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

Eighty-First Session
February 10, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:33 p.m. on Wednesday, February 10, 2021, Online. 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/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Stephanie Woodard, Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services
Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services
Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator, Rural Regional Behavioral Health Policy Board
Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe Regional Behavioral Health Policy Board
Teresa Etcheberry, Clark Regional Behavioral Health Coordinator, Clark Regional Behavioral Health Policy Board
Jessica Flood, Northern Regional Behavioral Health Coordinator, Northern Regional Behavioral Health Policy Board
Zach Conine, State Treasurer
Erik Jimenez, Senior Deputy Treasurer, Office of the State Treasurer
Dora Uchel-Martinez, Private Citizen, Reno, Nevada
Connor Cain, Vice President, Nevada Bankers Association
Andrew Campbell, Private Citizen, Yerington, Nevada
Steven Cohen, Private Citizen, Las Vegas, Nevada
Liz Davenport, representing American Civil Liberties Union of Nevada
John Piro, representing Clark County Public Defender's Office and Washoe County Public Defender's Office
Beth Jones, Private Citizen, Henderson, Nevada
Harrison Jones, Private Citizen, Henderson, Nevada
Alexis Jones, Private Citizen, Henderson, Nevada
Jennifer Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services
Jamie Stetson, Private Citizen, Reno, Nevada
Nicole Willis-Grimes, representing Special Olympics Nevada

Chair Nguyen:
[Roll was taken.] I would like to welcome our audience joining us either virtually on the legislative website or on YouTube. Today, we have presentations on mental health in Nevada and hearings on two bills.

Before we begin, I would like to make several housekeeping announcements. Agenda items may be taken in a different order than listed. Two or more agenda items may be combined for consideration, an item may be removed from the agenda, or discussion of an item may be delayed at any time.

This virtual meeting format via Zoom is important to keep everyone safe during the COVID-19 pandemic. Members of the public may provide testimony in several different ways, all of which are listed on the agenda. Right now, you can register to participate online through the

Legislature's website on the Nevada Electronic Legislative Information System (NELIS) or by sending your comments directly to our staff.

Any committee exhibits may be submitted electronically. Our members can see them online, as well as the public, and we try our best to keep those up to date so you can have access to them before our meetings. If you are not able to submit public comment over the telephone, at the end of the meeting, or during the bill presentations today, you will be able to do so in writing up to 48 hours after our meeting adjournment.

We will now begin our first agenda item. There will be an opportunity for limited comments or questions from Committee members, but our policy analyst will send out our presenters' contact information; so if you are not able to ask your questions today under these limited circumstances, I encourage you to reach out to them. They have been very forthcoming with information when I have needed it, as I am sure they will be with you. Now I would like to start off with our first presentation from the Department of Health and Human Services.

Stephanie Woodard, Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services:
We are here today to provide a brief overview of the State of Nevada's behavioral health system and to discuss the impacts of COVID-19 on behavioral health in Nevada and opportunities for behavioral health going forward [Exhibit C]. This presentation is intended to be very high-level as an introduction to the state system; we recognize from the outset that the behavioral health system is vast and incredibly complex. We are not going to be able to go into much detail here; however, both Dr. Megan Freeman and I are available for questions following this presentation as well as offline if there are any specific issues or topics you would like to learn more about.

There are lots of different departments and divisions within the State of Nevada that have touchpoints to behavioral health and play critical roles in ensuring that services and supports are provided within other systems such as criminal justice [page 2]. But the Division of Public and Behavioral Health (DPBH), the Division of Child and Family Services (DCFS), and the Division of Health Care Financing and Policy all function together under the Department of Health and Human Services (DHHS) to provide essential elements for the statewide, community-based, behavioral health system. Behavioral health in Nevada has evolved over the past decade, especially with implementation of the Patient Protection and Affordable Care Act. These state-driven systems have helped to expand access to care when previously the state itself was the largest behavioral health provider in Nevada. This evolution has required a concerted effort and coordination across divisions within DHHS, and DPBH serves as the state mental health authority and the single state authority for substance abuse treatment and prevention.

Collectively, the three divisions work together to plan, regulate, and provide oversight, training and technical assistance, and financing to this complex system. In order for us to do the planning and oversight we provide to the state behavioral health system, we have several boards and commissions that help guide our work [page 3]. These include the State Board of

Health, the regional behavioral health policy boards, the Behavioral Health Planning and Advisory Council, and the Substance Abuse Prevention and Treatment Agency Advisory Board. Collectively, these have, in one way or another, an opportunity to provide planning, oversight, regulation, and advocacy for behavioral health in Nevada.

The DPBH has several priorities moving into this biennium, and they include things like evidence-based forensic services, improved behavioral health through promotion, prevention, early intervention, and access to quality behavioral health services, and continuing to improve inter- and intra-agency communication and collaboration [page 4, Exhibit C].

This is a brief summary of what the behavioral health system looks like in Nevada, specifically as it relates to DPBH. As the state mental health authority, we have direct services in both civil and forensic. We also provide a high level of policy advisement, and we manage a number of federal and state grants that are often passed through to community programs to assist in prevention programming as well as to support community behavioral health providers to establish new programs. We work with those programs toward sustainability, and we use some of the funding to help provide services for individuals who are uninsured or underinsured [pages 5-7]. The behavioral health system also includes the Bureau of Health Care Quality and Compliance. They often assist with the licensure of health care facilities including some of the foundational facilities that are part of the behavioral health system in Nevada. Then we have administrative services which are absolutely essential for us to be able to administer the grant funds we receive.

For our clinical services on the civil side we have two inpatient psychiatric hospitals, one each in Washoe and Clark Counties [pages 8 and 9]. The access to inpatient services usually is for an individual who is admitted under an emergency through a mental health crisis; however, they do also have voluntary admissions. There are also several outpatient clinics that make up a network of care within our state. There are four of these clinics in urban areas—three in Clark County and one in Washoe County—as well as eighteen community-based clinics throughout rural Nevada.

Access to outpatient services is completely voluntary unless the individual has been ordered to mental health court or to assisted outpatient treatment. It is important to note that our civil service outpatient programs really do provide the safety net services for individuals in Nevada who are uninsured or underinsured. They also work very closely in collaboration with community partners to provide a no-wrong-door approach on the campuses of both the Northern Nevada Adult Mental Health Services—Dini-Townsend Hospital—and the Southern Nevada Adult Mental Health Services. But they also provide coordination of care with many community-based programs. In addition to the community-based programs they work in, they also provide an array of services related to outpatient mental health services.

On the forensic side, we have two hospitals in Nevada—Lakes Crossing Center in Sparks and the Stein Hospital forensic facility in southern Nevada [pages 10-12]. These two hospitals care for individuals who are working toward restoration of competency. They have long-term inpatient forensic programs for individuals who are committed to the division, and

they are serving individuals who were acquitted as not guilty by reason of insanity. These forensic hospitals have been working very hard over the last several years to assist in addressing the federal consent decree around the inability of the state's single forensic hospital to admit all court-ordered referrals in a timely manner. They have recently been able to move out of the consent decree, but it is important to acknowledge that the forensic hospitals remain at or near full capacity. Although the consent decree has expired without penalties or further oversight, the state is continuously focused on careful management in order to meet demand and avoid any other legal challenges.

Those are the two areas where there are direct clinical services that are provided within the Division of Public and Behavioral Health on both the civil and forensic side, but as we have worked to move away from being the largest behavioral health provider in Nevada and to build capacity at the community level, we have recognized the need for additional support to help build that community capacity. The behavioral health policy unit works to administer the majority of our large federal funding streams that are used to address specific populations, including those who are uninsured and underinsured [page 13, Exhibit C]. This also requires the policy division to work on additional supports such as technical assistance, strategic planning, and implementation of systems within the state and in communities.

Some of the behavioral health policy areas of focus include addressing minority health inequity and disparities and supporting evidence-based practices. After COVID-19, we did a lot to help support community agencies to fully implement telehealth and to focus on suicide prevention and crisis services.

That is my very brief overview of the behavioral health system as it relates to the Division of Public and Behavioral Health, and now I will hand this presentation over to Dr. Megan Freeman at the Division of Child and Family Services to provide a similar overview of their system.

Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services:
Thank you for the opportunity to present to you on children's mental health [Exhibit D]. Today I would like to give you an overview of our agency operations and explain how our work shapes the children's mental health system in Nevada. On this slide [page 3], you will see our agency vision and mission. In trying to improve conditions for youth in every Nevada community, we seek to break down barriers to access to care in every region across the state, to eliminate disproportionality in our systems, and to meet the needs of special populations.

In addition to our agency vision and mission, three regional children's mental health consortia guide the growth and development of our children's mental health system. The makeup and roles of the children's mental health consortia are defined in *Nevada Revised Statutes*, and the consortia chairs and I will speak to this Committee on February 15 in more detail about this [page 4].

Next, I would like to touch on another important value system that guides our work. Nearly 30 years ago, a federal initiative known as the Children's Mental Health Initiative was authorized to facilitate the delivery of comprehensive community mental health services to children and youth. Through this initiative, hundreds of demonstration grants, cooperative agreements, and expansion grants have been funded throughout the United States to encourage the widespread adoption of what is called the "system of care" approach. The Division of Child and Family Services (DCFS) has received three grants under the Children's Mental Health Initiative and is committed to the system of care (SOC) approach. The core values of an SOC approach include providing services and creating systems that are family-driven and youth-guided. The services are community-based, accessible, and provided in the least restrictive environment, and services and systems are culturally and linguistically appropriate [page 5, Exhibit D]. The Division of Child and Family Services' operations are divided into four separate areas, which you can see here [page 6]. In 2019, DCFS underwent an internal reorganization to move away from our traditional orientation around children's mental health, child welfare, and juvenile justice services. This resulted in new coordination of our services around community-based services, residential or 24-hour services, and quality and oversight. Since the reorganization, we have been working to break down silos, incorporate children's mental health programming throughout the child and family services system, and incorporate continuous quality improvement into all programs at all levels to better serve youth—many of whom touch multiple of our systems.

