

3-2014

Time to Talk: The Mental Health of Adults in Nevada

Ramona W. Denby

University of Nevada, Las Vegas, ramona.denby@unlv.edu

Sandra D. Owens

University of Nevada, Las Vegas, sandra.owens@unlv.edu

Sarah Kern

Lincy Institute

Follow this and additional works at: https://digitalscholarship.unlv.edu/lincy_publications



Part of the [Community Health Commons](#), and the [Substance Abuse and Addiction Commons](#)

Repository Citation

Denby, R. W., Owens, S. D., Kern, S. (2014). Time to Talk: The Mental Health of Adults in Nevada. *The Lincoy Institute Issue Brief Social Services Series(2)*, 1-16.

Available at: https://digitalscholarship.unlv.edu/lincy_publications/8

This Report is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Report in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Report has been accepted for inclusion in Lincoy Institute Reports and Briefs by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

March 2014

Time to Talk: The Mental Health of Adults in Nevada

RAMONA W. DENBY, PH.D.
SANDRA OWENS, PH.D.
SARAH KERN, B.A., MSW CANDIDATE

Abstract

About 11.3% of the adult population in Nevada report a past-year mental illness, with nearly 4% of them experiencing disorders serious enough to impair their functionality. Almost 13% of Nevada adults have substance abuse disorders, this is the second highest statewide substance abuse prevalence rate in the country; the District of Columbia is first at 14.7% of its population (SAMSHA, 2013). With most states (including Nevada) now increasing their mental health care budgets after years of spending cuts—between 2009 and 2012 there was a \$4.35-billion drop in state mental health spending (Ollove, 2013)—pertinent questions center on needed treatment, research, and policy directions. The increased federal attention and support given to mental health care access has primed states across the nation like Nevada to move toward strengthening their service infrastructure. In this brief we first compare Nevada’s mental illness prevalence rates with those of peer states and national trends and then explore some strategies that could prove useful in positioning our state to address the mental health needs of its residents. We must elevate the discussion of mental health to the same level of seriousness given to the concern for physical health challenges as experienced by adults.

Introduction

The Neglected Discussion of Mental Health

Good mental health is as critical as good physical health, yet public discussions about mental health topics are rare. Some communities and the nation in general seem reluctant to engage in public

discourse about mental health challenges until faced with unimaginable tragedy or horrific events. Mental health issues are a public health matter and should be discussed with as much ease, concern, and urgency as other public health issues such as obesity, influenza, smoking, or food-borne illnesses. More than 18% (41 million) of adults in the U.S. have a mental health illness and 8% (20 million)

have a substance abuse disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). In 2011, 9 million U.S. adults experienced mental health disorders so severe that their day-to-day living and functionality were impaired (SAMSHA, 2013). If we consider service utilization as a measure of the seriousness of mental health disorders, it is significant that between 1996 and 2010 the number of prescriptions filled to treat adults for mental illness increased dramatically, with the most common medication being antidepressants. Likewise, in 2011 more than one in eight adults received some level of mental health intervention or service (SAMSHA, 2013).

The purpose of this brief is to examine the prevalence of mental health disorders and substance abuse among Nevada's adult population and compare rates with national trends and figures found in comparable states. Additionally, in this brief we explore the state's service delivery structures and access to care, summarizing some of Nevada's major initiatives and responses and considering the potential of national best practices. Finally, we suggest strategies for positioning the state to increase its responsiveness to adult mental health needs.

Background

Prevalence of Mental and Behavioral Health Disorders

In this brief we examine data reported by SAMHSA's Center for Behavioral Health Statistics and Quality. The Center defines adult mental illness as *"The presence of a diagnosable mental, behavioral, or emotional disorder in the past year*

(excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV); and the level of interference with or limitation of one or more major life activities resulting from a disorder (functional impairment)." (SAMHSA, 2013, p. 35). Likewise, we are guided by SAMHSA's definition of substance use disorders, which are conditions "meeting the criteria for alcohol or illicit drug abuse or dependence" as they adhere to DSM-IV diagnostic hierarchy classification (SAMHSA, 2013, p. 35).

Generally speaking, the prevalence of different types of mental and behavioral health disorders vary across an individual's lifespan. Research reveals that anxiety disorders (e.g., obsessive compulsive disorder, post-traumatic stress disorder, social anxiety disorder, specific phobias, and generalized anxiety disorder) tend to be prevalent in all four adult age sequences (i.e., 18–29, 30–44, 45–59, 60 years and over). Impulse control disorders (e.g., Intermittent Explosive Disorder (IED): outbursts of anger or extreme temper tantrums, pathological gambling) are the second most frequently occurring conditions for adults between the ages of 18 and 29, but these conditions do not seem to manifest as frequently when adults are older than 44. However, mood disorders (e.g., depression, mania, and bipolar disorder) are manifested in each of the adult lifespan markers and represent the third most frequent condition for adults 18–29 and 30–44 (SAMSHA, 2013). National household survey data reveal that 21.1% of U.S. women experience mental illness compared with 14.5% of men.

