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

Eightieth Session
March 4, 2019

The Committee on Health and Human Services was called to order by Chair Michael C. Sprinkle at 1:33 p.m. on Monday, March 4, 2019, 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, and to Room 102, McMullen Hall, Great Basin College, 1500 College Parkway, Elko, 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/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chair
Assemblyman Richard Carrillo, Vice Chair
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (excused)

GUEST LEGISLATORS PRESENT:

Senator Pete Goicoechea, Senate District No. 19

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Terry Horgan, Committee Secretary
Alejandra Medina, Committee Assistant

OTHERS PRESENT:

Valerie Cauhape, Coordinator, Rural Regional Behavioral Health Policy Board
Fergus Laughridge, Chair, Rural Regional Behavioral Health Policy Board
Ty Trouten, Captain, Police Department, City of Elko
Lea Bastin, Private Citizen, Elko, Nevada
Nancy Snyder, Private Citizen, Spring Creek, Nevada
Joelle Gutman, Government Affairs Liaison, Washoe County Health District
Eric Spratley, Executive Director, Nevada Sheriffs' and Chiefs' Association
Joan Hall, President, Nevada Rural Hospital Partners
Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board
Sarah M. Adler, President, National Alliance on Mental Illness, Western Nevada Affiliate; and representing the National Alliance on Mental Illness-Nevada
Kathy McIntosh, Director, Silver Stage Pantry, Silver Springs, Nevada
Jennifer Claypool, Private Citizen, Dayton, Nevada
Adrienne Sutherland, Clinical Director, Community Chest, Inc., Fernley, Nevada
Danica Pierce, Private Citizen, Sparks, Nevada
David Wm. Fogerson, Chair, Northern Regional Behavioral Health Policy Board; and Deputy Fire Chief, East Fork Fire Protection District
Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board
Lesley R. Dickson, Private Citizen, Las Vegas, Nevada
Jessica W. Murphy, Public Defender, Office of the Clark County Public Defender
Edrie LaVoie, Private Citizen, Fernley, Nevada
Joseph McEllistrem, Director, Forensic Health Services, Carson City and Douglas County Jails
Sara Cholhagian, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals
Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office
Robin V. Reedy, Executive Director, National Alliance on Mental Illness-Nevada
Brian Evans, representing the Nevada State Medical Association

Chair Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] Over the weekend, I was reflecting on last Friday afternoon and a situation that occurred here during our Committee meeting. I may have been a little short with some presenters. I was thinking about my expectations of people who are presenting; I realized that we are still relatively new into the session, and I am not positive that my expectations are known. So I want to read something to everyone, but certainly to anyone who will be presenting in front of this Committee in the future just so you know exactly what my expectations are as Committee Chair. What I am about to read comes from our Assembly Standing Rules and is an excerpt from Rule No. 54: Testimony, Witnesses and Exhibits:

2. In addressing the committee, a person must state for the record whether he or she supports, opposes or is neutral to the bill or resolution before the committee. For purposes of legislative intent:
    (a) "Support" of a bill or resolution shall be construed as:
        (1) Approval of the measure as written; or
        (2) Approval of the measure as written along with proposed amendments that have been approved by the sponsor of the measure.
    (b) "Opposition" to a bill or resolution shall be construed as:
        (1) Not supporting the measure as written; or
        (2) Opposing the measure as revised by an amendment that has not been approved by the sponsor of the measure.
    (c) A "neutral" position on a bill or resolution is one in which the person offers particular insight on the measure but expresses no position on the measure.

I just want to make sure we are totally clear about Rule No. 54, because it is important for the future, and it is certainly important out of respect for whoever is bringing the bill forward. My expectation is that if you do come up in support of a bill, it is because you support the bill. There are no exceptions to that. If you do not support the bill, it does not mean that you still cannot work with the sponsor about potentially changing some of the things you are not supportive of. If you are not 100 percent supportive of the bill, please do not come up in support of it. I hope that is clear, and once again, I do want to apologize to the extent that I may have come across as being a little harsh on Friday afternoon to some of the presenters. I just want to be sure we are clear about this, and thank you for the indulgence, Committee.

At this point, I would like to open up the hearing on Assembly Bill 47.

Assembly Bill 47: Makes an appropriation to the Division of Public and Behavioral Health of the Department of Health and Human Services to establish a pilot program to address behavioral health crisis response in certain counties. (BDR S-501)

Senator Pete Goicoechea, Senate District No. 19:
I had the pleasure of being the legislator who was serving on the Rural Regional Behavioral Health Policy Board for northeastern Nevada—Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties. That is quite a distance represented by those counties, and we are definitely in need of some help, which brings us to Assembly Bill 47. I am glad to have had the opportunity to have worked with this group on this bill. As a legislator, I go into hospital emergency rooms (ERs) looking at what is going on there, especially as we deal with mental health patients. Typically they are in an ER, and typically there is a police officer or someone there to supervise the patient. Until a bed is available for the patient, those officers will be supervising and that could last for two or three days. When we are lucky enough to get a bed, the patient will be transported out of the rural area; however, a lot

of times, sometimes within the next 30 days, that patient will be back in the spin cycle again, and we will be going through the same thing.

That litany of events is what brings A.B. 47 forward as the pilot program. It will allow us to take a long, hard look at mental health crises, and as we walk through this pilot program, we will focus on training for the people who are supervising and transporting as we try to move patients out of these rural communities. The training and personnel in some of our rural counties are stretched, but they do the best they can. For instance in White Pine County, they are probably lucky to have five deputies, so to provide 24-hour coverage, in that jurisdiction just to maintain a person while he or she is having problems and in the ER will take all the officers off the streets. We have to make sure we can get those officers the training they need and the ability to transport that individual. Today, that individual would be put into the back of a patrol car and transported that way. That is typical. We do not like it; and typically the transport over long distances is not good for the patient. It is over 300 miles from Ely if the patient goes to a bed in Reno.

This pilot program is going to cost us some money, but it is costing us a lot of money right today—and worse than the expense is what we are doing to those patients we are seeing in these rural communities. There was a patient in Elko who was chewing on himself and on other people, and officers were there for at least three days supervising him until we got a bed for him. That is a waste of resources, it is horrible for the patient, and we have to do something different. Yes, we are frontier out there and we are proud of that, but the bottom line is that we do need some help.

Valerie Cauhape, Coordinator, Rural Regional Behavioral Health Policy Board:
[A PowerPoint presentation accompanied this testimony (Exhibit C).] The Rural Regional Behavioral Health Policy Board represents seven of the frontier counties across northern and northeastern Nevada. The reason these counties are considered to be frontier is not only because of their low population densities, but also because they are located at great distances from population centers. It is in these population centers where oftentimes crisis care is located, which can become quite a problem.

There are a few different components to the pilot program proposed by A.B. 47. Eligible counties would be those with populations less than 55,000. There is an asterisk on that slide [page 3, (Exhibit C)] because there is an amendment that has been included on the Nevada Electronic Legislative Information System regarding the population caps (Exhibit D). This refers back to the 2010 Census data, meaning that all seven of our counties would be eligible to participate. The main components of the pilot program would be crisis intervention team CIT training; access to a mental health professional; identification and testing of non-law enforcement transportation to inpatient facilities outside the region; and the inclusion of four case managers to coordinate care once a person is stabilized.

Let us talk about CIT—the crisis intervention team—training [page 4, (Exhibit C)]. The purpose is to reduce any unnecessary arrests of persons suffering from mental illness. This is done through education of law enforcement and other first responders regarding the signs and

symptoms of mental and behavioral health crisis—what services are available in their community and how to de-escalate the crisis once it is happening and they come upon the person. This is built off the Memphis Model which is a national model used across the country.

There are five legs to the CIT stool [page 5]. First is the police and first responder training I just mentioned. Second is the basis of the training itself being developed through community collaboration. During CIT training, a broad variety of stakeholders will be present to discuss their needs, the issues they see on a daily basis, and also what resources they have and how those resources can be accessed. The third leg includes a vibrant and accessible crisis system. By vibrant and accessible we mean there are enough services available to people who need them, there is transportation to those services, and there are payment mechanisms in place so services can be utilized. The fourth leg includes family and community education. This helps people recognize the signs and symptoms of behavioral health issues within their loved ones so they can help support that person through this. Additionally, this helps community members recognize services that are available within their community and advocate to get the services that are badly needed. The last component is behavioral health staff training. That would include training regarding how to communicate with outside organizations and other stakeholders and how to build positive referral systems.

In 2018 there were two CIT trainings held within our region—one in Winnemucca and one in Elko [page 6, (Exhibit C)]. The participants at these trainings represented six of our seven counties. Comments made by participants afterward included that they noticed there was a large amount of awareness regarding not only the crisis issues they faced in these communities but also the resources available to them as first responders. Furthermore, the training acted as a forum to open channels of communication and improve referral systems that might have been broken. Some members of law enforcement told me that they had really been able to work on relationship building with organizations within their communities.

The next component of the pilot project is the inclusion of a mental health provider [page 7]. This could be a psychiatrist, psychologist, physician's assistant, advanced practice registered nurse, or a licensed clinical social worker. Ultimately, the purpose of this mental health provider is to work in conjunction with first responders during the crisis and help coordinate appropriate care for the person in crisis. This can be done either via telemedicine or in person. Furthermore, this mental health provider will be responsible for coordinating and building the CIT trainings throughout the region.

Transportation is an enduring problem that has been quite an issue largely due to the long distances a lot of these communities are from services [page 9, (Exhibit C)]. Currently, transportation to inpatient services requires law enforcement to give up one, two, or more officers for 8 to 12 hours or sometimes longer. As was mentioned, not only is that not the best use of resources, but it also poses a public safety issue. It is not dignified and is hugely stigmatizing for those who are experiencing the actual crisis. The pilot program proposed by

A.B. 47 would identify and test other means of transportation that must be safe, dignified, and timely so that once a bed is made available, the person can be transferred before the bed is taken by someone else. This may open up the opportunity for private-party contracts or other services as designated appropriate by the Division of Public and Behavioral Health.