In our community services area are located all our outpatient, mobile, and other community-based services including child protective and welfare services for rural Nevada. We offer services for ages 0 to 17, or into the early 20s if the youth is still enrolled in K-12 school. We primarily serve Medicaid fee-for-service, uninsured, underinsured, and undocumented families. For some programs such as our mobile crisis response team, we serve any family in need at no cost.

The focus of our residential services programs is 24-hour care. This includes acute care, residential treatment, and juvenile justice youth facilities. Our youth facilities are focused on programming and not on punishment. Per policy, every youth receives an assessment for mental health and substance-use treatment needs, and treatment is provided as needed. Our youth facilities also operate under a recently modernized suicide prevention policy.

Our quality and oversight area is focused on policy, quality assurance, and DCFS in its oversight/regulatory role as a state agency. Additionally, our systems advocate is located in the quality and oversight area. This position functions as our public information officer and legislative liaison.

Division of Child and Family Services administrative services are focused on support and infrastructure with the additional recent expansion of our victims services area. Nevada's Victims of Crime Program is located here and provides financial support to individuals who have been the victims of violent crimes. Additionally, victims services holds Nevada's Antiterrorism and Emergency Assistance Program, a $16 million multiyear award to support victims of the Route 91 Harvest Festival shooting on October 1, 2017, in Las Vegas.

Behavioral health support is a main focus of recovery for Route 91 survivors. Finally, through our victims of crime funding, we are providing funding for innovative programming that addresses the needs of children exposed to domestic violence and for victims of commercial sexual exploitation, including children.

In 2020, our psychiatric residential treatment facilities achieved accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). This was a multiyear, highly intensive process that has resulted in more in-state beds for youth with higher levels of need. In the coming biennium, residential services will be focused on implementing the Building Bridges program—a set of best practices for transforming systems to create partnerships and collaboration between families, youth, advocates, service providers, and oversight agencies. A primary goal of the Building Bridges program is to sustain positive outcomes after a discharge from residential placement.

On the next slide [page 8, Exhibit D] you will see our two active sources of competitive federal funding including our pediatric mental health care access grant which works to integrate pediatric psychiatry and behavioral health consultation services into rural primary care. Our system of care expansion grant has multiple goals, but the overarching objective is system improvement which will expand the service array in rural Nevada and provide infrastructure to grow DCFS's capacity to serve in an oversight role for children's behavioral health. In particular, this system of care grant will expand access to wraparound services, respite care, and family care support. We have also been focused on supporting the implementation of a 1915(i) Medicaid state plan amendment to expand the service array for youth in specialized foster care, also known as treatment foster care for youth with intensive behavioral health needs.

In our community services area, it is important to highlight the work of our mobile crisis response teams as a primary method or point of entry for families to access services and become matched to the correct services and supports for their needs [page 9]. Using some emergency COVID-19 funding, we were able to temporarily expand the mobile crisis program to meet increased need and create additional teams, as well as expand our ability to provide telehealth services 24/7 statewide when previously, statewide 24/7 response was only available in Las Vegas. However, the funding is temporary.

Finally, within community services, tiered care coordination is available to youth with multiple system needs, in order to build the family's capacity to meet their youth's needs as well as match them to formal services and supports. Tiered-care coordination includes High Fidelity Wraparound and a program called FOCUS for youth with intermediate-level needs.

A lot of what we do is focused on direct services, but our quality and oversight area is where we focus more on policy and our regulatory role. In our quality and oversight area we are currently recruiting for a position that would be embedded in Nevada Medicaid to support policy development and on-the-ground technical assistance for schools implementing Medicaid billing. The position will have a particular focus on the Clark County School District as the largest district in the state.

Looking to the future, there are significant workforce needs in quality and oversight. The Division of Child and Family Services would like to move forward with becoming the children's mental health authority in Nevada, which would allow us to set provider standards, run a technical assistance and training center for evidence-based practices, and provide oversight and quality assurance to ensure that providers using public funding for mental and behavioral health care for children are adhering to standards in quality criteria. We currently lack the staffing necessary to stand up the technical assistance and training center or to scale up oversight and quality assurance. By creating an infrastructure for widespread dissemination and oversight of evidence-based practices, particularly home and community-based services, we can follow the footsteps of other communities that have returned youth from out-of-state placements, closed residential treatment centers and juvenile justice centers, and achieved the system of care expansion goal of curating an array of effective, evidence-based, community-based treatment options. Our previous system of care grant identified the need for a children's mental health authority, and we were planning to begin those efforts during this legislative session. Given the current budget constraints, we are looking at alternate ways to begin this work. Our current system of care grant provides the theoretical framework in initial funding to build the beginning infrastructure for the children's mental health authority. However, we need a sustainable plan to position DCFS as the entity in Nevada that ensures children, youth, and families receive the best possible mental and behavioral health care so they can achieve their goals. I will now turn this over to Dr. Woodard to continue the presentation on behavioral health needs in Nevada.

Stephanie Woodard:
Recognizing that we have time constraints today, you have been provided with slides [Exhibit E] as well as with a few final slides on the two previous presentations which provide some links to additional resources that may be helpful if you wish to learn more about any of the topics we discussed today.

We will now look at behavioral health in Nevada and the impact of COVID-19. It is important to recognize that COVID-19 as a pandemic is considered a disaster. Looking at how we can best estimate the impact of COVID-19 on behavioral health in Nevada and internationally, we have had to look at an existing body of research that helps us to better understand what the impact of previous disasters has had on behavioral health. As a disaster, COVID-19 has impacted virtually everyone in one way or another. Individuals who have been most directly impacted may have the most adverse experiences when it comes to responding to COVID-19. We have looked at a body of literature related to disaster behavioral health to help us better conceptualize what we needed to address in the response and recovery efforts [page 2].

Most disasters have a very clear beginning, middle, and end, and when they do, there is a typical trajectory in which individuals will experience different types of stressors at different magnitudes throughout their response and recovery time periods. This is the best model we have had in order to better anticipate what the impacts on behavioral health could be related to COVID-19 [page 3]. However, we recognize that there are some significant limitations to using this model. One of the primary limitations is that this model assumes that there is a

very clear beginning, middle, and end to a disaster, and as we all know with COVID-19, it has had a very prolonged existence in Nevada and the recovery—although coming—is relatively slow. We also recognize that the recovery from an impact such as a hurricane or tornado tends to follow a normal trajectory where there is an opportunity for inventory and community cleanup and engagement. However, in COVID-19, we have experienced something that is very different.

One of the best ways for us to conceptualize the impacts of COVID-19 is to look at the stress continuum [page 4, Exhibit E]. We recognize that there are different impacts depending on different degrees of stress. This includes individuals who are experiencing healthy amounts of stress all the way to individuals who have experienced incredibly prolonged exposures to high degrees of stress. What we know from previous disasters is that individuals who were already experiencing high degrees of distress prior to the disaster are most likely to continue to experience moderate to severe levels of distress during and post the disaster. However, we also know there are several impacts that a disaster can cause such as economic uncertainty, housing instability, as well as grief from experiencing bereavement that can also contribute to high levels of stressor. How long an individual is experiencing high degrees of stress can impact how vulnerable they are to either having difficulty in coping or beginning to experience the onset of behavioral health conditions.

We were fortunate in Nevada to be eligible for what is called the Crisis Counseling Assistance and Training Program grant through the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) after the declaration of the emergency was approved in April 2020. To formulate how we as a state were going to respond to the behavioral health needs in Nevada subsequent to COVID-19, we developed, along with FEMA and SAMHSA, this population exposure model [page 5]. This model allows us to better understand what the potential impacts are for different populations, including vulnerable populations, so we could target our responses and resources based on the level of exposure or the potential for significant distress due to COVID-19.

At the very bottom, we have prioritized those individuals who are bereaved or who have experienced a hospitalization, recognizing that both those events could be incredibly difficult for someone to manage. We also prioritized frontline health workers, especially knowing that we have been experiencing a considerable medical surge as of late. We see that frontline health workers, as well as emergency responders, have really been shouldering a lot of the burden related to the response to COVID-19. We recognize that it is not only those individuals who have been directly impacted, but the secondary and tertiary impacts that COVID-19 has had on individuals. This could also be loss of employment, students who have been disconnected from school, and other individuals in the community who have been responding to COVID-19.

We have been able to respond in a number of different ways [page 6]. Some highlights from our response and recovery activities include training well over 700 people in psychological first aid. We have worked with the Nevada Hospital Association on engaging hospitals in

crisis standards of care around behavioral health, crisis services, and emergency room diversion. We have worked to establish 24/7 psychiatric triage centers for children, adults, and adolescents to help divert them from emergency rooms. We have developed some programming and public service announcements, including our "Home but Not Alone" campaign, to get the message out to help individuals understand where resources are available should they need them.

Starting in March 2020, within DCFS and DPBH we developed a behavioral health task force that began to look at some of the data available to help us better understand what the immediate needs and impacts were so we could develop our response strategies [page 7, Exhibit E]. Collectively, we authored the COVID-19 behavioral health recovery plan in May 2020. The plan spans a number of different areas we had identified as priorities with an emphasis on promotion, prevention, and early intervention. It also helped us identify, if we received additional federal funds, which we have, how we would plan to allocate that funding to some of the highest needs.

The Crisis Counseling Assistance and Training Program [page 8] funded the development of the Nevada Resilience Project, which has allowed Nevada to hire a number of resilience ambassadors statewide, with a focus on intervening and providing promotion, prevention, and early intervention for individuals who are struggling with stressors related to COVID-19. This helps us direct them to needed resources as well as to reduce stress and build on coping skills. We have worked with a number of community partners including the Human Services Agency of Washoe County, the Boys & Girls Club of Truckee Meadows, the Boys & Girls Clubs of Southern Nevada, and a number of other community organizations to ensure that our resilience ambassadors are available statewide when and where an individual needs additional support. With that, I will hand it over to Dr. Freeman.