Men, however, have higher prevalence rates than women for any substance abuse disorder (11.5%), alcohol-only use disorders (9.6%), and illicit drug use disorders (3.4%). Women's prevalence rates nationally for any substance use disorder are 5.7%, 4.7% for alcohol only, and 1.6% for illicit drug use (SAMSHA, 2013).

Impairment and Functionality

Daily impairment is a reasonable gauge for measuring the effect of mental and behavioral health disorders. It is important to note that serious mental illness is a classification often used to differentiate between conditions that are persistent and disabling to one's day-to-day functioning versus those conditions that result in less severe impairments to routine functioning. Individuals who suffer with serious mental illness tend to experience difficulty sustaining employment and housing as well as maintaining good physical health. They can be frequent users of emergency and public services, typically experiencing regular contacts with law enforcement (SAMSHA, 2013). About 4% of the adult U.S. population experiences serious mental illness (SAMSHA, 2012a).

Typically, discussions concerning the impact of disabilities on the individual and society assume the frame of reference of physical impairment, neurological conditions, intellectual or learning disabilities, or visual or hearing impairments. However, mental health and substance abuse disorders are among the leading causes of disabilities (World Health Organization, 2004), accounting for about 25% of years of life lost or premature death (Centers for Disease Control and Prevention, 2010). It is

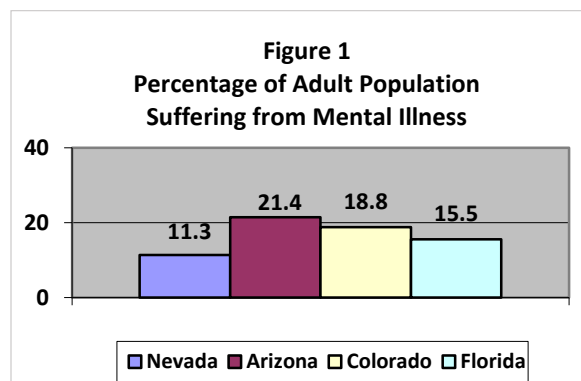
projected that by 2020, mental and substance use disorders will become the leading cause of disabilities worldwide, surpassing all categories of physical diseases (Substance Abuse and Mental Health Services Administration, 2011a). Violence is another area of concern with respect to mental illness. Some studies (e.g., Goodman et al., 2001; Hiday, Swanson, Swartz, Borum, & Wagner, 2001) have revealed that individuals suffering from serious mental illnesses are more likely to perpetuate violence; however, Choe, Teplin, and Abram (2008) conducted a meta-analysis of the literature and found that adults with serious mental illness are victimized more often than individuals who do not have serious mental illnesses.

State Comparisons

Prevalence of Mental Health Disorders

For comparison with Nevada, we examined the mental health service delivery systems of Arizona, Colorado, and Florida. The rationale for selecting these three states is that Phoenix, Denver, and Orlando are considered peer cities to Las Vegas for multiple reasons, but largely because of similar economic drivers, urban population size, and the emergence of medical and health education structures that support mental health workforce development and service delivery. Although the prevalence rates of mental illness are comparable among Nevada and peer states Arizona, Colorado, and Florida, a review of recent research reveals that consumers of mental health services in each of these states suffer from specific diagnoses at varying rates. During the year 2011, 11.3% of Nevada's adult population was suffering from some form of mental

illness, compared with 21.4% in Arizona, 18.8% in Colorado, and 15.5% in Florida (SAMHSA, 2013).



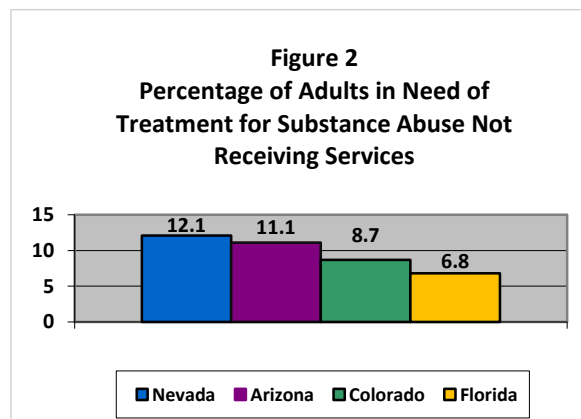
According to SAMHSA's National Outcome Measures (NOMS) report, the majority of Nevada's mental health consumers (55.6%) are diagnosed with bipolar and other mood disorders (SAMHSA, 2012e). Arizona, Florida, and Colorado report similar rates among their consumers at 51.6%, 54.1%, and 57.9% respectively (SAMHSA, 2012b, 2012c, 2012d).

