The Performance Objective Reference Material is designed to accompany the P.O.S.T. mandated Performance Objectives of each N.A.C. mandated course for Category I, II, III, and Reserve peace officers.

Thoroughly reviewing this document will help in your preparation to teach the related course.

An instructor will not be successful by reviewing the Performance Objective Material the night before or the day of instruction. Instructors are expected to spend time studying this reference material, researching supplemental material, and developing student activities which will in effect enhance the learning for students. DO NOT be an instructor who shows up unprepared and expects a "canned" presentation to be given based on this reference material.

The Performance Objective Reference Material is to be used for the purpose of understanding the Course Performance Objectives and to be used as a guide for lesson plan development.

P.O.S.T. would like to thank you for being a part of the training of new Peace Officers in the State of Nevada.

Significant changes or notable sections are outlined in red.

Updated August, 2019 with additional updates made in June, 2020.

Title: Handling of Persons in a Mental Health Crisis
Category: I II Reserve
NAC: 289. 140, 150 and 170

Attitudes about Mental Illness (PO A)

By nature, people fear what they do not know or understand. A grossly misunderstood, generator of fear is that of mental illness. Not only is mental illness misunderstood by the sufferers, but it is also misunderstood by the community at large, and, also, by law enforcement officers. This misunderstanding inevitably leads to misconceptions and results in stigmatization (stigma is defined as a mark of disgrace). Considering the fact that more than 54 million Americans suffer from mental illness in any given year, it is easy to imagine how many contacts law enforcement officers make with mentally ill persons. Thus, the stigma of mental illness in the field of law enforcement is extremely unfortunate and unacceptable.

The stigma of mental health/illness in the field of law enforcement is twofold. First off, law enforcement officers do not have an immunity to, and are as susceptible to mental illness as is anyone else. Secondly, officers interact daily with mentally ill individuals in the community. Not only does an officer have to overcome an internal stigma, he/she must possess accurate knowledge of mental health and illness when dealing with citizens, victims, and/or suspects who have mental disorders. This is hugely significant considering that approximately 9% of all law enforcement emergency dispatch calls are related to a mental illness crisis. Misconceptions can only be corrected by educating yourself about mental health and illness. Dispelling common myths is an essential step toward abating the stigma and diminishing the fears associated with mental illness.

10 Myths about Mental Illness for Law Enforcement Officers

Myth #1: Mental health problems are uncommon.

Fact: Mental illnesses are surprisingly common. In fact, mental illnesses are more common than cancer, diabetes, or heart disease. The U.S. National Institute of Mental Health estimates that 26.2% of the population suffers from mental illness. Psychiatric disorders affect almost every family in America. Mental illnesses do not discriminate; they can affect anyone regardless of gender, race, age, ethnicity, and socio-economic status. According to the World Health Organization, four of the ten leading causes of disability in the United States and other developed countries are mental disorders.

Myth #2: People with severe mental illness are dangerous and violent
Fact: The vast majority of people with mental illnesses are no more violent than anyone else. In the cases when violence does occur, the incidence typically results from the

same reasons as with the general public, such as feeling threatened or excessive use of alcohol and/or drugs. The media often sensationalizes accounts of crime by a mentally ill individual. Actually, people with mental illnesses are much more likely to be the victims of crime. More than 25% of persons with severe mental illness were victims of a violent crime in the past year, a rate more than 11 times that of the general population.

Myth #3: Mental illnesses are not real medical problems or diseases.

Fact: The definition of disease is a pathological condition of a part, organ, or system of an organism resulting from various causes. The brain is an organ; lungs, the heart, liver, kidneys, skin, etc. are examples of other organs. Mental illness is a disorder of the brain. Brain disorders are related to anomalies of the brain's chemistry at nerve cell junctions and metabolism in different brain regions. Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Myth #4: People who talk about suicide do not commit suicide.

Fact: Few people commit suicide without first letting someone else know how they feel. Eight out of ten people who commit suicide have spoken about their intent before killing themselves. Suicidal comments have to always be taken seriously as they often lead to plans, attempts, or completions.

