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Mental Health Problems and Needs in Nevada

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Mental Health Problems and Needs in Nevada*

Introduction

Attitudes toward people with mental health problems have varied throughout historical periods and cultures. At times, they were believed to possess divine powers, and at others were cast as possessed by evil forces. In ancient Greece, Iraq, and India, for example, people with mental disorders were treated humanely, while in other cultures they were executed, tortured, shunned, and pushed to the margins of society. Today, most societies strive to treat the mentally ill in a humane manner and integrate them in society's mainstream.

Although the number of people classified as mentally ill varies depending on the definition, it remains substantial.

- There are more than 450 million people with mental, neurological, or behavioral problems throughout the world (**World Health Organization**, <http://www.who.int/en/>).
- 25% of individuals will develop one or more mental or behavioral disorders at some stage in life, in both developed and developing countries.
- Worldwide, suicide causes more death every year than homicides or war, and over 90% of suicide-related death is caused by depression.
- A report issued by the U.S. Surgeon General estimates that about 20% of Americans is affected by mental disorders in any given year (Mental Health: United States Public Health Service).
- 19% of the adult population in the U.S. has a particular mental disorder in any given year; 6% have addictive disorders; and 3% have both mental and addictive disorders. Thus, 28-30% of the population have either a mental *or* addictive disorder (Regier et al., 1993b; Kessler et al., 1994; see table 1 for details).
- Mental illness involves staggering financial costs. In the U.S., the annual economic indirect cost of mental illness is estimated to be \$79 billion. In 1997, the latest year comparable data is

available; the United States spent more than \$71 billion on treating mental illness (Rice and Miller, 1996).

- Mental health is funded primarily through public sources (57% compared to 46% of overall health expenditures). Between 1987 and 1997, mental health spending did not keep pace with general health care expenditures because of declines in private health spending under managed care and cutbacks in hospital expenditures (Coffey et al, 1997).

In the last few decades, the number of Americans classified as having mental disorders saw a dramatic increase, as did the number of people seeking and receiving mental health services. This increase can be attributed to the growing understanding that mental illness is a treatable disease, as well as the lessening of the stigma surrounding mental illness. Improved diagnoses, innovative therapies, and radically new medications, coupled with recent breakthrough prescription medications with higher effectiveness and fewer side effects have also contributed to this trend, which is now evident in Nevada and throughout the nation. Despite these advances, delivering mental health services to the affected population remains a major challenge requiring the concerted efforts of government, local communities, and families of consumers of mental health services.

Federal involvement in mental health policy has grown in the last decade, pushing the public mental health systems in a new direction. Perhaps the most important development in this respect has been the creation of the **Substance Abuse and Mental Health Services Administration**(SAMHSA), <http://www.samhsa.gov/>, established by Congress in 1992. Other landmark developments in the field of mental health include a **1999 U.S. Surgeon General report**, <http://www.surgeongeneral.gov/library/reports.htm>, highlighting mental health as a major national public health issue; a **United States Supreme Court landmark decision** appearing in the same year, commonly referred to as *Olmstead*, that established a constitutional mandate to provide mental health treatment to individuals in the least restrictive environment appropriate to their condition; and the creation in 2002 of the federal **New Freedom Commission on Mental Health**, <http://www.mentalhealthcommission.gov/>, that promoted

community-based models of mental health care. Mirroring these national developments is the **Nevada Mental Health Plan Implementation Commission**

Report, <http://www.leg.state.nv.us/lcb/research/05InterimReports/Bulletin05-08.pdf>, which laid groundwork for the provision of mental health services in the state. The overall shift away from inpatient treatment is a national trend that has also been evident in Nevada (*State Profile Highlights*, 2005).

While federal policy has had a major influence on the delivery of mental health services, the responsibility for the organization and dispensation of public mental health in Nevada has, by statute, been vested in the state government. The present report reviews the quality of mental health care in the Silver State. After a brief historical overview, we identify the most urgent needs, point to work ahead, and describe community resources available in our state to individuals and families with mental health problems.

