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

Seventy-Eighth Session
May 13, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 2:00 p.m. on Wednesday, May 13, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4404B 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 Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

Assemblyman John Moore (excused)

GUEST LEGISLATORS PRESENT:

Senator Moises (Mo) Denis, Senate District No. 2

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Karyn Werner, Committee Secretary
Norma Mallett, Committee Assistant

OTHERS PRESENT:

Jill Marano, Deputy Administrator, Family Programs, Division of Child and Family Services, Department of Health and Human Services
Amber Howell, Administrator, Division of Child and Family Services, Department of Health and Human Services
Brigid J. Duffy, Chief Deputy District Attorney, Juvenile Division, Clark County District Attorney
Jason Frierson, Chairman, Legislative Committee on Child Welfare and Juvenile Justice
Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Kathleen O'Leary, Chief Deputy Public Defender, Washoe County Public Defender's Office
Bill M. Welch, President/Chief Executive Officer, Nevada Hospital Association
Dan Musgrove, representing The Valley Health System, Amerigroup of Nevada, and WestCare of Nevada
Sara Cholhagian, representing Sunrise Hospital and Medical Center
Mary-Sarah Kinner, representing United Health Services of Delaware
Lesley Dickson, M.D., representing Nevada Psychiatric Association
Grayson D. Wilt, Policy Research and Government Affairs Specialist, Nevada State Medical Association
Kim Frakes, Executive Director, Board of Examiners for Social Workers

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] We will now begin our work session. We will start with Senate Bill 33 (1st Reprint).

Senate Bill 33 (1st Reprint): Authorizes the board of hospital trustees of a county hospital to hold a closed meeting under certain circumstances. (BDR 40-475)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 33 (1st Reprint) is brought forth on behalf of Clark County (Exhibit C). It was heard on May 11, 2015. It authorizes the board of hospital trustees of a county hospital to hold a closed meeting to discuss providing a new service at the hospital, materially expanding an existing service, or acquiring an additional facility for the hospital or materially expanding an existing facility. The records of such a meeting become public five years after the date of the meeting or when the board determines that confidentiality is no longer required, whichever occurs first. There were no proposed amendments for consideration.

Chair Oscarson:
Is there a motion?

ASSEMBLYWOMAN DICKMAN MOVED TO DO PASS SENATE BILL 33 (1ST REPRINT) .

ASSEMBLYMAN TROWBRIDGE SECONDED THE MOTION.

Assemblyman Sprinkle:
I completely understand what the bill's sponsor is trying to do. I am in support of their concerns and their arguments, but I just cannot get past the point that the public needs to have more say in this. I just cannot quite get there, and I am concerned about the decisions that can be made behind closed doors, so I will be a no.

Assemblyman Gardner:
I want to say that I will be voting in support of this bill as long as they can only discuss these two issues. I have assurances that it is only these two issues that they can discuss behind closed doors. As long as that is what it is, I am in support.

Assemblyman Thompson:
I understand the intent of the bill, but I will be voting no. I feel that transparency with the members of the public is important. Even though it says they are only going to deal with two areas of concern, I still have concerns, especially with the fact that the minutes can be completed as far out as five years. I will be voting no.

Chair Oscarson:
Is there any other discussion? [There was none.]

> THE MOTION PASSED. (ASSEMBLYMEN SPRINKLE AND THOMPSON VOTED NO. ASSEMBLYMEN JONES, MOORE, AND SPIEGEL WERE ABSENT FOR THE VOTE.)

Assemblyman Gardner will do the floor statement. We will go to Senate Bill 35.

Senate Bill 35: Ratifies and enacts the Interstate Compact on Mental Health. (BDR 39-330)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 35 is sponsored on behalf of the Division of Public and Behavioral Health. It was heard on May 11, 2015. It ratifies the Interstate Compact on Mental Health. That compact would appoint the Administrator of the Division of Public and Behavioral Health to serve as the Compact Administrator. [Continued to read from work session document (Exhibit D).]

Chair Oscarson:
Is there a motion?

> ASSEMBLYWOMAN TITUS MOVED TO DO PASS SENATE BILL 35.
>
> ASSEMBLYMAN GARDNER SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN JONES, MOORE, AND SPIEGEL WERE ABSENT FOR THE VOTE.)

Assemblywoman Titus will do the floor statement. The next bill will be Senate Bill 114 (1st Reprint).

Senate Bill 114 (1st Reprint): Makes changes relating to prescriptions for certain controlled substances. (BDR 40-239)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 114 (1st Reprint) is sponsored by Senator Hardy. It was heard on May 1, 2015. The bill requires the State Board of Pharmacy to allow a law enforcement officer to have Internet access to the prescription drug monitoring program database if the employer of the officer approves and submits

certification to the Board that the officer meets certain requirements. [Continued to read from work session document (Exhibit E).]

Chair Oscarson:
Is there a motion?

> ASSEMBLYMAN SPRINKLE MOVED TO DO PASS SENATE BILL 114 (1ST REPRINT).
>
> ASSEMBLYMAN GARDNER SECONDED THE MOTION.

Assemblywoman Titus:
I will be an adamant no on this bill. I think it is a potential civil liberties issue. It allows law enforcement way too long of a leash. I have huge patient concerns over this bill. I have expressed this to law enforcement already.

Assemblyman Thompson:
I will be voting yes; however, I did have some concerns about the access, et cetera. I have been talking to some of the bill's proponents, and I thank them. I hope in the regulations there will be some type of frequency in the auditing to ensure there is no misuse of the system.

Chair Oscarson:
As with all bills, we appreciate the sponsors and the folks talking with the members of the Committee and sharing their thoughts and the intent of the legislation. Is there any further discussion?

> THE MOTION PASSED. (ASSEMBLYWOMEN DICKMAN AND TITUS VOTED NO. ASSEMBLYMEN JONES, MOORE, AND SPIEGEL WERE ABSENT FOR THE VOTE.)

Assemblyman Trowbridge, would you do the floor statement? The next bill will be Senate Bill 247 (1st Reprint).

Senate Bill 247 (1st Reprint): Revises provisions governing new construction by or on behalf of health facilities. (BDR 40-981)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 247 (1st Reprint) was sponsored by the Senate Committee on Health and Human Services. It was heard on May 6, 2015. It allows the Department of Health and Human Services to deposit fees collected from persons who apply for approval of proposed health facilities or services. [Continued to read from work session document (Exhibit F).]

Chair Oscarson:
Do I hear a motion?

