for those patients who need it most.

What we suggest is a demonstration pilot program in Clark County and Pahrump for a two-year period. Southern Nevada Adult Mental Health Services (SNAMHS) outpatient physicians already see these patients. We see mandatory outpatient treatment as a resource for our judges, the judicial system, and that will assist in reaching the objectives of the mental health court. Intensive case management is a keystone of mandatory outpatient treatment. Intensive case management and life skills training will be provided through grant and research funding. Let the community capacity come to the table and help the public groups that are currently working on this get it done once and for all. The supported living assets exist in the community. Coming together as an integrated system of care, we know we can make a difference and keep these people from killing each other, killing themselves, and hurting our state's children.

Assemblyman Hambrick:
I appreciate the fact of continuous inpatient readmittance. I have more of a pragmatic question: What would be the mechanics if this bill were enacted? Where are most of the individuals that are released? Would you find them at home or walking on the streets? I take it that our law enforcement community would be expected to pick up these people. It is going to be time consuming. Are they going to be patrolling the back streets and alleys and where these people sometimes walk or hide? It could be a logistical nightmare to expect the law enforcement community to go out and get—you gave us a number—people that have been consistently readmitted. Then would they be released or would they be held? I read the bill, but what about the mechanics of how all of this is going to be accomplished? I would like to have some explanation. As a former law enforcement officer, I do not know whether there are constitutional questions. I just see some problems coming down the pipeline on this.

M. Frances Barron:
That was an excellent question, and let me clarify. The key component of a mandatory outpatient treatment system is intensive case management. We would identify these people by having them in an intensive case management system. Once the judge would identify that this person needed mandatory outpatient treatment for protection of himself or herself and others, then he or she would fall into an intensive case management system that the community would underpin and provide. This intensive case management system and life skills training would be provided through grant and research funding that we are currently working on. I have spoken with several funding sources, and there is a real interest in doing a pilot program in an area such as ours, southern Nevada

and the Pahrump area. As you know, we have the highest suicide rate anywhere, and we feel that we have a very compelling program that can be put together as a partnership with those that are already providing it. I hope that answers your question. The intensive case manager would know immediately if the patient had chosen not to return for his monthly injection. It is a monthly injection. Compliance is one of the biggest problems with making sure that people get their treatment and stay on their treatment. As I know from being a nurse for so long, health care is touching the patient and keeping in contact, and that is what intensive case management does.

Assemblyman Stewart:
Mr. Delay from the Las Vegas Metropolitan Police Department has an amendment that would address some of Mr. Hambrick's concerns.

Chair Mastroluca:
My question would be based on what was just said, and I apologize for jumping ahead of the other folks who are waiting. You mentioned there was grant money available that was currently being pursued. This would be very expensive legislation. I have a lot of questions, because a lot of these things that are referenced relate to *The Executive Budget*, and there are things in this bill that will no longer exist if the Governor's budget passes. I have a lot of questions about the fiscal responsibility of this and what your backup plan is if the grant funding does not come in.

M. Frances Barron:
This bill says it is not a mandatory issue; it is only if the county has the capacity to provide the services. We are asking to pass this bill, and give us an opportunity to put a grant together for intensive case management. Let me tell you that Southern Nevada Adult Mental Health Services already sees these patients. That is part of the outpatient treatment that the mentally ill do receive. Certainly the supportive living assets exist in the community. They exist with the current systems of care such as the Salvation Army and the other nonprofits that provide assistive supported living. I hope that answers your question.

Chair Mastroluca:
It does, thank you. I appreciate the clarification that this is enabling language. I would be very surprised if the county had the capacity to do this. Some of the SNAMHS programs are slated to end due to lack of funding.

Assemblyman Anderson:
We are not mandating any new commitment procedure, correct? This is just giving the court an option in addition to the existing ones—involuntary commitment to inpatient mental health facilities, correct?

M. Frances Barron:
If I understand your question, Mr. Anderson, yes, it is an optional mandate that the court may decide to employ. Did I understand your question appropriately?

Assemblyman Anderson:
That is correct. I want to make sure because I am not very familiar with mental health issues. We already provide for involuntary commitment in some cases. We are just adding additional options, whether they are community based, like nonprofits, or other social services, correct?

M. Frances Barron:
Yes, sir. If I may give you an example, being the Chair of the State Board of Health, I was aware that there was a patient that went into SNAMHS on a "Legal 2000," which is a mandatory admission. The person was determined to be a danger to himself and others, particularly others. The patient was put on oral medication and stabilized. While the patient was on his oral medication he did just fine and was stable. The family, however, requested that the patient not be discharged because they would have felt in danger if the patient would have been discharged. The patient had to be discharged because he was stable. The patient went home, stopped taking his medication, and it became a circular issue. I hope that helps you understand.

Assemblyman Anderson:
It does, thank you. That is what I thought and that is the way I read the bill, but I wanted to double check. You are talking about mandating that people go somewhere. It is just something I wanted to clarify and make sure.

Assemblyman Stewart:
I wanted to add that at the bottom of page 8, section 12, subsection 2, it states "A court shall not admit a person to a program of community-based or outpatient services unless . . . outpatient services is available in the community . . . ." I think that might be helpful to you as well.

Assemblyman Livermore:
Is that a mental health court, a drug court, or a general district court? What kind of court is it?

M. Frances Barron:
Yes, there is a mental health court, a criminal court in Las Vegas, and a civil court. It could be any one of those. Judge Jackie Glass oversees the criminal court, and Judge William O. Voy oversees the civil court.

Assemblyman Livermore:
I appreciate you sharing that with me. You reference "frequent fliers." They go in one program, out one program, then in one program, and out the other program. You are completely right about the community-based outpatient service of case management. That is the only way you are going to monitor and that is the only way you are going to make sure that these individuals take their medication. I guess the question is, are you going to provide them those medications and if not, who is?