Myth #5: Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or "bad".

Fact: Addiction is a neurobiological disease that results from changes in the brain's chemistry. It is not the result of a character flaw or weakness. Addiction often results when a person with untreated mental illness tries to self-medicate using drugs and/or alcohol. Addiction may also mask additional underlying mental illnesses. It frequently results in behavioral and emotional problems. Addiction has nothing to do with being a bad person.

Myth #6: Mental health disorders are often life-long and difficult to treat.

Fact: Many times, individuals with a newly diagnosed disorder such as depression or anxiety, are prescribed medication. Yet, when they question their physician about how long they must remain on medication, they are only told "as long as you need to be". Actually, most medications, with a few exceptions, (such as those prescribed for bipolar disorder and schizophrenia) prescribed for mental disorders should be taken for short-term (under a year) symptom relief.
Myth #7: Persons with mental illness never recover.

Fact: Studies have shown that people with mental illnesses can recover and resume normal activities. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. With treatment and support most mentally ill individuals can lead productive lives, work, pursue education and religion, enjoy hobbies, recreational activities, and contribute actively to society. For others, recovery implies the reduction or complete remission of symptoms.

Myth: #8: Mental health problems are best treated by my primary care physician.

Fact: Mental disorders should be taken as seriously as any potentially chronic/ disabling medical condition; therefore, mental disorders are best treated by a trained specialist: a mental health professional; psychiatrist, psychologist, or other clinician specially trained to diagnose and treat mental health problems. If you were diagnosed with cancer, wouldn't you want to consult with an oncologist? Your primary care doctor is a good place to start to discuss your symptoms, rule out other medical conditions or medication side effects that may help explain your symptoms, and to get an appropriate mental health referral. It has been estimated that up to ½ of all visits to primary care physicians are due to conditions that are caused or exacerbated by mental illness.

Myth #9: Depression is a normal part of the aging process.

Fact: It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed or misdiagnosed. Depression is not synonymous with dementia. Elderly white males have the highest suicide rate when compared to all other groups (triple the overall rate). With treatment and support, depressed older individuals can enjoy their golden years.

Myth #10: I can handle my own mental health problems, and if I can't, I'm weak.

Fact: The first part of this statement may not be so much a myth; most people who have a mental health problem do not seek treatment. They rely on traditional coping mechanisms (exercise, socializing, working harder, etc.) to deal with their symptoms. Many diagnostic mental health problems may be mild enough for this type of self-care to be sufficient. Talking with friends, reading a self-help book on the subject, or visiting an online self-help support group may be enough to get you through tougher times. However, a serious mental illness cannot be willed away. When problems become chronic or even worsen despite your efforts to cope, you should take that as a strong indication that additional help is needed. Ignoring the problem does not make it go away. Getting treatment for a mental illness does not mean you are weak, weak-minded or weak-willed. It simply means that you realize and accept your human and natural limitations. It takes courage to seek professional help.

Implications for Law Enforcement Officers

Fact is, officers that deal with four people in a day, statistically, will be dealing with at least one person that is suffering from a mental illness. That is why it is imperative for officers to be armed with actual knowledge and not to be misguided by false assumptions about mental illness. Officers who are knowledgeable, regarding mental illness, are more positive when dealing with those they come in contact with, including other officers and medical personnel. These same officers then serve to combat the stigmatization of mental illness.

Americans with Disabilities Act (ADA 1990) (PO B)

The President's Committee on Employment of People with Disabilities in March of 1994 stated, *"People with mental, cognitive and psychiatric disabilities constitute perhaps the single most persecuted and least understood group of individuals in the disability community. The stigma associated with mental illness remains an oppressive obstacle to employment and integration, hampering the efforts of people with mental disabilities to enter the workforce, attend schools and contribute their talents and energy to society."* Like other members of the community, people who have mental illnesses may live in houses, apartments, group homes, or on the street without shelter or resources. They may be professionals, office workers, laborers, homemakers, children, elderly people, or people who depend on welfare and social services for survival. They may call for police assistance, be a victim of a crime or accident, be a witness, be the subject of a call, attend a community crime prevention program, or be encountered in all the situations in which police personnel encounter other citizens.