Another 12.4% of Nevada's mental health consumers are diagnosed with schizophrenia and related disorders (SAMHSA, 2012e), a lower rate than that reported in Arizona (13.1%), Colorado (13.2%), and Florida (18.4%) (SAMHSA, 2012b, 2012c, 2012d). Despite having the lowest rates of schizophrenia among Nevada's consumers, the report reveals that a larger percentage of patients are diagnosed with other psychotic disorders when compared with those in peer states. Approximately 5.4% of Nevada's consumers are diagnosed with other psychotic disorders (SAMHSA, 2012e), contrasting with Arizona at 2.7%, Colorado at 2.7%, and Florida at 4.1% (SAMHSA, 2012b, 2012c, 2012d).

Substance Abuse

The number of individuals with substance abuse disorders in Nevada represents a major challenge for the state's service delivery systems. In Nevada, approximately 12.6% of adults surveyed in 2011 struggled with a substance abuse disorder during the previous year. This contrasts with rates of 11.6% in Arizona, 9.5% in Colorado, and 7.4% in Florida (SAMHSA, 2013). Among this group, a large percentage abused alcohol, with Nevada possessing the highest rate of alcohol use disorder among its peer states at 9.9%. This contrasts with a rate of 9.0% in Arizona, 8.7% in Colorado, and 5.7% in Florida (SAMHSA, 2013). Unfortunately, a significant percentage of adults in need of substance abuse treatment and services do not receive them. In Nevada an estimated 12.1% of adults had unmet need for substance abuse treatment in the past year. In Arizona, this rate was 11.1%, in Colorado the rate was 8.7%, and Florida's rate was 6.8% (SAMHSA, 2013). When examining Nevada against national comparisons, we find that Nevada has the second highest rate of unmet need for substance abuse treatment. Nevada is second to the District of Columbia where the unmet service need is 13.7%. It should be noted that these data are based on household surveys of representative samples where respondents' perceptions of their need is the unit of measurement. Perceived unmet need is operationally defined as a respondent self-report of at least one occurrence in the past year where he or she felt that he or she needed services but was not able to receive such. We suspect this to be a highly conservative estimate

of unmet need given national findings where it is surmised that a large majority of individuals who are actually diagnosed with substance abuse disorders do not get treatment (SAMHSA, 2013) due to multiple reasons including that they feel they do not need it (Edlund, Booth, & Feldman, 2009). According to the 2011 National Survey on Drug Use and Health (NSDUH) the other major reasons for not getting treatment include: not ready to stop using; fear of negative consequences with respect to employment; not knowing where to get help; belief that they can handle the issue on their own; inconvenience, and no time to seek treatment (SAMHSA, 2011b).

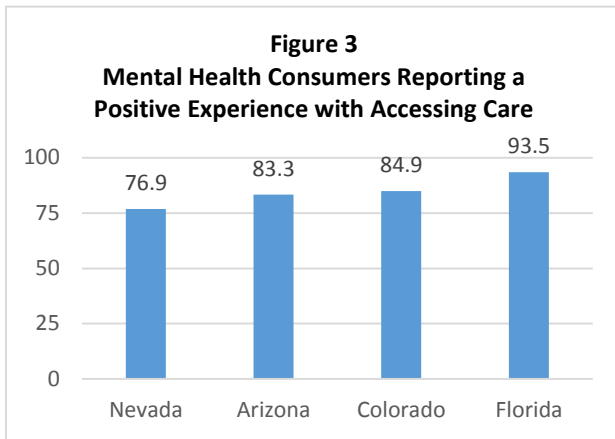


What We Know

Service Delivery Structure and Access to Care

While Nevada’s mental health consumers suffer from diagnoses at rates similar to peer states, they may experience worse living conditions because of reductions in public mental health expenditures and inadequacy of services. As of 2012, approximately 6.9% of adults served by

the Nevada State Mental Health Authority were homeless or living in shelters (SAMHSA, 2012e). In Colorado, 5.6% of adults were living under similar conditions (SAMHSA, 2012c). This contrasts with lower rates of 3.3% in Florida and 2.8% in Arizona (SAMHSA, 2012b, 2012d). The NOMS Consumer Survey Report revealed that fewer consumers of mental health services in Nevada report being able to easily access care compared with consumers in peer states. In Nevada, only 76.9% of adult consumers reported positive experiences accessing care, contrasted with Arizona (83.3%), Colorado (84.9%), and Florida (93.5%). Furthermore, Nevada performed the worst regarding treatment outcomes, with only 63.1% of consumers reporting positive outcomes (SAMHSA, 2012e). This contrasts with rates of 72% in Arizona, 66.8% in Colorado, and 91.9% in Florida (SAMHSA, 2012b, 2012c, 2012d). Nevada received a “D” grade on the National Alliance on Mental Illness’s report *Grading the States: A Report on America’s Health Care System for Serious Mental Illness*. Florida also earned a “D,” whereas Colorado and Arizona both received “C” grades (National Alliance on Mental Illness [NAMI], 2009). A close inspection of the scoring criteria reveals that Nevada is lacking mostly in the areas of health promotion and management, as well as community integration and social inclusion. These categories encompass the provision of services to uninsured individuals, housing, and reentry/jail diversion programs. Despite the significant contribution of these services to a community’s overall behavioral health, they are greatly lacking in this state (NAMI, 2009).