> ASSEMBLYWOMAN DICKMAN MOVED TO AMEND AND DO PASS SENATE BILL 247 (1ST REPRINT).
>
> ASSEMBLYMAN TROWBRIDGE SECONDED THE MOTION.

Assemblyman Gardner:
I will vote for this, but I have some concerns, and I will review them. I will support it out of Committee, but I reserve the right to change my vote on the floor.

> THE MOTION PASSED. (ASSEMBLYMEN JONES AND MOORE WERE ABSENT FOR THE VOTE.)

Assemblywoman Dickman is going to do the floor statement. Next, we will hear Senate Bill 314 (1st Reprint).

Senate Bill 314 (1st Reprint): Revises provisions governing certain health districts. (BDR 40-957)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 314 (1st Reprint) is sponsored by Senator Roberson. It was heard on May 11, 2015. It revises the composition of a health district in a county whose population is 700,000 or more, which would currently be Clark County, to include a chief medical officer and a public health advisory board. [Continued to read from work session document (Exhibit G).]

Chair Oscarson:
Is there a motion to approve?

> ASSEMBLYMAN THOMPSON MOVED TO DO PASS SENATE BILL 314 (1ST REPRINT).
>
> ASSEMBLYMAN GARDNER SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN TROWBRIDGE VOTED NO. ASSEMBLYMEN JONES AND MOORE WERE ABSENT FOR THE VOTE.)

The floor statement will go to Assemblyman Thompson. We will now go to Senate Bill 327 (1st Reprint).

Senate Bill 327 (1st Reprint): Revises certain provisions governing air ambulances. (BDR 40-1017)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 327 (1st Reprint) was sponsored by Senator Farley. It was heard on May 8, 2015. It provides for the minimum number of attendants and qualifications for those attendants aboard an air ambulance. The bill revised the training requirements for a licensed physician, registered nurse, or licensed physician assistant to be certified as an attendant. [Continued to read from work session document (Exhibit H).]

Chair Oscarson:
Do I hear a motion?

> ASSEMBLYWOMAN TITUS MOVED TO AMEND AND DO PASS SENATE BILL 327 (1ST REPRINT).
>
> ASSEMBLYMAN SPRINKLE SECONDED THE MOTION.

Assemblyman Gardner:
Are these both friendly amendments?

Chair Oscarson:
They are indeed. Any further discussion? Seeing none, we will take a vote.

> THE MOTION PASSED. (ASSEMBLYMAN MOORE WAS ABSENT FOR THE VOTE.)

Assemblyman Sprinkle will do the floor statement. The next bill will be Senate Bill 402.

Senate Bill 402: Makes various changes concerning the prevention and treatment of obesity. (BDR 40-891)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 402 is sponsored by Senator Denis. It was heard in this Committee on May 4, 2015. It defines the term "obesity" in the preliminary chapter of *Nevada Revised Statutes* as a chronic disease having certain characteristics. [Continued to read from work session document (Exhibit I).]

Chair Oscarson:
Is there a motion?

ASSEMBLYMAN THOMPSON MOVED TO AMEND AND DO PASS SENATE BILL 402.

ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

Assemblywoman Titus:
I understand that there are going to be some changes to this bill by the bill's sponsor, who is willing to do some amendments. Otherwise, if there is not, I cannot support it the way it is written.

Chair Oscarson:
That is also my understanding. I see Senator Denis nodding, but it is hard to put a nod on the record. Would you like to come up and put that on the record?

Senator Moises (Mo) Denis, Senate District No. 2:
For the record, we have discussed this and, because of the time factor, we were not able to get it ready for today. There are some areas that we can work on, and it is such an important issue that we really need to make sure we get the right pieces in it.

Assemblywoman Titus:
I will support this bill as it is written now with the understanding that there are some amendments that I and the rest of the Committee can concur with, but I will reserve my right to vote no on the floor if that falls apart.

Assemblywoman Dickman:
Ditto.

Assemblyman Gardner:
Ditto.

Chair Oscarson:
Are there any more dittos?

Assemblywoman Benitez-Thompson:
I want to say on the record for this particular colleague, he is the only colleague in the building who has never said a curse word in his life, so when it comes to honesty and being above board, I will vouch for him. He is a saint.

Assemblywoman Dickman:
I want to make it clear that I was not impugning the Senator's integrity. I want to make sure that whatever comes out is something I can agree with.

THE MOTION PASSED. (ASSEMBLYMAN MOORE WAS ABSENT FOR THE VOTE.)

Assemblyman Araujo, will you do the floor statement? The next bill is going to be Senate Bill 441 (1st Reprint).

Senate Bill 441 (1st Reprint): Enacts provisions relating to craft food operations. (BDR 40-988)

Kirsten Coulombe, Committee Policy Analyst:
Senate Bill 441 (1st Reprint) is sponsored by the Senate Committee on Commerce, Labor and Energy. It was heard on May 8, 2015, in this Committee. It exempts a craft food operation from the requirements of a food establishment and are not subject to certain inspections by a health authority. [Continued to read from work session document (Exhibit J).]

Chair Oscarson:
Is there a motion?

ASSEMBLYWOMAN DICKMAN MOVED TO DO PASS SENATE BILL 441 (1ST REPRINT) .

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN MOORE WAS ABSENT FOR THE VOTE.)

This is also called the pickle bill. Assemblywoman Spiegel will do the floor statement. That will end the work session. We will have one more meeting on Friday and then the rest of it should be moving forward. With that, we will skip over Senate Bill 15 (1st Reprint) and we will open the hearing on Senate Bill 88.

Senate Bill 88: Revises provisions governing the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child. (BDR 38-337)

Jill Marano, Deputy Administrator, Family Programs, Division of Child and Family Services, Department of Health and Human Services:
I am here to present Senate Bill 88, and this is a straightforward housekeeping bill. It is regarding who can access the Central Registry portion of Unified Nevada Information Technology for Youth (UNITY), which is our child welfare database. The Central Registry is actually the portion of the database

that collects the statewide listing of people who have substantiated cases of child abuse and neglect. Right now, by statute, only child-welfare agencies can access the Central Registry. One of the units in the state; however, that needs this information is Child Care Licensing. In 2011, the Child Care Licensing Unit transferred to the Division of Public and Behavioral Health (DPBH) from the Division of Child and Family Services (DCFS). When it transferred, the need for this information on substantiation history transferred as well, so the Child Care Licensing Unit cannot do background checks and look at history for potential child care employees. We have been operating under a daily use agreement for the last few years so they could continue to access the registry. We really do need to bring the statute in line with practice. I am here today to request that change, so we can share the Central Registry with DPBH staff.