Historical Overview

Nevada's mental health system traces its roots to 1868 when the Nevada territory became a state (Chanslor, 1968). Four years after achieving statehood, the Nevada Legislature authorized a contract with the State of California for the admission and care of insane residents in Nevada. In 1871, the Nevada legislature created the first "Board of Commissioners " to keep control of and provide care for the insane. Comprised of the Governor and a treasurer, this first board authorized the building of Nevada's first state asylum, which was completed in 1882. Most of these original structures remain standing, and many are still in use. In 1883, 148 "inmates" were transferred from Stockton California to Nevada's new hospital. By the 1880's, the need for a state hospital became apparent, as some early settlers experienced fatigue and mental illnesses while traversing the United States during the western expansion. Nevada records show that even the bravest and most courageous families were not immune to mental illness.

In one of the very few historic reviews of mental health services in Nevada, Pillard (1979) identified three characteristics of Nevada's system: (1) marked fluctuations in service capacity; (2) a lack of

public supervision or independent professional review of mental health programs; and (3) absence of long-term planning. The Nevada system of mental care first appeared in Northern Nevada, starting with a single hospital in Reno that was called at the time the Nevada Insane Asylum. In 1895, the name changed to the Nevada Hospital for Mental Diseases. In the early 1900's, patients stayed almost entirely within the confines of this institution. Many worked on the hospital ground, with the family members helping along. In time, this "asylum" evolved into what is now the **Northern Nevada Adult Mental Health Services**.

Notable improvements occurred throughout the 1940's thanks to the legal actions that produced better treatment activities, separate programs for men and women, appointments of guardians, and the allowance of "voluntary" commitments. Beginning in 1943, the Superintendent was no longer required to be a physician. In 1944, conditions in the hospital reached a level that required a legislative investigation, which brought in its wake structural changes in the system. In the mid 1940's, a new board of **Commissioners for the Indigent Insane** was created to assist the governor. The commission elected a state Superintendent for the Hospital. It is interesting to note that, until the late 1930's, many patients lived most of their lives in the hospital and were actually buried on the campus. This practice was discontinued in the 1940's.

The mental health care system in Southern Nevada is of much more recent vintage. The **Community Mental Health Act** passed under the administration of President John F. Kennedy paved the way for Southern Nevada to develop its first mental health outpatient clinics in the mid 1960's, nearly 100 years after Northern Nevada blazed the trail. Around 1975, the first public psychiatric hospital opened its doors in Southern Nevada (C. Brandenburg, Personal Communication, January 2006).

As the above overview suggests, the mental health delivery systems differed substantially in southern and northern parts of the Silver State. Whereas in northern Nevada, mental health services evolved from a hospital based institutional setting, in southern Nevada the mental health service system relied primarily on community-based

programs. And when the federal government announced its policy favoring community-based services in the 1960's, this shift caused more cultural problems and organizational changes in the state's northern regions.

Reflecting a new attitude toward mental illness as a component of public health and human development, the division's name was changed in 1998 from the obsolete "Mental Hygiene and Mental Retardation" to the current "Mental Health and Developmental Services." Modern day governance of Nevada's public mental health system is vested in the Division Administrator appointed by Governor. Dr. Carlos Brandenburg currently serves as the Mental Health & Developmental Services Administrator in Nevada.

Problems and Delays in Service Delivery

In a 1995 article published in the *Nevada Public Affairs Review*, Brian Lahren, former Administrator of the state Division of Mental Hygiene and Mental Retardation (now the **Division of Mental Health and Developmental Services**), traced the deterioration in Nevada mental health services over more than a decade. This decline started in 1983 when the state, facing financial exigency, cut funding for mental health services. After a temporary reversal in the late 1980's, the state mental health budget plummeted again in 1991-92 when the budget was cut by a crippling 12%. Adjusted for inflation and population growth, this reduction led to an effective 40% drop in the overall funds available to treat mentally ill residents of the state. While the situation improved in the late 1990's, but state mental health services have never fully recovered from the precipitous decline of the prior decade.