The last component is four regional case managers [page 10]. Currently, while there are case managers in the region, there are insufficient numbers of them to really meet the need. What happens is that people can fall through the cracks as they move through the care system. Once people are stabilized, the inclusion of additional case managers can help those people navigate this behavioral health care system so that they stay in care and do not experience subsequent crises. The total fiscal note for the biennium proposed by A.B. 47 is $575,000. I will turn the mic over to my Board Chair, Fergus Laughridge, for further comments.

Chair Sprinkle:
If I might interrupt for one second. Understanding the fiscal note is important to the policy decisions, but since this is the first time that issue has come up with this Committee, I just want Committee members to understand that the fiscal aspect of this bill will be heard in a different committee, so please keep any questions you have just to the policy aspects.

Fergus Laughridge, Chair, Rural Regional Behavioral Health Policy Board:
Ms. Cauhape has summarized the bill's intent for your Committee, and we would urge you to move forward with it. The CIT training is emphasized both for law enforcement and non-law enforcement personnel such as first responders and emergency medical technicians in the rural areas. They are the safety net. In 40-plus years in public safety, both in law enforcement and emergency medical services, never once did I think that behavioral health would be the major issue it is now in our everyday lives. We are working in the rural areas, but this pilot program would help us bring more information to you and subsequently report during the interim as to the process and successes of the program.

Case management is a big investment. We want to keep these people from returning back into the cycle Senator Goicoechea identified—30 days later they are back. We believe there is a mechanism that is available that, with support, would keep most of those clients within their communities, getting the appropriate care that they need, and not continue to have this impact on law enforcement, our hospitals, and our emergency medical services.

Chair Sprinkle:
Are there any questions?

Assemblyman Thompson:
Do you have an annual scope of the need? About how many people do you anticipate will be served? I notice that you have identified a certain number of case workers, but what would the ratio be?

Valerie Cauhape:
Unfortunately, we do not know exactly because there is not a lot of data available. We are working with stakeholders to improve data collection on projects, but that is also a long-term project we will be working on simultaneously.

Senator Goicoechea:
I do not think anyone realizes what few services we are actually providing out in these communities. I do not know if we could get a head count or a name count. We hold these people until we can deliver them someplace else, then sometimes as soon as 30 days later, they come back and start all over again. I am not sure if we know whether we are getting the same patients back.

Assemblyman Thompson:
We have three continuums of care in the state of Nevada—one in the south, one in the north, and one in the balance of the state which mainly addresses the needs of the rural communities. Even though it is specifically addressing homelessness, as we know, homelessness is a big root of the problem. Do you have a connection with your rural continuum of care because they do an annual homeless count? With that count, there are to be as many community interviews as possible to see the different types of needs, illnesses, and struggles people are dealing with. Have you made that connection, because that is really key? They are the experts who know about bed use and need to have that data when applying for the federal grant we receive for our state. This could be part of the policy area.

Valerie Cauhape:
I am new to this position and in the process of building those relationships and finding those contacts. Unfortunately, not all that information is published online, so a lot of it is just beating the bushes to discover who is where and what people are doing. It is a work in progress, but I am also working on another project related to that which should allow for a lot of those contacts within the next month or two.

Fergus Laughridge:
The conditions are very different in the rural areas than they are in metropolitan Las Vegas or Reno areas that you may be familiar with where there is a larger homeless population. In the rural areas, these are residents of the counties. They are not homeless, but they still have behavioral health issues. They are removed from available resources just by the fact that they live in rural areas. They do not have access to continued care that you would normally have in a metropolitan area. That has further impact on the rural areas and is another reason why this is very important. I work with the ambulance service in Winnemucca, and we transport and work with individuals in crises whom we have to take to Reno. They have homes, they have jobs, but there is still that crisis need, and they sometimes sit for hours or days waiting for care, unlike anyone else who gets immediate care.

Chair Sprinkle:
I am sure you are aware that one of the other behavioral health boards is bringing forward legislation that may deal with the data collection you were referring to. Also, the rural

hospitals may be able to address this issue further, so we may be able to get more information for you, Assemblyman Thompson.

Assemblywoman Titus:
Each quadrant, and some other sub-areas that we found in the state, have unique experiences when it comes to the mental health realm and needs. I have a question about the bill concerning section 5, subsection 1, paragraphs (a) and (b). Really, this bill is doing two things. One is training for crisis intervention at the site, but it is also allowing for transportation of the person in a mental health crisis, possibly to a tertiary facility or mental health facility. Would you be transporting prior to getting the medical clearance or would you be transporting after? Is this going to divert the patient from getting the medical clearance? Are you going to be able to clear them in the field and take them directly to the mental health facility?

Valerie Cauhape:
From the way the bill is written, the transportation would happen after the clearance. The bill specifically did not address that language because there are other bills that may be addressing some of those issues.

Assemblywoman Titus:
It is indeed open, so we will have to see how this all comes out in some of the other bills. Certainly, you would have to have the patients accepted at the mental health facility for you to take them there, and there are a number of steps to go through before they can be transported. I am appreciative of crisis intervention at the site, which could possibly divert the need for transportation. That would be one thought. Then the thought is that someone other than a police officer or law enforcement officer could transport them once they are accepted at another facility. These are clearly two different issues in this bill, and I think we need clarification.

Senator Goicoechea:
We are presuming that we are going through the same process. You do not move them anywhere until you have a bed. What this is focused on is trying to remove the need to have the law enforcement officer there, which raises the next question—do we have to define what vehicle we are going to use for transport? If it is a private sector vehicle, what would that vehicle look like? I do not care where you are in rural Nevada, if you do not have a bed, that patient will not be moved anywhere by anyone, and we understand that.

Assemblyman Assefa:
Language in section 5, subsection 1, talks about a population cap. Why is there a cap? Has a program like this ever happened anywhere in our state or anywhere else? What were the results?

Valerie Cauhape:
The population cap was designed to target the resources toward the most frontier counties. While there is a huge need for services throughout the state, these frontier counties may

benefit the most from some specified programming. Furthermore, it is my understanding that this pilot program has not been piloted anywhere in the state, and it is also unique across the country.

Assemblyman Assefa:
If there were published results, if it happened somewhere else, if we learned from those experiences—that was what I was trying to get to.

Senator Goicoechea:
In this case, 55,000 is the population cap that is in place. We have to go back to the 2010 United States Census to include Elko County in this program. You have to understand, when talking about Elko County, you are talking about the communities of Carlin, Mountain City, Owyhee, Jackpot, Wendover, Wells, Elko, and Lamoille—a lot of jurisdictions. Geographically it is so big, but if you throw them all together, you end up with over 50,000 people in that county. In most of those communities, outside of the City of Elko which is a community of about 14,000, the population cap more reflects the geographic area of Elko County. We are trying to make sure that Elko can still be counted among the seven counties so it will still be serviced because the people in these small communities are dealing with the same problem. It might be the Wendover police chief trying to hold someone in a clinic and ending up transporting that person.

Fergus Laughridge:
The population cap has been addressed and answered. The CIT Program has been effective in this state. In Carson City, Sheriff Ken Furlong has been working with CIT-trained officers, and I believe the Las Vegas Metropolitan Police Department has also embraced this. This program originated in Memphis, Tennessee, in 1988 and has been adopted throughout law enforcement and first-responder communities across the country. We can get further information for you if you would like.

Chair Sprinkle:
Are there any further questions, Committee? [There was no reply.] I have a couple of questions specific to the pilot portion of this bill. In regard to defining it as a pilot, what results are you looking to achieve?

Valerie Cauhape:
I have been keeping communications open with the Division of Public and Behavioral Health regarding evaluation measures and what could be designed through the program plan, which would be separate from the policy itself. The intent of the pilot program is to reduce repeated crises and also to reduce the amount of staff time utilized by law enforcement and emergency medical services in transportation and needing to stay with a patient in the emergency room. I was also led to believe that the reduction in bed use would also be another measure we could look at when we are talking about outcome measures, but those have not yet been defined.

Chair Sprinkle:
Would those results you just talked about show this pilot to be successful?

Valerie Cauhape:
Yes, outcome measures are one of the best ways to look at success. We would also want to look at what type of process measures we want to build into the program to make sure that if the pilot program is being replicated in different communities within Nevada, what are the ways they are or are not—and hopefully not—being implemented differently; and what is successful and what is not. A proper program evaluation piece is something we are very interested in.

Chair Sprinkle:
What is the time frame for this pilot program?

Valerie Cauhape:
I believe it is the biennium, so until the next legislative session.

Senator Goicoechea:
I believe it is June 30, 2021. There may also be a reversion. Any remaining balance must not be committed for expenditure after September 17, 2021. Even if the money does not revert, we cannot spend it.

Chair Sprinkle:
If there are no other questions from the Committee, I will call forward anyone wishing to speak in support of A.B. 47. I am going to start taking testimony from Elko.

Ty Trouten, Captain, Police Department, City of Elko:
I am in favor of A.B. 47 as amended. One of the critical things to understand is that this is a ground-up approach to the issues we are specifically facing in these rural, frontier counties. As a member of CIT International, I can tell you that the definition of rural is interpreted differently across our country. In many places, rural is considered having to spend 30 minutes to transport someone to a critical care facility when they are in crisis. When we start traveling—sometimes 300 miles or, as in the case of West Wendover, 400 miles—we get deer-in-the-headlight looks. We are unique in the hurdles we are called upon to overcome. The Rural Regional Behavioral Health Policy Board did a great job preparing this bill and outlining the needs and potential solutions to this pilot program to overcome some of these issues.