M. Frances Barron:
Currently those medications are being provided by the SNAMHS outpatient department. The problem has been compliance.

Assemblyman Livermore:
Right. Get them to come in and pick up their medication, and that is what intensive case management would do. There is a huge cost with that. I am also concerned about potential Health Insurance Portability and Accountability Act (HIPAA) violations. I think a patient is entitled to privacy under certain conditions, and I would make sure that you verify that too.

M. Frances Barron:
I know the HIPAA regulations on this would allow the judicial system to preempt it. This would only be done under a partnership with the judicial system, with the medical health system, and with the police system. The other place that these patients end up in is jail.

Assemblywoman Benitez-Thompson:
I want to make sure that I understand the population that you are trying to target, because as I read this language, I feel like the scope is really broad. So is your intent to get at those folks who are known within the system to have a mental health diagnosis? I have a feeling that is who you are trying to get at, correct?

M. Frances Barron:
Thank you for the question. Yes, we are. But it would only be a patient who was identified by the team, and the key components of that team are the judge and the psychiatrist. They would identify the patient. It is not for everyone. It is just those that are a true, true danger to self and others.

Assemblywoman Benitez-Thompson:
I do not see any language in the bill where there needs to be an actual diagnosis. I think there are a lot of folks who might present with mental illness-type behaviors, but in fact it could be substance abuse. It does not necessarily rise to the level of addiction, or it could be a couple of different things. So I want to make sure that somewhere in here is an actual diagnosis of a person with mental illness. I do not see that language and I would want to specifically see it.

Once again I think section 2 is very broad. I think the intent is to funnel someone into a mental illness program that might provide a number of different kinds of services like vocation rehab, or drug abuse treatment, therapy, and counseling, but the way I read it is you can send someone into a program for vocational rehabilitation that really has nothing to do with mental health treatment. I think there is some work to tighten down and get to the population that you are trying to target.

M. Frances Barron:
I believe that the bill specifically exempts those people who are involved in short-term alcoholic consumption and short-term drug abuse. I will have to go back and reference and perhaps Assemblyman Stewart can help me—part of the bill does have a physician diagnose the patient with a disorder that can be helped. The second question you had is in terms of the community services in intensive case management. Intensive case management involves life skills training and supported living systems. We agree that people need to think of something else to do. Once they are medicated they start getting better. They need to think of something else to do besides thinking about taking drugs or abusing alcohol and having a co-occurring disorder. Part of this is life skills training and helping these people understand that they can lead productive and functional lives if we can have them in a treatment plan that is appropriate for them.

I have Dr. Lesley Dickson here. One of her many specialties is co-occurring disorders, and maybe she could address that.

Assemblyman Stewart:
I would like to refer you again to the bottom of page 8. "The person has a history of noncompliance with treatment for mental illness which has been a significant factor in the need for his or her hospitalization . . . ." He has been involved in one or more acts of violent behavior, and has a history of noncompliance. I think that tightens it up fairly well.

Assemblywoman Pierce:
We have the most underfunded mental health system in the country. We have the least number of mental health beds in the country. Our prison system essentially becomes our mental health system, which is a very expensive way to do things. I am a little surprised. This is sort of a big government bill, Mr. Stewart. There is no question about this. I would be interested in looking at how other states do this. Untreated mental illness is not good for people and is not good for their families. If we are making the decision to have a fully functioning mental health system and ceasing to use our prison system as a mental health system, it is going to cost some serious money. I know where to get it, but do you?

Assemblyman Stewart:
To the contrary, Assemblywoman Pierce. We are actually saving money here, but the treatment—which in most cases is a shot—runs about $900 to $1,000. That is one shot per month. If we send them to Rawson-Neal Psychiatric Hospital, which nearly always happens, then it is $850 per day for an average stay of five days, which would be over $4,000. So we are saving around $3,000 per person.

Chair Mastroluca:
Are you aware that in the Governor's budget there is a plan to close 22 beds at Rawson-Neal Psychiatric Hospital?

Assemblyman Stewart:
Yes, I am. This would be better for us all.

Assemblywoman Pierce:
I agree that in the long run this will save money. There is no question about it. Liberals like me have been saying for 20 or 30 years that there are much cheaper ways to go than using the prison system as a mental health system. There is an initial cost to getting these kinds of programs working, and making that transition from a fully functioning prison system to a fully functioning mental health system. I am interested in talking about that, but everyone has to bring some dough to the table.

Assemblyman Stewart:
I appreciate your support, Ms. Pierce. We have agreed on many things over the years, and this is going to be one of them. I am relying on Ms. Barron to come up with some grants to get it started.

Assemblywoman Benitez-Thompson:
I struggle with the idea that just being mentally ill in and of itself is a crime, and that we should force people to end up in programs when they may or may not be willing or ready to do that. I think especially in the case of substance abuse you might have someone who is kind of known out there, but research tells us a person relapses eight times before he gets well, so that relapse could be on that road to recovery. I am wondering why outpatient as opposed to inpatient. If these people have a couple of different mental health issues going on, a shot once a month is not going to take care of it. I get it that you are trying to build a supportive network around them, but if you really wanted to get at this, then why not inpatient?

M. Frances Barron:
As we have discussed, inpatient care costs $850 per day. Many of these patients have been inpatients. Many of these patients who would go on mandatory outpatient treatment would spend five days getting stable in an inpatient environment and then be discharged to intensive case management with mandatory outpatient treatment, which would be a monthly injection. This would end or make a big difference in what we call the revolving door.