Assemblyman Thompson:
In section 1, subsection 4, paragraph (c), starting on line 35, it talks about "an employee." Will there be more than one employee accessing the database or is that just the way the language has to be?

Jill Marano:
I believe that is just the way the language is written. Their practice now is that just one person actually goes into the Central Registry to look things up. Technically, they would all be able to do that.

Assemblyman Thompson:
If it were everyone from that division, how many employees would that be? To me, that would make a big distinction if we are saying an employee in the statute, but if it is true that any employee of that division can access it, how many people would that be?

Jill Marano:
I do not know how many staff the Division has. I could find that out. The purpose for this is so that the staff of the Child Care Licensing Unit can access it. I do not have the staffing numbers, but I can get them.

Assemblywoman Spiegel:
Are there requirements that contractors sign confidentiality agreements? Are there requirements that they maintain record security practices?

Amber Howell, Administrator, Division of Child and Family Services, Department of Health and Human Services:
Yes. They have to sign a data use agreement, and follow all of the provisions under that, and we attach it to their contract.

Assemblyman Araujo:
Does the data agreement specify how long the contractor is allowed to hold that information before they have to get rid of it?

Amber Howell:
Currently, in order to access information in the Central Registry system, they need to have clearance through the Case Management System, which is a computerized system. Once the contract is ended or a person ends their term with the state, their access is cut off so they do not have access to the information any longer.

Assemblyman Sprinkle:
I may be reading this slightly different. I am looking at section 1, subsection 4, paragraph (d) that says, "an employee." This is referring to an individual situation. An employee may come up to the administrator and ask for permission because they have shown a bona fide need. That is the way I am reading it. Am I reading that wrong? It could be any employee as long as they have a reason to ask the administrator to do so. Is that correct?

Jill Marano:
The intent behind that was to put some teeth into the contracts and data use agreements. They are generally with contracted agencies that may have staff who have a bona fide need. It is only for those specific staff to be able to access it. That would be outlined in an agreement.

Assemblyman Sprinkle:
What I am saying is that the word "an" typically means one. It would be one employee if he needs permission because he has a bona fide need. That is the way I am reading it.

Amber Howell:
You are reading it correctly. What we are trying to do is allow other agencies and/or employees to have access to the system, but because of confidentiality and the nature of the information, it is on a per-employee basis. We will not, or I personally as the administrator, will not do a carte blanche. The agency has full access. It will be on a per-employee basis.

Chair Oscarson:
We will take testimony in support of S.B. 88 here or in Las Vegas. Seeing none, I will ask for testimony in opposition. Seeing none there either, is there any testimony in the neutral position? Seeing none, I will close the hearing on S.B. 88. We will open the hearing on Senate Bill 148.

Senate Bill 148: Revises requirements governing certain child welfare proceedings. (BDR 38-195)

Brigid J. Duffy, Chief Deputy District Attorney, Juvenile Division, Clark County District Attorney:
I have the honor of presenting Senate Bill 148. I presented it on the Senate side at the request of the Chair of the Interim Committee on Juvenile Justice and Child Welfare, Jason Frierson, who is in the audience today.

I am going to walk you through the amendment proposed by Clark County (Exhibit K). Senate Bill 148 amends *Nevada Revised Statutes* (NRS) 432B.520, which is the section of child welfare statutes that requires that after the state files a petition that a child is in need of protection, how service of that petition would be effectuated. In section 1, subsection 4, it states in our amendment that, except as provided in subsection 5, the summons must be served personally by a service of written notice—or registered or certified mail—to the last known address. This will make NRS 432B.520 similar to NRS 432B.470, which is the notification requirements in the first 72 hours after that for the hearing when we actually remove a child. That is the bill.

Assemblywoman Spiegel:
In section 1, subsection 4, if they have an email address, can they also send the notice by email since it is traceable and date and time stamped?

Brigid Duffy:
That is a very good question. The Department often communicates with parents via email because that is a preferred method of communication. However, even as attorneys, we cannot serve anything by email without the other side agreeing to it in the first place. If I serve a document to an opposing counsel by email, that is not good service until they agree to accept it by email. We would have to get that agreement.

Assemblywoman Benitez-Thompson:
Would you please talk to us about what this does functionally and what changes we are going to see in the status quo? What problem are we fixing with this language?

Brigid Duffy:
In Clark County, we make 40 to 50 personal service attempts a week to parents. Oftentimes, my process server says that the parents would not answer the door. We then follow up with certified mail, although it is not currently statutorily good service. We find that they will answer the certified mail more often than they answer the door. It will allow another level of ability

to make good service when we serve them and they accept the certified mail, whereas they may not be home or will not open the door for a process server. What happens is that there will be an argument that we did not properly serve because we did not personally serve; we only sent registered mail, which currently is only acceptable if they are out of state. This will give us an extra level of protection against unraveling an entire case when we serve them. We know they know about the date by a method other than personal service.

Assemblywoman Benitez-Thompson:
Knowing that this applies statewide, would the intent be to make one or two attempts at personal service before certified mail? Since the amendment says "or," do you want to leave it up to the child welfare districts to say they can do personal service or certified mail? I would imagine that everyone would default to certified mail if given the option. Is that the intent?

Brigid Duffy:
The intent is to make it either/or. I do not know what anyone else in the state would do as far as default, but we have process servers for this job. When we serve someone other than personally, we must ensure that it is good service. It is important for the children to make sure we are moving forward in a case instead of backward if it is deemed that we did not serve them appropriately.

Chair Oscarson:
Are there any other questions? There are none. Mr. Frierson, would you like to make a statement?

Jason Frierson, Chairman, Legislative Committee on Child Welfare and Juvenile Justice:
I was not actually here to testify on this bill, but Ms. Duffy did advance the measure at our request. In a practical sense, the reason it was advanced was due to a circumstance where a parent had notice but not technical service of process. While we do not want to play games with whether a parent knows and to take action without being assured that a parent knows, there were circumstances where the parent admitted that she knew. Because she did not get a formal, personal service like the law requires, the court was forced to ignore the fact that the parent knew but just did not come to court or comply with any other directive. The introduction of the bill was requested to address circumstances where a parent has actual notice, but was not personally served and used that requirement as a technical way of getting out of complying with any directive or coming to court.

Chair Oscarson:
Is there any testimony in support of S.B. 148? Seeing none, is there testimony in opposition either here or in Las Vegas? There is none, so is there any neutral testimony? Seeing none, we will close the hearing on S.B. 148. We will now open the hearing on Senate Bill 7 (1st Reprint).