The other thing to understand is that this is not just about one person, one time, getting care. This is a greater program that is looking at CIT—the collaboration between law enforcement and mental health professionals—to actually help these people. As has been previously stated, this is not just about homeless and transient folks. This is about all people within our community who are in crisis and helping them to obtain the services they need to overcome these mental health issues so they can be productive and happy members of our society,

which also, in turn, serves our greater community. Please keep those items in mind and understand that this is a solution for a unique problem that this rural part of Nevada is facing.

Lea Bastin, Private Citizen, Elko, Nevada:
I am a family advocate for Elko, Eureka, Humboldt, and Lander Counties through the Ron Wood Family Resource Center. I am also the wife of a military veteran with post-traumatic stress disorder and the mother of a son with untreated autism because of lack of services in our community.

The military heavily recruits from our rural communities and they send these people home with little or no care. We are currently facing a crisis with our veterans in our rural communities. Miners work long hours without care. Unless you are suicidal, you can wait up to six months to see a mental health care specialist in our community. Actively suicidal people are currently being released after the attempt, going to work, and working long hours—night shifts in many cases for miners. I had been a mental health advocate for over three years when my husband had an allergic reaction to medicine prescribed by the Department of Veterans Affairs facility here in town. He spent 72 hours in the drunk tank because there were no facilities for him. After several similar encounters with veterans and suicide attempts in our community, Ty Trouten really stepped up and went to bat for veterans in our community. We now have better services in the hospital, but people are still being released without care or information about where to receive care. And these people are returning to work and to their families untreated.

I currently contract with child protective services in the four counties I mentioned before, and I respond daily to cases of children with untreated mental health conditions and parents with untreated mental health conditions. It is a tragedy. Suicide rates for our children are astronomical. We have children who do not know how to deal with today's technology, and their parents work long hours. They may be bullied at home, or there may be inadequate care at home, and they are committing suicide at an alarming rate.

We want a healthy community. We want people to be treated with dignity and come home safely after being treated instead of being released to come back again during their next crisis. We need a bed facility in our area, but we will take a crisis team if you will give us one. Driving two to four hours to get care for your loved ones is really hard. My husband currently lives in Reno so he can receive treatment. I am also facing the tough decision concerning whether to send my child to Reno to live with my husband because my son cannot get services in our community because there is no one who can diagnose him. He has been on a wait list for over a year at the University of Nevada, Reno to receive a diagnosis. Nevada needs mental health services and treatment in your rural and frontier communities. I know you do not understand this because you can go down the street two or three miles and visit a mental health professional. We have to drive hours or hope that a telemedicine facility will prescribe the accurate medicine and that our loved ones will not end up in the drunk tank.

As I said, I am a mental health advocate in our community and I am working a lot of overtime. I am basically doing triage for our communities because I am a volunteer whose loved ones have mental health conditions. That is how we are treating these conditions—not with professional care but with parents, friends, family advocates, and peer advocates. We need your help. Please consider this bill, and thank you for your time.

Nancy Snyder, Private Citizen, Spring Creek, Nevada:
I would like to give a personal view on this. Some years ago when I was working fulltime at a professional job, I had some mental health difficulties. I fell into despair and was suicidal. I ended up at the hospital here in Elko. I waited not quite a full day, but it seemed longer. A decision was made to transport me to Reno—a 300-mile trip. I went by car. I was feeling really bad—seeing no light, no hope. It was a long trip, so in Fernley we made a stop to go to the bathroom. In my pit of despair, they handcuffed me, led me into and through the middle of a busy truck stop and into the bathroom, and proceeded to observe me as I went to the bathroom. That had not been done at the hospital, but for some reason, they felt it necessary to observe me on this trip. It was humiliating, it was horrific, and it was not something I needed at that point in my emotional state. It was devastating. We need a better system.

Chair Sprinkle:
Is there anyone else in Elko in support of A.B. 47? [There was no reply.] All right, who would like to speak in support here in northern Nevada?

Joelle Gutman, Government Affairs Liaison, Washoe County Health District:
We are here today to support the Rural Regional Behavioral Health Policy Board bill, A.B. 47, because it establishes a behavioral health crisis response program that fits the unique needs and challenges of their expansive region. According to recent numbers provided by local mental health hospitals in Washoe County, approximately 10 percent of all admissions into inpatient psychiatric facilities are residents of our rural communities. That number is more than the total population in the rural areas.

While our rural neighbors are always welcome in our community, we realize that being up to 320 miles away from home and in crisis is not always the most therapeutic intervention. However, currently and oftentimes it is the only option for our rural residents due to the lack of local services. Discharge coordination with local providers can also be problematic, and return transportation to the individual's community can be challenging and costly, putting further strain on our already strained emergency rooms, shelters, and human service resources. Keeping individuals in their own communities with their support systems is best practice. Crisis intervention team (CIT)-trained first responders, a localized clinical mental health professional to provide therapeutic intervention, and follow-up case management to help an individual stabilize, will help prevent many individuals from needing to leave their communities in the first place.

Washoe County's Mobile Outreach Safety Team is a comparable urban crisis response service that has greatly benefited our community, reducing unnecessary emergency room

admissions and arrests. This proposed pilot program is a creative rural twist to a nationwide model of a crisis response. We support CIT training for first responders, safe and dignified transportation for a mental health crisis transport, access to mental health providers, and case management in all corners of Nevada, making the state healthier across all 110,000 square miles.

Assemblyman Thompson, I wanted to respond to your question about the four case managers mentioned in the bill. That number of case managers is a geographic number rather than a population-related number because four case managers barely cover the area, but could cover those seven counties pretty well.

Eric Spratley, Executive Director, Nevada Sheriffs' and Chiefs' Association:
I am here in support of A.B. 47, the provisions outlined in this bill that you heard, and all its benefits. It will greatly assist our public safety and first responder professionals in our frontier jurisdictions to better serve the public in those communities.

Joan Hall, President, Nevada Rural Hospital Partners:
Five of our member hospitals are in this region in Humboldt, Lander, Lincoln, White Pine, and Pershing Counties. We are very supportive of this initiative and look for great results from it. Nationally, CIT training has proven to be very beneficial as it provides de-escalation training for frontline personnel which significantly reduces agitation, aggression, the risk of violence, or the need for more sedation or restraints once that individual is taken to a hospital.

This is a huge reach for this portion of Nevada, but with the exception of Elko, which has a certified community behavioral health clinic, and Humboldt, which has some private agencies, the rest of these communities have nothing besides the rural behavioral health clinics, open 9 to 5, and the rural hospitals. There are no other service providers—no mobile outreach safety teams (MOST), no forensic assessment service triage teams, no juvenile justice assessment services triage teams.

We are very supportive of this initiative. This is something that is needed for this region. We see great benefit for this. Also, I have some answers to Assemblyman Thompson's questions because we at Nevada Rural Hospital Partners have been collecting data on these individuals. Our data excludes Elko, so it would just be the hospitals in the five counties I previously spoke of. In 2018 there were 84 patients brought in on legal holds to those hospitals. Forty-six patients were in Winnemucca, twenty in Ely, and six each at Grover C. Dils Medical Center in Caliente, Pershing General, and Battle Mountain. The majority of those patients were brought in by law enforcement or emergency medical services. Through a grant Nevada Rural Hospital Partners has, we coordinated with licensed clinical social workers through the Division of Public and Behavioral Health and used telemedicine to assist us in assessing these patients. It was amazing to see the decrease in the numbers of transfers we had to make once we used that system. We believe in all these innovative types of systems.

To Assemblywoman Titus's question about whether this would stop the process, no. You still have to go through the medical clearance before you can get a bed and transfer those patients. We believe that would decrease the number of patients needing transfer if, when the patients came in, they were not as agitated because of the CIT training the first responders had when they first approached those patients.

Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board:
[Charles Duarte supplied a letter in support of A.B. 47 (Exhibit E).] I am here today to provide the board's support for A.B. 47 as it is introduced. We are working collaboratively as regional behavioral health policy boards across the state to try to improve the quality of crisis care statewide, and I believe A.B. 47 goes a long way to dealing with the unique needs of rural Nevada. Again, we strongly support this piece of legislation.

Sarah M. Adler, President, National Alliance on Mental Illness, Western Nevada Affiliate; and representing the National Alliance on Mental Illness-Nevada:
[Sarah Adler read from a letter in support of A.B. 47 (Exhibit F).] On behalf of the National Alliance on Mental Illness (NAMI) Nevada and its three affiliates, we appreciate the opportunity to sit before you today in support of A.B. 47. We also appreciate those of you who were in the 2017 Legislature and helped pass Assembly Bill 366 of the 79th Session, which produced the four regional behavioral health policy boards that have done such terrific and integrated work.

I see this as a series of microtargets trying to test and address some of our most important problems as we try to build a more cohesive mental health care and response system. We in the NAMI Western Nevada Affiliate have worked closely with the Rural Regional Behavioral Health Policy Board and with the concepts contained in this bill. The core issue and goal this bill drives at—being able to respond with de-escalation, empathy, and professional care to mental health crises—is one that occurs frequently, if not on a daily basis, in Nevada's rural and frontier communities.

We are proud to be on the regional CIT committee that designs and presents crisis intervention team training to rural law enforcement and related community agencies. So far, only the Elko and Winnemucca Police Departments have offered CIT training, and yet that training must be a continuous process. It is not one and done, because there are always new members in these community agencies—law enforcement and first responders.

There are several benefits of this bill beyond decreasing the trauma being experienced by individuals with mental illness and their families. First, when qualified alternative transportation can be developed, it will greatly reduce the transportation overtime costs of rural law enforcement agencies that are doing that work now. Second, the addition of case managers to the care team of those who exit crisis treatment centers will reduce the likelihood of repeating this traumatic and expensive cycle. As you all know, we are always looking for Medicaid reimbursement. This will allow us to bring in those rural case managers and see if we can connect them to our Medicaid reimbursement system. We urge

your support for A.B. 47 and we appreciate your support of these costs as the bill heads over to the Assembly Committee on Ways and Means.