Several historical factors have contributed to the critical state of affairs in the Nevada mental health delivery system, including a rather unique statewide delivery structure in which the state has been the sole provider and a primary source of funding for public agencies delivering mental health services. Historically, Nevada lacked acute care facilities that were designed as part of the public mental health system, with Southern Nevada completely lacking a psychiatric acute care infrastructure. The Silver State was also uniquely vulnerable to budget cuts due to the personnel-intensive

nature of mental health services and the relatively powerless political voices of those most affected by the cuts. We also should note the unprecedented population growth, particularly in Southern Nevada. For 18 consecutive years, Nevada has been the fastest growing state in the nation. This population explosion has led to a dramatic increase in consumers needing mental health services. Adding to the mental health delivery crisis in the state was the decision by private providers, particularly psychiatric inpatient facilities, to reduce or eliminate their beds at the time when state agencies were already losing ground in their ability to meet demand for services.

A recent report by the National Alliance of the Mentally Ill (2006) ranked all 50 public mental health systems. In Nevada, the grade received was a disappointing "D-". This NAMI report went on to indicate that

- Nevada ranks very poorly – 37th – in overall mental health spending, and 36th in per capita MH expenditures, while at the same time ranking 4th in the nation for suicide rates.

In spite of acknowledged long-standing system shortcomings in Nevada's system, the NAMI report went on to discuss outstanding strengths and challenges in Nevada's public system of mental health in 2006, which included;

Innovations

- State funded mental health courts
- Transparency, demonstrated by self-reported data posted on the MHDS website
- Efforts to reduce restraints and seclusions in hospitals
- Funding increases for emergency room and jail diversion programs

Urgent needs

- Overflowing emergency rooms, particularly in Las Vegas
- Implementation of evidence based practices and Act programs
- Supportive housing options especially in rural areas

NAMI is not the only source to note the persistent reports of long waits to obtain services in Southern Nevada. In fact, delays in access to Southern Nevada's only public psychiatric facility have continued particularly since Clark County Manager Thom Reilly's declaration of a state of emergency in July of 2004. Because of the statutory requirement that consumers must receive a medical clearance prior to acceptance by a state psychiatric facility, local hospitals were overwhelmed by the influx of psychiatric patients waiting for access to Southern Nevada Adult Mental Health Services (SNAMHS). Hundreds of psychiatric patients were warehoused in local emergency rooms, claiming nearly one-third of the total number of emergency beds.

While the news might have been startling to the public, the problem had become chronic and all too familiar to those working in the Nevada public mental health system. In fact, it had been growing for more than a decade.

The long waits in Southern Nevada have impacted not just those with an acute mental health crisis. Emergency room operations are designed to turn patients over approximately every 4 hours, either by releasing them to the streets or admitting to another hospital department. Mental health patients may occupy the same bed for 27 times that length, which means that each patient potentially displaces approximately 26 emergency patients. Multiply the number of displaced by 70 – the number of patients held for sustained periods – and the crisis for acute medical care becomes apparent. In December 2005, Nevada had almost 1,600 people waiting at some time in the Clark County emergency rooms to be admitted to the mental health system (see Appendix for detail).

Reports found in the publications section of the **MHDS**, <http://mhds.state.nv.us/sn/index.shtml>, reveal a crying gap between the psychiatric needs and available services. The emergency rooms in Las Vegas Valley are overwhelmed by the number of psychiatric patients who are held for extended times in emergency room facilities because there are insufficient Psychiatric Emergency Beds and Psychiatric Acute Care Beds at SNAMHS.

- In 2003, the patient to psychiatrist ratio in Nevada was approximately 700:1, as opposed to the target of 345:1. In the same year, there were 36 private psychiatric beds for the entire Clark County region with a population of 1,620,748.
- The State of Nevada estimated that in December 2005, 1595 people waited on average of 85 hours in hospital emergency rooms for access to the public mental hospital (Crowe, 2006).
- As many as 50% of those held in hospital emergency departments are eventually released to the streets without receiving any treatment.
- State officials estimate that about 40% of all clients leave the state psychiatric emergency clinic without being served because of intolerably long waits.