While all four peer states lack services for those without insurance, their scores on the other measures vary. Arizona's score on accessibility of jail diversion and reentry programs lies just below the national average, while their housing score exceeds the national average (NAMI, 2009). Colorado is greatly lacking in housing, but also has jail diversion and reentry programs accessible just under the national average (NAMI, 2009). Finally, Florida's jail diversion and reentry programs exceed the national average, but their housing availability falls below the national average (NAMI, 2009). Nevada conducted a statewide gaps analysis to determine the current challenges in providing behavioral health services and to identify areas where there is opportunity for improvement. As part of the analysis, a survey was administered to consumers of social services to determine whether they had received treatment for behavioral health concerns. Individuals identifying as recipients of services were then asked to rate the issues that had been the greatest impediments to receiving timely, adequate treatment (Watson & Marschall, 2013). Among this group, lack of transportation was rated as the greatest concern. Following this, lack of medical insurance and costs of services were also

identified as major concerns when accessing care (Watson & Marschall, 2013). Despite these weaknesses, the consumer surveys revealed a desire within the community to address these barriers and improve services. Of 277 social service consumers surveyed, 62.5% identified the provision of behavioral health services as a large issue with many needs that must be addressed, while another 18.4% identified it as a moderate issue with some ongoing concerns (Watson & Marschall, 2013).

Reductions in Funding

The economic crisis that began in 2008 has contributed to the lack of adequate services for those struggling with mental illness and/or substance abuse. According to the National Alliance on Mental Illness, many states made significant cuts to their mental health budgets between fiscal years 2009 and 2012. Of the four peer states discussed, Nevada sustained the largest percentage cut at a staggering 28.1% (NAMI, 2011). Colorado's budget sustained a 7.8% decrease, whereas both Florida and Arizona actually increased their budgets by 1.3% and 5.6% respectively (NAMI, 2011). Nevada's reduced budget for mental health services translated into a mere \$64.00 per capita expense during fiscal year 2009 (NAMI, 2011). Florida's per capita spending was even lower at \$40.90, but in contrast, Colorado spent \$86.83 per capita, while Arizona's per capita spending was \$196.13 (NAMI, 2011). It is significant that our neighboring state of Arizona spent three times as much per capita in their 2009 mental health budget as Nevada.

What We Do Not Know

The Future of Care

Most mental and behavioral health conditions are treatable, and the adults who experience these conditions are able to lead healthy and productive lives, maintaining a regular schedule and attending to their day-to-day responsibilities. The issues of treatment, services, and support are multifaceted and becoming increasingly more complex with the implementation of the 2008 Mental Health Parity and Addiction Equity Act and the Patient Protection and the Affordable Care Act. Federal guidance on the issue of treatment pinpoints four questions that should be considered (SAMHSA, 2013): (1) *What proportion of individuals with mental illness receives treatment?* (2) *Where do individuals access treatment?* (3) *How much treatment do individuals receive?* (4) *Is treatment at least minimally adequate?*

Question 1 and 2: What proportion of individuals with mental illness receives treatment and where do they access treatment? Nationally, more than one third of adults with serious impairments received no treatment in the past year (SAMHSA, 2013). When individuals are able to access services and treatment, they typically receive prescription medications, outpatient treatment, and inpatient treatment. The type of treatment received varies by the level of impairment. Although most individuals with serious impairments tend to receive medication as a treatment of first response, medication is also often used in connection with outpatient and inpatient services. As it specifically relates to diagnosed substance abuse disorders, only 10% of U.S. adults who needed

treatment in the past year received it (SAMHSA, 2013).

Question 3 and 4: How much treatment do individuals receive, and is treatment at least minimally adequate? Across the nation, adults who receive treatment for mental illness receive on average about four visits for treatment each year, and those suffering from substance abuse disorders receive about six visits; these rates increase slightly if the individual has access to a specialized mental health setting (SAMHSA, 2013). However, data reveal that most treatment does not meet standards of adequacy (Wang et al., 2005), especially for individuals with substance use disorders. Those individuals who are able to receive minimally adequate care (for mental illness and substance abuse disorders) do so in the specialty mental health sector as opposed to the general medical sector.

What is not known now is the effect that the implementation of the 2008 Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act (ACA) will have on access, adequacy, or frequency of treatment rates for individuals who may need mental health services in the future. The final rule was issued by the Obama administration in November 2013, mandating mental health care provisions in insurance plans in parity with physical health coverage (U.S. Department of Health and Human Services, 2013a). The final rule becomes the operational piece of the 2008 Mental Health Parity and Addiction Equity Act taking effect on July 1, 2014, and combined with the ACA, there is now federal guidance concerning the essential benefits that must be offered by health insurance policies. However, the ACA and the rule that implements the

Parity Act do not apply to Medicare and state-run Medicaid policies. The Obama administration has not specifically instructed states with respect to Medicaid policies but instead has instructed that state policy should align with the Parity ACT.