Kathy McIntosh, Director, Silver Stage Pantry, Silver Springs, Nevada:
I support NAMI and I am also a trainer and a facilitator. I am the director of the Silver Stage Pantry. We see between 700 and 900 families a week in our facility in Silver Springs. Within those numbers, a lot of people are bipolar or have schizophrenia or drug-related episodes. They have no place to go. A lot of the people are very depressed because of their situations, they are crying, needing someone to talk to, and they just do not have it. There are homeless people living in the desert, at the lakes, and along the river. They also have nowhere to go.

We did a homeless count with the Department of Health and Human Services. My area was along the southern part of Silver Springs, and we counted 71 homeless people there. They are in little groups, they are with children, and it is very, very sad. A lot of them have mental illness. We have the MOST team and some of the officers in our area are CIT-trained, which is invaluable. I want to tell you about two cases.

Chair Sprinkle:
I am going to ask you to please make it quick, because we have another committee that will be meeting shortly in this room.

Kathy McIntosh:
One lady in one of the groups was raped when she was little and then again when she was older. She has post-traumatic stress disorder, she is bipolar, and she also has manic depression. She went to report the assault, but the officer was not trained to know her condition. The interview did not go well and put her into mania. It was not the officer's fault, but had he been trained in CIT, he would have dealt with it better.

The other case involves a murder. A mother was called at 6:30 a.m. by her granddaughter who was yelling that her mom was not breathing. After telling her granddaughter to call 9-1-1, which she already had done, both parents rushed over to the house where they found their daughter lying on the floor and the paramedics working on her. They pronounced her deceased 45 minutes later. The parents were in a state of shock and the granddaughter was in a state of shock and disbelief. They were being bombarded with questions and, at the time, they could not even think. Meanwhile, the daughter/mother was lying on the floor deceased, and they were told to write a statement. When you cannot think, when your hands are shaking so badly that you can hardly hold a pen and you are supposed to write what you know, it is very difficult. The granddaughter was only 14 years old. She had been mentally and physically abused by the stepfather, who was still in the house at the time. She was scared to death. She had been told not to say a word. The grandparents knew nothing about the abuse. They wrote their statements, but to this day, I cannot tell you what was written.

When interviewed a couple of months later, after feeling safe because of now living in a different environment, the granddaughter was able to remember and tell her story. The

detectives told her she was lying because she had not said any of those things in her statement and that her grandparents had put her up to saying them. She was devastated, and when she came out of that interview she went into shock again. I believe if the detective had been trained in CIT, he would have been able to see the panic, the shock, the disbelief in the child and grandparents, and a different outcome might have come out of the situation. It has only been a year and four months, but it feels like yesterday; and yes, I am the mother who lost the daughter that day, and now I am raising my granddaughter. Over the years, she has told us a lot of what happened in her life. We do not ask; we let her tell it in her own time. Yes, she is in counseling. Had any of those officers at the scene been trained in what to look for in people who are in shock and crisis as we were, I think things would have gone differently.

I want to make this perfectly clear. My husband retired from the California state prison system; I retired from Tulare County's probation and juvenile division. I also worked for the sheriff's department and I have been POST-trained [Peace Officers' Standards and Training Commission]. I do not blame the officers—they are good men and good women. They just need additional training in mental health issues that might arise for the victims in cases like these and in so many others they see during their day-to-day work. Mental illness is so real but the stigma is still so strong. Unless you understand it a little, you cannot help the people who need it the most.

Chair Sprinkle:
Thank you for your comments. I truly am sorry for your loss and thank you for sharing your story today.

Jennifer Claypool, Private Citizen, Dayton, Nevada:
I am a member of NAMI, Western Nevada Affiliate, speaking today in support of A.B. 47. I have lived in Lyon County, Nevada, for 21 years. I am 52 years old and mom to four remarkable children and grandmother to four perfect grandchildren. In my early 20s I was diagnosed with a mental illness which advanced in severity throughout my life. By the early 2000s my illness exploded to an extreme which required many medications, several hospitalizations, and intensive therapeutic treatment.

Though in many ways rural Nevada was and still is lacking in a realm of services, I was fortunate enough to receive the care of an amazing therapist as well as a psychiatrist who had both been on this journey of healing with me. In approximately 2010, while at an appointment with my therapist, it became quite apparent to both of us that I was in need of hospitalization where I could receive care. Had the situation warranted, I know my therapist would have immediately called 9-1-1, but I was adamantly against that and in such a mental state that he decided to look for other options. Unfortunately, living in rural Nevada, the only other option was having a sheriff pick me up. This would have meant a ride in the back of a sheriff's car with a potential for legal action. That was an option that was unacceptable to both of us. Through the determination of my therapist and myself, we made phone calls and contacted the pastor of a church I had once attended. Upon speaking with the pastor, he was able to find two members to pick me up and take me to Carson Tahoe Regional Medical

Center. From when I arrived to my therapy appointment to when I was picked up by the church members, almost four hours had elapsed.

By the time I was finally admitted to the emergency room, my mental state had deteriorated tremendously and immediate emergency care was necessary. After some stabilization by hospital staff, it was many more hours before I was finally transported to behavioral health services in Carson City. It would have been so much easier to have a phone number to call that would have provided me with access to the transportation I so desperately needed that day. A ride in the back of a sheriff's car was both unwarranted and would have caused me further stress as well as embarrassment. There is enough stigma in the world regarding mental illness, and riding in a sheriff's car, even for a well-meaning reason, adds to the stigma. Furthermore, with lack of insurance or financial considerations, an ambulance can seem personally unattainable to a person who might not feel that they need that kind of assistance.

With the transportation assistance A.B. 47 is suggesting, and with the help of a medical attendant to transport me to the hospital, my situation might have been much different that day in 2010. The spike in my mental instability might not have happened, and I suspect that a wait of four hours might not have been a part of the plan. I am forever grateful to all the people who played a part in helping me that day. It was one of many, many dark days in my life during that period. I am in support of A.B. 47 and A.B. 85, and I hope that those in need of transportation for mental health crises can be supported as soon as possible. Being transported in a safe and respectful way and in a timely manner is of utmost importance. Assembly Bill 47 and A.B. 85 would ensure that this would be available for residents in our smaller, outlying, rural communities.

I have made huge strides in my mental health over the years. I have a great job that sustains me, I have a family that makes each day meaningful. I am living with my mental illness every single day, but I also know that I am at a point in my life where recovery has led me to being able to give back to others with similar challenges. Dealing with a mental illness takes a willingness to love oneself as well as to trust others when we are in need. If you or a family member has a mental illness, please know that you are not alone. There is always room to learn and grow from our experiences. There is a time for healing as well as understanding that not every day is a good day, but good days do make the bad ones more tolerable. "Never give up" may sound like a cliché to some, but it is true. There is always hope, there is always help. Our illness should never define who we are.

Chair Sprinkle:
At this point, I am going to bring up anyone in opposition to A.B. 47. Is there anyone in Elko wishing to come forward to speak? [There was no reply.] Is there anyone in Las Vegas or in Carson City wishing to come forward in opposition? [There was no reply.] Is there anyone in Elko or Las Vegas wishing to come forward in neutral? [There was no reply.] Is there anyone up here in the north?

Adrienne Sutherland, Clinical Director, Community Chest, Inc., Fernley, Nevada:
I am speaking as a mental health professional in rural Nevada, practicing in Storey and Lyon Counties. I am very much in favor of this bill. The only piece I would suggest taking a look at is section 4 where it limits who may work on this project. As a clinician practicing in rural Nevada, as well as someone responsible for the hiring of other mental health professionals, it is incredibly difficult to find only licensed clinical social workers. I encourage an amendment that would state, "licensed mental health professionals." I assume the reason that has not been done at this point is because currently marriage and family therapists and clinical professional counselors are prohibited from diagnosing and treating psychotic disorders. There is a bill currently in the Legislature, Senate Bill 37, which attempts to rectify that.

Chair Sprinkle:
Have you talked to the sponsors about your suggested changes?

Adrienne Sutherland:
No.

Chair Sprinkle:
That is usually an appropriate thing to do before providing testimony, so if you would not mind, please reach out to them.

Adrienne Sutherland:
Yes, thank you.

Danica Pierce, Private Citizen, Sparks, Nevada:
I am a licensed clinical social worker and I would just like to say, "Ditto."

Chair Sprinkle:
Not seeing anyone else who wishes to speak as neutral, do the sponsors wish to make any closing comments?

Valerie Cauhape:
We are open to working with the comments made earlier and we will move forward.

Chair Sprinkle:
I am going to close the hearing on A.B. 47.

[(Exhibit G), (Exhibit H), and (Exhibit I) were submitted but not discussed and are included as exhibits for this meeting.]

I will now open up the hearing on Assembly Bill 85.

Assembly Bill 85: Revises provisions governing mental health. (BDR 39-443)

Assemblywoman Robin L. Titus, Assembly District No. 38:
This bill is being presented on behalf of the Northern Regional Behavioral Health Policy Board. The committee previously heard overviews from all four of the regional behavioral health policy boards that were created during the 79th Session. Nevada state legislators recognized that, although many of the behavioral health needs of Nevadans were similar, there were also unique needs for many parts of the state and for different regions. This bill was created on behalf of the northern region. This board spent month after month holding meetings and hearings, and stratifying needs and priorities. This bill works to address issues regarding persons in mental health crises.