Southern Nevada has been losing ground for years in mental health delivery services. In the past five years alone, Clark County lost 133 private beds. The number of psychiatric beds in private facilities has been dropping nation-wide due to emphasis on the more lucrative general medical surgical facilities. The decline was especially precipitous in Nevada as a whole, where it produced more adverse consequences.

With strong leadership from Governor Guinn and the Nevada State Legislature, MHDS managed to secure major budget and staff increases in 2003, which significantly improved the Division's ability to provide mental health services in the state.

- The most recent 2005 legislative session marked the largest budget increase to date at over 47%. In the MHDS State Fiscal Year (SFY) 2005, the Legislature-approved budget of \$194,976,376, of which \$99,876,254 was dedicated to mental health services, \$91,647,821 was budgeted for developmental services, and the remaining \$3,452,301 was earmarked for administration (see Appendix for budgetary and staffing details).
- Additional mental health allocations of over \$19.5 million made through Assembly Bill (AB) 175, sponsored by Assemblywoman Sheila Leslie, resulted in total budget growth for MHDS of 51.6% during SFY 2006 – 2007 (see below).

By the start of the 2005 legislative session, the Guinn Administration had already taken crucial steps to address the growing crisis. Foremost was the decision to move the building of a new psychiatric facility in Southern Nevada to the top of the state's list of capital improvements. With bi-partisan leadership provided in particular principally urged by Governor Guinn and Assemblywoman Sheila Leslie, the Nevada Legislature responded with the unprecedented 51.60% (\$91 million) increase in mental health funding. Additionally, AB 175 further added 12.6 million for expanded mental health crisis services, and mental health courts.

Although the three principal state facilities – SNAMHS, NNAMHS, and Rural Clinics Community Mental Health Centers (RC) – all received substantial increases, the lion's share of the increase was used to mitigate the Southern Nevada emergency room crisis. Funding also aided the expansion of the Clark County Mental Health Court, the continuation of a community triage center, and the establishment of a temporary 50 bed 50-bed overflow treatment facility (Westcare). These budget increases and organizational measures bode well for the mental health services delivery in the three primary regions of the state. Yet even these boosts failed to stem the crisis in southern Nevada.

Demand for Mental Health Services

To appreciate the magnitude of the problem, consider the following data pertaining to the mental health needs in our state:

- In a 2003 report of the **Kaiser Family Foundation**, <http://www.kff.org/>, Nevada ranked 1st (worst) in the nation with 42% of the population reporting poor mental health in the prior 30 days.
- At the other end of the spectrum, states reporting low incidence of mental illness included Hawaii (19.3%) and North Carolina (24.8%). Neighboring California ranked relatively poorly in third place behind Nevada with 40.9% reporting poor mental health.
- In 2004, the national average of publicly funded psychiatric inpatient beds was 33 per 100,000 residents. By comparison, Nevada had some 4.5 beds per 100,000. (Even with the

significant anticipated increases, the ratio in Clark County would grow just to 21:100,000).

- The 2004 Center for Mental Health Services report ranked Nevada as the worst among 15 western states for mental illness prevalence. The study projected that 23.7% of Nevada residents will have a diagnosable mental disorder at some point in their lifetimes.

Estimates of the prevalence of individuals in the population who have serious disorders in a given year are useful in planning and generating performance indicators. A direct survey of the population is the best way to make these estimates, but a well-designed survey is expensive. Special techniques have been developed that allow indirect inferences from national epidemiological studies regarding the trends at the county. The federal government has funded two major national epidemiological surveys for adults: the **Epidemiological Catchment Area Survey** and the **National Comorbidity Survey**. These surveys used structured diagnostic interviews to obtain detailed information about prevalence rates for mental disorder in various sociodemographic groups (age, sex, race, ethnicity, education, poverty level, marital status, etc.)

There have been a number of studies of the mental health of children and adolescents, although these fall far short of the massive scope of surveys such as the ECA and the NCS. Estimation relies heavily on the methods of the CMHS reports, *Estimation Methodology for Children With a Serious Emotional Disturbance (SED)* (1997), and *Children With Serious Emotional Disturbance; Estimation Methodology* (1998).