Senate Bill 7 (1st Reprint): Revises provisions governing the admission of persons with certain mental conditions to and the release of such persons from certain facilities and programs. (BDR 39-64)

Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:
First, I would like to say that Senate Bill 7 (1st Reprint) originated from the Governor's Behavioral Health and Wellness Council and the Legislative Committee on Health Care.

The bill has been significantly amended. It will not, at this point, increase the number or type of individuals who can place a person on a legal hold. It will not let additional individuals evaluate inpatients. Senate Bill 7 (1st Reprint), as written with the conceptual amendment, will only allow additional qualified health care specialists to evaluate and complete a certificate for individuals in an emergency room (ER) on a legal hold. These individuals include a physician, a physician assistant under the supervision of a psychiatrist, a clinical social worker who has the psychiatric training and experience prescribed by the Board of Examiners for Social Workers, an advanced practice registered nurse who has the psychiatric training and experience prescribed by the Board of Nursing, and/or an accredited agent of the Division.

In the end, this bill is to allow for the more rapid and efficient evaluation of individuals waiting in the ER. We have had over 6,000 individuals waiting in our ERs this year that were placed on a legal hold. Of those, the data reflects that greater than 50 percent of them do not require admission to an acute inpatient facility. We believe the addition of these individuals will allow for evaluation and completion of the certificate in a more rapid and timely manner.

Chair Oscarson:
This is in response to some of the questions that this Committee had on a previous bill that I will not mention. This allows the decertification process to get these folks off of the legal hold and moved into the system and into an outpatient setting, if that is appropriate.

Tracey Green:
Partially, in that it does allow the certificate to be completed, but it would still require the ER physician to discharge the patient from the ER. It merely allows the evaluation and determination whether the individual is at risk to himself or others and the completion of the certificate. The actual medical clearance and the discharge from the ER are both done by the ER medical doctor.

Chair Oscarson:
As I understand this, it will expedite the process of moving forward through the system.

Tracey Green:
That is correct. In fact, there are individuals waiting to be evaluated. We know that some ERs have psychiatrists, but we clearly have a deficiency in the number of psychiatrists available, especially in our public facilities. This would allow additional individuals with experience to complete the certificate on a legal hold.

Chair Oscarson:
Seeing no additional questions, we will move to testimony in support. We have Kathleen O'Leary on the phone who would like to testify.

Kathleen O'Leary, Chief Deputy Public Defender, Washoe County Public Defender's Office:
I am testifying at the request of Assemblywoman Benitez-Thompson. I am not sure I have the most up-to-date copy of the bill, but I would be happy to entertain questions. I represent all of the patients on a 72-hour hold or petition for involuntary civil commitment in northern Nevada. We are having a substantial increase in the average number of people we represent. In the past two years it has increased to over 5,000. I heard Dr. Green indicate there are over 6,000 in Clark County.

Assemblywoman Benitez-Thompson:
I realized during the course of discussion that some different points were getting confused, like the 72-hour hold versus the Legal 2000 hold. A small thing that I did not realize is that the Legal 2000 is called a Legal 2000 because we last updated the bill in 2000. There is nothing more special than that about the name.

How can we potentially prevent people from entering the Legal 2000 process? Once the initial 72-hour hold time frame is up, the hospitals are having to ask for people's civil rights to be held longer by starting the Legal 2000 because

there is no one there who can decertify them. Can you please explain that process from the vantage point of doing Legal 2000s all of the time?

Kathleen O'Leary:
We see a significant issue in all of the ERs, and I understand it is just as critical in Clark County. Our rural areas are a separate issue. When the 72 hours are expiring and the question of whether a petition for involuntary civil commitment should be filed, a court case is opened while it is being determined if the entire hold and restraints on the individual's liberties should be extended beyond the 72 hours. At that critical juncture, ER physicians who do not have a psychiatry background are frequently reluctant to take the hold off of an individual. Therefore, the petition is filed almost as a fail-safe. In a lot of cases it is warranted, but in a substantial number of cases it is not warranted. What happens is the individuals not only remain on the hold in the ER, but then they are transferred to a psychiatric hospital where they may have to wait to be evaluated again. It is our understanding that hospitals in the community are much more likely to discharge the patient from the hospital if another clinician who has experience and training in psychiatric and mental health proceedings recommends taking the hold off and decertifying the individual. The attending physician in the hospital generally is reluctant to take the hold off because he does not have that specific psychiatric or mental health training that the mental health provider does. Although a petition is filed, a patient may be discharged immediately upon arriving at a psychiatric hospital if a person in that specialty finds that the patient does not meet the criteria and it is safe to discharge him. Because our office represents individuals' liberty interests, we are in favor of procedures and practices that will extend and/or restore someone's liberty once the danger has been reassessed and is no longer present.

Assemblywoman Joiner:
Do you expect this bill to decrease the number of legal holds? Would it increase it or not affect it?

Kathleen O'Leary:
It is a two-step process. The 72-hour hold is just that, 72 hours—that is Legal 2000 vernacular. If the 72 hours expire and no one takes any additional action, the patient is discharged and free to go. There are no further legal implications. In some cases where the clinicians are not sure, or are not totally confident that they have the expertise, they authorize a petition—a legal filing in the courthouse—for an involuntary civil commitment to be filed. At that point, the hold is extended indefinitely waiting for a hearing on the involuntary civil commitment. A number of things happen as a result of the filing: the case is assigned to a judge; an independent psychiatrist or psychologist exams the patient to determine whether he meets the legal definition of mental illness and

danger to self or others; and the requirement of a hearing. The district attorney represents the public safety perspective, and a public defender is appointed to each and every case. A substantial number of cases will never go to petition provided another psychiatric, clinical professional helps with the assessment and the 72-hour hold is allowed to expire, or the person is released before the 72 hours expire. We can have fallout with patients at two stages: those who could be discharged prior to the 72 hours expiring, and all of the petitions filed in court which require due process and a legal process that will never be filed. My guess is that right now there is probably—and I have been doing this 18 years—between 10 and 20 percent or more of the patients who could have been discharged prior to that petition being filed. There would be a substantial decrease in petitions and a substantial increase in freedom for persons who may have a mental illness but do not require a restraint on their liberty.

Tracey Green:
As written, this bill is intended to impact those individuals who have been placed on a legal hold and need evaluation to determine whether they need to be an inpatient or to be discharged to community services. It would not necessarily impact the front-end or those individuals being put on a legal hold.

Assemblyman Sprinkle:
I am supportive of what this bill is trying to do. My question might be slightly outside of the realm of the bill, but are there enough psychiatrists in our system today to be dealing with all of this? Ultimately, do we need to have more of these top-end professionals dealing with this overall problem?