Let me give you the example of how this thing got started. In 1999, a law was passed in New York and it was called Kendra's Law. It mandates outpatient care for New Yorkers with psychotic disorders and other mental illnesses. It was named after Kendra Webdale, who died after being pushed in front of a New York City subway train by a schizophrenic man who had skipped his treatment. He just did not take his medication. We have seen this time and time and time again. If you read the Las Vegas paper or the Reno paper, you see people who are committing suicide, people who are killing others, and people who are hurting their children. One hundred percent of these people are not mentally ill, but some of them are. We have people who want to testify here who are going to tell you about some of these cases that could have been prevented with mandatory outpatient treatment.

As I am a businessperson, I would like to address the money issue. These people are currently being seen at the outpatient department at Rawson-Neal Psychiatric Hospital. They are currently getting medication. They may not be getting this injection and we have no way of getting them back. They see them first at the county jail or they see them first at a readmit to an emergency room. It would be cost saving. I know it is hard to believe, but it would save money.

Lesley Dickson, M.D., State Legislative Representative, Nevada Psychiatric Association; and Chair, Governor's Committee on Co-Occurring Disorders: I am the former president of the Nevada Psychiatric Association and now serve as the State Legislative Representative; I am a member of the Nevada Psychiatric Association, and I am Chair of the Governor's Committee on Co-Occurring Disorders. The Co-Occurring Disorders Committee took a lot of testimony over the last 1 1/2 years looking at this problem of the mentally ill in the criminal justice system. We see the same thing as Ms. Barron was just describing with Southern Nevada Adult Mental Health Services. The same people are going back and forth between all these places, and there is a lot of disorganization and lack of communication between the separate agencies.

Assembly Bill 94 will get things organized. There will be a treatment plan put together for these patients that incorporates an outpatient setting and helps people coming out of the hospital. I think it is important, given some of the questions, that people understand these patients almost always will be starting at Southern Nevada Adult Mental Health Services at Rawson-Neal Psychiatric Hospital. People who have similar problems who are jailed frequently get referred to mental health court. This is a separate situation for those who have not gone through the mental health court; this is for patients who have not committed too many criminal acts. They may have been in the jail for being homeless or walking the streets, but usually not for violent criminal acts. As far as mental illness, yes, they have all been committed to Southern Nevada Adult Mental Health Services at one time, and if you understand commitment law, you will know that they have to have a mental illness in order to be committed. So they have already started with a diagnosis, and there has been a treatment plan established in the hospital. This is a way to keep that treatment plan going.

As far as the cost, I know everyone says there is a huge cost, and I suppose if this bill went into effect October 1, and it applied immediately on that date to the 100 or so patients that Ms. Barron described, yes, that would cost some money. That is not the way you roll out a program like this. This is a program that we start up patient by patient by patient, and it would probably take years to address all 100 patients that we are talking about. It will help those of us who take care of these patients. For instance, when they are ready to be discharged and we are giving them their medications, they tell us they are not going to take them, and so long. This will try to stop some of that behavior. We know that if they do not take their medication, their psychotic symptoms will reoccur and they will go back to engaging in the behaviors that are so troublesome to us and their families.

On a personal note, I lived in New York City when Kendra Webdale was killed. It happened at my subway stop. This was a horrific thing for all of us in the mental health system to experience, because some of my friends even knew this patient who pushed Kendra. We felt very strongly that we needed to do something, and I was very proud that New York State took the lead in putting together the first law. They then put together the first model program at Bellevue Hospital Center. It has been very successful. It has been expanded to several other community mental health systems in New York State.

I sent a copy of Dr. E. Fuller Torrey's editorial in the *New York Times* "Make Kendra's Law Permanent" from May 31, 2010. Those of us in the psychiatric community know that if E. Fuller Torrey endorses something like this, it is serious, because he is a bit of a skeptic about a lot of things. He worked for many years at Saint Elizabeths Hospital in Washington, D.C. He knows mental illness. If Dr. Torrey thinks this is a good thing, then I think a lot of us think it is a good thing. I will stop there and take any questions. I think Ms. Barron really covered most everything.

Chair Mastroluca:
Since you seem to be so familiar with the process that you are advocating for, as well as the current process we have now in Nevada, can you tell me why this is so much better than the mental health courts that we currently have operating?

Lesley Dickson:
Mental health court comes out of the criminal court system. These are people who have been in significant trouble with the law. They are not your public inebriants or the people who are found homeless wandering the street. These are people who are being adjudicated for some kind of a misdemeanor or minor felony. There are a limited number of spots. I believe Clark County has only 100 spots. It is a very highly intensive program. This is a complement to the mental health court for the other group of patients who have not ended up in the criminal court system.

Chair Mastroluca:
Are there questions for Dr. Dickson? [There was no response.] Are there still people in Las Vegas to testify in support of A.B. 94?

Frank Reagan, Chairman, Southern Nevada Mental Health Coalition; and Lieutenant, Clark County Detention Center, Las Vegas Metropolitan Police Department:
I signed in as neutral on this bill because I have two positions, which I will go into briefly.

First, as you have heard from two distinguished members of the Coalition, there is a lot of motivation and education on the Coalition which supports A.B. 94. As the Chairman of the Coalition, I want to voice the support of the Southern Nevada Mental Health Coalition for the bill, and for Mr. Stewart's support and pushing of the bill.

I also have to show concern with section 16, which has already been brought up, but that is the law enforcement aspect. The Las Vegas Metropolitan Police Department (LVMPD) Office of General Counsel and Office of Intergovernmental Services will be putting information forward to Mr. Stewart with their concerns on some of the response protocols and how the verbiage has a little bit of ambiguity in section 16. I will take any questions.

Assemblyman Stewart:
I think Mr. Delap has reached a compromise amendment that takes care of the police issue on this. Thank you.