What Can Be Done

Federal Legislative Budget Allocations for Mental Health Services

President Barack Obama's [Fiscal Year 2014 Budget](#) includes billions of dollars for a variety of programs to help identify and treat mental health concerns early, and to improve access to evidence-based mental health services in an effort to create better outcomes for those needing services (U.S. Department of Health and Human Services, 2013b). Several of the 2014 budget initiatives related to increasing the mental and behavioral health workforce and to increasing prevention and treatment of mental illness are summarized below. A new \$130-million initiative to expand mental health prevention and treatment services includes \$50 million to train 5,000 new mental health professionals to serve students and young adults, including social workers, counselors, psychologists, and other mental health professionals (U.S. Department of Health and Human Services, 2013b). The Substance Abuse and Mental Health Services Administration received \$3.6 billion to maintain the Community Mental Health Services Block Grants and to increase the Substance Abuse Prevention and Treatment Block Grants, and to encourage states to build provider capacity to bill public and private insurance companies (U.S. Department of Health and Human Services, 2013b). Additionally, the federal

budget will substantially increase support for the National Registry of Evidence-Based Programs and Practices. This searchable online system supports states, communities, and tribes in identifying and implementing evidence-based mental health and substance abuse prevention and treatment interventions (U.S. Department of Health and Human Services, 2013b).

The 2014 federal budget provides millions of dollars to enhance and expand the workforce that will specifically be trained to serve vulnerable groups experiencing mental illness within our society, such as children enrolled in primary schools and military veterans and their families. For example, the health professions programs of the Health Resources and Services Administration (HRSA) will receive \$39 million to increase the mental health workforce of social workers and psychologists who work in rural areas and who serve military personnel, veterans, and their families (U.S. Department of Health and Human Services, 2013b). An additional \$35 million is provided within SAMHSA for a collaboration with HRSA to increase the workforce of mental health professionals as part of President Obama's "Now is the Time" proposal, which was initiated as a response to the 2012 shooting tragedy at Sandy Hook Elementary School.

Positioning Nevada to Improve Mental Health Care

Through recent legislation, the federal government has helped expand the health and mental health insurance protections for the vast majority of Americans, paving the way for improved access to needed care and treatment for individuals with

mental and substance abuse disorders. Now that the major legislation is being implemented, the time is right for federal, state, and local governments to focus their workforce spending budgets on increasing the number and quality of health and mental health professionals in the geographic areas and with the populations that most need better access to services, including Nevada. The Health Resources and Services Administration (HRSA) develops shortage designation criteria and uses them to decide whether or not a geographic area, population group, or facility is a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) or Medically Underserved Population (MUP) (see <http://www.hrsa.gov/shortage/>).

Medically Underserved Areas (MUAs) may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services (HRSA, 2014). Medically Underserved Populations (MUPs) may include groups of people who face economic, cultural, or linguistic barriers to health care. HPSAs, MUAs, and MUPs are used to determine eligibility for a number of government programs. According to the designation criteria of HRSA, in 2013 in Nevada there were 12 MUAs and 6 MUPs. HPSAs may be designated as having a shortage of primary medical care, dental, or mental health providers. They may be urban or rural areas, population groups, or medical or other public facilities (HRSA, 2014). As of 2013, there were 29 mental health care professional shortage areas. We suggest a combination of efforts to help position Nevada to systemically improve mental and behavioral health care and substance abuse treatment.

Consideration would be given to the following efforts to improve the necessary workforce:

1. Create public initiatives to encourage Nevada residents to utilize and maximize the public and private services available;
2. Evaluate and disseminate outcome data regarding the effect of mental health services and the availability and affordability of treatment;
3. Improve outcomes based on any shortcomings and deficiencies in availability and affordability;
4. Recruit, train, incentivize, and deploy mental health practitioners to work in Nevada Health Professional Shortage Areas; and
5. Decrease the number of HPSAs, MUAs, and MUPs in the future.

It is very difficult to thoroughly analyze and describe the prevalence and experiences of all the people living and functioning with mental illness in Nevada, because our statewide behavioral health system includes a mix of both public and private, inpatient and outpatient psychiatric hospitals and service centers that often have competing priorities and conflicting goals as they serve populations of clients with fluctuating needs for access and utilization of services in the state. Still, among the many questions that remain, two seem imperative given our workforce supply and the probable increase in service demands brought on by insurance coverage: Will the newly insured who are in need of mental health services increasingly access private providers? Will public services need to increase in order to care for the newly insured given the workforce shortages among private and public providers?

In October 2013, the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, released a comprehensive gaps analysis of the public mental and behavioral health service delivery system at the state and local levels as part of their ongoing planning processes, delineating some of the state's unmet needs for services and providing recommendations for system improvements (Watson & Marschall, 2013). The findings from their evaluation provide a sound context within which to understand and improve the mental health care access and outcomes of Nevada residents, especially those residing in southern Nevada with its unique sociodemographics. For example, Watson and Marschall (2013) found that in every racial category, Nevada lags behind in its reach when compared with national averages. They also found that on average, Nevada continues to serve one individual for every two served nationally, a dynamic that is most pronounced among American Indian/Alaskan Native populations and among people of more than one racial heritage. These gaps and ethnic and racial disparities in gaps have greater impact in the south where the population is relatively denser and more ethnically diverse than in the northern and rural areas of Nevada.