The Americans with Disabilities Act (ADA) entitles people with disabilities to the same service and protections that law enforcement agencies provide to anyone else. They may not be excluded or segregated from services, denied services, or otherwise provided with lesser services or protection than are provided to others. This law has refocused awareness on police response to people with mental illnesses.

The ADA does not call for a fixed set of rules to be followed in all cases involving a person who has--or exhibits symptoms of-mental illness. Rather, the ADA calls for law enforcement agencies and personnel to make reasonable adjustments and modifications in their policies, practices, or procedures on a case-by-case basis. For example, if a person exhibits symptoms of mental illness, expresses that he or she has a mental illness or requests accommodation for a mental illness (such as access to medication or water), officers and call takers may need to modify routine practices and procedures, take more time or show more sensitivity to extend the services or protections that would be extended to someone else in a similar circumstance.

Officers experienced in community policing and problem solving should find themselves well-prepared to serve the population of people with mental illnesses. The nature of the interaction between the police and people with mental illnesses is varied. While responses to some calls for service (such as those requiring medical assistance or involving criminal activity) are well-defined, others are less clear and may require the application of problem-solving skills to handle the immediate situation or assist the individual and his or her family in identifying and obtaining lasting solutions and appropriate support services.

Define Mental Illness per NAC (PO C)

Nevada Revised Statutes Regarding Mental Illness/Persons in a Mental Health Crisis:

According to NRS 433A.115 a "Person in a Mental Health Crisis" is defined by the following:

"Person in a mental health crisis" means any person: (a) Who has a mental illness; and (b) Whose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of the mental illness, to the extent that the person presents a substantial likelihood of serious harm to himself or herself or others, as determined pursuant to **section 4*** of this act.

2. The term does not include any person in whom that capacity is diminished by epilepsy, intellectual disability, dementia, delirium, brief periods of intoxication caused by alcohol or drugs, or dependence upon or addiction to alcohol or drugs, unless a mental illness that can be diagnosed is also present which contributes to the diminished capacity of the person.

***Sec. 4**: For the purposes of this chapter, a person shall be deemed to present a substantial likelihood of serious harm to himself or herself or others if, without care or treatment, the person is at serious risk of:
1. Attempting suicide or homicide;
2. Causing bodily injury to himself or herself or others, including, without limitation, death, unconsciousness, extreme physical pain, protracted and obvious disfigurement or a protracted loss or impairment of a body part, organ or mental functioning; or
3. Incurring a serious injury, illness or death resulting from complete neglect of basic needs for food, clothing, shelter or personal safety.

Differences between Mental Illness/Developmental Disability (as used in NRS 435.007)/Neurological Disorder (PO D)

Autism and intellectual disabilities are two developmental disabilities that can be confused with mental illness. Autism is characterized by one or more of the following:

- severe disorders of communication and behavior
- difficulty communicating or relating to other people
- non-responsiveness to sound
- total lack of interest in nearby people or objects
- lack of meaningful speech or echoing others' words

"Developmental disability" means autism, cerebral palsy, epilepsy or any other neurological condition diagnosed by a qualified professional.

Intellectual disability is not a disease, and it should not be confused with mental illness. This disability is permanent, although the degree of disability can be lessened. With appropriate support over time, the functioning of a person with profound intellectual disability will generally improve. Intellectual disabilities can be caused by factors that may be biological, environmental, or a combination of both.