David Wm. Fogerson, Chair, Northern Regional Behavioral Health Policy Board; and Deputy Fire Chief, East Fork Fire Protection District:
I represent the fire and emergency medical services (EMS) section of our board. Our board has done some great work over the last few years to collectively and collaboratively, across silos, discuss our region's behavioral health needs. One legislative empowerment to the board was our ability to present this bill for consideration. Our board has worked feverishly to identify our region's strengths, weaknesses, opportunities, and threats. We identified regional gaps in our annual report and worked to address those gaps, but our report at the end felt our largest gap was our mental health hold process. Our board heard testimony from our various stakeholders on the issues—from behavioral health patients, emergency departments, behavioral health professionals, law enforcement, lawyers, firefighter paramedics, and others. We found the existing *Nevada Revised Statutes* (NRS) Chapter 433A language to be interpreted differently by courts, lawyers, physicians, law enforcement, and behavioral health providers [(Exhibit J) and (Exhibit K)].

The 72-hour hold has many different time frames in applications throughout our state. We found the reasons for using a hold vary greatly from behavioral health patients to some elderly care facilities looking to remove patients from their facilities. We found emergency departments inappropriately receiving behavioral health patients. We found that many providers who can place a patient on a mental health hold lack training to apply one and did not fully understand the removal of a patient's civil liberties. You will notice I used the word "patient," and it was deliberate. Mental health is a medical issue—not a law enforcement issue. It is one we must address more holistically.

Our board realized that NRS Chapter 433A changes have been tried in previous sessions without complete representation of everyone involved. Our board also realized that we did not necessarily have the time to look at every detail of this law, so we tasked our Regional Behavioral Health Coordinator, Jessica Flood, with creating a statewide work group to discuss everyone's concerns. The group met in person or on the phone almost weekly for the last few months. The group consisted of over 16 individuals representing every facet of the behavioral health world—judges, Division of Public and Behavioral Health personnel, police officers, public defenders, elected officials, physicians, forensics personnel, health service

providers, hospitalists, lobbying groups, behavioral health providers, behavioral health facilities personnel, and even those with behavioral health issues (Exhibit L).

Ms. Flood brought updates to our board's monthly meetings where we discussed the direction of the proposal. While not everyone on the state working group would agree 100 percent with the outcome we have today, everyone received the ability to provide input, have their voices be heard, and be considered. The collaboration, understanding, and cooperation of this statewide work group that Ms. Flood formed is a great testament to how we can come together to discuss concerns civilly. At the end, the board voted unanimously to bring forth this bill draft.

Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board:
The Northern Regional Behavioral Health Policy Board's bill, Assembly Bill 85, is focused on updating and clarifying NRS Chapter 433A which details Nevada's mental health crisis hold process. I would like to review the document titled "Nevada's 72-Hour Mental Health Crisis Hold" (Exhibit M) to provide an overview of the current process described in the law. Then I will present the seven major changes A.B. 85 proposes to make in NRS Chapter 433A (Exhibit N) and the amendment the stakeholders of the statewide committee and the Northern Regional Behavioral Health Policy Board support (Exhibit O).

In the document "Nevada's 72-Hour Mental Health Crisis Hold" (Exhibit M), you can see that the hold process starts when a person who is deemed to be a danger to self or others, or who is gravely disabled, is detained by law enforcement or a health care professional. If they are not already at a hospital, the patients will be transported to one where a health care professional will carry out a medical clearance process to determine if they are medically stable, and certify the hold through attesting that the mental illness is part of the patients' risk of harm to self or a grave disability. Only after this process occurs does the 72-hour time period start, even though the person has already been detained for an undefined amount of time—which could have lasted from a few minutes to a few days. This means that if you are on a mental health crisis hold and ask when the hold is due to end, the medical staff may tell you that the 72 hours will not start until tomorrow when your labs come back and the doctor rounds on you and signs off on medical clearance.

Being placed on a mental health crisis hold is one of the most extreme losses of liberty in our society—surpassed only by being arrested. When an individual is placed on a hold, he loses his right to leave the scene, vehicle, or health care setting, often losing access to most of his personal possessions and items. Once at the health care facility, he is personally monitored and often is restricted in day-to-day actions that we take for granted such as getting food, using the restroom, and using the phone. It is important to note that individuals who are placed on holds are not "those other people who have a mental illness." As a social worker working at Carson Tahoe Health's Mallory Behavioral Health Crisis Center in an inpatient unit, I can tell you that the people who arrive there during mental health crises are people like you and me. I have seen police officers, engineers, nurses, college students, EMS workers, and other contributing members of society who are just experiencing unfortunate circumstances.

While mental health crisis holds are a necessary mechanism to protect individuals at risk of harm or death due to mental illness, the process in Nevada is currently opaque and practiced differently from county to county. In any hospital patients can be placed on a hold and receive no clear information about the time line, the process, their rights, or what to expect. Assembly Bill 85 focuses on clarifying and standardizing the mental health crisis process so that we can move forward in developing standardized education that every patient on a hold in a hospital emergency room or an inpatient psychiatric facility can receive to understand his rights and due process.

I will discuss the seven major changes proposed in A.B. 85 (Exhibit N) based on priority instead of in the numerical order of each section, and I will present the amendments to the bill after that. The first major change is in sections 9 and 10 and clarifies that the 72-hour detainment starts at the initiation of the hold—at the time when the individual is detained and loses his liberty. As depicted in the flow chart (Exhibit M), counties and providers currently interpret the 72-hour clock to start either at the initiation of the hold or after medical clearance and certification. Currently in many counties in Nevada, one could say that because of the time it takes to carry out a medical clearance and certification, Nevada has a 72-hour-plus hold. This can cause much confusion to health care providers attempting to refer patients to other counties based on their interpretation, and cause a lot of confusion for patients and families as well. As a social worker, I have to explain that the 72 hours does not start for a period of time, and that can be very frustrating for patients who are in that situation. We understand that it is the provider's responsibility to carry out medical clearance and certification to deem the mental health crisis hold valid. However, we also see the 72-hour time in which a person's liberty is restricted as a parallel process that allows the courts to have oversight if the patient needs to be held beyond 72 hours. This ensures consistent and timely court oversight that is transparent to all parties and allows the patient to access his right to counsel and due process.

The second change in the bill proposes to remove the stigma and update language and criteria for the existing term "person with mental illness." In NRS Chapter 433A [section 115], "person with mental illness" means any person whose capacity to exercise self-control, judgment, and discretion in his conduct is diminished as a result of a mental illness to the extent that the person presents a clear and present danger to self or others. This is not an accurate definition of mental illness and is stigmatizing for anyone who may have mental illness. Assembly Bill 85 proposes to update the term "person with mental illness" to "person in a mental health crisis." Also, A.B. 85 updates the language of the criteria for mental health crisis hold in line with national recommendations from the Treatment Advocacy Center. It is important to note that with our changes, we did not have any intention of either expanding or limiting the current criteria and worked closely with all partners, including hospitals and law enforcement, to ensure that was the case.

The third major change was focused on improving the efficiency of the court process. Assembly Bill 85 extends the time by one judicial day for a court to set a hearing for a court order petition. This allows courts to calendar all petitions on one specific day a week, providing greater organization and transparency through regularly held court hearings and

reducing court costs. Assembly Bill 85 also codifies the current process of stipulated continuances which allows patients to agree to treatment with court oversight without the need for commitment. This increases court flexibility to address the individual's needs for a brief treatment without being committed, and it reduces the need for court hearings.

The fourth major change addresses information sharing to enhance coordination and continuity of care. Assembly Bill 85 clarifies information sharing between providers that is already allowed by the Health Insurance Portability and Accountability Act (HIPAA). Often there is confusion with providers and they believe that HIPAA does not allow them to share information, and that really gets in the way of continuity of care. Assembly Bill 85 also allows limited information sharing by courts with providers for the purposes of continuity of care. Often the courts can see patients in chronic crisis repeatedly and see providers re-creating or duplicating treatment plans. This would allow for courts to support care coordination and reduce repeated treatment efforts, especially in Las Vegas where there are 20 hospitals.

The fifth change is focused on behavioral health transport. The need for behavioral health transport was discussed during the hearing on Assembly Bill 47 and is a need being experienced in both regions. Assembly Bill 85 proposes to use accredited agents, which already exist in law, as a mechanism for behavioral health transport. In current law, accredited agents have the ability to "detain" and "transport" individuals on mental health crisis holds. Assembly Bill 85 takes away the accredited agent's ability to detain someone. That term has been in NRS Chapter 433A since 1975 and to our knowledge has never been used. So we essentially are just leaving a behavioral health transport function. Medicaid has stated its intent to create a reimbursable provider type for behavioral health transport and has identified using accredited agents as a mechanism to do so. So A.B. 47 has that pilot piece, and we are really hoping to create a mechanism for sustainable funding of behavioral health transport in our bill. Assembly Bill 85 also removes the restriction that an individual must be accompanied by at least one attendant of the same sex or relative if the individual is being transported by a member of the opposite sex. This was removed, as stakeholders from the Department of Health and Human Services believe they can address this concern through training, allowing for greater flexibility for transportation in the rural areas.

The sixth change in A.B. 85 requires hospitals to release a person within 24 hours if the court has determined the person does not meet criteria for civil commitment, unless the person remains at the facility or hospital voluntarily. In current law there is no existing time frame to release an individual, and stakeholders from both the courts and hospitals agreed that 24 hours would be sufficient time to develop an adequate discharge plan for the individual to be released, and that allows for respecting the individual's right of freedom.