A. J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department; and representing Nevada Sheriffs' and Chiefs' Association:
I am sorry for the confusion on this. I am a former student of Assemblyman Stewart and through all his efforts he has brought us to neutral on this bill, so we are going to work through that.

It is a conceptual amendment that we received just before this Committee started. Primarily, our concern has to do with the warrantless pickup order, or the vagueness of that order. Police in general get very concerned about making an arrest or taking people into custody without specific information about the purpose. Our conceptual amendment—and I will be more than happy to get that to this Committee as soon as I finish—is to simply change the language from "shall" to the word "may." We would like to add language that would allow us to conduct a welfare check of the person with the understanding that there may be issues that could lead to what we call a "Legal 2000." If the person is a threat to himself, to others, or unable to take care of himself to a certain degree, then we would pursue that Legal 2000. It would not be a mandatory pickup per se, and it would be based on the circumstances of when we come into contact with that person. That is the meat of the amendment, which I will have to you soon.

Chair Mastroluca:
By soon, you mean by the end of the day tomorrow, correct?

A. J. Delap:
I can have that for you by the end of the day today.

Assemblyman Hambrick:
Where are most of these individuals found? Are you confident you could go to residences, or are they going to be out walking in the community? Many of the people who have these problems are wanderers, as you know. So where are you going to find them?

A. J. Delap:
I am only talking off the top of my head here after reading the bill several times, but it sounds to me like there is going to be pretty good documentation on them. In order for them to be in the program, it will probably be more than just the general mentally ill person who is getting rotated through the system. I think they are going to be identified and evaluated—probably fairly extensively—and documented. I would assume, based on the way that this bill is written, that there will probably be fairly significant information about his whereabouts, but I am sure it would not be 100 percent.

Chair Mastroluca:
As we move on, I really just want to hear from people in support of the bill. We are not at neutral yet, so if we can just stay with people who are supporting the bill in Las Vegas, will the next person please identify yourself and give your testimony.

Connie Cox, L.S.W., Private Citizen, Las Vegas, Nevada:
I will first give you some background on myself, and then tell you a story that will bring home the scope of this problem. I will then offer some facts that support A.B. 94. I am a psychiatric social worker who has practiced in Nevada since 2007. I am here in this capacity to testify on behalf of A.B. 94. I am presently an inpatient social worker at Rawson-Neal Psychiatric Hospital in Las Vegas, but I want to make it clear that I am not permitted by my employer, the Division of Mental Health and Developmental Services of the State of Nevada, to testify on its behalf. They do not support this bill. I am here representing myself as a social worker.

I have an active license to practice social work in the state of Nevada and I have inactive social work licenses in Montana, Michigan, Ohio, and Pennsylvania, and have practiced in all of these states except Ohio. My scope of practice has included aspects of psychiatric social work including group homes, inpatient settings, outpatient therapy settings, and in my own limited private psychotherapy practice. I have worked with all age ranges with managed care and for the state system of my current employ. I have worked across my

career with co-occurring disorders in diverse populations, as well as economic statuses. I have attended national and international conferences on various psychiatric topics. I am currently working with a population that includes the homeless mentally ill, the bulk of which have co-occurring disorders. I am on a team in the hospital that includes a psychiatrist, a psychologist, a nurse, an activity therapist, and another social worker. Our team is fortunate enough to have as its lead, Jacob Manjooran, M.D., who was recently voted as one of the top doctors in Las Vegas by *Vegas Seven* magazine. I mention my team now because although the Division of Mental Health and Developmental Services does not support my testimony here, my team does, and both my team and I deal with these individuals on a daily basis and this is why I felt I needed to explain my credentials to you.

I am now going to tell you a story. It is about a man. This man does not have a mental illness and he does not need medication. This man is riding in the back of a police car. The police are taking him somewhere and he does not know why. He is poked and prodded by the young doctors in the emergency room, he is placed in an ambulance and then he is brought to Rawson-Neal Psychiatric Hospital, where more people ask him stupid questions. They keep asking him why is he here, and he cannot tell them. Finally, he gets to my unit on H4A and yet again is asked, "Why do you think you are here?" He says, "I do not know why I am here; the police brought me here." He cannot remember taking his clothes off and wandering in the fountain at the Bellagio. He cannot remember that he was pissed when his swim was interrupted there. We ask him, "When was the last time you took your meds?" He tells us, "Two weeks ago." He left the hospital at that time with follow-up appointments for psychiatry, group therapy, and psychosocial rehabilitation. I ask him why he did not follow up with treatment—the specific treatment that we recommended for him—and he replies, "I am not mentally ill, and I do not need treatment and I do not need medication." Further assessment reveals that he is hearing voices and the voices told him to go into the fountain at the Bellagio.

This man has been diagnosed with schizoaffective disorder since he was 30 and he is now 59. He has been at our hospital at least 20 times in the last 2 1/2 years. In fact, he is in the hospital more often than he is not. He has burned through one case manager after another, and the group homes cannot hold him because he is a wanderer. It is always the same old story. He does not have a mental illness and he does not need medication. Now each time he comes into our hospital, it costs the taxpayers $850 per day, and remember, he is in the hospital more often than he is out, and there are at least 20 or 30 more like him in our system. Do the math. He and his friends are costing the State of Nevada hundreds of thousands of dollars per year for inpatient services. If a tally were truly taken on the enormous cost of this, I think it would be well

beyond the $200 million mark. Why is this cost like it is? Because these people do not need medication and they do not believe they are mentally ill. That is right. He does not need to take medicine. That is his right and he does not have to. Now if he were in the hospital, we would get a court order to help him take his medication. No such possibilities now exist in the land of the outpatient clinics in southern Nevada. Those in the land of the outpatient clinics basically just have to wait until they get so sick they become a public nuisance, are harmful to themselves or others, and then finally meet the criteria for admission to Rawson-Neal Psychiatric Hospital.