Watson and Marschall (2013) also found that the most pronounced gap in service reach among racial/ethnic groups when compared with national averages occurred with Nevada's Hispanic population. For fiscal year 2012 the national U.S. penetration rates of mental health services to the Hispanic populations were 18.3 per 1,000 people in the population, whereas Nevada reached only 4.9 per 1,000 (Watson & Marschall, 2013).

This gap is particularly notable, considering that during the same year, only 16.9% of the U.S. population were Hispanic or Latino, whereas in Nevada a significantly higher percentage, 27.3%, of residents were Hispanic or Latino (U.S. Census, 2014). As mentioned earlier, Watson and Marschall (2013) conducted a comprehensive survey of a large group of consumers of mental and behavioral health care in Nevada, asking them to rate the significance of unmet need. These researchers also conducted key informant interviews and elicited opinions as to why gaps exist in the Nevada public behavioral health system. The informants identified weaknesses that need to be addressed such as strengthening the workforce, expanding the provider network, and increasing the availability of resources.

Mental health and substance abuse challenges are conditions that are treatable and manageable in ways similar to physical diagnosable medical diseases like diabetes or high blood pressure, and like people with diabetes or high blood pressure, people with mental illness and substance abuse disorders are encouraged to seek both formal care from qualified professionals as well as informal social support from family members and peers. Research has shown that social support in the form of a knowledgeable confidant or empathetic peer can assist with the coping and recovery of various challenges such as mental illness, cancer, or physical disability (Swarbrick, 2013; Swarbrick et al., 2011; Vestal, 2013). Nationally, there has been a steady increase in efforts to train and certify peers to support the recovery of people with mental and behavioral health problems and substance abuse problems. Nevada should consider the use of peer support models by actively pursuing

certification and increasing the use of this practice. The SAMSHA National Registry of Evidence-Based Programs and Practices, a searchable online system, includes descriptions of dozens of SAMSHA-funded, evidence-based mental health and substance abuse prevention and treatment interventions that include peer advocates, peer educators, or specialists.

Through recent federal legislation, it is anticipated that individuals with mental health needs will have increasing opportunities to seek treatment through expanded private health care insurance options, improved mental health benefits, and lowered costs associated with mental health co-payments. And although not yet a mandate, the federal government has urged states to voluntarily continue

efforts to expand mental health parity to those receiving Medicaid in an effort to facilitate timely and appropriate behavioral health care for this population as well. It is hoped that Nevada will be one of the early adopters of an innovative care plan that will proactively expand full mental health parity coverage to the most vulnerable Medicaid residents in the state. Given that in Nevada, 11.3% of residents have a mental health condition and nearly 13% have a substance abuse disorder, and many do not receive the treatment they require, we think now is the time for a serious and critical public discussion aimed at improving Nevada's service delivery system to promote the overall behavioral health of Nevada's citizens, and to support the recovery of individuals with mental health and substance abuse needs.

Suggested Mental Health Resources

Behavioral Health, United States, 2012. SAMHSA's newly released publication, *Behavioral Health, United States, 2012*, the latest in a series of publications issued by SAMHSA biannually since 1980, provides in-depth information regarding the current status of the mental health and substance abuse field. It includes behavioral health statistics at the national and state levels from 40 different data sources. The report includes three analytic chapters:

- Behavioral Health Disorders Across the Life Span
- Mental Health and Substance Use Disorders: Impairment in Functioning
- Mental Health and Substance Use Disorders: Treatment Landscape

This publication also includes state-level data and information on behavioral health treatment for special populations such as children, military personnel, nursing home residents, and incarcerated individuals. <http://www.samhsa.gov/data/2012BehavioralHealthUS/Index.aspx>

National Survey on Drug Use and Health. This report with its detailed tables presents a first look at results from the 2012 annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. Both the report and tables present national estimates of rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco products, with a focus on trends between 2011 and 2012 and from 2002 to 2012, as well as differences across population subgroups in 2012.

NSDUH also includes national estimates related to mental health and NSDUH state-level estimates related to both substance use and mental health. <http://samhsa.gov/data/NSDUH/2012SummNatFindDetTables/Index.aspx>

The Health Insurance Marketplace. This website provides information and helps uninsured people find health coverage. The website includes important information about private health insurance plans and whether a person qualifies for lower costs based on household size and income; explains that plans must cover essential health benefits, pre-existing conditions, and preventive care; and gives information about Medicaid and the Children's Health Insurance Program (CHIP). These programs provide coverage to millions of families with limited income. Nevada, like many but not all states, is expanding Medicaid in 2014 to cover more people. <https://www.healthcare.gov/>