The seventh change allows the State Board of Health to adopt regulations for five issues. First, Nevada currently has no guidelines for involuntary administration of medication to persons with mental illness. With no statewide guidelines, hospitals need legal counsel to understand the process based in court law, and many new hospitals do not have that legal counsel. By creating a regulation, hospitals and other stakeholders will have a central place

in law to turn for this information. Without this, involuntary administration of medication is like the Wild West. Second, Assembly Bill 85 also provides the State Board of Health with the ability to develop regulations for hospital reporting of mental health crisis holds. This was unanimously supported by stakeholders as they all see the need for data and insight into community needs in response to mental health crisis holds. With the Southern Regional Behavioral Health Policy Board's bill also looking at legal holds, you can see there is a lot of focus on getting data such as that.

Third, Assembly Bill 85 also provides the State Board of Health with the ability to develop regulations for discharge planning practices from public and private mental health facilities. Discharge planning has been a high priority for all regions in Nevada for several years. This regulation allows for the state to partner with psychiatric hospitals in developing strong discharge planning processes to support continuity of care. Fourth, A.B. 85 also provides the State Board of Health with the ability to develop regulations to become an accredited agent for behavioral health transport. Finally, A.B. 85 provides the State Board of Health with the ability to define the process for medical clearance. As mentioned earlier, medical clearance is widely interpreted across the state leading to confusion for practitioners, patients, and families. Assembly Bill 85 also makes several other minor changes such as standardizing the 72-hour clock in different situations for clarity and conforming changes.

The proposed amendments to A.B. 85 (Exhibit O) were identified by stakeholders in the statewide committee and are supported by the Northern Regional Behavioral Health Policy Board. In section 4, lines 24 through 28, we would like to remove the criteria for substantial likelihood of serious harm to himself or herself or others that talks about "Suffering from or continuing to suffer from severe and abnormal mental, physical or emotional distress . . . ." We were working to respond to national recommendations and included this language, but in the end, we felt it was not vetted enough and it could cause significant changes to our system. So we would like to process that more before including that criteria.

In section 6 we added "and NRS 433A.115" which identifies the meaning of mental illness so that it is very clear to stakeholders what definition we are referring to. In section 7, line 8, we would like to remove the phrase "been diagnosed with" as this was not the original intention of the group. We also reinserted the exclusion criteria for mental illness, as stakeholders wanted that exclusion criteria to be very clear even though it is noted in the definition of mental illness. We also moved "as determined pursuant to section 4 of this act" to conform with proposed language changes.

In section 10, subsection 2, we would like to clarify when the hold starts by adding the words "initiation of the" in the phrase "after the application for emergency admission," and further clarify by adding a subsection 4 that states, "As used in the section, the initiation of the application for emergency admission is deemed to have occurred when the date and time in the first section of the application for emergency admission is complete."

In section 14, we would like to strengthen care coordination and align state statute with HIPAA through the following changes. In section 14, the amendment mandates psychiatric

hospitals to ask the person on a hold "for permission to contact a family member, friend, or other person identified" to give that individual notice of the admission. That is allowed by HIPAA and should be best practice, but it may not always be practiced. Still in section 14, the mandate to inform a spouse that an individual is on a legal hold is removed. This concern was raised because of situations in which it may not be appropriate to identify a spouse such as during times of domestic violence and abuse. Also in section 14, we update authorized types of notification provided by psychiatric hospitals to align with current practices and include electronic forms of communication for notification. Still in section 14, a mandate was included to share information with the durable power of attorney for health care that may be identified in a psychiatric advanced directive.

In conclusion, A.B. 85 is primarily focused on enhancing patient rights by clarifying the process and reducing provider confusion and potential trauma for the patient. We have done this through seven major changes and the four amendments I presented. The Substance Abuse and Mental Health Services Administration just released a report on civil commitments this morning and highlighted the four ethical principles of patient care: respect for autonomy; nonmalfeasance; beneficence; and justice. The report emphasizes that relevant information be clearly communicated to the patient about commitment status, purpose, process, reevaluation, criteria for ending commitment, risks and benefits of treatment, legal issues, and right to appeal or refuse treatment. Information about commitment is shared with supportive family members and significant others, consistent with patient rights and wishes. That is what they think all states should have in their legal code. Also, due process protections should be understood and employed at every level for the person.

We believe the changes made in A.B. 85 take major steps toward aligning our state with national recommendations. The statewide committee realizes that there is much more work to be done and sees this as an initial step toward the greater overhaul of our mental health crisis hold process. The statewide committee intends to continue working to provide more substantial updates to our system for the next legislative session as well. Although we made great attempts to engage all stakeholders across the state, we realize there could be differing opinions about the changes we made today. I do not think there is any disagreement about the importance of the needed improvements, but due to the nature of its contents, there still may be differing opinions.

Chair Sprinkle:
Are there any questions from the Committee?

Assemblyman Carrillo:
Regarding section 4, subsection 3, is this going to open up floodgates, assuming that everyone who is homeless is in need of Legal 2000? It seems like the language could be interpreted to include all persons who may be homeless.

Jessica Flood:
Actually, no. You have to have a mental illness to be a part of subsection 3 which reads "Incurring a serious injury, illness or death resulting from complete neglect of basic needs for food, clothing, shelter or personal safety." That is the grave disability clause in NRS Chapter 433A. We had a grave disability clause before; it is a national standard. It is in all states—someone is so psychotic they cannot take care of themselves and they would be placed on a hold.

Assemblyman Carrillo:
In sections 9 and 10, my concern is related to when the time frame starts after listening to testimony on A.B. 47. Knowing people in my district who have had relatives going through this process, there is sometimes a wait for a psychiatric bed. I am concerned that some people who need mental health services would be released before ever hitting a psychiatric bed or might even be released before receiving the necessary psychiatric or psychological assistance they need.

Jessica Flood:
If someone needs more care after 72 hours, there is an extension process, a petition process, that goes to the courts. The courts will then extend the time that someone can be kept on a hold.

Assemblyman Carrillo:
Let us say the facility does not have a bed and that 72 hours have passed. Essentially, they have not really gone through because they are waiting.

Jessica Flood:
That is when you would petition the courts. There are essentially two different tracks. One is a clinical track where the clinician is deciding whether the person needs to be on a hold, whether the person has been medically cleared, are we certifying him, et cetera. That is just moving forward. Then the clinician may deem that the person is still unsafe. From a clinical point of view, that person stays on the hold. From a legal perspective, after 72 hours, that comes under the purview of the courts and is just to give them due process. Losing all your rights is a big deal. We want a court to supervise that. The courts are the ones to continue the hold process after 72 hours. Also, 14 states in the nation have 72-hour holds. That is the standard time frame for legal holds.

Assemblyman Carrillo:
Could the courts possibly get overwhelmed by this extra step?

Jessica Flood:
Both Judge Cynthia Lu from the Second Judicial District Court in Washoe County (Exhibit P) and Hearing Master Bita Yeager from the Eighth Judicial District Court in Clark County (Exhibit Q) were very much in support of this and did not think it would be overwhelming for them.

Chair Sprinkle:
You mentioned trying to have a specific day set aside for this. If it is in regard to Assemblyman Carrillo's line of questioning, how does that work? Seventy-two hours is a very specific time frame, but if you are only going to adjudicate these, say only on Fridays, how does that work?

Jessica Flood:
Under current law when you petition the court, the court has five days to schedule the hearing. Those five days basically extend the hold until you get to court. They would like to extend that to six days because then they could have court once a week and be within the legal mandate. Right now, they are a little outside of it. There are times when the hospitals apply for a court hearing and if it does not hit their regularly scheduled court—in Washoe County, legal hold court is every Wednesday—this change would allow them to keep with Wednesdays and be aligned with the law. In Clark County they have court twice a week, so this would not apply to them. In 15 out of the 17 counties, we do not have a legal hold process that is set up in compliance with law, and we are working on it right now with judges and stakeholders. This would allow the rural counties to be able to achieve that because they could have court once a week and it could be regularly scheduled.

Chair Sprinkle:
Then after that 72-hour hold, that involuntary legal hold can continue until that next court hearing?

Jessica Flood:
Yes, even now with this change, you extend that hold until the court hearing.

Assemblywoman Nguyen:
I am happy you were able to put forth this bill. About 16 years ago when I first started practicing law and handled civil commitment hearings, you had no idea what was going to go on. Having represented patients in those civil commitment proceedings, I feel as though this process makes it more clear and transparent for patients as well as for the hospitals. I know the hospitals have a lot of responsibilities under NRS 433A.200 and 433A.165—where the orders come from.

For the rest of the Committee, can you address what you mean by medical clearances? There has been some confusion, and people want to know when that starts.

Assemblywoman Titus:
It is important before you send somebody off to a mental health facility that you make sure that his crisis is not due to a medical problem. If someone comes in with hypoglycemia and his blood sugars are low and he is acting very strange and confused, we do not want someone with low blood glucose going to a mental health facility. What that person really needs is to have his blood sugars elevated. We do not want someone who is depressed, intoxicated, and suicidal because he is intoxicated going to a mental health facility. We want to make sure that the mental health crisis is not due to a medical reason we should be fixing prior to the

transport. That is part of the medical clearance. Facilities do not want to accept a patient they are going to have to be giving blood pressure medicine to or diabetic medication to beyond the scope of what they can do in these facilities.

To be clear, in my facility, if they are there for 72 hours, we can clear them so we do not have to continue on a mental health hold once the crisis has been averted. Just because they have been there 72 hours and still may not be cleared medically, we have the ability to release them from the hold. That was the other backlog that was happening. These people needed to be cleared—they were no longer suicidal, or that moment of crisis had resolved—and we could release them once there was proper follow-up and we did not have to transport them.

We have been dealing with this mental health crisis and legal hold situation for at least three legislative sessions—who does the medical clearance, how long does it take, and who can release them from that prior to extending the hold? It is the whole litany of problems we need to deal with, and blood tests, electrocardiograms, and examinations are a part of the medical clearance.

Jessica Flood:
To clarify, medical clearance does not get in the way of petitioning the courts. There is a mechanism for the hospitals to petition the courts and explain that the person is not medically cleared yet. The courts will then have that information in their purview so there will be oversight of that person. The individual will not be lost in a hospital, which is sometimes what is happening in Nevada.