Now what does this high recidivism rate at Rawson-Neal Psychiatric Hospital really mean? First, we are treating a large group of people who are not mentally ill and do not need medication. Second, these people who are not mentally ill and do not need medication are receiving necessary treatment on an inpatient basis only. They are utilizers of expensive services repeatedly and often at the cost of $700 per day per person. Third, those people who are not mentally ill and do not need medication create hidden costs to the financial fabric of Nevada for the police, the medical hospitals, and the incarceration facilities that wind up dealing with them when they somehow do not make it to the hospital. Now Rawson-Neal Psychiatric Hospital is a new hospital that was built to ease the burden on the emergency rooms that had been housing those people who are not mentally ill and do not need treatment for years. Here are some facts about the recidivism rates and my final remarks on A.B. 94.

Between January 1 and March 1 of 2011, there were 67 people readmitted to Rawson-Neal Psychiatric Hospital within 30 days of their original discharge. These people had lengths of stay that ranged anywhere from 1 to 29 days. These were rapid readmissions that may not have occurred if A.B. 94 were in place, and those who were not mentally ill and did not need medication were able to be managed in the outpatient setting. Within the last 36 months, there were a total of 9,186 admissions with stays longer than 30 days. Many of these admissions were rapid readmissions and many of those numbers include the same people who were readmitted over and over and over again. My final remark is this: in the last 4 1/2 years that I have been a social worker at Rawson-Neal Psychiatric Hospital, I have seen the length of stay decrease from about 3 1/2 weeks down to about 2 weeks with acute admissions being 5 days. But inpatient treatment is only half the equation. The other half—the outpatient arena—has no method of assisting those who are not mentally ill and do not need treatment. I want to forcefully remind everyone that the treatment of the chronic mentally ill population in Nevada requires that the inpatient and outpatient teams work together.

Assembly Bill 94, which supports involuntary court-ordered admissions to community-based or outpatient treatment services in certain circumstances, would address the chief complaint we hear every day in the hospital and every day on our treatment team: "I am not mentally ill and I do not need medication." Just for the record, I would like to state that there is actually a syndrome associated with folks who are so chronically mentally ill that they do not know they have an illness and they do not think they need medication. That syndrome is called anosognosia. Thank you, and that is all I have to say.

Chair Mastroluca:
I want to let the people in Las Vegas know that we are going to continue, but if you need to leave, you are welcome to leave written testimony and we will include it in the record. If you are unable to stay for any reason, we are going to continue to move on, but we are going to lose our room quite rapidly. I would ask that you make sure that your statements are concise. Please do not repeat anything that has been said.

Is there anyone else in Las Vegas in support of A.B. 94? Please come to the table.

Marjorie Bull, Private Citizen, Las Vegas:
Arabella was my granddaughter, and this is the second time that Assemblyman Stewart has sponsored this legislation—during last session, he and Joe Heck attempted to get Assembly Bill No. 368 of the 75th Session through. I truly hope that we can get it through this time. Are there any questions?

Chair Mastroluca:
Thank you very much for your dedication to this. We appreciate it. Are there any questions from the Committee? [There was no response.] Thank you very much.

Chair Mastroluca:
Is there any one else in Las Vegas or Carson City that would like to speak in support of A.B. 94? [There was no response.] We will move to the opposition. If there is anyone in Las Vegas or Carson City who would like to oppose Assembly Bill 94, please come forward.

Coni Kalinowski, Medical Director, Mojave Mental Health, University of Nevada School of Medicine:
[Witness read from prepared testimony (Exhibit E).] I am here to implore you to not support Assembly Bill 94. For nine years I trained and worked in Wisconsin where involuntary outpatient commitment was used to force people into

treatment for over 30 years, and I can tell you firsthand it does more harm than good.

First, let us be clear. Assisted outpatient treatment is neither assisted nor is it treatment. It is a court order to force people to undergo medical intervention and primarily that means that they are forcibly medicated. The term "assisted outpatient treatment" sounds very nice, but what it means is that people are subjected to drugs and procedures that they object to.

It is true that 44 other states have outpatient commitment laws; however, in fact, very few of them actually implement them. There are many reasons for this. These laws are impractical, they are cumbersome for the judicial system and law enforcement, and they entail significant additional cost for court process, court-ordered evaluations, and expert testimony. They also entail very expensive injectable medications.

You have heard commentary today claiming efficacy for outpatient commitment, but keep in mind that if you look broadly at the actual research, the results are very variable. Most studies do show that you can decrease the use of inpatient services and homelessness using outpatient commitment, but one has to ask, "How does it do that?" Is it because individuals are well treated, less symptomatic, healthier, and recovering? Consumers have been saying for years that that is not the case, that it is because they are overly sedated by medications, incapacitated, and therefore no longer perceived to be a "problem" to others. There is certainly some research to support their view.

Outpatient commitment has not been shown persuasively in any studies to improve social functioning or increased employment. Some studies suggest that individuals who receive involuntary outpatient commitment are not even less symptomatic. There is also no evidence that involuntary outpatient commitment improves public safety, even though most of these laws were enacted in response to tragedies involving people having mental health or substance abuse problems.

Most of the evidence in support of involuntary outpatient commitment, including the evidence presented here today, comes from New York State and the implementation of Kendra's Law. What proponents of outpatient commitment will not tell you is that the reason that Kendra's Law has shown some success is that, at the time the law was enacted, the governor of New York pumped $200 million into mental health services. We know from research that people participate more in treatment and need less acute hospitalization when consumers are offered expanded outpatient treatment options, so it is very likely

that New York could have achieved these things without compromising the rights of its citizens.