Results from these studies are applied to census data to generate estimates. At the national level, epidemiologists have applied this technology for several states including Colorado, Nebraska, South Dakota, Washington, Washington D.C., and Wyoming. For Nevada, this source data was updated using the 2003 Nevada Census data (July 1, 2003, Estimates). This results in Nevada having the most up-to-date and accurate prevalence estimated available nationally. Estimates were made for children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness

(SMI). Estimates generated were based on the National Comorbidity Survey for adults, the Epidemiological Catchment Area survey for the elderly. Both studies were used in combination with other research and expert opinion for estimates for children and adolescents (Kessler et al, 1996).

The most serious mental illnesses are generally classified into two service strata, referred to as those with serious mental illness (SMI) or serious *and persistent* mental illnesses (SPMI). Unlike other states in the region, Nevada focuses on provision of services to those who qualify for the SPMI category. SPMI populations are the most difficult and expensive to service, as this generally includes all aspects of life, money management, residential supports, and use of the most expensive medications. Other states often provide less urgent services to a wider strata of the general population, sometimes providing services to milder and situational disorders, for example.

Although this prevalence data is subject to varying interpretations, it may be concluded that it reflects a public system focused largely mostly on serving just those consumers with the most serious and persistent mental illness. In addition, the picture suggests a significant focus on crisis response rather than on health maintenance and prevention. Further, the lack of adequate numbers of community-based programs and the location of state hospitals at just two locations in the state, one in Clark County and the other in Washoe, may result in higher rates of hospitalization and treatment at greater distance from one's home.

Estimation tables were developed for counties and aggregated to service areas and the State (Holzer, 2004). Tables were broken down by age, gender, race/ethnicity, poverty level, and residence type.

- Nevada has fewer public psychiatric beds per 100,000 population than Oregon, Utah, Idaho, or California. Nevada ranks 43 nationally and is significantly lower than any of these states.
- Nevada has fewer public psychiatric beds per capita than the surrounding states. To meet the national avg. ratio of 33

psychiatric beds per 100,000, the new hospital would need to provide 511 beds (*Overview of Plans for the New Psychiatric Hospital In Las Vegas, 2004*).

- The total number of available psychiatric beds in the private community has dropped dramatically since 2000. There are insufficient private acute psychiatric beds in Las Vegas Valley to provide services to the people living there. This has caused a 44% drop in available private adult psychiatric beds in less than 3 years.
- Nevada spends much less than the national average on Mental Health including funding for hospital services (*Facts about the New State Psychiatric Hospital in Las Vegas Valley, 2004*).

Mental Health Care Delivery in Nevada

The Division of Mental Health and Developmental Services (MHDS) will provide services to approximately 25,000 Nevadans in State fiscal year (SFY) 2005 (*Facts About The New State Psychiatric Hospital in Las Vegas Valley, 2004*). In addition to serving these direct consumers, MHDS works with many stakeholders including family members, advocates, service providers, legislators, law enforcement, and the public. As a result of these diverse interests, the issues facing MHDS are complex and require input from many different perspectives. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public mental health and developmental services system that meets the needs of Nevada's citizens.

MHDS is responsible for the operation of State-funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services, and all developmental services programs and facilities. By statute, the Division is responsible for planning, administration, policy setting, monitoring, and budget development of all State-funded mental health and developmental services programs. MHDS Administration is also directly involved in decisions regarding agency structure, staffing, program, and budget development.

The mission of the Division is to develop and operate programs that assist individuals who have mental illness or developmental

disabilities to live as independently as possible. The Division is obliged to offer care regardless of ability to pay, provide services in the least restrictive environment, base services upon individual needs, and honor clients' rights. MHDS is committed to providing cost-effective services that ensure consumer and citizen safety, can be readily accessed by all persons in need, are consumer-driven, and promote self-sufficiency.

Appointed by the Governor, the Division Administrator relies on the oversight and direction of stakeholders as represented in several advisory groups:

Commission on Mental Health and Developmental Services (MHDS Commission). The MHDS Commission is appointed by the Governor to articulate policies and ensure effective administration of services for persons with mental illness, mental retardation, and related conditions. The Commission has several powers related to the oversight of programs within the Division.