MentalHealth.gov. This website includes information targeted to people with mental health problems, their parents, caregivers, families, and friends, and for educators and other community members affected by those with mental health problems. The site provides basic information about identifying signs of mental illness and coping with mental illness, and provides links to resources to get treatment and supports for those living with mental health and substance abuse problems. <http://www.mentalhealth.gov/talk/index.html>

SAMHSA Enrollment Toolkit. The Substance Abuse and Mental Health Services Administration has released a training resource toolkit, developed through the Enrollment Coalitions Initiative, titled Getting Ready for the Health Insurance Marketplace. This toolkit will assist organizations with outreach, education, and enrollment of individuals in the Health Insurance Marketplace. It is composed of three sections: a description of the health care law, how it works, and why it is important for uninsured individuals with behavioral health conditions; an explanation of how the Health Insurance Marketplace works, how to apply for health coverage and where to get help; and numerous communication ideas and materials from the Centers for Medicare and Medicaid Services (CMS) that can be used to raise awareness and encourage uninsured individuals to enroll. The toolkit has been developed in six slightly different 30-minute, interactive formats, each of which can be accessed and viewed online.

<http://tiny.cc/GettingReady> (General information)

<http://tiny.cc/CommunityPrevention>

<http://tiny.cc/ConsumerPeerFamily>

<http://tiny.cc/HomelessServices>

<http://tiny.cc/CriminalJustice>

<http://tiny.cc/TreatmentProviders>

References

- Centers for Disease Control and Prevention and National Center for Injury Prevention and Control. (2010). *Web-Based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from <http://www.cdc.gov/injury/wisqars/index.html>
- Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services, 59*(2), 153–164. doi:10.1176/appi.ps.59.2.153
- Edlund, M. J., Booth, B. M., & Feldman, Z. L. (2009). Perceived need for treatment for alcohol use disorders: Results from two national surveys. *Psychiatric Services, 60*(12), 1618–1628. doi:10.1176/appi.ps.60.12.1618
- Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., & Swanson, J. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress, 14*(4), 615–632. doi:10.1023/A:1013026318450
- Health Resources and Services Administration (HRSA). (2014). *Shortage designation: Health professional shortage areas & medically underserved areas/populations*. Retrieved February 5, 2014, from <http://www.hrsa.gov/shortage/>
- Hiday, V. A., Swanson, J. W., Swartz, M. S., Borum, R., & Wagner, H. R. (2001). Victimization: A link between mental illness and violence? *International Journal of Law and Psychiatry, 24*(6), 559–572. doi:10.1016/ijlp.2004.08.010
- Ollove, M. (2013, November 22). *In shift, most states increase mental health spending*. Retrieved December 10, 2013, from <http://www.disabilitycoop.com/2013/11/22/in-shift-mental-health/18915/>
- National Alliance on Mental Illness (NAMI). (2009). *Grading the states: A report on America's health care system for adults with serious mental illness*. Arlington, VA: Author.
- National Alliance on Mental Illness (NAMI). (2011). *State mental health cuts: The continuing crisis*. Available at http://www.nami.org/Template.cfm?Section=state_budget_cuts_report
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2011a). *Leading change: A plan for SAMHSA's roles and actions 2011–2014*. HHS Publication No. (SMA) 11-4629. Rockville, MD: Author. Retrieved February 24, 2014, from <http://store.samhsa.gov/shin/content/SMA11-4629/01-FullDocument.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2011b). *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Author.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012b). *Arizona 2012 mental health national outcome measures (NOMS): CMHS uniform reporting system*. Retrieved from <http://www.samhsa.gov/data/outcomes/urs/2012/Arizona.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012c).

Colorado 2012 mental health national outcome measures (NOMS): CMHS uniform reporting system. Retrieved from <http://www.samhsa.gov/dataoutcomes/urs/2012/Colorado.pdf>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012d). *Florida 2012 mental health national outcome measures (NOMS): CMHS uniform reporting system*. Retrieved from <http://www.samhsa.gov/dataoutcomes/urs/2012/Florida.pdf>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012e). *Nevada 2012 mental health national outcome measures (NOMS): CMHS uniform reporting system*. Retrieved from <http://www.samhsa.gov/dataoutcomes/urs/2012/Nevada.pdf>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Behavioral health, United States, 2012*. HHS Publication No. (SMA) 13-4797. Rockville, MD: Author.

Swarbrick, M. A. (2013). Integrated care: Wellness-oriented peer approaches: A key ingredient for integrated care. *Psychiatric Services*, 64(8), 723–726. doi:0.1176/appi.ps.201300144

Swarbrick M, Murphy, A. A., Zechner, M., et al. (2011). Wellness coaching: a new role for peers. *Psychiatric Rehabilitation Journal*, 34(4), 328–331.