The National Association of State Mental Health Program Directors cautions against enacting outpatient commitment in an environment where there are insufficient resources for community mental health treatment. So even if you believe that involuntary outpatient commitment is justifiable, what does that mean for Nevada? Our mental health system has been stripped to the bare bones and will undergo further cutbacks in the coming year. Proposed grants are truly hypothetical. I would put to you that it is very unlikely that A.B. 94 will be implemented as intended with intensive community-based services. Outpatient commitment for Nevadans is likely to mean only one thing. They will be medicated against their will and then they will be neglected.

Medications help many people, but only about a third of people will have a significant improvement in their symptoms. Generally the people who get a good response to medications are not the people who are targeted for outpatient commitment. Outpatient commitment targets people who are noncompliant, and most of these individuals are noncompliant specifically because they do not get a very good response to medications, or they struggle with terrible side effects. They are understandably ambivalent about treatment.

To my mind, if we are going to take away people's rights, we are obligated to offer them some significant benefits in return. It is very clear to me that Nevada does not put enough resources into mental health to achieve this goal. Forcing people to take medications that are not very effective and cause them to feel horrible is not treatment. It is chemical jail. It is also important to keep in mind that these medications are not benign. They cause seizures, serious neurological problems, diabetes, heat stroke, and other potentially life threatening conditions. Due largely to psychotropic medications, people having psychiatric disabilities now have a life expectancy that is 25 years less than the average population.

Lastly, we need to evaluate the impact of involuntary outpatient commitment on our ability to serve people in general. The single most important therapeutic tool that mental health professionals have is the trusting relationship that we build with our clients. In my experience, the threat of involuntary outpatient commitment undermines that relationship, and will deter people from seeking the help they need. Thank you.

John W. Griffin, representing Nevada Justice Association:
We are neutral on the bill, but we are opposed to section 2. Section 2 contains an immunity provision for the state for post-release actions. I think, as most of

the Committee knows, the state currently has a cap on liability, so its exposure is extremely limited without this provision. This provision is unnecessary, not only for that reason, but it also tends to relax standards. The bill refers to court-ordered admittance, and then it refers to immunity upon the condition or release in the judgment of the professional responsible. To give an example, if there is a court-ordered admittance and the professional responsible releases the person six hours later because they want to go home and watch the Super Bowl, I do not think there should be some absolute immunity in that instance. For that reason—and we spoke with the sponsor of the bill—we have problems with section 2.

Chair Mastroluca:
Were you referring to the actual section 2, or to section 4, subsection 2?

John W. Griffin:
Thank you for pointing me in the right direction. I was referring to section 4, subsection 2.

Assemblyman Sherwood:
So by that logic, you would say that if the state did not pick up, who pushed another person under the front of a bus, the state would be liable for his actions too, correct? You are condemned if you do, and you are condemned if you do not. If you are the state with this liability clause . . . , correct? If you follow that line of reasoning to its logical conclusion . . .

John W. Griffin:
I do not follow that line of reasoning. I think when you try to prejudge a set of circumstances and provide absolute immunity, before you know the facts and circumstances . . . . I am not following your hypothetical example. I guess the comment would be that if there is culpability, and there is responsibility for harm, there should not be immunity attached to that harm before the facts and circumstances are laid out, regardless of the circumstances.

Assemblyman Sherwood:
I am just putting it out there. The next thing that would happen would be that when it is a relative of someone, where you say "Well, you should have known, and you did not put this person under supervision," and they went out and did something. We can go around and around. It is not unprecedented for the state to have immunity from liability, especially when it is trying to do something like protect everyone from the mentally ill or give discretion to the mental professional that says, "It has been a couple of days; we need to release this person." It could have a chilling effect on trying to do their job. We do not need to debate it; I just wanted to put it on the record.

Chair Mastroluca:
Mr. Stewart, do you mind coming to the table? I was just wondering if you could talk about the reasoning behind this language and why you felt it necessary.

Assemblyman Stewart:
This was patterned after Kendra's Law in New York and part of the language was taken from that. If there is some liability issue, I would be willing to work with the parties involved on it.

Jack Mayes, Executive Director, Nevada Disability Advocacy & Law Center:
We are opposed to A.B. 94 and opposed to outpatient civil commitment in general.

You have touched on many of the issues already. Our concern is that it infringes on individuals' constitutional rights. Basically people will be put on probation simply for having a mental illness. I would ask that as a policy decision in a time of limited resources, we really should be prioritizing helping those that want our help instead of forcing treatment on those that do not want our help. Those held against their will potentially will get better services than those that want to get treatment, so we have concerns about the prioritization of those that are held under this program. If you want to help the most severely disabled, we would suggest that you not cut the Program for Assertive Community Treatment (PACT) teams or reduce the outpatient programs that are proposed in the Governor's budget.

I was doing a little research, and the 70th Session of the Nevada Legislature actually did a study on this issue. Most of the issues have not changed. Some of the additional concerns that were listed in the study are that this potentially interferes with the right to refuse treatment; it may be used as a substitute for inadequacies in community-based services and programs; and it undermines the therapeutic relationship and has broad potential for abuse. In general, outpatient commitment penalizes individuals for what is essentially a system problem. Lack of appropriate and acceptable community mental health services is the real issue. Thank you for the opportunity to share these concerns.

Chair Mastroluca:
Thank you for spending the afternoon with us. We appreciate it. You have been in quite a few Committee meetings, so thank you for your attention.