Megan Freeman:
I am going to talk now about the state of youth mental health in terms of mental health needs before the pandemic, and what some of the impacts of the pandemic have been. The "State of Mental Health in America" is an annual report produced by Mental Health America, a community-based nonprofit utilizing national survey data. As you can see, Nevada typically does not fare well in the youth rankings [page 9]. We have been 51st for the past three years, and the same is true for the overall rankings. On Monday, you heard from Public and Behavioral Health Deputy Administrator Julia Peek that, throughout public health in Nevada, if there is a list that is good to be at the top of, we tend to be at the bottom. In the youth section of the Mental Health America report there are seven indicators that make up these rankings. These indicators fall within the core general topic areas listed here. Our biggest areas of difficulty are in access to care and prevalence of substance use disorder among youth. These are very actionable concerns and can be addressed with investments in screening, prevention, and early intervention. However, it will take resources and time to move the needle on these rankings.

The Youth Risk Behavior Surveillance System is a population-level survey supported by the Centers for Disease Control and Prevention (CDC) and designed to monitor health risk

behaviors, identify health disparities, and monitor the effectiveness of public health interventions. The most recent data were collected in 2019 by the University of Nevada, Reno. We do our own version of the survey here and sample more widely than the CDC does. The data were collected at all regular public, charter, and alternative high schools and middle schools in Nevada. This slide [page 10, Exhibit E] draws attention to some of the most important behavioral health findings from the survey, including up to two in five youth struggling with significant feelings of depression, up to one in five youth having seriously considered suicide in the past year, and one in five youth engaging in self-harm. On this same survey, 15 percent of middle schoolers and 56 percent of high schoolers reported that they never or rarely got the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious. This data is consistent with our core national rankings on access to care.

On this next slide [page 11], you will see the top ten diagnoses most commonly associated with Medicaid billing for behavioral health for youth ages 0-18. These are 2019 numbers, so this was prior to the pandemic. For the sake of time, I will leave this for reference, but you will notice that mood and anxiety disorders are prominent.

These are some of the risk factors and stressors that youth and families are coping with right now [page 12]. I want to emphasize that isolation and loneliness are associated with risk of future mental health problems, most commonly depression. However, while youth are reporting increased anxiety, depression, and stress right now, some teenagers are actually reporting increased life satisfaction which they say is because of more time for sleep, more time with family, and protection from some of the stressors of regular in-person life, like bullying.

One of the major concerns that has been well documented throughout the pandemic is the lack of adult eyes on children who would normally be interacting frequently with teachers, school staff, pediatricians, coaches, faith leaders, and in lots of other arenas. We have seen a significant drop in calls to child protective services (CPS) from educational professionals in schools. However, over time, we have started to see more calls coming in from law enforcement and other professionals such as physicians. Total call numbers have returned to overall seasonal patterns at a slightly decreased rate compared to prior years [page 13]. I see this as an overall systems success as our communities have adjusted to the needs and current circumstances.

This graph shows calls to our children's mobile crisis response hotline [page 14]. You will notice the same general pattern as the CPS hotline calls—a large decrease at the onset of the pandemic followed by a gradual return to regular seasonal patterns. For mobile crisis, the return to normal happened when children returned to school in the fall. This actually caused a spike in need, but it has remained high since that time.

This slide shows a change in the hospital diversion rate for mobile crisis [page 15]. This is the number of youth stabilized safely in the community or diverted from psychiatric hospitalization. Initially, mobile crisis saw a decrease in hospital diversion, indicating that more youth were being hospitalized. The program reports that this is due to youth with more

serious levels of risk presenting for care and more difficulty in placing community supports around the youth due to isolation and quarantine.

I also want to make you aware of a national trend reported by the CDC in the fall. Although the overall number of pediatric visits to emergency departments decreased by about 7 percent during lock-down and stay-at-home efforts, the proportion of visits that were related to behavioral health was 40-60 percent higher than normal during April through October [page 16, Exhibit E]. Most emergency departments lack the appropriate resources for providing behavioral health care, so we want to increase the availability of immediate in-crisis care when and where youth and families need to access it.

Finally, I would like to address the topic of youth suicide. On the blue bars on this chart [page 17], you are looking at the total number of suicides for ages 0-17 for 2010 to 2020. The dotted line is the national suicide rate, which has been increasing steadily over the past decade. The black line is Nevada's suicide rate, which has been fluctuating around the national rate.

On Monday, you heard a little bit about public health surveillance from Division of Public and Behavioral Health Deputy Administrator Julia Peek. She talked about how typically public health surveillance does not occur in real time, and youth suicide is the same. Although I know this topic has been in the news and in all our hearts recently, our 2020 numbers have not yet been finalized through the Office of Vital Statistics, so they could change from what you see here. It is too early to draw conclusions about how the pandemic has changed the youth suicide rates in Nevada or anywhere. What we do know so far about the impact of the pandemic on suicide in Nevada is that our 2020 total is not out of the realm of what is normal for Nevada over the past decade.

I am a parent. One fatality is too many, and we strive for zero suicides, but I would like to encourage us as a public health system not to focus on fatalities as the only important indicator of the burden of suicide in Nevada. That is why we are putting into place syndromic surveillance at hospitals and urgent care centers to better understand the full spectrum of help-seeking for suicidal behavior. This is monitoring of the number of visits where the person presents with a suicide attempt. Additionally, we must continue to expand crisis services and provide outreach so that children, youth, families, and individuals who are suffering know where to go to get help.

Stephanie Woodard:
I will take a little glimpse into the Mental Health America report, this time specific to adults and mental health. This report comes out annually and uses a number of different metrics to look at the progress, or lack thereof, that mental health services are having in specific states. Here you will see a number of different rankings [page 18]. The category of "adults with any mental illness" has continued to increase. Where Nevada is about 20 percent, the United States average is 19 percent. In Nevada, the category of "adults with a substance use disorder in the past year" is at 9 percent where the United States is 7 percent. These data are from a study done in 2018. One of the issues we have with these reports is because the data

is so outdated, sometimes it is very difficult to attribute what it is we are seeing in the data to what we are seeing in the state here and now. But we do use these as indicators to be able to measure progress as we look at this data year over year.

I also want to note that there have been some improvements in some of the areas related to adult mental health, including a reduction in adults expressing serious thoughts of suicide and adults with any mental illness who did not receive treatment. We actually have increased the number of individuals who may have needed treatment and did receive treatment. As for adults with cognitive disability who did not see a doctor due to cost, we have seen a good reduction in those numbers, which has enhanced our scores here. The reason I think it is important to discuss these data is because far too often we hear people use the shortcut that Nevada ranks fifty-first, but there are a lot of nuanced data points that go into that overall ranking. It is important to look in a more detailed fashion to understand what could be driving some of our rankings [page 19, Exhibit E]. As was pointed out, the rate of suicide in Nevada in 2020 specific for youth was not unusual compared to years past, and we see similar trends across all age groups including adults and individuals aged 65. Again, I want to caution that these data are preliminary and subject to change.

We have experienced an increase in opioid overdose deaths over the course of COVID-19 [page 20]. We had seen a relatively steady reduction over the last few years, but now we have seen the highest rate we have had in the past decade with 484 fatalities in 2020. There are a lot of reasons why this could be, not the least of which are increase in isolation and lack of access to care. In November we had a red alert through the national drug helpline which noted that Nevada had a 50 percent increase in overdose deaths between the first and second quarters of 2020. Much of this is driven by non-COVID-19-related issues, including the proliferation of synthetic opioids including fentanyl. We have been seeing this troubling trend growing nationally even pre-COVID-19, but we realize that COVID-19 could have had a significant impact in changing some of these numbers in Nevada. We have also seen an increase in emergency room (ER) utilization rates for individuals with suspected opioid-related emergency department encounters. We had a 26 percent increase in 2020, while the overall drug-related emergency department use increased only 3 percent. So, while we saw a 3 percent increase overall, the vast majority—26 percent—was related to opioid overdoses. We are seeing an increase in utilization within Medicaid for substance use disorder, and we saw a pretty significant increase in 2020 for individuals in the Medicaid programming accepting substance use disorder treatment services [page 21].

We have been watching very closely a number of different indicators to help us better understand what is happening with traditional behavioral health service utilization. We have not seen a very significant increase in overall utilization during COVID-19 [page 22]. There are a number of different reasons for this, not the least of which is that we did have a substantial time period where we had stay-at-home orders, and we know that individuals have been avoiding care. We also know that, following disasters, we typically see an increase in need for traditional behavioral health services between 12 and 18 months following the anniversary of the appearance of the disaster. We anticipate that we may see increased needs for services moving forward following March 2021. We have seen an

increase in crisis services. We have seen a 170 percent increase in calls to the warm-line and increases in both acuity and the length of calls for our lifeline for crisis support services of Nevada. Through the Nevada Resilience Project, which is about promotion, prevention, and early intervention, we have been able to serve almost 73,000 individuals statewide since June. Our COVID-19 ER grant recipients who are providing crisis triage and inpatient services have seen an approximately 100 percent increase year over year in individuals looking to access care. We continue to watch and monitor to see what the impact could be on overall traditional behavioral health services, and currently, we have not seen a significant increase.

Where we have seen a nice change is in telehealth [page 23, Exhibit E]. Telehealth utilization for behavioral health services helped with continuity of care for individuals who had previously been engaged in behavioral health services. But we also saw a marked increase in individuals who initiated treatment services utilizing telehealth. Pre-COVID-19, approximately 24 percent of individuals had had their initial visit via telehealth, and that moved to 41 percent of initial visits during the six months following March 2020.

There is certainly a lot of work to do in the road ahead [pages 24 and 25]. We have to recognize that there is a risk for increased and severe distress as it relates to our economic recovery; the more prolonged this recovery is, the more likely that individuals will continue to experience distress. We have to recognize there is a risk for increased suffering among children, parents, and caregivers due to isolation, loneliness, and stress related to school closures as they persist. We must address the needs for individuals who are struggling to cope and manage with new or ongoing stressors, and recognize the opportunities for prevention and early intervention as recovery continues.