Neurological disorders can also be confused with mental illness. Neurological disorders are impairments of the brain and nervous system. Because mental illnesses are also neurological diseases, differentiating between mental illnesses and these other disorders may be difficult. Some of the other types of neurological disorders that law enforcement officers might encounter include seizure disorders (epilepsy), cerebral palsy, alzheimer disease, strokes and brain injury. Behaviors associated with developmental disabilities and neurological disorders may include the following:

- receptive or expressive communication difficulty
- seizures
- muscle control difficulty
- slurred speech
- confusion and/or disorientation
- lethargy
- self-endangering behavior
- inappropriate response to situations
- purposeless repetitive behavior
- deficits in common knowledge

Behaviors and Interaction with People with Mental Illness/ In a Mental Health Crisis (PO E)

Officers may encounter the following types of situations when responding to calls for service involving people with mental illnesses. The suggested techniques for handling the scenario descriptions are not to be considered as techniques that must always be used nor will always work. They are merely suggestions that have been gathered through experience of the author of this class.

The subject is a compulsive talker.

People engaged in compulsive talking produce a stream of sometimes meaningless chatter at a rapid, almost nonstop rate. These communications are understandable but bear little or no relation to the problem at hand. This behavior indicates high levels of anxiety. If your requests to slow down are not effective, you can interrupt the compulsive speech pattern by asking the individual specific concrete questions. For example, ask his birth date or address, ask him to give the full name of his children or parents, or ask him where he works or goes to school. Your goal is to interrupt the speech to break its pattern and bring it somewhat under control.

The subject is conscious but non-responsive

This happens in cases in which the person may be catatonic or severely depressed. You should never assume that because a person is not responding to your statement, she is not hearing what you say. In these situations, there is the temptation to begin acting and talking as if the subject were not present. This is a mistake. Mental illness does not render a person deaf. Therefore, you should make every effort to obtain a response from the individual. This can be done by quietly asking questions and being sensitive to any types of reply, such as a head nod. If this is not successful, you should attempt to understand the person's feelings and communicate that understanding to her. These "guesses" can be based on the information that you acquire at the scene, as well as on the individual's body posture and emotion. By making this effort, you communicate to the subject that you wish to understand her situation. The subject may then feel less threatened about discussing their difficulties with you.

The subject is hallucinating

Hallucinations are very frightening for the person who is experiencing them. Difficulties emerge when the person is actively hallucinating in the officer's presence. The first response you must give is to validate the hallucinatory experience for the individual, but, at the same time, indicate that the hallucination does not (objectively) exist. If an individual is seeing or hearing things, you must indicate that you understand that those

experiences are real and frightening for the subject, but that they do not exist in reality. Second, you must firmly and empathically indicate that those sensations are due to the extreme emotional stress that the person is experiencing, and that once the stress is lessened, the hallucinations will disappear. You may have to repeat this assuring message many times before the individual can respond to it.

The subject exhibits paranoid tendencies

Paranoia often involves very serious delusion. You must be very sensitive (both verbally and physically) when you respond to such individuals. People experiencing paranoia can be extremely suspicious and tense. They can appear very frightening to others. You must be acutely aware of any indications that the person is feeling threatened by you. If you detect this fear, you should become as nonthreatening as possible, giving the person a feeling that she is in control of the situation. You should neither pick up on any verbal challenge, nor agree that you know anything more about the subject than she tells you. Many people experiencing paranoia may say things such as, "You know what has been happening to me," or, "You're a police officer, you have those secret records on me." You must not confirm that you have any special knowledge about the person. When you are moving into or around a room in which a person experiencing paranoia is present, it is good practice to announce your actions before initiating them. Telling the subject that you are moving across the room to sit in a chair reduces the probability that he will think you are about to attack him. This telegraphing of your actions assumes that your goal is not to subdue the individual physically. Except in situations in which the person must be physically detained, avoid any physical contact with the person. Do not move into the person's personal space. Their comfort zone may be much larger than others'.