Assemblyman Hammond:
You made a statement that we should prioritize and put our money towards those who are seeking help as opposed to those who may be put in there

involuntarily. I always thought that was part of the problem. I thought there were a lot of people who need help but do not know they need help. So in a way, you are actually getting people off the street who may potentially do harm to themselves and to others around them, but mainly to themselves. Am I incorrect?

Jack Mayes:
That is an assumption that people with mental illness need to be protected from themselves, but there are other ways to provide treatment that does not put them in a position where they can be picked up for not taking their medication. The problem that we often see is that people have issues with medication. It makes them groggy or gives them an inability to function. I do not believe that bringing them in once a month and injecting them with medication is really going to solve their issues.

Assemblyman Hammond:
So the gentleman who is swimming in his birthday suit in the Bellagio fountain, if you do not take him into a facility such as was discussed earlier—the community-based mental facility—then he goes to jail. Is that not what we are trying to avoid?

Jack Mayes:
That is partly why we developed programs such as the PACT team to address those ongoing reminders or reassurances to take their medications on a daily basis. I believe that a gentleman like this would benefit from that type of program more than a forced treatment program that he does not want to participate in. There are people who do not follow their doctor's advice for diabetic medications, or we have reoffenders who are substance abusers, but we do not put them on ongoing probation. It comes down to a civil rights issue. I respect the concerns of the families and some bad things have happened, but we are here to protect the rights of the individual.

Assemblyman Hammond:
So the programs that you are talking about, are those the programs that would help them to regulate their medication? Are you saying that they are underfunded right now?

Jack Mayes:
They are proposed to be cut.

Assemblyman Hammond:
I see. Thank you.

Jack Mayes:
Right now, someone who rotates through the system, if they rotate through enough, he gets referred to the PACT teams. Someone who rotates through 20 times in two years does not rotate enough, because we do not have enough placements in the PACT teams. The people who rotate the most are the ones who go to the PACT teams. I do not believe this gentleman is associated with a PACT team. If he was, he would have daily or every other day contact with his social workers, they would ask him if he was taking his medications, and if he had followed up on his appointments. As was stated, he missed his appointments. No one checked on him to make sure that he followed up.

Assemblyman Hammond:
For two weeks?

Jack Mayes:
Yes.

Assemblyman Sherwood:
I know there is the best treatment; unfortunately we are in a situation where we cannot fund everything that we would like to fund. If the choice is what we are talking about right now—the bill that has been proposed—or sending these folks to either the emergency room for 72 hours handcuffed to the bed, or to a Clark County Detention Center, is this a better choice than that, if those are the options?

Jack Mayes:
Neither of those choices is optimal. I prefer that they use the triage systems to get people in, identify if they need treatment, and get them treatment instead of holding them for 72 hours handcuffed to a bed. No, I do not want to see people go to jail.

Assemblyman Sherwood:
Is this better than jail and the emergency room, and if you are saying it is not, then . . . ?

Jack Mayes:
It is about the same, because they are held in emergency rooms like jail.

Chair Mastroluca:
The big difference is what you just named are the two most expensive beds we have in the state.

Christina Remmes, Private Citizen, Las Vegas, Nevada:
I am a client at Mojave Mental Health. Mojave Mental Health is a voluntary mental health care agency. Although I am mentally ill, I am still a human being. By choosing to participate in my treatment, I am more deeply committed to bettering my health and I am empowered to make the right decisions regarding medication and therapy. Mandatory outpatient programs would not necessarily make room for the honesty needed between the patient and the doctor to regain mental stability. I am privileged to receive Medicaid. Many are not so fortunate. Nevada's public mental health system is already strained financially.

Allowing involuntary treatment, especially medication, on a massive scale with limited resources, has a potential to create personally devastating results. Using risky psychiatric medication with the mentally ill without the consent of the patient seems inhumane. Using the legislative branch to enforce intellectual conformity in an increasingly repressive society is undoubtedly unconstitutional. This law does not value the human rights of the mentally ill. I urge you to invest your time, energy, and taxpayer dollars in comprehensive treatment that treats the mentally ill as human beings with the potential for real growth. Please do not assume that giving a medication will solve the problem when in many instances the wrong medicine will make it worse. Please do not further criminalize mentally ill people through the implementation of nonconsensual outpatient treatment plans. Thank you for the opportunity to share my opinion with you.

Chair Mastroluca:
Thank you, Ms. Remmes. We appreciate you coming down and waiting to speak to us. Are there any questions from the Committee? [There was no response.] Thank you very much. We appreciate your time.

Rebecca Gasca, Legislative and Policy Director, American Civil Liberties Union of Nevada:
I do have some comments, but honestly a lot of them would be reiteration of some of the statements placed on the record. I would prefer to yield my time to some folks in southern Nevada if at all possible.

Chair Mastroluca:
Thank you very much. We appreciate that, Ms. Gasca.

David Mandzak, Private Citizen, Las Vegas, Nevada:
I am a client at Mojave Mental Health, and my personal statement on this is that they tend to think of it as a revolving door. I tend to think that we are just adding more window panes to the revolving door. In my opinion, when a person goes to drug court, he does whatever the drug court says. He does

his piss test and he stays clean. But once that sentence is up, he goes right back to doing whatever paraphernalia or whatever drugs and intoxicants he can get his hands on. I think that this is just delaying the inevitable. The mental health community is also turning us into some Salem witch hunt. I, as a person of the mental health community, feel like a person of Jewish descent during Nazi Germany times, because I feel like this is inhumane and a witch hunt to point us out and use stereotypes against us and discriminate against us. I think that this will not only not help, but also bring a rebellion, which is human nature, and maybe even more violent tendencies from the mental health community. Thank you.

Chair Mastroluca:
Thank you so much for your testimony. We appreciate it and we appreciate your time. Are there any questions? [There was no response.] Thank you very much.