Some of our priorities are to prioritize basic systems that help keep people safe and secure, focusing on social determinants of health such as economic factors—food security, housing stability, access to health care, and access to education. We need increased capacity to provide school-based behavioral health care for children. We need to continue efforts to promote, prevent, and intervene early when individuals are having difficulty coping; provide crisis services for individuals and families when and where they need them, to include suicide prevention; and continue efforts to build community and family resilience.

Chair Nguyen:
You did an amazing job, and I know I asked a lot by asking you to consolidate everything that is going on in this mental health field. We do have a couple of questions.

Assemblywoman Peters:
I echo what the Chair said about getting all that information to us in such a shortened period of time. I have a question related to your data. Are there any data gaps you have identified? We need to ensure that we have all the information we need to develop response policies, to be certain we are getting those resources to children and families when and where they need them.

Megan Freeman:
An amazing thing about Nevada is that we are collecting a ton of data on children. We have data on crisis teams, and we get a lot of data through the schools. There are a couple of different initiatives on collecting data through the schools. Right now, we need to focus our efforts on suicide prevention. We would like to be getting more real-time information from hospital emergency departments and urgent cares about individuals across the lifespan who are presenting with suicidal behaviors. That will help us understand in more recent or more real time what the needs are and who has the need—where we need to focus our prevention efforts.

Assemblywoman Peters:
That is great to hear. I have been working with Dr. Woodard on a bill that I hope will help allow us to fill that data gap in particular.

Assemblywoman Titus:
I appreciate Dr. Woodard and Dr. Freeman presenting today. I know it was a lot of information in a short amount of time. I have questions regarding slides 8 and 18 [pages 8 and 18, Exhibit E]. Nevada continues to be fifty-first in all those data points—the worst of the worst, as you pointed out. This is my fourth session. I have seen presentations every session because I have been on this Health and Human Services Committee each time. We are not moving that needle at all. Each time we hear these presentations, we talk about collecting data. At some point, we have to make some changes because, before I am termed out, I would love to see some of those needles moving and that there is some improvement. I have not heard anything more than that you are collecting more data. I am not hearing any solutions.

I would like to know whether the number of childhood behavior specialists has increased. What are we doing about reaching out and educating folks so that we can get more providers so there is more access to care? I know we have more Medicaid recipients signed up, but that does not mean there is better access to care, and I have huge concerns about that. At some point—you may not have that today, and we are limited for time—but I would like to see the number of providers available in your system. What are we doing to outreach? Are we using reciprocity to get these people licensed so there will be more access? That is my first question—what are you doing for the specialists these people see?

My second question concerns telehealth data. You said we have increased the use of telehealth from 24 percent to 41 percent, but that does not mean there has actually been increased access to care. It means that maybe the individual was unable to get into the office and might not otherwise be going to see that provider unless it was via telehealth. I do not know that is actually a greater percentage of access, so I would like to see some data on what we are actually doing to have folks get access to care. At the end of the day, follow-up access to care, getting into treatment programs, and having specialists available for adults and children is really when we are going to start solving these problems, so perhaps you can get us more information on the actual providers.

Megan Freeman:
I will briefly speak on your question and then it might be best for me to take this back to our division leadership, and they can submit more information to you in writing. One thing I will point out is Mental Health America reports in any given year are based on data that was collected three years prior. It is very possible that we have made strides in the past three years that will not be reflected until we see the rankings on future years' reports. We have been working to expand our system of care in Nevada. I think that is very significant for children, and we just may not be seeing those numbers reflected yet in the report; however, we will submit a response to you in writing regarding your questions about providers and the other aspects of your questions.

Assemblywoman Titus:
Thank you. I do not think there is a person in this meeting who does not want to see Nevada rise out of that fifty-first ranking in so many things, and I appreciate all you are doing.

Assemblywoman Summers-Armstrong:
Is your department partnering with any national organizations or nonprofits to address some of the mental health issues throughout the state? Do you have any certified nonprofit organizations able to go into the schools and give presentations to kids or do outreach and get the message out that there are resources and help available so people know more about them? In southern Nevada, I am seeing a lot more open, frank discussion about mental health. The more support we have for those conversations from your department, the better we will be able to reach people in our community.

Megan Freeman:
We would love to partner with you to understand more about what you are seeing. We can get you a list of our community and national partners that provide us with technical assistance. We seek a lot of support and technical assistance, but there is always room for improvement, so we would love to have that conversation with you.

Chair Nguyen:
If there is any other documentation you have, please provide it to our policy analyst, and he can distribute it to all Committee members. I also encourage everyone to reach out to our presenters. Their contact information has been provided to you, so you may follow up with any additional offline conversations about what we can do in our state. We will now move on to our regional behavioral health policy boards. I have basically asked almost the impossible from our next presenters. I have asked them to introduce themselves and give us a five-minute presentation each, so we will begin.

Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator, Rural Regional Behavioral Health Policy Board:
There is a handout in your packet [Exhibit F] that accompanies this presentation [Exhibit G] which gives far more detail about the board than I am able to present to you today. The Rural Regional Behavioral Health Policy Board represents a six-county region in northeastern Nevada which includes Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties. The combined area of this region is slightly larger than the state of Mississippi, and the population sits at just under 100,000. So, this large expansive space covered by the region and the geographic distance of specialty services influences a lot of our board's priorities. The priorities seen here were adopted by the board in early 2020 and will be revised and updated at the board's next meeting on February 24 [pages 2 and 3, Exhibit F].

One of the major issues community members in our region face is transportation, both to and from behavioral health services. This is the case for both crisis and noncrisis services. While a person in crisis may be able to get emergency transportation to in-person services in Reno, Carson City, or Las Vegas, our stakeholders have alerted us to many persons being released from emergency care without direct transportation home. In those cases, they may be stuck in the city where they were released or sometimes they have been put on public transportation for the return home, often without medication, food, or water, and, due to multiple connections, this may take more than one day.

Initially, the lion's share of the persons in our regions seeking behavioral health care services are either covered or eligible for Medicaid. Thus, previous to the COVID-19 pandemic, it was a priority of the board to seek improved Medicaid reimbursement for behavioral health services to ensure the providers could maintain service levels to meet their needs. Due to budgetary cuts and concerns over the last year, that conversation has changed to preserving the Medicaid services that are currently available.

While most of the state can be considered health care service shortage areas, the issue is exacerbated in our frontier communities and is often even worse in regard to behavioral health services. The board has prioritized seeking ways to improve the ability of local organizations to recruit behavioral health providers, including improving paths to licensure for those who are moving to Nevada from out of state. This is addressed in the board's bill this legislative session, Senate Bill 44.

While state and local partners have made great strides in improving data quality and communication, this is still a persistent issue within our region. Assisting our local stakeholders in improving the quality and accuracy of the data collected at the local level and how it is communicated to state and other regional stakeholders is another priority of the board.

The board has thought to increase its visibility in an attempt to better engage local, regional, and state stakeholders and increase communication regarding current resources and challenges. The board prioritizes supporting programs that consider the needs of youth, elders, and families in a holistic approach, as issues within family units do not frequently happen in a vacuum, and addressing the issues throughout the family circuit may have improved outcomes.

Last but not least, the Nevada Department of Veterans Services has made it known to us that our region has a comparatively high percentage of veterans within our population. The board prioritizes efforts that improve the quality and access to services for those who have served our nation in the armed forces.

While many communities in our region may be geographically isolated, they were not unaffected by the COVID-19 pandemic [page 3, Exhibit G]. The information we are discussing here has been shared in community stakeholder meetings. It should be cautioned that many local organizations involved are focusing their limited resources on response, so data available may not currently reflect these concerns. Hopefully, they will be able to catch up as pressure from COVID-19 response subsides. Also, please remember that in such small communities, large increases may constitute small numbers in comparison to urban communities. However, with the already thin behavioral health services available, it does not take much to overwhelm local resources.

Early on, our local hospitals saw an increase in the number of persons presenting to the emergency departments in crisis. While some of these community members had presented to the local hospitals in crisis before, most of them were experiencing mental health crises for the first time. This was followed by a sort of second wave of problems where hospitals were seeing more patients who were presenting for reasons related to increased alcohol and substance abuse, as well as increased intentional overdoses.

Our local stakeholders have reported major concerns regarding increases in depression and anxiety among youth as well as frontline workers in health care, law enforcement, and other emergency health services. Additionally, increased isolation among community members is leading to concern, but even more so for those who are homebound or geographically isolated.

That is my very brief introduction to the Rural Regional Behavioral Health Policy Board. Thank you for your time and if you have any questions or comments, I can be reached by email.

Chair Nguyen:
Thank you. I appreciate your brevity. I know this is a complex subject. I will now move on to Ms. Dorothy Edwards who is with the Washoe Regional Behavioral Health Policy Board.

Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe Regional Behavioral Health Policy Board:

[Dorothy Edwards presented a PowerPoint Exhibit H and a summary sheet Exhibit I]. I will share a few of the main priorities, action strategies, and some challenges that the Washoe Regional Behavioral Health Policy Board has identified for support and to expand throughout Washoe County [page 1, Exhibit H]. An analysis of where Washoe County is in terms of readiness to stand up a crisis stabilization center remains something on which the board is focused. In response to the ongoing issue of individuals experiencing behavioral health crises and often being taken to jail or emergency rooms inappropriately, these facilities are considered an emergency health care alternative. The strategy for success for this state-supported endeavor began in the 80th Legislative Session with the introduction and passage of Assembly Bill 66 of the 80th Session which addressed some components of this type of facility. During this biennium, our strategy for moving forward includes the completion of an assets-and-gaps analysis, a visit to one of the originators of the concept in Arizona, and increased collaboration with partners in our state, city and county leadership to discuss the next steps.

While Washoe remains well-poised in some required elements, challenges to success include finding sustained funding, infrastructure, and then developing the policies and processes required for collaboration between agencies [page 1, Exhibit I]. It does remain a strong priority in our county.

A second priority is equitable focus on substance misuse [page 1]. While we know that behavioral health encompasses mental health and substance misuse, there has been some concern expressed that the focus of programs, funding, and policy might be inequitable between the two. Understanding that the two are often co-occurring, we need to work to ensure that there is inclusion and collaboration with all sectors of behavioral health.