U.S. Census Bureau. (2014). *State and county quick facts. Nevada*. Retrieved from <http://quickfacts.census.gov/qfd/states/32000.html>

U. S. Department of Health and Human Services. (2013a). *Administration issues final mental health and substance use disorder parity rule*. Retrieved December

10, 2013, from <http://www.hhs.gov/news/press/2013pres/11/20131108b.html>

U.S. Department of Health and Human Services. (2013b). *Fiscal Year 2014 budget in brief: Strengthening health and opportunity for all Americans*. Retrieved December 16, 2013, from <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf> and <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf>

Vestal, C. (2013). 'Peers' may ease mental health worker shortage under Obamacare. Retrieved February 24, 2014, from <http://www.usatoday.com/story/news/nation/2013/09/11/stateline-mental-health/2798535/>

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 603–613. doi:10.1001/archpsyc.62.6.603

Watson, L., & Marschall, K. (2013). *Nevada Department of Health and Human Services, Division of Public and Behavioral Health: Comprehensive gaps analysis of behavioral health services*. Prepared by Social Entrepreneurs, Inc. Retrieved from <http://www.socialent.com/wp-content/uploads/2013/12/FINAL-Behavioral-Health-Gaps-Analysis-Report-10-11-13.pdf>

World Health Organization. (2004). *Changing history. Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002* (pp. A126-Z127). Geneva, Switzerland: Author.

About the Authors

Dr. Ramona Denby-Brinson is Professor, School of Social Work, and Senior Resident Scholar, The Lincy Institute, at the University of Nevada Las Vegas. Dr. Denby-Brinson completed her Ph.D. in social work at The Ohio State University. Prior to her academic career, Dr. Denby-Brinson worked with children and families in a wide capacity for more than 10 years. Dr. Denby-Brinson conducts research in the areas of child welfare, children's mental health, juvenile justice, and culturally specific service delivery. Her goal is to help practitioners bridge the gap between theory and practice by utilizing science-based interventions to support vulnerable populations.

Dr. Sandra Owens is an Associate Professor in the School of Social Work at the University of Nevada Las Vegas, and is a Hartford Faculty Scholar of Gerontological Social Work. Dr. Owens completed her Ph.D. in Social Welfare at the University of California, Berkeley. Prior to her academic career, Dr. Owens' clinical experience was gained working with children and adults admitted to inpatient psychiatric units in Monte Vista Hospital, Charter Hospital, and Southern NV Adult Mental Health Services. Dr. Owens' research has focused on family caregiving, cross-cultural competency, and the mental health and social functioning of Black, White, and Latino female caregivers of the elderly. Dr. Owens is committed to assisting agencies with meeting their organizational goals and to helping address the myriad problems facing individuals, groups, and communities. Dr. Owens is actively involved in leadership roles in a variety of community organizations, and she recently served as President's Fellow in the cabinet of UNLV President Neal Smatresk.

Ms. Sarah Kern is a graduate student the University of Nevada Las Vegas and a former graduate research assistant at The Lincy Institute. She completed her B.A. in Psychology and is currently working toward her Master's in Social Work at UNLV with a concentration in direct practice. Her interests include child welfare policy and mental health service and delivery.

Acknowledgments

The authors wish to thank Dr. Christa Peterson for reviewing drafts of this brief. Also, we would like to express our gratitude to Alexandra Nikolich, Business Manager, for her important contributions to this brief. Finally, we extend our appreciation to Maya Porter for her professional editing services.

About the University of Nevada Las Vegas

UNLV, founded in 1957, is an institution of approximately 26,000 students and 3,100 faculty and staff located on the southern tip of Nevada, just minutes from the Las Vegas Strip. Classified by the Carnegie Foundation for the Advancement of Teaching as a research university with high research activity, UNLV offers more than 200 undergraduate, graduate, and doctoral degree programs including innovative academic degrees in such fields as gaming management, entrepreneurship, entertainment engineering, and much

more. UNLV is accredited by the Northwest Commission on Colleges and Universities (NWCCU). The entertainment capital of the world, Las Vegas offers students a “living laboratory” for research, internships, and a wide variety of job opportunities. UNLV is dedicated to developing and supporting the human capital, regional infrastructure, and economic diversification that Nevada needs for a sustainable future. For more information, visit: <http://www.unlv.edu/>

About The Lincy Institute

Established in 2009, The Lincy Institute conducts and supports research that focuses on improving Nevada’s health, education, and social services. This research is used to build capacity for service providers and enhance efforts to draw state and federal money to the greater Las Vegas. The Lincy Institute also highlights key issues that affect public policy and quality-of-life decisions on behalf of children, seniors, and families in Nevada. The Lincy Institute has been made possible by the generous support of The Lincy Foundation. Robert E. Lang, Ph.D., serves as the Institute’s Executive Director. To learn more visit: <http://www.unlv.edu/lincyinstitute>

UNLV | THE LINC
INSTITUTE
4505 S. Maryland Parkway, Box 453067
Las Vegas, NV 89154 (702) 895-0088

This information may be used and copies made for noncommercial purposes. Proper attribution is required.

Please visit our website to access other issue briefs in the [mental health series](#).

For citation purposes, please use: Denby, R., Owens, S., & Kern, S. (2014, March). *Time to talk: The mental health of adults in Nevada*. Social Service Series No. 2. Las Vegas: The Lincy Institute at the University Nevada Las Vegas.