Local Advisory Boards. The MHDS Commission has created advisory boards in Washoe and Clark Counties and makes appointments to these boards from stakeholders in the community. The boards serve to provide information to the Commission regarding service needs, public input, and other issues pertaining to mental health.

Mental Health Planning Advisory Council (MHPAC). Public Law 102-321 mandates that stakeholders, including mental health consumers, their family members, and parents of children with SED must be involved in mental health planning efforts related to the block grant through membership in planning advisory councils (PACs). To this end, the State of Nevada Mental Health Planning Advisory Council (MHPAC) was established in 1989. PACs have three federally mandated duties: (1) To review the Mental Health Block Grant Plan and make recommendations; (2) to serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses; and (3) to monitor, review, and evaluate at least once each year the allocation and adequacy of mental health services within the state.

Administration and services are organized into three regions: north, south, and rural. Four agencies deliver mental health care in the state:

Northern Nevada Adult Mental Health Services (NNAMHS) – north. This inpatient psychiatric hospital provides a variety of outpatient, community-based services.

Lake’s Crossing Center – north. Co-located with NNAMHS, this is the State’s facility for criminal offenders with mental illness.

Southern Nevada Adult Mental Health Services (SNAMHS) – south. This is a n inpatient psychiatric hospital offering a variety of outpatient, community-based services through four community mental health centers.

Rural Clinics – rural. This organization operates a network of 18 community mental health centers in the state’s rural counties. In addition to providing services to adults with SMI, Rural Clinics provides services to children with SED in the rural areas in cooperation with DCFS.

Although much media attention has been focused on the hospital bed shortage in Southern Nevada, it would be unfair to conclude that the mental health services system is functioning adequately throughout the rest of the state. In large measure, the psychiatric bed shortage crisis reflects the lack of adequate community-based outpatient and prevention resources. Since responsibility for public mental health services rests exclusively by statute with the state, counties are dependent upon state resources to provide such services. According to State of Nevada sources, in FY04

- 80% of Nevada’s mental health spending (approximately \$69 million) came from the state general fund, 11% was attributable to federal sources, and 9% was paid by other sources (with less than 1% paid by clients).

State-by-state comparisons are difficult to make because state delivery systems differ in significant ways, yet some noteworthy trends can be discerned from a MHDS July 2005 report by Donald R.

Karr and Laura Valentine summarizing FY03 and FY04 multi state data (Karr and Valentine, 2005) reached the following conclusion:

- Although Nevada fares quite well in mental health spending on a per-consumer basis (\$5,067 compared to \$4,917 nationally), when mental health expenditures are spread across the entire state population, Nevada ranks below most of its neighbors and well below the national average (\$59 per 1,000 in population versus \$92 nationally).
- Nevada state agencies serve a smaller portion of resident consumers than the national average (11.7 consumers per 1,000 versus 18.6 nationally).
- The percentage of mental health consumers served in psychiatric hospitals significantly exceeds the national average. In fact, the proportion of Nevada consumers served in state psychiatric hospitals is more than twice as high as its neighbors and the U.S. as a whole (7.7% compared to 3% nationally).
- With respect to the provision of funding for community-based services, Nevada ranks below all of its neighboring states (Utah, Arizona, and California), one exception being Oregon, if we consider per client spending (see Appendix for detail) National comparative statistics are not available).
- As to percentages of consumers being served in their own neighborhoods, Nevada again reflects substantial disparity with most of its neighbors and with the United States as a whole (88% compared to 96%).