Strategy for success began as we invited presenters from all sides of behavioral health including substance misuse treatment, prevention, and recovery, to provide information, education, and solicitation for a change in legislation through a bill draft. Several of those were selected for the board's current bill, Senate Bill 69. Our work and focus will include supporting the development of a diverse, culturally appropriate, inclusive, and well-trained workforce in both areas of mental health. Behavioral health response before, during, and after a crisis needs to be talked about [pages 1 and 2]. If we learned anything from this public health crisis, it is that we need a robust plan and trained staff to focus on the sometimes overwhelming behavioral health consequences of an emergent event.

Our strategy in Washoe for success included participating in the resilience project. Another strategy was the development this year of a draft behavioral health annex to our regional emergency response plan. We will continue to encourage and reach out to all organizations to take advantage of resources for training, such as in psychological first aid, with the goal of creating community response teams to activate when needed during an event. We look forward to conducting drills and exercises with local and state partners when it is safe and practical to do so.

The Community Health Improvement Plan (CHIP) was actually developed by the Washoe County Health District [page 2]. It is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. Behavioral health is seen as the top concern cited by the community, and one that greatly suffers from lack of adequate resources and an available workforce. It also ties in closely to the housing focus area, as many chronically homeless individuals suffer from mental illness and substance use disorders, and adequate housing is seen as a critical foundation to providing successful treatment.

The Washoe board committed its support of the behavioral health focus areas within the CHIP, which will include some robust and improved data collection and analysis, support and participation in the Built for Zero homeless initiative which is being implemented by Washoe County. Challenges include the lack of housing and resources, along with a trained workforce.

As we have all talked about today, the board understands that accurate data around behavioral health is necessary to inform trends and assist in making decisions. The annual Regional Profile is nearing completion as is the policy board's annual report. Both will include the most recent behavioral health data available for state and regional comparisons. A data website, or dashboard, is required for the regions, and Washoe continues to work on it with a target completion date of this year. I am happy to provide additional information on any of these subjects or on the reports I addressed, so feel free to reach out to me, and I will get you what you need to know.

Chair Nguyen:
We will move next to the Clark Regional Behavioral Health Coordinator, Teresa Etcheberry.

Teresa Etcheberry, Clark Regional Behavioral Health Coordinator, Clark Regional Behavioral Health Policy Board:
[Teresa Etcheberry presented a summary Exhibit J and a PowerPoint Exhibit K]. Clark County is one of the largest counties in Nevada. To give you an overview, per the Office of the State Demographer and the U.S. Census Bureau, the population in 2019 for Clark County was 2,255,175 persons. Clark County holds 73.6 percent of Nevada's population.

We have a very diverse board. Board members are well versed in behavioral health issues, and they hold different positions throughout the county on other boards [page 1, Exhibit J]. They also share the demographics for our county.

The Clark Regional Behavioral Health Policy Board embraces a data-driven approach to identify the behavioral health outcomes and system gaps of the region; therefore, the success of the approach depends on the existence of data, the types of data, and the quality of data gathered. What we are looking for in our data are the gaps and challenges in our area [page 1, Exhibit J]. We need to collect civil commitment data, including details from law enforcement, transports by emergency medical services to hospital emergency rooms, the treatment in the emergency rooms, and a summary of any transition to psychiatric services.

We also would like to know where people are placed and discharged and the length of stay for those hospitalized and treated in emergency rooms. This will guide the board in assessing the after- and ongoing care, and in developing the different reports we have to produce for our stakeholders and the state.

Workforce development is another concern. We would like to have an increase in the supply of providers in behavioral health. The board recognizes that the availability of qualified behavioral health providers is a concern here in Clark County. While the region has seen steady growth, our community still falls below the average of providers per capita. The board wants to further investigate what measures it could take to improve the behavioral health workforce supply in Clark County.

Regarding data management and application, we are working on a data dashboard, but we also need to have a data management system for Clark County, such as a health information exchange to provide access to behavioral health data and for the ease of use for providers and residents of Clark County.

The big thing that happened in 2020 is the pandemic crisis. We have seen an increase in the number of people seeking services on a national level as well as in Nevada. As we heard in previous presentations, we have an increasing number of adults, youth, and children reporting symptoms of anxiety and depression, and we have had an increase in the number of suicides. We are also seeing disproportionate impacts on Blacks, indigenous people and people of color, and on other populations including the elderly, individuals with developmental disabilities, residents of rural communities, and people living in poverty.

These concerns and challenges drive the board's priorities [page 3, Exhibit K]. As I spoke about the priorities for mental health and workforce development, we also want to see dedicated funding for crisis services. We spent many weeks working on Crisis Now, gathering information, talking about a Crisis Now system. We would like to expand our mobile crisis teams all over the county. We have a large urban area, but we also have many rural areas that lack crisis teams. The board also wants to increase community access to crisis intervention, and we want to increase the stabilization of crisis services for after-care and ongoing services. The board recognizes the behavioral health issues in our community and we must recognize the abuse of substance misuse and mental health and the use of telehealth services.

Chair Nguyen:
Finally, we will hear from Ms. Jessica Flood.

Jessica Flood, Northern Regional Behavioral Health Coordinator, Northern Regional Behavioral Health Policy Board:
This region includes Carson City, Lyon, Douglas, Churchill, and Storey Counties [Exhibit L]. Here is an overview of the regions, with my region circled [page 2]. These are the members of the board [page 3]. Our board priorities have remained pretty stable over the last five years [page 4]. By far, the top priority is obtaining sustainable funding for crisis

stabilization and jail diversion programs. We have our mobile outreach safety team (MOST), which is a co-responder team, our Forensic Assessment Services Triage teams are jail reentry, and CIT is Crisis Intervention Team training for law enforcement—mental health training. Our Mallory Behavioral Health Crisis Center is run through the Carson Tahoe Regional Medical Center and is our psychiatric emergency room.

Our priorities include increasing the behavioral health workforce with the capability to treat adults and youth, increasing access to treatment in all levels of care, increasing access to affordable and supported housing, and developing services to support continuity of care. That is looking at wraparound and community health workers.

To Assemblywoman Titus's point, we have seen some progress in our region, and it is quite exciting. I spoke about the Mallory Crisis Center [page 5]. That has been really pivotal to have that 24/7 access for people in crisis. We are also very lucky to have certified community behavioral health centers (CCBHC), and both Carson Tahoe and the CCBHCs have assertive community treatment teams which provide this wraparound to people who are in serious mental illness. Through those programs, along with our mobile outreach safety teams, we are seeing this incredible ability to identify individuals in crisis and get them into treatment and stabilized in a way we have not seen before. I was speaking to the MOST officer in Carson City yesterday, and he was saying there were individuals who had been in crisis for ten years who are now stable.

Dr. Woodard mentioned their emphasis on making jail reentry and criminal justice diversion evidence-based. The state has done a lot of work with us to bring our jail reentry teams up to evidence-based practice, and we are very grateful for that. So we think we are making progress in developing this comprehensive mental health system bit by bit.

What we think is working in our region is that we have these local behavioral health task forces that provide community input into the northern board [page 6, Exhibit L]. We also have a culture of collaboration in the northern region with a lot of organizations partnering on grants. Again, I have to give a lot of credit to the state. We have been able to identify community partners that are willing to expand their treatment services, and the state has been able to obtain some funding for those programs. Along with that, the state provides quite a bit of technical assistance that has allowed our programs to, hopefully, achieve sustainability in the future.

Our gaps and needs mirror our priorities [page 7]. We need access to care for youth and adults, especially youth. I have received calls from parents who have insurance and, despite their best efforts, cannot find treatment for youth coming out of inpatient psychiatric hospitalization. We need more behavioral health workforce. It is inhibiting us from creating more programs and expanding access to care. We are rich in crisis lines, and we appreciate many of them, but we have noticed that we still need in-person outreach for people who are in crisis, and that is in both the youth and adult perspectives.

In our region we see a gap for supported housing, including group homes and long-term supported living arrangements for people with serious mental illness. As has been touched on, we see this need for support for COVID-19-induced risk factors—isolation, unemployment, grief, and loss—and in particular for seniors. We are seeing a lot of seniors and older adults who are in crisis and starting to need hospitalization due to the isolation.

We are working on regional behavioral health emergency operations planning. We are trying to develop a website for the board that shows the data dashboard. Our region is trying to educate ourselves about what regional behavioral health authorities would look like, related to taking the next step to regionalize mental health through these boards. With these multi-county arrangements, we find there is no central way to apply for grants or to bring funding to the regions. As a result, there may be a benefit to looking at formalization [page 8, Exhibit L].

Chair Nguyen:
At this time, I am not going to take any questions; however, I would encourage Committee members to contact our presenters if you have any questions. Prior to my participation last session on this Committee, I was unaware of all these policy boards that exist in our state. They really are a resource about things happening regionally, particularly in your districts, and I highly encourage you to reach out to them. They are the boots on the ground; they have a better idea of what is going on locally, and can give you that information, especially if you are looking at crafting legislation in the future in these areas.

We have two legislative measures being presented this afternoon, and I have allocated equal time for testimony in support, opposition, and neutral for each bill after its introduction. Each person providing testimony in support, opposition, or neutral will be given a maximum of two minutes, and staff will be timing them so everyone will have a fair opportunity to speak. We will limit the overall testimony to 20 minutes for each measure. All testimony in support, opposition, and neutral will be over the audio lines to ensure fairness to all testifiers. Anyone joining the meeting on camera is either a Committee member, staff member, bill sponsor, presenter, or staff from agencies to help respond to any questions we may have throughout this hearing. At this time, no one will be joining the meeting on camera. I am open to changing this policy to make certain we are as open and as transparent as we possibly can be so as to engage as many members of the public who want to appear in the new format as possible. I am working with broadcast services as well as with all of you to make sure we are able to do that fairly.

I will now open the hearing on Assembly Bill 62. This bill revises provisions related to the Nevada ABLE (Achieving a Better Life Experience) Savings Program. Hopefully, you all had an opportunity to review some of the legislation from the 2019 Session and the links we provided to you on Monday.