The subject is psychotic and aggressive

This is probably the most troublesome situation for any police officer to respond to effectively. If the subject is in the act of attacking you or another individual, there is no question that you should respond with your police control skills. However, in many instances, the subject will not be acting out, but will be threatening someone. He may be waving his fists, or a knife, or yelling. If the situation is secure, and if no one can be accidentally banned by the individual, you should adopt a nonthreatening, non-confrontational stance with the subject. You may point out that you do not like to get injured or beaten up, that there is no need for the individual to threaten you because you are going to "listen" to him, and that getting into a pitched battle with you may cause more problems than it will solve. You should then begin talking to the subject as outlined above, allowing the individual to vent some of his hostility. You can also indicate this low-threat, low-offensive style by sitting down, removing your hat or otherwise trying to put the person at ease. Sit a comfortable distance from the subject, move the chair so that its back faces the subject and straddle it. This permits you to use

it as a protective block if the person suddenly charges you. It is essential that you appear relaxed and nonthreatening, but you must also be on your guard.

The subject makes delusional statements

Delusions are unique ways of viewing the world, and delusional statements frequently conflict with others' views. There are three possible responses to a person's delusions:

- agree with them,
- dispute them, or
- defer the issue.

If you agree with the mentally ill person's delusion, you may become ineffective in your attempts to provide the person with help. The individual could legitimately ask, "Why do you want me to go to the hospital, since you agree that what I say is true?" Such agreement can also increase the subject's upset state, since the delusion is only a means for her to reduce anxiety. To have others begin to believe in "her world" may be more frightening than helpful. The next option, disputing the delusions, is equally ineffective. A direct confrontation with the subject over her disordered thinking may well result in her withdrawing from the person making the attack. She will become inaccessible, or arguments may ensue. This might result in the individual's acting out aggressively due to the threat she experiences. This leaves the third option: deferring the issue. In this response, you do not agree with or dispute the person's statement; rather, you acknowledge the person's view of the world, indicate that it is not your own, and follow with a statement of how you understand the person's feelings. An example of this type of response would be as follows:

Subject: There are many people who want me dead. There is an organization on T.V. that had my name on T.V.

Officer: I can see you are worried about someone harming you. I don't know of anyone who wants to hurt you, but I really would like to assist you in any way I can to help you feel safer.

By this response, you neither confirm nor dispute the person's view of the world. Rather, you give the person a message of the availability of help.

Unpredictable / Dangerous Behavior and Suicide / By Cop (PO E1i- ii)

Suicide Prevention: The Role of the Officer

Unfortunately, there are also situations where law enforcement officers have to deal with individuals who are suicidal. These situations could include a person who is

communicating a desire or an intent to attempt suicide, a person who has just made a suicide attempt or a person who has died by suicide.

In a significant number of cases, officers receive a call that is not described as a suicidal crisis, but rather as a general disturbance, domestic violence, or similar type of situation. Upon arriving at the scene, the officers need to determine whether the situation involves someone who is suicidal.

You have an important role to play in all of these situations. It is generally considered to be within the scope of a law enforcement officer's duty to protect the safety of the community as a whole as well as individuals. Your first responsibility is to deal with any safety issues that may affect you, the person who is suicidal, or others present at the scene, especially if the person has immediate access to lethal means. You can also provide clarity and support to the person who is suicidal and the other people who are there. Then your role, along with that of EMS providers and mental health professionals if they are present, is to ensure the person receives an evaluation as soon as possible.

Identify People Who May Be at Risk for Suicide

There are some behaviors that may mean a person is at immediate risk for suicide. These three should prompt you to take action right away:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Other behaviors may also indicate a serious risk, especially if the behavior is new; has increased; and/or seems related to a painful event, loss, or change. Ask if the person has been behaving in any of the following ways:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Be alert to problems that increase suicide risk

Certain problems may increase a person's risk for suicide. Asking if the person has any of these risk factors can help you assess the current situation more accurately and enable

you to provide more complete information to medical staff. Some of the most significant risk factors to ask about are:

- Prior suicide attempt(s)
- Alcohol and drug abuse
- Mood and anxiety disorders, e.g., depression, posttraumatic stress disorder (PTSD)
- Access to a means to kill oneself, i.e., lethal means

Suicide risk is usually greater among people with more than one risk factor. For individuals who are already at risk, a "triggering" event causing shame or despair may make them more likely to attempt suicide. These events may include relationship problems and breakups; intimate partner violence; problems at work; financial hardships; legal difficulties; and worsening health. Even though most people with risk factors will not attempt suicide, they should be evaluated by a professional.