Assemblyman Hafen:
In section 1, subsection 1, paragraph (a), you are adding language that states, "including, without limitation, regulations governing the procedure for the involuntary administration of medication to persons with mental illness," but then later on [section 2, subsection 1, paragraph (a)] you change "mental illness" to "mental health crisis." Did you intend to use "mental illness" there or did you intend to use "mental health crisis"? Could you elaborate, please?

Jessica Flood:
We intended to use the term "mental illness" because that is the current practice in hospital emergency rooms where people may not be on a mental health crisis hold but still have a mental illness and require involuntary administration of medication. Mental illness is a criteria for mental health crisis, but then there are people who have mental illness who are not on a mental health crisis hold but who might require involuntary administration of medication.

Assemblyman Hafen:
Do you have an example?

Jessica Flood:
An example would be someone who comes in on a mental health crisis hold but is still psychotic and decides to sign in voluntarily. If that person is still not doing all that well, the hospital can decide to apply to the courts for a court order to administer medication involuntarily. The court then allows that hospital to provide that medication. It is a different mechanism from the original mental health crisis hold.

Chair Sprinkle:
Are there any other questions for the presenters? [There was no reply.] We will start bringing people up in support of this bill. I do not want to limit comments, but if someone has already said what you were going to say, please just say, "Ditto." Is there anyone in Elko who wishes to come up in support of A.B. 85?

Lea Bastin, Private Citizen, Elko, Nevada:
I am in support of A.B. 85. It is great that we are streamlining this process to eliminate the confusion. As one who had a loved one incarcerated because of his mental health condition, to have clarification and guidelines for people in our community to follow will be great. Currently, it depends on who is on shift, who has detained the person, where that person was detained, and when. That is how we are getting people help, if they are being detained at all. This will definitely clarify things, streamline it, and eliminate confusion.

Nancy Snyder, Private Citizen, Spring Creek, Nevada:
Ditto.

Chair Sprinkle:
In southern Nevada, is there anyone in support of A.B. 85?

Lesley R. Dickson, Private Citizen, Las Vegas, Nevada:
I am a psychiatrist and past president of the Nevada Psychiatric Association, and I was a member of a Legal 2000 (L2K) group from its beginning. I have been following L2K bills for years. Basically we support this bill, particularly with the amendment that puts the exclusions back in, because we believe that the exclusions are very important. Folks with some of those problems belong somewhere other than in a psychiatric hospital.

Jessica W. Murphy, Public Defender, Office of the Clark County Public Defender:
I have also been on the statewide legal hold group. Our office is appointed to represent every person in Clark County who is subject to the involuntary hospitalization court process. Our office supports A.B. 85 with the amendments.

Chair Sprinkle:
Is there anyone else in support of A.B. 85 in southern Nevada? [There was no reply.] Is there anyone here in the north? Please begin.

Edrie LaVoie, Private Citizen, Fernley, Nevada:
I am a recently retired human services administrator for county government and I also serve on the Northern Regional Behavioral Health Policy Board. I want to read a story, but first, I would like to thank Ms. Flood for really defining the problems with NRS Chapter 433A. On the Policy Board, I really supported A.B. 85 because I could not imagine someone getting tangled up in this legal process, then I had a family member recently experience it. The testimony I would like to read is on behalf of my family member who could not be here today. It speaks very profoundly to the concerns with NRS Chapter 433A:

> I am writing this in the midst of the most serious crisis my family has ever experienced. I feel like you need to understand how we came to experience Nevada's Legal Hold Law, so you can fully understand the gravity of our experience. And I hope that by writing my experience down, it will help me process the health care nightmare I've lived for those two weeks.
>
> We are educated, successful, and respected in our community. Middle class Americans. Financially stable. We have a strong marriage and beautiful, healthy children.
>
> My husband has had a lifelong struggle with depression and anxiety. In spite of having a very stable and beautiful (although imperfect) family life, his depression seems to be there almost always, varying in degree of intensity. It is more severe in the winter time, and stress can trigger intense episodes of depression. He doesn't want anyone to know because of the social stigma associated with mental illness. He feels like people will think he's weak, or they'll judge him. A lot of folks don't understand what depression is, and I think he's right about being judged.
>
> The social stigma and fear of judgement is the first issue mentally ill people and their loved ones deal with. By the way, why can't we come up with a politically correct term for mentally ill? Why can't my husband be mentally resilient? He doesn't strike me as an ill person, he strikes me as a resilient person. Do you know anyone who feels absolutely despondent almost every day but still gets up and gets on with living life?
>
> The night my husband tried to kill himself, he had been dealing with a plethora of life issues. He'd been particularly distant for about two weeks before the incident, but I didn't anticipate that he was about to attempt suicide. Nothing like this had ever happened before.
>
> I've thought a lot about how I found him—what I found with him—and my decision to call 911. Hindsight is 20/20 and I can honestly tell you that if I had it to do over again, I wouldn't call 911. For us, the Legal Hold system in Nevada was so horrible, and living through my husband's involuntary incarceration was so painful for him, our kids, and me, that I would have

rather tried to take care of my husband by myself at home, without medical help. I would risk my husband's life in order to avoid the circumstances of the next six days. It may sound like I'm being dramatic, or that I'm crazy, but the fact that this thought ever even crossed my mind should be a wake-up call for our legislators. A law that's supposed to keep a vulnerable person safe shouldn't result in the most dehumanizing experience of his life. It shouldn't make anyone afraid to get help.

After we arrived at the ER, I began to learn about a complex mental health care system the hard way. First, I wasn't allowed to see my husband. When I finally gained access, the nurse explained that my husband could be held for anywhere from 12 hours to three days under the "legal hold" that the doctor had placed on him. This means that they can legally keep him there even if he wants to go home.

I hope you can imagine how uncomfortable and anxious that made my husband and me feel. My husband is an adult man, who is capable and sane. He's used to being in charge of his own life, and especially his own health care. How would you feel if you were effectively removed from making decisions about your own health care, and you were held against your will? How would you feel if your loved ones weren't allowed to visit you in your most vulnerable state? It should be a scary thought, like something out of a horror film. I can testify that it felt just like I was in a horror film when we were living through it.

I went from feelings of discomfort to feelings of hopelessness and powerlessness after my husband was transferred from the ER to a nearby Mental Health Care Facility. What I perceived to be a good thing was, in fact, the worst possible thing for all of us. The Facility limited visitation to 30 minutes every third day, based on staff availability. Only two people were allowed to visit. There was nonexistent contact with his health care team—I called and left messages for the doctor for three days with no response. Nurses didn't call me back. Front line staff treated me like I was a nuisance. We were denied a "Family Session," where the health care team and patient all get together to discuss a plan. At one point, a nurse threatened to call the police on me because I showed up to the hospital in person and was waiting in the lobby for information on my husband's discharge plan. She told me that they didn't like people waiting in the lobby.

Ultimately all decisions related to my husband were based on some nebulous "standard of practice." "This is just how it's done" was the only answer that I ever received when I asked questions. Health care decisions were made without any concern or knowledge of my husband's individual circumstances. He was treated as simply "a statistic." The doctor interpreted the statute to allow him to retain my husband over the weekend, even though the 72 hours

is clearly defined as a maximum time limit (not a minimum). In effect, he was imprisoned for an additional three days. When I finally spoke with the doctor, he explained that my husband wasn't being held for treatment. He was being held for observation.

Every step toward release was a battle, and we could never obtain documentation or verbal information on what was actually being done to help my husband, or the rationale for the actions being taken. I read and reread the statute. I tried to find information on the internet. I looked for advocacy groups. I have never met failure so absolutely as I did when trying to rescue my husband from this prison.

Even now that he's safely at home, we still don't know if he was admitted under the "voluntary" label or the "emergency" label. He came in to the ER voluntarily. When the Paramedics asked him if he wanted to go to the hospital, he said yes. But they held him for well past 72 hours. If he was admitted voluntarily, his legal hold would have been up after 48 hours. In fact, the Mental Health Facility interpreted the statute to mean that his 72 hour legal hold restarted after he was admitted there, not when he came into the ER. These interpretations matter immensely to the person who's being detained.

What I learned over those 130 hours is that the mental health care system in Nevada is set up to treat a demographic that isn't us. It is not for a highly functioning family unit that includes a depressed husband. Not for someone who fights the good fight but lost one battle. It's not for someone who has an extensive support network. It's not for someone who is knowledgeable about their condition and expects to be engaged in making decisions for their health care. It's not for someone who fights a daily war against depression so that they never miss work, never miss their kid's baseball games, never gives people a reason to suspect that there's anything wrong with their brain chemistry. It's not set up to treat a human being as an individual.

Joseph McEllistrem, Director, Forensic Health Services, Carson City and Douglas County Jails:

I am a forensic psychologist in private practice in Carson City as well as being the director of forensic health services at the Carson City and Douglas County jails. I was the architect of FASTT, the forensic assessment services triage team, and I am currently a member of the Northern Regional Behavioral Health Policy Board. I am here today in support of this bill because as it stands, the legal hold process is in trouble. This is far too confusing for the clients we serve who are already in psychiatric crisis and it leaves their parents and family members wondering what is happening to them.

As the language is written, it is confusing and is interpreted in a multitude of ways by a multitude of agencies and providers that lead to systemic processes and problems in

implementation and initiation of a simple hold. When it is initiated improperly, the burden falls to very busy hospitals that are often forced to take someone who could be better treated with another level of care rather than occupying a bed somebody else could use. The changes made to this bill better appreciate the experiences of the client. That was the guiding principle in the changes that were made. Also, it establishes a universal start and stop time in the process of initiating and extending holds. Finally, it demands a more timely process through the court system since they may, in fact, have to be engaged to extend the hold. There have been tremendous amounts of changes and improvements to this bill, and it will go a long way toward helping the consumers and clients of our state.

Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board:
[Charles Duarte provided a letter in support of the bill (Exhibit R).] I am here to support the bill and proposed amendments to A.B. 85 as well as the efforts by the Northern Regional Behavioral Health Policy Board to improve crisis services in Nevada.

Sara Cholhagian, representing Dignity Health-St. Rose Dominican Neighborhood Hospitals:
I am here on behalf of Dignity Health-St. Rose Dominican and their seven acute care hospitals in southern Nevada to formally support A.B. 85. Eugene Bassett, Senior Vice President of Operations, submitted a letter of support for the record and I encourage you to read it (Exhibit S). I would like to highlight a few things important to Dignity, as we would be remiss if we did not mention the amount of thoughtful work put into this bill. Since the summer, Dignity has participated in the Legal 2000 statewide working group of the Northern Nevada Regional Behavioral Health Policy Board, and we fully support the working group's efforts and their amended version of A.B. 85. Changes in the amended version include: removing stigma and clarification of criteria for a person with a mental illness; clarification on the 72-hour hold time frame with additional time for the court process and continuances; clarification on information sharing between providers, the courts, and family members; Medicaid reimbursement for licensed behavioral health transport of these patients; and a request for the State Board of Health to adopt regulations on a number of items including a definition of medical clearance.

We believe that many of these changes are in the best interests of the patients. Even though Dignity's emergency departments are not licensed mental health facilities, they are often the place where patients end up in a crisis. Because of this, we have participated, and continue to be eager to participate in, this working group. Once again, we feel very strongly that the Northern Nevada Regional Behavioral Health Policy Board's amended version of this bill is a step in the right direction to treat patients with dignity, and we encourage you to vote yes on A.B. 85.

Kendra G. Bertschy, Deputy Public Defender, Washoe County Public Defender's Office:
We want to thank Assemblywoman Titus for bringing forward this bill, as well as the Northern Nevada Regional Behavioral Health Policy Board for all their hard work on this bill. They allowed us to participate in the statewide work group, and we support this bill as

written as well as with the amendments as proposed. This bill creates clarity and oversight for this difficult process, as well as protects and provides adequate due process rights and the right to counsel for those in crisis.

Joan Hall, President, Nevada Rural Hospital Partners:
I would like to disclose that Jessica Flood works for Nevada Rural Hospital Partners. I wanted that on the record. The amount of work that has gone into this, as you have heard, has been amazing. People from the north, the south, rural areas, big facilities, little facilities, jails, everyone got together and everyone had a say. It was wonderful. People really want to change this law for the better. I urge your support.

Chair Sprinkle:
I appreciate your comments and your brevity. It is obvious to the Chair the amount of work there has been from many stakeholders on this, so, thank you for that.

Robin V. Reedy, Executive Director, National Alliance on Mental Illness-Nevada:
[Robin V. Reedy provided a letter in support of the bill (Exhibit T).] Ditto, and I can speed things along by asking whether anyone else back there in the audience agrees. If so, raise your hand. [About a dozen people raised their hands.]

Brian Evans, representing the Nevada State Medical Association:
We are here in support of A.B. 85 and would like to commend all the work done during the interim by the stakeholders and a few of our member physicians. We also want to put ourselves out there as a resource for any work that needs to be done going forward.

Joelle Gutman, Government Affairs Liaison, Washoe County Health District:
Addressing behavioral health is a priority for our community. Destigmatizing the language we use while addressing people in crisis, and outlining a clear and consistent process statewide, lay an important foundation to address this need.

Chair Sprinkle:
I do not see anyone else coming forward in support of A.B. 85. Is there anyone in opposition wishing to come forward in Elko? [There was no one.] Is there anyone in southern Nevada coming forward in opposition to A.B. 85? [There was no one.] Is there anyone here in the north in opposition? [There was no reply.] Is there anyone in Elko or in southern Nevada who wishes to speak in the neutral position on the bill? [There was no one.] Is there anyone in northern Nevada neutral to A.B. 85? [There was no reply.] Do you want to make any closing remarks?

Assemblywoman Titus:
I want to acknowledge all the hard work that went into this bill, and, as Joan Hall mentioned, thank our wonderful coordinator, Jessica Flood, for being so detailed. This is a difficult subject. This is not a complete solution, but I think it is a very good step forward towards clarifying what can be an emotional and difficult issue for families and people in our state.

Jessica Flood:
One document inspired a lot of the committee stakeholders [pages 14-22, (Exhibit U)]. This is from Colorado and is titled "Involuntary Commitments and Psychiatric Hospitals: What does this mean to You and Your Loved Ones?" This is a document that could really be a guiding light forward if we all have standard changes in Nevada for our legal hold process. This could be handed out in hospital emergency rooms, in crisis triage units, and to people who are on legal hold so that situations like the one Ms. DeVoie's family experienced do not have to happen.

Chair Sprinkle:
I do recognize how much work has gone into the bill presented today. I applaud everyone who has worked so diligently, and I appreciate your bringing this bill forward. With that, I will close the hearing on A.B. 85 and open up for public comment. We shall begin in Elko, does anyone wish to come forward in Elko? [The answer was no.] Is there anyone in southern Nevada wishing to come forward? [There was no reply.] How about here in the north? [There was no reply.] I will close public comment. This meeting is adjourned [at 3:41 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblyman Richard Carrillo, Vice Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Summary of Rural Behavioral Health Crisis Response Pilot Program As Proposed by Assembly Bill 47," dated March 4, 2019, presented by Valerie Cauhape, Coordinator, Rural Regional Behavioral Health Policy Board, in support of Assembly Bill 47.

Exhibit D is a proposed amendment to Assembly Bill 47, dated March 1, 2019, presented by Valerie Cauhape, Coordinator, Rural Regional Behavioral Health Policy Board.

Exhibit E is a letter dated February 20, 2019, to Chairman Sprinkle and members of the Assembly Health and Human Services Committee, written and submitted by Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board, in support of Assembly Bill 47.

Exhibit F is a letter dated February 21, 2019, to Chairman Sprinkle and members of the Committee, written and presented by Sarah M. Adler, President, National Alliance on Mental Illness, Western Nevada Affiliate; and representing the National Alliance on Mental Illness Nevada, in support of Assembly Bill 47.

Exhibit G is a memorandum dated February 28, 2019, to the Assembly Health and Human Services Committee from Nevada Attorneys for Criminal Justice (NACJ), submitted by Jim Hoffman, NACJ Legislative Committee, in support of Assembly Bill 47.

Exhibit H is a letter dated February 26, 2019, to Chairman Sprinkle and members of the Assembly Health and Human Services Committee, from Amy Adams, Private Citizen, White Pine County, in support of Assembly Bill 47.

Exhibit I is a letter dated February 28, 2019, to Chairman Sprinkle and members of the Assembly Health and Human Services Committee, from Richard Howe, Commission Chairman, White Pine County Board of County Commissioners, in support of Assembly Bill 47.

Exhibit J is a summary titled "Assembly Bill 85: Reforming Nevada's Involuntary Mental Health Hold Process," presented by David Wm. Fogerson, Chair, Northern Regional Behavioral Health Policy Board; and Deputy Fire Chief, East Fork Fire Protection District, in support of Assembly Bill 85.

Exhibit K is an outline titled "AB 85: Frequently Asked Questions," presented by David Wm. Fogerson, Chair, Northern Regional Behavioral Health Policy Board; and Deputy Fire Chief, East Fork Fire Protection District, in support of Assembly Bill 85.

Exhibit L is a document titled "AB85 Statewide Committee Overview," presented by David Wm. Fogerson, Chair, Northern Regional Behavioral Health Policy Board; and Deputy Fire Chief, East Fork Fire Protection District, in support of Assembly Bill 85.

Exhibit M is a flow chart titled "Nevada's 72-Hour Mental Health Crisis Hold (AKA: Legal 2000/L2K) NRS 433A.150," presented by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board, in support of Assembly Bill 85.

Exhibit N is a document titled "AB 85 Overview: Seven Principal Changes to 433A," presented by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board, in support of Assembly Bill 85.

Exhibit O is a proposed amendment to Assembly Bill 85, dated March 4, 2019, presented by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board.

Exhibit P is a letter dated March 1, 2019, to Nevada Legislature, Assembly Health and Human Services Committee, authored by Cynthia Lu, District Judge, Department Five, Family Court, Second Judicial District Court, Washoe County, in support of Assembly Bill 85, and submitted by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board.

Exhibit Q is a letter dated March 1, 2019, to Nevada Assembly Committee on Health and Human Services, authored by Honorable Bita Yeager, Hearing Master-Specialty Courts, Eighth Judicial District Court, Clark County, in support of Assembly Bill 85, and submitted by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board.

Exhibit R is a letter dated February 20, 2019, to Chairman Sprinkle and members of the Assembly Health and Human Services Committee, authored by Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board, in support of Assembly Bill 85.

Exhibit S is a letter dated March 4, 2019, to Chairman Sprinkle and Assembly Health and Human Services Committee Members, authored by Eugene Bassett, Senior Vice President, Operations, Dignity Health Nevada, in support of Assembly Bill 85.

Exhibit T is a letter dated February 21, 2019, to Chairman Sprinkle and Members of the Committee, authored and presented by Robin V. Reedy, Executive Director, National Alliance on Mental Illness-Nevada, in support of Assembly Bill 85.

Exhibit U is an informational document regarding Assembly Bill 85 titled "A Look into Nevada Revised Statutes Chapter 433A: Presentation for the Northern Nevada Regional Behavioral Health Policy Board," submitted by Jessica Flood, Coordinator, Northern Regional Behavioral Health Policy Board.