Tracey Green:
We are going to have testimony from those representing the Nevada Psychiatric Association, but we did what we call a secret shopper. We called every psychiatrist in Nevada and asked them if they were accepting new Medicaid clients, and of approximately 200 psychiatrists, we identified 33 that were accepting new Medicaid patients. That is not a reflection of all of the psychiatrists who might evaluate patients in the emergency room, but since a large number of our patients are recipients of Medicaid, it is important that we provide coverage for them. In addition, we have difficulty both hiring and retaining psychiatrists. The rate of salary for our providers has been an issue, but the sheer number of psychiatrists is not adequate to cover every single ER. Perhaps the psychiatry board could speak more to this. There are some hospitals that have hired psychiatrists, but that is a small number compared to the total number of emergency rooms.

Assemblywoman Titus:
I understand that this bill is to expedite appropriate discharges from a facility or ER after patients have been placed there, but are cleared by the ER medical doctor for medical issues. However, the Legal 2000 is potentially still there and needs to be signed off so that the patient does not need to be transported or admitted to a facility or to receive medication.

I am concerned with section 1.7, which says "Except as otherwise provided in this section…other public or private mental health facility or hospital shall not accept an application for an emergency admission under NRS 433A.160 unless that application is accompanied by a certificate of a licensed psychologist, a physician, a physician assistant…." It goes on to expand who can still admit someone with a Legal 2000. I am confused by that.

Tracey Green:
The intent of the amendment is to only affect the individual being evaluated in the ER, nowhere else.

Assemblywoman Titus:
It is not just about evaluating to release; it expands who can actually commit.

Tracey Green:
Working with Risa Lang, we rapidly went through it, but the conceptual amendment is to only affect individuals in the ER.

Assemblywoman Titus:
Again, the individuals can choose to discharge or to admit them. It is not just about discharging them. Could they say that the person has to be admitted?

Tracey Green:
Absolutely. The individual could determine that the patient is a risk to self or others and require a subsequent evaluation in an inpatient facility. That would still require the discharge and acceptance by a free-standing or a psychiatric facility. The individual evaluator would absolutely be able to determine that a person was still at risk, which I think is a critical part of this. The completion of the certificate is warranted if they are still at risk. That is the key, not to go further to state anything besides those two elements.

I would like to add that, currently, the mobile crisis team and the mobile outreach team are comprised of these individuals. They require additional follow-up. While they are evaluated once and sometimes twice more, this delays the rights of the individuals before they can actually be released since they are not at risk to themselves or others.

Assemblywoman Titus:
Section 2 states what you had originally stated: under that section, a physician assistant under the supervision of a psychiatrist, a clinical social worker who has the psychiatric training and experience, an advanced practice registered nurse with training, or an accredited agent of the Department stating he has personally observed and examined the person can conclude that the person is not a person with a mental illness. The original intent is to make sure they are being cleared out of the ER, and you have expanded who can do that. At the same time, you have expanded who can still admit.

Tracey Green:
The mirroring paragraph is the end portion of section 1, which states that the individual who has personally observed and examined the patient has concluded that the person has a mental illness. It would be the clinical evaluation that determines risk, thus the definition of mental illness. That would be the determination of the ER physician because the patient remains with the emergency room.

Kathleen O'Leary:
As a practitioner, I have the same concerns as Assemblywoman Titus that the amendment suggests there would be an expanded pool of people who could do the certification. Right now, the Legal 2000 has a number of parts to it. There is a range of professionals and law enforcement who can initiate the hold, but then it must be certified by either a psychiatrist or a psychologist or, in their absence, a physician who completes the 72-hour process along with the medical clearance. To the extent that this bill allows someone other than a psychiatrist, psychologist, or physician to certify and allow the 72-hour hold to be completed, the Public Defender's Office will not support it. We support the expansion of clinicians who can support discharges for the reasons I previously stated.

Chair Oscarson:
We will ask for testimony in support at this time.

Bill M. Welch, President/Chief Executive Officer, Nevada Hospital Association:
We are in support of S.B. 7 (R1) as it is being proposed today with the amendment. There have been many steps taken during the interim, as well as during this legislative session, to help ensure that patients with mental health conditions receive the care they need. This goes a long way to help expedite movement of the patients through the system and not having patients be held unnecessarily. Dr. Green spoke briefly about the number of secret shopper calls they did where they identified 33 psychiatrists who would see Medicaid

patients. Most of the population coming in under these conditions are going to be uninsured, Medicaid-related patients. That is a significant point to consider.

Dr. Green also mentioned that there were several hospitals that have engaged psychiatrists, and that is true. My understanding is that there are three psychiatrists who are doing that. I would like to point out that we have 14 acute-care hospitals in Las Vegas, 5 in northern Nevada, and 14 rural, community hospitals. We need to make sure we have appropriate resources to deal with these patients' needs, and we think this bill goes a long way in helping to ensure that goal.

Dan Musgrove, representing The Valley Health System, Amerigroup of Nevada, and WestCare of Nevada:
I also represent Amerigroup, which is a unique and important part of this whole population. With Medicaid expansion, they have taken on many of these people and have worked to find dispositions for them. One of my other clients is WestCare, which services as an end user—a place where these folks can be sent—so it is a unique three-legged, important stool. I want to echo Mr. Welch's comments that this is a huge tool for us in our toolbox. I have been working on this issue with this legislative body since 2001. Every year we come back with one more thing that we think we need in order to help move this along, where we can best serve the constituents that we have—your constituents in the state. I urge your approval.

Assemblywoman Spiegel:
Do the hospitals think we have enough psychiatrists to meet the needs?

Dan Musgrove:
Absolutely not. That is why we need other folks to help. It is tough to get someone at a Valley hospital on a Sunday morning at 4 a.m. to make a decision whether the person really needs to be there, or where the best place for them is. At Valley Hospital Medical Center, we have a room that warehouses these folks until they can move into the system. At Spring Valley Hospital Medical Center, we had to convert three beds and make them into mental health beds at a cost of $1 million because of the overload of folks we had at the hospital. We absolutely need folks who can help move them through the system quicker.

Assemblywoman Titus:
I am still concerned about not having enough psychiatrists. I also have concerns that we do not have enough neurosurgeons, but just because we do not have enough neurosurgeons, we do not bring in proctologists. Just because we do not have enough psychiatrists does not mean we expand the people who can do these very critical admissions that take people's personal rights away.

They need to be trained to do it. I am still concerned that this bill, as it reads today, expands those who can do the Legal 2000 on the admitting side.