Is there anyone else in Las Vegas who wishes to testify on A.B. 94?

Thomas Newman, Private Citizen, Las Vegas, Nevada:
I am a client at Mojave Mental Health. I notice that we have a lot of people there; it is not just a few. If you add more people to that system, you are going to have to build more buildings to accommodate these people that you are bringing into the system. With the cuts to Medicaid, I do not know how you are going to afford to do this. What are they doing at Rawson-Neal Psychiatric Hospital where it is $850 per day for one person? What prescription causes it to cost so much money? It is ridiculous. That infuriates me a little bit. I think we should be looking at our medical system, paying more attention to our teachers, and trying to figure out what needs to be done properly. I think there is overspending on things. Thank you very much.

Chair Mastroluca:
Thank you very much, Mr. Newman. We appreciate your time and thank you for waiting this afternoon to share your testimony.

We are now in the neutral category. Good afternoon, Dr. Cook. It is nice to see you.

Harold Cook, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services:
Despite what you heard earlier, the Division is not opposed to this bill; the Division is neutral on this bill. We have some concerns about the bill and I have worked with Assemblyman Stewart to suggest some amendments to the bill (Exhibit F).

I do not have anything new to say. You have heard a lot of testimony. This is an extremely complex issue. It is complex from the viewpoint of civil rights, treatment, and the judicial system. There would be a lot of work that would need to be done to successfully implement this bill. I will tell you that as it is currently written, there would be a fiscal note attached to the bill because there would be—as Ms. Pierce has indicated—startup costs and treatment costs that would need to be resourced before we achieved any kind of savings in our inpatient program. I have worked with Assemblyman Stewart on this. I have some suggested language changes and I would be willing to answer any questions you might have regarding this bill.

Chair Mastroluca:
Are there any questions for Dr. Cook? [There was no response.] Will you get with Mr. Stewart so that we can have this amendment by the end of the day tomorrow?

Harold Cook:
It is already available.

Chair Mastroluca:
Thank you, Dr. Cook. I appreciate it.

Tierra D. Jones, representing Office of the Clark County Public Defender:
Just like Dr. Cook, a lot of our concerns have already been stated. We are neutral with the amendments submitted by the Las Vegas Metropolitan Police Department, because we did definitely have some concerns about the warrantless pickup of those persons who are suffering from mental illness. We share the concerns that were expressed by Dr. Cook as well as the mechanical concerns that have already been expressed by this Committee, but we do support the idea behind the bill of outpatient treatment for those who are mentally ill. Thank you.

Chair Mastroluca:
Thank you, Ms. Jones. Are there any questions from the Committee? [There was no response.]

Alex Ortiz, representing Clark County:
I am testifying here on behalf of the Clark County Eighth Judicial District Court. Their official position is neutral; however, they do have some concerns with this bill. First, the outpatient services do not currently exist and they are unsure how useful the procedures will be. Second, implementation would have a direct fiscal impact on the court and the county. Currently the commitment court is held on Wednesday and Friday afternoons. This bill requires a substantial

increase in the number of hearings and formal independent reviews by the court-appointed experts. This could require a full-time hearing marshall, court clerk, and court reporter, for example. In addition, the number of formal independent evaluations could double. The rest of the fiscal impact, which was provided to me by the Eighth Judicial District Court, is approximately $690,000, and that would include salaries, benefits, and psychiatric reports necessary to conduct follow-up check statuses, and potentially the creation of a new department.

I think we would be happy to work with the sponsor, as well, to help alleviate some of those concerns that the court has. Thank you.

Chair Mastroluca:
Are there concerns from the county that in addition to what you are looking at for cost-based on just this bill—that the proposed budget would push a lot of these responsibilities back down to the counties? Has that been included or were you waiting to see what happens?

Alex Ortiz:
No, we are not waiting to see what happens. I think all the program shifts, assessments, and costs to the county are going to definitely be more difficult on the current resources. This is just the court's view and its perspective on this actual bill, but there is a lot more that is beyond this that is actually going to impact the county in a detrimental way.

Chair Mastroluca:
Mr. Delap, did you have another word?

A. J. Delap:
I failed to mention that I am also representing the Nevada Sheriffs' and Chiefs' Association. They wanted to go on record as also being in support of the amendment that was submitted by the Las Vegas Metropolitan Police Department and that they are neutral on the bill itself. I apologize for that.

Chair Mastroluca:
Thank you very much. Is there anyone else who would like to testify on Assembly Bill 94? [There was no response.] Mr. Stewart, would you like the last word?

Assemblyman Stewart:
I appreciate your willingness to hear this. I am sorry it took so long. I would like to reiterate that on pages 8 and 9, that the person has to have a history of

noncompliance, he has to have a need for the program, and he has to have been involved in one or more acts of violence. We are not picking people off the street. Again, I think the choice is between a quick program that would make the person who has the mental illness safe and make those around him in the general public safe, and it would be cheaper by far than going to Rawson-Neal Psychiatric Hospital or other places. Thank you very much.

Chair Mastroluca:
I will close the hearing on Assembly Bill 94. Is there any public comment, either in Las Vegas or Carson City? [There was no response.]

Seeing none, our next meeting is Wednesday. We did have to roll today's work session to Wednesday because of the delay in start times, so we will have a jam-packed meeting on Wednesday. Please be prepared and be on time.

The meeting is adjourned [at 4:59 p.m.].

RESPECTFULLY SUBMITTED:

_____
Linda Whimple
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: April 11, 2011 Time of Meeting: 2:55 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Kathleen Silver	UMC Presentation
A.B. 94	D	M. Frances Barron	Testimony
A.B. 94	E	Coni Kalinowski	Testimony
A.B. 94	F	Harold Cook, Ph.D.	Proposed Amendment