Children and Youth with Mental Disorders

The consequences of unaddressed severe emotional disturbance (SED) in children and youth include school failure and entanglement with the criminal justice system. Understanding the dimensions of mental health needs for this young segment of our population is crucially important. Although we do not have reliable statewide data for the general school age population, we have some information from which we can reasonably extrapolate. In 2004, the **Clark County Children's Mental Health Consortium**, http://www.dcf.state.nv.us/Plans/CCCMH_Annual_Plan_2004.pdf,

sampled elementary students in the Clark County School District. The major findings are summarized below:

- Approximately 20% of the children required some level of mental health care, a number mirroring national data. Although studies have not yet been conducted for Washoe County and the rural areas, there is no reason to doubt the 20% figure as a good benchmark.
- About 13% of the students sampled required targeted intervention, while the 6% were in need of intensive services, and; the remainder would benefit from school support programs.
- Other Nevada studies which focus on relating to youth in state and local juvenile justice residential programs have found that the percentage with a specific mental health diagnosis can reach 40 or 50%.

The level of unmet needs in the general population, as well as the child welfare and juvenile justice systems, is striking:

- Some 83% of the children sampled in the Clark County School District were not getting the level of services needed. A full 63% of those in need were getting no services at all.
- In the child welfare system, 70% were getting less than adequate level of service, and 44% of youngsters with psychiatric needs received no treatment. Similar numbers were reported by the Nevada juvenile justice system.

Key to addressing mental health problems in children and youth are early identification and quick referral to obtaining appropriate services. Assuring access to such resources can be particularly challenging in the rural communities. Nevertheless, the introduction of **wrap-around services** (WIN) throughout the state – the provision of a range of comprehensive community-based supports for the child and family – has shown promise for helping young people achieve good mental health without having to leave their communities.

Socio-Demographic Factors in Mental Health

Individuals suffering from serious mental illness are further burdened with a range of other hardships and obstacles to quality of life.

- The MHDS The State of Nevada 2004 Biennial Report, <http://mhds.state.nv.us/pdfs/BiennialReport2004.pdf>, indicates that approximately one third of state clients have never been married, and a majority identify themselves as single.
- A 2005 MHDS report (Karr and Valentine, 2005) revealed According to the 2005 that , just 18% of Nevada mental health consumers are in competitive employment, compared to about 22% nationally.
- It is estimated that 92% of all clients earn below \$16,000 annually, compared to about 10% of the general population in Nevada living below the poverty level.
- The 2003 data from Clark County Detention Center points out that approximately 20% of the inmate population have a serious mental illness (SMI). This number understates the extent of the problem, since it does not include inmates awaiting screening and those on suicide watch.
- The last estimate is somewhat higher than the national figure of 16.9% used by the United States Department of Justice. It is also known that a substantial percentage of inmates in the Nevada State Department of Corrections have SMI.
- Suicidal behavior is known to correlate with certain psychiatric disorders; over the last couple of decades, Nevada ranked at the top of the nation for per capita suicides, dropping to fourth place in 2003.
- Nevada also ranks higher than average in incidence of tobacco, alcohol, and marijuana use, behaviors that are known to bear relevance to correlate with mental illness rates.
- Occupational stressors, social isolation, single status, poverty, homelessness, migration, rapid social change, and other social factors correlate strongly with increase in mental illness rates.

As many of these factors seem to be prevalent in Southern Nevada, more systematic research research that is more systematic is needed to assess their separate and cumulative effects. We need

more precise and systematic data on the distribution of patients by mental illness categories, age, ethnicity, social class, gender, race, occupation, and other important social-demographic variables which are known to correlate with mental illness.

Prospects for the Future and Recommendations

The MHDS *2004 Needs Assessment* provides a progress report on unmet needs identified in the previous 2002 report for central office improvement. The 2002 report singled out seven areas of unmet needs. Substantial progress was made within the following six areas (Valentine, 2004):

- Agency accreditation
- State participation in the Western Interstate Commission for Higher Education (WICHE)
- Management information system conversion and upgrade
- Disaster preparedness
- Statewide Consumer Assistance Program (CAP)
- Workforce recruitment and retention especially in rural Nevada

The future efforts requiring long-term investment(s) include several key areas.

Adequate Hospital Capacity

The anticipated opening of a 190-bed state psychiatric hospital in Southern Nevada with full staffing is an essential first step to alleviating the immediate crisis in service delivery. Regrettably, an attempt to obtain funding for a projected \$18 million on-site medical screening capability at the state facility failed. Such an investment, which would largely be a one-time expense, would have increased the likelihood for expedited assessment and treatment of those in need of psychiatric services.