Chair Oscarson:
I think the proctologist versus these other people is disingenuous to the conversation.

Sara Cholhagian, representing Sunrise Hospital and Medical Center:
We are in support of S.B. 7 (R1) as written with the proposed conceptual amendment. We want to echo the comments of Mr. Welch in that the limited authority to decertify patients on a legal hold in the ER creates an overcrowding issue, and we believe this bill is an important measure that will help alleviate that problem. We are in support.

Mary-Sarah Kinner, representing United Health Services of Delaware:
We are here on behalf of United Health Services of Delaware and their four behavioral health hospitals in Nevada: West Hills and Willow Springs in Reno, as well as Spring Mountain Treatment Center and Spring Mountain Sahara Hospital in Las Vegas. We are here in support of S.B. 7 (R1) and I would also echo Mr. Welch's comments.

Chair Oscarson:
Is there any other testimony in support here or in Las Vegas? Seeing none, I will take testimony in opposition.

Lesley Dickson, M.D., representing Nevada Psychiatric Association:
I do not know if there have been changes from the bill that I have here. I cannot tell from Dr. Green's testimony if she has made any new changes. I want to speak in opposition to S.B. 7 (R1). We are opposed to this and do not think it is safe to have people who lack the training that a psychiatrist or psychologist has when certifying a patient from a Legal 2000. We are fine with section 1.5, which allows a physician assistant to also initiate the front page of a Legal 2000.

The other thing that concerns us is that the previous bill was amended to include data collection, which we thought was a great idea. We actually made a proposal of what data we think should be collected. I think you should put it in this bill if it goes forward so we will start to understand what really is going on. A lot of numbers get thrown around, but they do not represent good data.

I would like to go on to sections 1.7 and 2. I believe the discussion is focusing on who can certify and who can decertify. The amended version says that people can be trained. It is very hard for the psychiatrists to understand and

envision what training could be required of these suggested professionals that would bring their confidence to a level that would make it safe for them to do what it takes a psychiatrist four years of residency training and thousands of hours in patient encounters to obtain the level of competence where they can safely do these evaluations.

There are a lot of problems in the ER, and decertifying patients and discharging them from the ER is not going to come close to fixing the problem. The patients still have their problems and still need good mental health help, but this bill is not coming close to doing anything about that.

Since this issue of not enough psychiatrists keeps coming up, yes, Nevada is short on psychiatrists; the whole country is short on psychiatrists. There are a lot of reasons for that. The whole country is short on doctors in general, including Nevada. You would expect the number of psychiatrists to be a problem. Solving that problem by making social workers do psychiatric work is probably not the way to go. I want to point out that we have a psychiatric practice now in southern Nevada that does ER consultations to see these people. They are now working in several hospitals and are going to hire the graduating residents, so they are expanding all the time. I would suggest those hospitals that say they cannot find a psychiatrist talk with that group about getting their services in their hospital.

Assemblyman Jones:
Could you tell me from your experience, by allowing physician assistants and accredited department personnel to do this work, what kind of damage could be done to these patients? They do not have thousands of hours of training and extra years of experience.

Lesley Dickson:
I appreciate your question about a certified agent because I do not know what that is either. Maybe Dr. Green could explain that. What you worry about when clearing someone from a Legal 2000 is whether they are dangerous to themselves or others: will they commit suicide, will they go out and hurt someone else in the community, or do something else that is damaging in the community like starting a fire. The other big concern is if they are going to get treatment. People who come into the ER in a mental health crisis frequently need treatment. They need a good diagnostic evaluation and treatment. Generally speaking, a lot of these people need detoxification from intoxicating substances and, more importantly, they need to get back on their medications or initiate new medications. That is unique to psychiatrists. We are also medical doctors, so we can appreciate the interaction between

medical problems and psychiatric problems. We might be the one who finally tells the ER doctor that he needs to think about the patient's medical problem.

Assemblyman Sprinkle:
Regarding my previous question and the answer that I got, do you take Medicaid patients, and how many members of your association take new Medicaid patients?

Lesley Dickson:
The answer to the first part of your question is no, I am retired. The only thing I do is work in a small clinic two mornings a week. We used to take Medicaid patients in our clinic and were getting about half of what we charged from Medicaid. Then we got a letter from Medicaid saying they were going to drop the reimbursement rate to half of that, so we were getting one-quarter of what we charged.

Assemblyman Sprinkle:
I understand that, but I was looking for the actual number of psychiatrists in your association who do take Medicaid patients.

Lesley Dickson:
I have no idea.

Assemblyman Sprinkle:
Is there any way you could get that information for us? It is very relevant to the topic we are talking about right now.

Lesley Dickson:
I have been asked this question before. I have sent out emails to my colleagues asking about that, but most of them do not respond or even send back an email. It is very hard to get this information.

Assemblyman Sprinkle:
That is fine.

Assemblywoman Benitez-Thompson:
Could you tell me how many pro bono hours members of your association do to take on impoverished patients, and those without insurance or Medicaid?

Lesley Dickson:
Most psychiatrists in this state work for an agency such as the state system, the U.S. Department of Veterans Affairs, Mojave Mental Health Community

Counseling, and the Department of Corrections. We prefer salaries—let us put it that way—then we do not have to deal with the issue of Medicaid.

Assemblywoman Benitez-Thompson:
Dealing with the issue of Medicaid and Medicaid patients I know is hard, but I think it is only fair and just that people have access to health care even if they are poor. Their civil rights are protected even if they are poor. I want to make sure that we are all doing our due diligence to not only make sure we are offering great care to people who can pay out of pocket, but also people who fall below the poverty line.

The other question I have is whether the law says psychiatrists or psychologists? I am trying to remember the current reference to statute.

Lesley Dickson:
Psychiatrists and psychologists are both in this law.

Assemblywoman Benitez-Thompson:
I am looking at the Legal 2000 form and have a question about it, but I will address it with the Legal Division and have them respond to all of the members.

I want more information about the group that the three psychiatrists who have testified belong to. We need them to help address this issue in our ERs. Do those three psychiatrists have a practice that is 24/7 that meets the needs of an ER?

Lesley Dickson:
I think you need to repeat the question because I am not sure what you are asking.

Assemblywoman Benitez-Thompson:
There was testimony on the record that there are three psychiatrists who have come together to go into the ERs to work with the decertification process. I wonder if you could tell me what their business model is, like knowing that the ER is open 24 hours a day, 7 days a week. If the ER calls one of the people in this group on Saturday night at 9 o'clock, is their business such that they can meet those needs?