Assembly Bill 62: Revises provisions relating to the Nevada ABLE Savings Program. (BDR 38-397)

Zach Conine, State Treasurer:
I am very excited to be here today to present Assembly Bill 62 which helps to innovate and strengthen Nevada's ABLE Savings Program to ensure that Nevadans with disabilities have the opportunity to save for a better future. Broadly speaking, ABLE accounts are tax-advantaged savings accounts that allow people with disabilities to earn and save money without losing access to vital programs like Medicaid and social security. By making these tax-free savings accounts available to individuals to cover qualified disability-related expenses for things like education, housing, and transportation, the program aims to ease the financial burden faced by citizens with disabilities who are the most underemployed demographic group in the state.

In the 2019 Legislative Session, our office worked with Assemblywoman Cohen and the Division of Aging and Disability Services to pass A.B. 130 of the 80th Session which moved the entire ABLE Savings Program into the Treasurer's Office. Since that time, our office has worked with hundreds of Nevadans with disabilities and their families to make sure they can gain access to these accounts without any impact or cost to the State's General Fund. The provisions of A.B. 62 would make Nevada the first state in the country to find innovative ways to incentivize people with disabilities to open these accounts and build up account balances to build their own great big, beautiful tomorrow. I will now ask Erik Jimenez from our office to walk through the specifics of the bill.

Before I do that, I would like to mention the tremendous work Erik has done focusing on the ABLE Savings Program over the last two years. His singular effort has helped hundreds of Nevada families, and he did that while helping me coordinate the largest recovery effort in the state's history.

Erik Jimenez, Senior Deputy Treasurer, Office of the State Treasurer:
Passage of the ABLE Act of 2014 was the single greatest move toward disability independence since the Americans with Disabilities Act. When we took the program over from the Aging and Disability Services Division (ADSD) in 2019, there were a little over 200 accounts with about $1 million in assets. We have grown that to more than 1,000 accounts with over $6 million in assets, all using zero dollars from the State's General Fund. We do this for free. It is not in the state's interest to make money on these accounts. We do it so people with disabilities can save, possibly get out of bad situations, and build a brighter future. Broadly speaking, we have a simple bill in front of you today, and I would be remiss if I did not thank Karly O'Krent from the Legislative Counsel Bureau for working with us on the bill.

This bill modernizes our ABLE accounts to mirror our Nevada College Kickstart program which gives $50 to every kindergartener in Nevada to kickstart savings. When I talk to families about the benefits of ABLE accounts, one of the biggest barriers is earning an income without losing their Medicaid and/or social security benefits, but they also do not

have the startup capital to open a bank account. We would like to find some innovative ways to pay for seeding and growing these accounts that make them more sustainable for the state going forward. The bill would authorize our office to promulgate regulations that would incentivize the opening of new accounts, similar to how we already do with Nevada College Kickstart, and then to incentivize regular deposits from existing account holders. So, if someone has an ABLE account and wants to start contributing, say $100 a month, how can the state meet that person halfway and start to figure out how to match? All of this we are proposing to not be funded out of the General Fund. There would be no tax for this program; it would be done purely through private philanthropy and federal grant funding. I want to thank some of the groups that have already expressed interest in doing that, particularly the Nevada Bankers Association. It has been a great partner in making sure we get awareness about these accounts to the public.

Chair Nguyen:
Are there any questions?

Assemblywoman Gorelow:
What is considered to be a qualifying disability?

Erik Jimenez:
A qualified disability expense is any expense that is incurred as a result of living with a disability. It is intended to improve someone's quality of life. When the bill was passed and signed, the idea was to make the categories as flexible as possible so as to encourage people to save but also allow them to use these expenses for pretty much anything the individual would encounter. Those vary from education, health and wellness, housing, transportation, legal and professional fees, financial management, employment training and support, assistive technology, and personal support services.

I get asked that question a lot when I talk to families. They ask things such as whether they could open an ABLE account and use that money to take a trip to Disneyland. We are trying to make the argument that, if it improves that individual's quality of life, better mental health, I could make an argument that it would be an eligible expense. The goal is to make it as broad as possible so these folks can spend this money just as anyone else would with their checkbook.

Assemblywoman Gorelow:
Who qualifies? What disabilities would qualify?

Erik Jimenez:
There is guidance from the Social Security Administration's "blue book," but people with significant disabilities that occur prior to the age of 26 are eligible for an ABLE account. In terms of disabilities, any intellectual development disabilities, autism, Down's syndrome, and those sorts of things would qualify. We work with the Nevada Justice Association on making sure that people with mental health disorders also can qualify for these accounts, but most disabilities are covered under the ABLE Act.

Assemblywoman Benitez-Thompson:
Thank you for all the work you have done on the ABLE Program. I have a question about section 1, subsection 4, paragraph (a), subparagraph (3), "Methods and incentives to encourage contributions to a savings trust account." Could you tell us more about what we might expect to see when talking about "incentives"?

Erik Jimenez:
We wanted to be very deliberate insofar as we do not know how much money we will be able to bring in either from federal grants or from private dollars. We did not want to commit in statute to a particular dollar figure if we could not meet that dollar figure. Assuming this bill works its way through the process, we can secure some funding and then outline what that minimum threshold would be. At this point, we are looking at between $50 to $100, and we would define that clearly through regulations that would go through the Legislative Commission. But at this point, we are giving ourselves flexibility if that dollar number moves around a little bit.

Assemblywoman Benitez-Thompson:
My assumption is that this would be a cash incentive for opening an account—perhaps like the College Kickstart Program. Is that what I should view as a frame of reference?

Erik Jimenez:
I think that is exactly right. We are continually working through this process, and I want to make sure that we clarify in the regulations that our ABLE account program is open to anyone in the country. It would be important to clarify this for the record that Nevada participants in this program would be eligible for the incentives. While I appreciate people from other states participating in our program, our goal here is trying to help as many Nevadans as we can.

Zach Conine:
That would match some of the work we do on the college savings front, where there are matching programs available for individuals living in Nevada, even though the programs are broadly available for everyone.

Chair Nguyen:
Are there any other questions? [There was no reply.] I have one comment. When we spoke about this bill, you mentioned that this has not been enacted anywhere else, so this would be a unique, innovative program. Other people around the country would be looking at Nevada as a model in this area. Can you speak to that?

Erik Jimenez:
That is why we wanted to bring this bill forward—to make it abundantly clear that the legislative intent is to move forward with a program like this. We would be the first program in the country to do something like this. We are part of an alliance of states that administer ABLE accounts, and I talk to most of them on a monthly basis. The states of California and Oregon are anxiously watching this bill to see if we are successful, because they would love

to replicate that success. Additionally, we have been in conversation with the United States Senate Special Committee on Aging and its chairman, who is from Pennsylvania. They are also watching us to see if this is successful. If it is, they could replicate this on the federal level and do some sort of block grant into ABLE accounts to make sure we incentivize that growth.

Assemblywoman Benitez-Thompson:
I see here that you are going to develop the methods and incentives to encourage contributions to the savings trust account but that there is also going to be an endowment piece. I imagine that once you are successful—which we know you will be—in getting grants into that main endowment, can you explain what that procedure will look like, in terms of distribution to those individual accounts? Will it be a penny-for-penny distribution? Will there be an administrative set-aside out of the endowment?

Erik Jimenez:
Conceptually, we want to figure out a way that we could find a dollar figure that works for either the initial contribution or the matching contribution. Not using General Fund dollars, it could be really hard to do an exact penny-for-penny match. We have some logistical things to work out on our end since we would be the first state in the country. Mechanically, we want to streamline this so it is a little more effective than our College Kickstart program. As you are aware, Nevada College Kickstart is a separate ledger account. The intention here would be to make that contribution go directly into the ABLE account, so there are not two separate accounts which would create more friction in the savings. The seed money would be earning interest, and then would be able to be used and saved by the individual.

Assemblywoman Titus:
Could the individuals contribute to the savings accounts themselves? We heard testimony from folks who had a small business selling popcorn that it would be counted against them when it comes to support for some of the social services they needed. Would they put that money into this account?

Erik Jimenez:
That is 100 percent accurate. Individuals with these accounts can save up to $15,000 a year without losing access to means-tested benefits—food assistance programs, Medicaid, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI). If one is working, for instance, Jack with the popcorn company, Jack can save an additional $12,000 into his account. The real benefit is getting people with disabilities to start saving, but also to start working so they can live independently. Twenty-seven thousand dollars a year is really beneficial, and can get someone out of poverty.

Assemblywoman Titus:
That is the thing I was most impressed by with this program, and why I am so supportive of it. It is really enabling them to get a business going, and while doing that, not fearing they would be kicked off the welfare system or their health care—things they need so desperately. Thank you for that clarification and thank you for bringing this forward.

Chair Nguyen:
Are there any other questions? I do not see any more, so at this time, we will hear testimony in support, opposition, and neutral. Again, to provide testimony, you have to register online at the legislative website. Registrants will receive a phone number, meeting ID, and instructions on how to join the meeting. Remember to clearly state your name and spell it for the record and limit your testimony to two minutes. Again, staff will be timing each speaker to make sure we are giving everyone a fair and equal opportunity to speak, and we will limit this to 20 minutes.

Dora Uchel-Martinez, Private Citizen, Reno, Nevada:
I am totally blind, and I absolutely support this bill. Thank you to Erik Jimenez and Zach Conine; you are awesome, as is Assemblywoman Cohen.

Connor Cain, Vice President, Nevada Bankers Association:
I am testifying on behalf of the Nevada Bankers Association in support of A.B. 62. The Nevada Bankers Association knows the importance of saving and has supported a number of banking and savings opportunities for Nevadans. We are excited to support Nevada's ABLE Savings Program as it makes sure that a person living with a disability is not penalized because that person is saving money. We think the proposed changes outlined in A.B. 62 provide even greater assistance for some of these savings accounts. We are very proud of State Treasurer Conine and Mr. Jimenez for being leaders in this, not only in our state but, as you heard, influencing policy around the country. We would also like to recognize the fact that these men have worked tirelessly throughout this pandemic to help countless Nevadans. They have been answering phone calls and emails late at night, working on the weekends and holidays, and they are still able to bring forward and tackle policy changes such as the one before you today. We very much appreciate them and everything they do for Nevada and are grateful for this opportunity to testify. We encourage your support of A.B. 62.