Suggested Recommendations When Arriving at the Scene of a Suicidal Subject

Take all suicide threats and attempts seriously. Follow the recommendations below as appropriate to the specific situation:

1. Ensure the safety of everyone present. This includes eliminating the person's access to any type of lethal means. Make sure you do this in a way that does not put you or others in danger. Be aware that the person may attempt to force you into a "suicide by cop" situation—where a suicidal person engages in life-threatening behavior toward officers or other people to provoke officers to fire at him or her. Also be aware of the danger of a potential murder-suicide, including in domestic violence cases. Try to recognize and de-escalate these types of situations.

2. Assess the person for need of medical treatment. If necessary, call for assistance from EMS providers. Then conduct any life-saving first aid that may be necessary before EMS arrives.

3. If you need assistance dealing with the person's mental health issues, call an officer with mental health training, a mental health clinician, or a crisis intervention worker. If no one is available, you can call the National Suicide Prevention Lifeline for assistance.

4. The following steps should be taken by the professional(s) at the scene with the most relevant training and experience. These might include EMS providers,

mental health providers, crisis intervention workers, or law enforcement officers with mental health training. In some cases, officers with no mental health training will need to handle the situation on their own.

a. Establish rapport with the person. Listen carefully to what the person says, and talk in a calm, accepting, non-confrontational, and supportive manner. Explain what is happening, that you are there to help, and how you can help.

b. Assess the person for risk of suicide
    i. If it is not clear already, determine whether or not a suicide attempt was made.
    ii. Encourage the person to talk about how he or she is feeling. Acknowledge the feelings and do not judge them.
    iii. If the person has not made an attempt, ask several direct questions to determine the person's risk for suicide, such as "Are you thinking about ending your life (killing yourself)?" and "Do you have a plan?" Do not be afraid to ask these questions. Asking a person about suicide will not encourage him or her to attempt it. Many people who are suicidal are relieved to find someone they can talk with about how they are really feeling.

c. Supervise the person constantly. Safety continues to be a top priority. If necessary, set up protective measures so that the person cannot engage in suicidal behavior.

d. Arrange for any person who is potentially suicidal to be transported to a local hospital's emergency department or a mental health center for an evaluation.

e. Collect items such as toxic substances, alcohol, drugs, or medications that might have been taken (even just empty containers). Bring these items to the medical and mental health staff to help them determine the appropriate treatment.
    i. If the person refuses to be transported, in Nevada law enforcement can issue a 72-hour hold for evaluation. Follow your agency's protocols on how to handle this kind of situation.

Mental Illness/Mental Health Crisis 72-hour Hold (NRS 433A.150, 160) (PO F)

Detention for evaluation, observation and treatment; limitation on time (NRS 433A.150):

1. Any person alleged to be a person in a mental health crisis may, upon application pursuant to NRS 433A.160 and subject to the provisions of subsection 2, be detained in a public or private mental health facility or hospital under an emergency admission for evaluation, observation and treatment.

2. Except as otherwise provided in subsection 3, a person detained pursuant to subsection 1 must be released within 72 hours, including weekends and holidays, after the application for emergency admission or any part of such an application is made pursuant to NRS 433A.160 unless, before the close of the business day on which the 72 hours expires, a written petition for an involuntary court-ordered admission to a mental health facility is filed with the clerk of the district court pursuant to NRS 433A.200, including, without limitation, the documents required pursuant to NRS 433A.210, or the status of the person is changed to a voluntary admission.

3. If the period specified in subsection 2 expires on a day on which the office of the clerk of the district court is not open, the written petition must be filed on or before the close of the business day next following the expiration of that period.