Lesley Dickson:
First off, it is a much larger group than three psychiatrists. They have hired several of the graduating residents over the years. I think they are up to six or seven psychiatrists now. I know they are going to hire two more. I do not

know if they do nights or weekends; you would have to ask them. Generally speaking, one thing that is happening in the ER is this rush to do something.

Assemblywoman Benitez-Thompson:
Is that rush because of the number of beds that are occupied by the mentally ill and the hospital has a sincere need for the beds?

Lesley Dickson:
It is because people are in a big hurry to get patients seen.

Assemblywoman Benitez-Thompson:
They are in a hurry to have those beds turn over so people with legitimate health issues, such as chest pains, can be seen.

Lesley Dickson:
I do not have to argue that the mentally ill are just as legitimate as other patients. A lot of these patients are intoxicated and it takes a while for alcohol and other drugs to wear off so you can see what is really underneath. Generally, it is better to leave them in a quiet place for a few hours rather than rush in at 4 o'clock in the morning.

Assemblywoman Benitez-Thompson:
The one thing I appreciate about our Nevada statutes is that we have a very good definition of mentally ill. Also, within this process, we have distinctive language that says why people cannot be held. That is very unique to the state of Nevada. We have language in there that says just because you are drunk does not mean you can be held involuntarily and that you can be in a hospital for 72 hours. We have good exclusionary language that says a person with Alzheimer's cannot be held as a mentally ill person, or someone who is intoxicated. Being intoxicated, in and of itself, does not count as being a mentally ill person. We also have in that exclusion to make sure we are not holding folks unnecessarily within that 72 hours. Is that correct?

Lesley Dickson:
That is why those exclusions are in there. You may have an old form before Alzheimer's was dropped and the word dementia was put in on the more recent form. It is correct. That is why I say it is best to give these patients a few hours so you can decide if this is a true mental illness—like bipolar—or if you are dealing purely with alcohol intoxication. It would be considered a bad idea or illegal to put a Legal 2000 on someone whose only diagnosis is alcohol abuse or dependence. It happens all the time, because ER personnel are in a hurry and they write the Legal 2000 too soon.

Chair Oscarson:
They want to use hospital ERs as drunk tanks. Are there any other questions? Seeing none, we will ask for other opposition.

Grayson D. Wilt, Policy Research and Government Affairs Specialist, Nevada State Medical Association:
We also oppose this bill.

Chair Oscarson:
Are there any other comments? Seeing none, I will take neutral testimony.

Kim Frakes, Executive Director, Board of Examiners for Social Workers:
I was not going to testify on the bill. I am here in case there were any other questions. I only have the first reprint of the bill, and I do not know if that is the conceptual amendment. If there are any questions of clarification as to why clinical social workers may be competent to complete the decertification, I would be happy to answer them.

Assemblyman Araujo:
Do clinical social workers currently handle mentally ill patients? If so, to what extent? Please elaborate further on the work they do.

Kim Frakes:
Yes. Clinical social workers provide a variety of services to the mentally ill, whether in their own private practice or within the hospital or residential treatment environment. We also have clinical social workers in the field who administer the mobile mental health crisis for both children and adults. We also have clinical social worker interns. These are the postgraduate master of social work (MSW) individuals who have earned their MSW that have indicated their willingness to go through an extensive two to three year postgraduate process which is part of a very extensive collaboration with our board, the agency, the supervisors which we have to approve—they need a minimum of three years postlicensed clinical social worker (LCSW) experience before we would even let them supervise—and the intern. It is very extensive and collaborative. It takes two or three years and we monitor them constantly through reports. There is also a very rigorous, high-stakes examination that they must take and pass in addition to that process. Our LCSWs are out there.

I am an LCSW as well and have also performed a lot of extensive psychiatric work in inpatient, residential settings. I am limited on private practice; I am more into the inpatient hospital setting. I have done Legal 2000s and have done extensive collaboration with psychiatrists. Often the psychiatrist will come to the LCSW in the hospital setting. In addition to seeing the patients and

doing groups and counseling, we also do family counseling or family therapy. We are very knowledgeable about postdischarge planning and how critical that is. We also express our feelings to the psychiatrists about the postdischarge success possibility for a patient. A lot of times the psychiatrist will utilize our information to decertify or continue on with a hold, if necessary.

Assemblyman Araujo:
Thank you for clarifying how extensive the requirements are for someone to get to the level of being a licensed clinical social worker. I know from someone who is new to this Committee, it is important to know that there is a big difference between a regular social worker and a licensed clinical social worker.

You touched on the services that you provide and there was a question that was asked in reference to Medicaid patients. That left a question in my head. If some folks are not willing to see Medicaid patients, who is? Do you see that clinical social workers tend to see more Medicaid patients? Can you address that gap in our system?

Kim Frakes:
Yes. Many of the social workers who are LCSWs and work in private agencies accept Medicaid. They are approved providers who are qualified mental health professionals and are allowed to accept Medicaid patients.

Assemblyman Jones:
Is there a definition of the accredited agent of the state somewhere in statute?

Chair Oscarson:
Our Legal Counsel will check and get back to you. Any other questions? Seeing none, Dr. Green, would you like to wrap it up?

Tracey Green:
First, the agents of the state include people such as interns and residents who are not actually listed as physicians or providers. We have interns and residents under the supervision of licensed clinical social workers and/or other physicians and psychiatrists, and those would be considered agents of the state.

The only other point I would like to make in closing is that we do have data surrounding some of the evaluations that were done. All of the evaluations were done by our mobile crisis or mobile outreach teams. That data is all done by LCSWs and psychologists. Also, as the law currently says, psychologists can do this process. They are not psychiatrists with four years of psychiatric training. This would provide the opportunity for other highly-trained individuals with psychiatric specialty that can not only evaluate and determine whether

a person is in need of a legal hold, but also to assist with discharge planning, which is very important for the success of our clients in the ER.

Chair Oscarson:
We will close the hearing on S.B. 7 (R1). We will open the hearing on Senate Bill 15 (1st Reprint) and hear from Dr. Dickson.

Senate Bill 15 (1st Reprint): Requires a mental health professional to take certain actions if a patient communicates an explicit threat in certain circumstances. (BDR 54-3)

Lesley Dickson, M.D., representing Nevada Psychiatric Association:
Senator Hardy, the sponsor of Senate Bill 15 (1st Reprint), regrets that he is unable to be here, so he asked me to introduce this bill. This bill is also called the *Tarasoff* bill and refers to the *Tarasoff* decision [*Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)]. The *Tarasoff* decision was a landmark decision in California that holds mental health care professionals to be proactive in preventing harm by a patient if that mental health care professional knows or has reason to suspect that the patient may present a risk of harm to a specific person or persons. What happened was, back in the 1970s, a young man was seen in one of the University of California campuses' student health service and he was upset about a girlfriend. He was hurt and angry and making threats against her life. Unfortunately, he left the clinic and did kill the young lady. Tarasoff was the name of the victim. The family sued and the resulting decision was that mental health professionals have a duty, if they become aware of a danger to another person and that person is easily identified, to inform the potential victim and law enforcement to provide for the safety of the potential victim.