Chair Nguyen:
Do we have any other people in support? [There were no others in support.] Is there anyone online for opposition testimony? [There were no callers in opposition.] Are there any callers in the queue for neutral? [There were no callers in neutral.] Do you have any closing remarks?

Zach Conine:
In the interest of time, we will waive them.

Chair Nguyen:
I will close the hearing on A.B. 62 and open the hearing on Assembly Joint Resolution 1. This resolution amends the *Nevada Constitution*, and Assemblywoman Titus will introduce the measure.

Assembly Joint Resolution 1: Proposes to amend the Nevada Constitution to revise terms relating to persons with certain conditions for whose benefit certain public institutions are supported by the State. (BDR C-477)

Assemblywoman Robin Titus, Assembly District No. 38:
I am introducing Assembly Joint Resolution 1, which proposes to amend the *Nevada Constitution* [Exhibit M]. This resolution is straightforward: it changes four words in the *Nevada Constitution*. Some may wonder why we need to change the *Constitution* to address four words. Well, let me tell you what these four words are: insane, blind, deaf, and dumb. These words are found in Section 1, Article 13 of our *Constitution*. This section requires the state to care for certain populations with disabilities or who suffer from a mental illness. The whole section reads like this:

> Section 1. Institutions for Insane, Blind, Deaf and Dumb to be fostered and supported by state. Institutions for the benefit of the Insane, Blind and Deaf and Dumb, and such other benevolent institutions as the public good may require, shall be fostered and supported by the State, subject to such regulations as may be prescribed by law.

I am aware that when the *Nevada Constitution* was written, different terminologies were used to describe persons with disabilities or a mental illness. However, more than 156 years after Nevada was admitted into the Union, it is time to give these words a more critical look. We should change them to contemporary language that is not deemed to be discriminatory or narrow. I propose we revise this terminology in the following manner:

1. from "the insane" to "persons with a significant mental illness";
2. from "the blind" to "persons who are blind or visually impaired"; and
3. from "the deaf and dumb" to "persons who are deaf or hard of hearing."

The idea to change this language in our *Constitution* came from one of my constituents, Mr. Andrew Campbell, who will be joining me later for this bill introduction. He works in the Churchill County Middle School as a special education teacher. Most of his students have severe to profound disabilities. Mr. Campbell also teaches American Sign Language in an after-school program, and he is very much aware of the needs of persons who are deaf or hard of hearing. He describes them as smart and dedicated people in our society who work in banks, are teachers or engineers. His own grandfather belonged to this population and was one of Boeing's first hundred employees who designed an aircraft. I am grateful to Mr. Campbell who brought this issue to my attention.

Let me explain more about the details of my proposed amendment. First, I want the new terms to start with "persons." We must stop categorizing people who suffer from an illness or disability by putting an emphasis on their illness or disability, for example, "the blind" or "the deaf." Instead, these are all individuals who happen to have an illness or disability, but first and foremost, they are "persons."

Second, calling persons who have a hearing loss "dumb" in our own *Constitution* is plainly offensive. This term must go. Additionally, many people in our society are not completely deaf but may suffer from different degrees of hearing loss. The definition in the *Constitution* is too narrow, and, therefore, I think it should say "persons who are deaf or hard of hearing."

"Insane" is another one of those derogatory terms I recommend replacing. We know that words matter, and when you stigmatize individuals with such a term, it may lead to negative results in the long run. Research has shown that stigmatizing persons with a significant mental illness may create barriers for them. They may face discrimination and prejudice when renting homes, applying for jobs, or accessing mental health services. Stigmatized people also are less likely to seek the help they need to treat their condition, which might make their condition worse. Using the term "insane" in our *Constitution* for people who suffer from a mental illness helps to perpetuate this stigma. Therefore, it should be replaced with the more dignified term "persons with a significant mental illness."

"Blind" is not necessarily a discriminatory term, but I think it is too narrow. If a person is blind, he or she may suffer a complete or nearly complete vision loss; however, this term does not include any of the people who have a visual impairment that causes difficulties with normal daily activities, and which cannot be fixed by simply wearing glasses or contact lenses. Persons with visual impairments may not be able to walk or read without adaptive training or the use of assistive technology. Contemporary training and assistive technology programs are for all people who have some kind of visual impairment. Therefore, this language should be updated as well, and I propose the term "persons who are blind or visually impaired."

In closing, I believe we must do a better job in making sure that we do not discriminate and stigmatize persons with disabilities or mental illnesses in our laws. A first step is to ensure no discriminating, stigmatizing, or derogatory language is in our *Nevada Constitution*, and A.J.R. 1 will provide for that.

Please keep in mind, this resolution is just a first step. It will not apply to the *Nevada Revised Statutes* (NRS). For example, if you do a simple search in our law library on the legislative website, you can find 67 hits with the term "insane." I hope there will be another opportunity soon to clean up our statutes as well. I urge you to support A.J.R. 1 to end the stigmatization of our citizens in the *Nevada Constitution*.

I might add that there has been a friendly amendment suggested; hopefully, the members of this Committee have a copy. If not, I will read it, and we will make sure everyone gets a copy. This amendment came from Dena Schmidt, Administrator of the Aging and Disability Services Division in the Department of Health and Human Services [Exhibit N]. She recommended, and I agree with her, that the new section 1 would read,

> Institutions for the benefit of persons with a significant mental illness, persons who are blind or visually impaired, persons who are deaf and hard of hearing,—and this is the friendly amendment, so it is not in the bill you

> received—"or persons who have an intellectual or developmental disability," and such other benevolent institutions as the public good may require.

I also might add that a number of members of this body in both the Senate and the Assembly have asked to be joint sponsors with me. If anyone else wants to sponsor this bill, I would welcome everyone's name on this bill as cosponsors. This was a prefiled bill, so I put it in on my own, but I think this is something we all should embrace. I will turn this over to Mr. Campbell to make some remarks.

Chair Nguyen:
I believe that friendly amendment has been uploaded onto the Nevada Electronic Legislative Information System so you all will be able to see it. If this bill goes forward to a work session it will be amended, so you may reach out to Assemblywoman Titus if you would like to be added on as a sponsor.

Andrew Campbell, Private Citizen, Yerington, Nevada:
Thanks to Assemblywoman Titus for initiating this process. It is one that is close to my heart. I am here testifying today as a citizen of the state of Nevada and resident of Churchill County. I have total deafness in one ear, and I have had total temporary blindness. I know what it is like to live with that, and it is a challenge. The fact that you are all attentive to this matter, not only for myself, but for so many members of our community and families, is much appreciated as this goes forward.

Chair Nguyen:
Are there questions or comments?

Assemblywoman Benitez-Thompson:
I love the bill, its language, and its intent. I was diagnosed with a hearing loss at age 30 and told I would be deaf within 20 years. That continues to progress, and I definitely do not want these adjectives applied to me.

I am wondering about the conforming language where you talk about a change in statute. This is a change to the *Constitution*, and it will take some time. If we have a successful constitutional change, is that when we would look at the NRS for the conforming language to make sure the statutes line up? Would we need a proactive bill draft request or, once there is a constitutional change, does it roll out on the back end?

Assemblywoman Titus:
I would like to turn this over to our legal counsel to answer that question. That is also why I am open to the process of getting the wording correct, because the wording has to be matched next session, and the resolution needs to be passed again. Then it has to go to a vote of the people to change our *Constitution*. That is why it is so critical that we get it as right as we can.

I know the wording regarding "insane" has been changed in prior legislative sessions, and we have changed definitions, but we have never gone through the entire NRS and retrospectively changed all that wording. That would take a different bill, I believe.

Chair Nguyen:
Ms. O'Krent, could you answer these concerns?

Karly O'Krent, Legal Counsel, Legislative Counsel Bureau:
Typically, when there are issues like this in a bill, we would include something that would authorize us to make the additional changes in the NRS when we are codifying things. Because this is a bill that does make a change to the *Constitution* and will have to be passed by another Legislature and then voted on, at the time it has been voted on, we would need to make the changes pursuant to a separate bill that would then make the proper changes in NRS.

Chair Nguyen:
Are there any other questions or comments? I see in the chat that Assemblyman Hafen and Assemblywoman Gorelow would like to be considered as cosponsors as you are going through the potential amendment process. I would like to be included as well. As I said, I would encourage all Committee members, if you are interested, to please reach out to Assemblywoman Titus if you want to be included.

Are there any additional comments or questions? [There was no reply.] With that, we will hear testimony in support, opposition, or neutral on A.J.R. 1. We will begin with testimony in support.

Steven Cohen, Private Citizen, Las Vegas, Nevada:
I would like to say "ditto" to the bill's sponsor and to the copresenter's remarks. I have one other friendly amendment, but I will address it offline.

Liz Davenport, Legal Legislative Extern, American Civil Liberties Union of Nevada:
As this bill removes derogatory and offensive language and provides modernization to the *Nevada Constitution*, we support A.J.R. 1. Legal terms must be updated so that they foster respect for people. Much too often, derogatory terms have fostered incorrect, negative social stigmas. The American Psychological Association's Committee on Disability Issues in Psychology has emphasized the need to avoid offensive expressions and recommends placing people first, just as Assemblywoman Titus explained. Further, when derogatory terms remain in statutes and constitutions, judges, lawyers, social workers, institutions, and others are then, unfortunately, compelled to apply these pejorative terms when applying the constitution. The United States Congress recognized this over ten years ago, and in 2010 and 2012, removed similar derogatory terms such as mental retardation and lunatic from the United States Code. Similarly, as this bill removes derogatory and offensive terms from the *Nevada Constitution*, we support A.J.R. 1.