Procedure for admission; evaluation at time of admission; approval by psychiatrist; regulations concerning accredited agent of Division (NRS 433A.160)[Effective Jan 1, 2020]:

1. Except as otherwise provided in subsection 2, an application for the emergency admission of a person alleged to be a person in a mental health crisis for evaluation, observation and treatment may only be made by an officer authorized to make arrests in the State of Nevada or a physician, physician assistant, psychologist, marriage and family therapist, clinical professional counselor, social worker or registered nurse. The officer, physician, physician assistant, psychologist, marriage and family therapist, clinical professional counselor, social worker or registered nurse may:

    (a) Without a warrant:

(1) Take a person alleged to be a person in a mental health crisis into custody to apply for the emergency admission of the person for evaluation, observation and treatment; and

(2) Transport the person alleged to be a person in a mental health crisis to a public or private mental health facility or hospital for that purpose, or arrange for the person to be transported by:

(I) A local law enforcement agency;

(II) A system for the nonemergency medical transportation of persons whose operation is authorized by the Nevada Transportation Authority;

(III) An entity that is exempt pursuant to NRS 706.745 from the provisions of NRS 706.386 or 706.421;

(IV) An accredited agent of the Division;

(V) A provider of nonemergency secure behavioral health transport services licensed under the regulations adopted pursuant to NRS 433.3317; or

(VI) If medically necessary, an ambulance service that holds a permit issued pursuant to the provisions of chapter 450B of NRS, only if the officer, physician, physician assistant, psychologist, marriage and family therapist, clinical professional counselor, social worker or registered nurse, based upon his or her personal observation of the person, has probable cause to believe that the person is a person in a mental health crisis.

(b) Apply to a district court for an order requiring:

(1) Any peace officer to take a person alleged to be a person in a mental health crisis into custody to allow the applicant for the order to apply for the emergency admission of the person for evaluation, observation and treatment; and;

(2) Any agency, system, provider, agent or service described in subparagraph (2) of paragraph (a) to transport the person alleged to be a person in a mental health crisis to a public or private mental health facility or hospital for that purpose. The district court may issue such an order only if it is satisfied that there is probable cause to believe that the person is a person in a mental health crisis.

2. An application for the emergency admission of a person alleged to be a person in a mental health crisis for evaluation, observation and treatment may be made by a spouse, parent, adult child or legal guardian of the person. The spouse, parent, adult child or legal guardian and any other person who has a legitimate interest in

the person alleged to be a person in a mental health crisis may apply to a district court for an order described in paragraph (b) of subsection 1.

3. The application for the emergency admission of a person alleged to be a person in a mental health crisis for evaluation, observation and treatment must reveal the circumstances under which the person was taken into custody and the reasons therefore.

4. To the extent practicable, a person who applies for the emergency admission of a person who is less than 18 years of age to a public or private mental health facility or hospital, other than a parent or guardian, shall attempt to obtain the consent of the parent or guardian before making the application. The person who applies for the emergency admission or, if the person makes the application within the scope of his or her employment, the employer of the person, shall maintain documentation of each such attempt until the person who is the subject of the application reaches at least 23 years of age.

5. Except as otherwise provided in this subsection, each person admitted to a public or private mental health facility or hospital under an emergency admission must be evaluated at the time of admission by a psychiatrist or a psychologist. If a psychiatrist or a psychologist is not available to conduct an evaluation at the time of admission, a physician or an advanced practice registered nurse who has the training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120 may conduct the evaluation. Each such emergency admission must be approved by a psychiatrist.

6. The State Board of Health shall adopt regulations governing the manner in which:

   (a) A person may apply to become an accredited agent of the Division; and

   (b) Accredited agents of the Division will be monitored and disciplined for professional misconduct.

7. As used in this section, “an accredited agent of the Division” means any person authorized by the Division to transport to a mental health facility pursuant to subparagraph 2 of paragraph (a) of subsection 1 those persons in need of emergency admission.