Senate Bill 15 (1st Reprint) was originally a section in a bill in the last session, but that bill did not make it all the way. Senator Hardy elected to take the language of *Tarasoff* out of that bill and make that a separate bill. What we did with the bill when it was originally presented was to add in what is called a duty to protect language, which gives the clinician the option and duty to admit the patient for everyone's safety—both the patient and the potential victim. This is generally what we do. We admit a patient to the hospital and deal with the problems of threats within the hospital. This is the kind of patient that probably does deserve a Legal 2000 in this state. Occasionally, it may happen that someone misses the boat and loses sight of the patient and they escape the emergency room, but they have made the threats, so the clinician should warn the potential victim if he knows who it is, or notify law enforcement.

Most states have already passed this law, but Nevada never did put it in statute. We would like to see it in statute. Clinically, we already do this. We are trained to do this; we know to do this. By putting it in statute, it gives it another level of authority or approval. The bill also provides for some protection from being liable for a bad outcome. When we warn a potential victim—who might be a boss who just fired the person—we cannot be sued for that person losing his job. The Nevada Psychiatric Association is speaking in favor of this bill (Exhibit L) and would like to see it in Nevada statutes. The Nevada Psychological Association is also in support of the bill (Exhibit M).

Assemblyman Thompson:
In section 1, subsection 1, paragraph (a), would it be more advisable to contact the law enforcement agency and then they would contact the person who is the subject of the threat? Does it not put a lot of liability on the mental health professional?

Lesley Dickson:
The way the bill is written, and the way a lot of these statutes are written, is that you do both. You inform the potential victim and the law enforcement agency that is closest to the location of the potential victim.

Assemblyman Thompson:
I understand that, but the way I read it is that this is like a laundry list of all the people who the mental health professional must contact. What I am suggesting is that lines 12 and 13 on page 2 would say that the law enforcement agency closest is contacted and then it is up to them to contact the subject of the threat.

Lesley Dickson:
I do not know what to say. The problem is sometimes law enforcement cannot find the person. It is like a double safety. You have two people making that effort to notify the person. We do both. You would have to talk to law enforcement about that; it is not always easy to find law enforcement to do this either.

Assemblywoman Spiegel:
My question is related to other people who might also receive these kinds of communications or threats, such as people who are volunteers or staff of a suicide hotline or clergy. Is there a reason why there are no obligations or protections for some of these folks as well?

Lesley Dickson:
I cannot answer that question. That would be up to all of you if you think that those people ought to be added to this bill. This has generally been considered a mental health issue. It is true that other people can hear these threats and if we want to write it into statute that they have an obligation to do something about it, I will leave up to you.

Assemblywoman Benitez-Thompson:
I am confused. When I look at section 1, subsection 4, you have language that says mental health professionals, including social workers, can play a part in this mental health issue for people who are in imminent crisis and I feel it is 180 degrees from the stance that you took on the last bill. I am really having trouble figuring out the reasoning. The only thing I can figure out is that there are no payment issues. Help me understand what the difference is.

Lesley Dickson:
I do not know what payment has to do with this. This is pure protection of society. This is all about that. I feel that people are being charged with an obligation to protect potential victims. It has to be specific victims, and not someone who says he might go out and make a bomb. You have to know who the target of the bomb is. If a social worker has a person in her office making these threats, she is obligated to warn the victim and/or to protect society and arrange for an admission. Usually they will be transferred to a facility that can in turn admit them to a psychiatric facility. This has nothing to do with a Legal 2000.

Assemblywoman Benitez-Thompson:
Correct me if I am wrong but, section 1, at the bottom of subsection 2, talks about who can be discharged from a facility, then you roll right into the definition of all of the professions that can do this. I guess that is where I am getting confused, that and the inconsistency of the argument on the quality of the professions that are needed to engage with folks who are mentally ill.

Lesley Dickson:
My understanding of the people listed in this bill are the people who are actually seeing these patients in their office or an agency. This is all it is covering. It is for those who are likely to hear these sorts of threats. That would be in a mental health professional's office. It was expanded by Senator Hardy to switch section 4 from a psychiatrist to a physician because an ER physician also hears these threats.

Assemblywoman Titus:
The way I look at this bill is that there are many cases in society where we, as professionals—whether educators, social workers, or mental health people—are obligated to report if we seem concerned. For example, if teachers or nurses or social workers suspect that a child has been abused, we are mandated to report that to law enforcement or Child Protective Services. I look at this bill as a mandate for professionals who are in the presence of someone making threats toward another person. We see this as a serious threat, and this mandates us to report this to law enforcement, or at least start the Legal 2000 process. Is that the intent of this bill, that if someone says they are going to kill another person, we are mandated to follow through?

Lesley Dickson:
If we believe this threat is real and the victim is apparent and the person has the ability to carry out this action then, yes, we are mandated.

Assemblywoman Titus:
By this bill only because we are not currently mandated in statute, correct?

Lesley Dickson:
Absolutely. It is not currently in statute, but it is part of our clinical training to do this—and we know to do this—but it is not in statute at this point.

Chair Oscarson:
Are there any other questions? Seeing none, we will take testimony in support. Seeing none, we will take testimony in opposition. There is none, so we will take testimony that is neutral. Seeing none, are there any closing comments? [There were none.] I will close the hearing on Senate Bill 15 (1st Reprint) and open the floor to public comment. Seeing no one for public comment, the meeting is adjourned [at 3:39 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karyn Werner
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Health and Human Services

Date: May 13, 2015 **Time of Meeting: 2:00 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 33 (R1)	C	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 35	D	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 114 (R1)	E	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 247 (R1)	F	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 314 (R1)	G	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 327 (R1)	H	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 402	I	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 441 (R1)	J	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
S.B. 148	K	Brigid Duffy, Clark County District Attorney	Proposed Amendment from Clark County
S.B. 15 (R1)	L	Lesley Dickson, Nevada Psychiatric Association	Letter in Support
S.B. 15 (R1)	M	Lisa Linning, Nevada Psychological Association	Letter in Support