John Piro, representing Clark County Public Defender's Office and Washoe County Public Defender's Office:
As lawyers, we understand that language is important, and the language Assemblywoman Titus is seeking to change in this bill is stigmatizing and detrimental to people in our state. We thank Assemblywoman Titus for bringing this legislation forward, and we echo the statements of the previous speaker. We support this bill.

Beth Jones, Private Citizen, Henderson, Nevada:
I also have two callers on the line who registered to give testimony here today. I will first introduce my son, Harrison Jones.

Harrison Jones, Private Citizen, Henderson, Nevada:
Good afternoon. I am nine years old. I am hard of hearing, and I am representing myself in support of A.J.R. 1. I do not think people called deaf or hard of hearing should be called deaf and dumb because it makes me feel like I am stupid. I am on the advanced placement honor roll at Gordon McCaw STEAM Academy. I am a blue belt in karate, and an actor in the deaf and hard of hearing theater program. I am the opposite of dumb; I am smart. If you are deaf, you can do anything anybody else can do but hear. Being deaf does not make you dumb. Thank you and have a good afternoon.

Alexis Jones, Private Citizen, Henderson, Nevada:
I am thirteen years old. I am representing myself in support of A.J.R. 1. I have severe and profound hearing loss in both ears and wear hearing aids. The terms deaf and dumb should not be applied to deaf and hard of hearing people because we are like everyone else. I have been in National Junior Honor Society for two years; I have gotten straight A's in all my honors classes for all my years in middle school so far. In elementary school, I won gold medals in the science Olympiad; I was a tour guide for McCaw School of Mines and continually on the honor roll. I testified for a different bill two years ago when I was eleven regarding deaf and hard of hearing kids. I sat with Assemblywoman Titus two years ago when my family attended children's day at the Legislature. I was in Girl Scouts for five years in the media/PR team and I served my community. On top of that, I have been playing soccer for over ten years. When I am older, my goal is to be on the U.S.A. Women's National Deaf Soccer Team. I am an avid reader and can read over a thousand words per minute. I have also been a part of the theater group for deaf and hard of hearing children for over six years. I applied to a magnet high school and will be finding out if I was accepted next month. I can do many, if not all, things hearing children can do, so the term "deaf and dumb" is not applicable in this situation anymore. It is not right to call deaf and hard of hearing people that term in the first place. I am proud to be hard of hearing and in the deaf community and to be here testifying to update disability-friendly language.

While being hard of hearing has its setbacks, it has lots of advantages too. If I had a choice to have normal hearing, I would not take it. Having hearing loss is what made me the person I am today, and I would not change that for the world. Thank you to Assemblywoman Titus for sponsoring this amendment and for allowing me an opportunity to speak, and have a great afternoon.

Jennifer Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services:
Our agency supports A.J.R. 1, and we are thankful to Assemblywoman Titus and this Committee for shining a spotlight on this issue. The language we use matters. The terms currently in our state *Constitution* are pejorative, they are offensive, and they are a reminder of a very dark chapter in our state and nation's history for persons with these disabilities. It was a time of compulsory sterilization laws, discrimination, lack of accessibility, and other atrocities. The United States Supreme Court upheld compulsory sterilization laws for those with intellectual disabilities in *Buck v. Bell*, 274 U.S. 200 (1927). The Court held that persons with disabilities do not have a fundamental right to make private decisions regarding their family lives. In delivering the decision, Justice Oliver Wendell Holmes, Jr., declared that "three generations of imbeciles are enough." The use of this term emboldened other states to adopt compulsory laws, and it perpetuated further marginalization and discrimination of persons living with disabilities for decades. Since that time, passage of the United Nations Convention on the Rights of Persons with Disabilities, the Americans with Disabilities Act (ADA), and other important legislation has helped usher in a paradigm shift from viewing persons with disabilities as objects of charity, medical treatment, or social protection to full and equal members of society with fundamental human rights.

All of us at ADSD, and DHHS as a whole, care about the people we serve in our state and we strive to use appropriate, person-centered language when providing those services. Again, we are very thankful to the Assemblywoman and to the Committee for addressing this issue.

Jamie Stetson, Private Citizen, Reno, Nevada:
Across the board I work for people who have different kinds of disabilities and I also have children who are on the autism spectrum. This bill, in changing the language throughout our NRS, is so important to legitimizing and taking away the stigma for people with disabilities in our communities. We have a significant lack of providers, a significant lack of ability to access resources in our community, and having this kind of language remaining in our NRS, and this kind of language still being used in our state, is shameful and something that needs to be taken care of. I am really grateful to see that something is being done about it. I strongly support this bill and any other bill changing the disgusting language that has been used and that also supports people and creates fewer barriers to access and shows our community members that we support them. I appreciate the time you have taken to get this put forward.

Chair Nguyen:
Are there other callers in support? [There were none.] Are there any callers in opposition? [There were none.] Are there callers who want to testify in neutral? [There were none.]

Are there any closing remarks, Assemblywoman Titus or Mr. Campbell?

Assemblywoman Titus:
I would like to thank you all for hearing this bill. I appreciate it and, as you could hear from the testimony, it is very important. To all Committee members who have reached out, I will

add your names, and when we hear this bill again, hopefully in a work session, we will add those amendments. I want to get this right, so if there are other suggestions, I am open to them. As you heard, we need to fix this, so thank you for all your time.

Chair Nguyen:
Thank you so much for your presentation. I would encourage Committee members to reach out to Assemblywoman Titus as she is working through this and preparing it for any work session. Anytime we have constitutional changes, we want to get them right. With that, I will close the hearing on A.J.R. 1.

[Exhibit O was submitted but not discussed and will become part of the record.]

Do we have any people on the line for public comment?

Nicole Willis-Grimes, representing Special Olympics of Nevada:
I apologize, I was not quick enough to dial in to support Assembly Bill 62. I recognize that you would prefer for public comment to focus on issues other than the bill, but I appreciate the opportunity to quickly voice our support on behalf of Special Olympics of Nevada. Special Olympics of Nevada is dedicated to enriching lives of children and adults with intellectual disabilities during inclusive sports, education, and health. We very much appreciate the State Treasurer and Mr. Jimenez's efforts on inclusive policy—especially financial inclusivity and providing a kickstart possibility for the ABLE accounts.

Chair Nguyen:
We are trying to be as flexible as possible and sometimes it is more difficult in this virtual and telephonic world, so that is fine.

Are there any comments from Committee members before we adjourn?

Dora Uchel-Martinez, Private Citizen:
I was going to speak before, but I was not fast enough. I really appreciate Assemblywoman Titus and Andrew Campbell for bringing A.J.R. 1 forward. After 30 years of the ADA passing, I am glad we are on the right path. Thank you for your time and for recognizing that people with disabilities are people first. We all have different abilities, and people with disabilities are resilient; you might learn something from us.

Chair Nguyen:
Is there anyone else on the line? [There were no more callers at this time.] Are there any more comments from Committee members before I adjourn the meeting today? [There was no response.] Thank you for being so patient, and this concludes our meeting for today. With that, the meeting is adjourned [at 4 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Assembly Committee on Health and Human Services Overview of the State of Mental Health in Nevada," dated February 10, 2021, presented by Stephanie Woodard, Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit D is a copy of a PowerPoint presentation titled "Assembly Committee on Health and Human Services Overview of Children's Mental Health in Nevada," dated February 10, 2021, presented by Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services.

Exhibit E is a copy of a PowerPoint presentation titled "Assembly Committee on Health and Human Services Overview of the State of Mental Health in Nevada, Behavioral Health in Nevada and Impacts of COVID-19," dated February 10, 2021, presented by Stephanie Woodard, Senior Advisor on Behavioral Health, Division of Public and Behavioral Health, Department of Health and Human Services, and Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services.

Exhibit F is a document titled "Rural Regional Behavioral Health Policy Board, Board Introduction and Overview, Presentation to the Assembly Committee on Health and Human Services, February 10, 2021," submitted by Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator, Rural Regional Behavioral Health Policy Board.

Exhibit G is a copy of a PowerPoint presentation titled "Rural Regional Behavioral Health Policy Board, Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties," dated February 10, 2021, presented by Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator, Rural Regional Behavioral Health Policy Board.

Exhibit H is a copy of a PowerPoint presentation titled "Washoe Regional Behavioral Health Policy Board, Current Priorities and Strategies to Success," presented by Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe Regional Behavioral Health Policy Board.

Exhibit I is a document titled "Summary Sheet: Washoe Regional Behavioral Health Policy Board, Prominent Objectives and Strategies," submitted by Dorothy Edwards, Washoe Regional Behavioral Health Coordinator, Washoe Regional Behavioral Health Policy Board.

Exhibit J is a document titled "Clark Regional Behavioral Health Policy Board (CRBHPB) Summary, Presentation to the Assembly Committee on Health and Human Services,

Wednesday, February 10, 2021," submitted by Teresa Etcheberry, Clark Regional Behavioral Health Coordinator, Clark Regional Behavioral Health Policy Board.

Exhibit K is a copy of a PowerPoint presentation titled "Clark Regional Behavioral Health Policy Board," dated February 10, 2021, presented by Teresa Etcheberry, Clark Regional Behavioral Health Coordinator, Clark Regional Behavioral Health Policy Board.

Exhibit L is a copy of a PowerPoint presentation titled "Northern Regional Behavioral Health Policy Board, Carson, Churchill, Douglas, Lyon, and Storey Counties, dated February 10, 2021, presented by Jessica Flood, Northern Regional Behavioral Health Coordinator, Northern Regional Behavioral Health Policy Board.

Exhibit M is a document titled "Assembly Joint Resolution 1, Remarks by Assemblywoman Robin L. Titus, M.D., Assembly Committee on Health and Human Services, February 10, 2021," presented by Assemblywoman Robin L. Titus, Assembly District No. 38.

Exhibit N is a proposed amendment to Assembly Joint Resolution 1 submitted by Jennifer Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services.

Exhibit O is a letter dated February 5, 2021, to the Honorable Robin Titus from members of the Nevada Statewide Independent Living Council in support of Assembly Joint Resolution 1.