- In 1996, the National Center for Mental Health Services (CMHS) determined that the national average of state hospital psychiatric beds per 100,000 population was 33.
- In comparison, Clark County is seriously under-bedded with only 4.5 psychiatric beds per 100,000.

- To meet the national avg. ratio of 33 psychiatric beds per 100,000, the new hospital would need to provide 511 beds.

Continued Commitment to Best Medication

Medications used to treat emotional disorders are often referred to as psychotropic medications. In the 1990s, new psychotropic medications began to enter commercial markets. These new generation medications are generally easier to administer and have fewer side effects. Use of these modern medicines consistent with evidence-based practices have proven to be substantially more effective than treatments available prior to 1990. Continued commitment to best medication. The state's continued commitment to provide a new generation of psychotropic medications in recent years has benefited many patients. In addition, And the implementation of mental health courts in the two urban areas has shown promise in addressing problems with treatment compliance that could otherwise lead to involvement in the criminal justice system. The provision of state funds to permit expansion of the mental health court in Southern Nevada will make a significant impact on the additional 75 clients served and will also decrease jail and hospital emergency bed usage. (See Appendix for a chart summarizing the funding levels for MHDS medication budget).

Round-the-Clock Crisis Centers

Crisis centers are small programs involving personnel trained to deal with people in acute distress. Such centers specialize in round-the-clock services for patients brought in by family members, law enforcement, or themselves so they can be observed and sorted out and transported to the most appropriate treatment facility (a process referred to as "triage"). In spite of these promising developments, a minimally acceptable mental health system is yet to be achieved. There is a compelling need for adequate crisis units operating on a 24/7 basis, and where clients can walk in or be dropped off by family, friends or law enforcement officers to get prompt assessment and treatment. Long term secure funding for such facilities is essential.

Use of Evidence Based Practices ccc (EBP's)

EBP's include interventions and techniques whose effectiveness is substantiated by valid and reliable data. Consistent use of these clinical practices statewide will require additional staff training and data reporting. Currently, MHDS does not have adequate infrastructure or training capacity to undertake most of these EBPS. Nonetheless, to the extent that resources allow, Nevada uses the following EBP techniques:

- Assertive Community Treatment
- Supported Employment
- Supported Housing
- Family Psycho-education
- Integrated Treatment for Co-occurring Disorders
- Illness Management
- Medication Management

Accessible Community- Based Services

Community based services cover all the services not provided in hospitals but available in neighborhoods and the community at large. Such community services can include outpatient clinics, medication clinics, medical and dental care, social services, child and respite care, etc. Other programs, such as drop in centers and clubhouses, are also community programs where people can visit informally, without any appointments, and where they can safely interact with peers, neighbors, and mentors. Such services are crucial to compliment adequate inpatient programs so that people do not return to hospitals unnecessarily. More importantly, there is a need to continue to expand services so that the system can adequately shift from crisis-oriented , hospital-based investment of funds to the longer term community-based service approach that will assure mental health consumers adequate access to counseling and prescription services before a crisis arises. Securing funding for medication clinics with adequate staffing to encourage medication compliance is an important step that will improve quality of mental health services in Nevada.

Community-based services must have flexible hours to allow adequate access. It is important, also, to take into account transportation needs of clients unable to drive or traveling long

distances, especially in rural areas. Residential programs are a crucial part of the system of community - based services. In spite of additional funding in recent years, adequate residential supports are still lacking for people with SPMI.

Lowering Language and Other Cultural Barriers

As the Surgeon General suggests, culture matters tremendously in every aspect of mental illness. Since Latinos represent a growing segment of the Southern Nevada population, much more needs to be accomplished to ensure that they and members of other minority groups have access to programs, agencies, and personnel which are sensitive to cultural differences with regard to mental illness. Written information should be available in their languages, and the provision of mental health services to these communities will require both bilingual mental health professionals and the recruitment and training of members of these communities.

Attention to Senior Citizens' Needs

Since senior citizens have different mental health needs than younger ones, more precise information about rates and types of mental illness by age categories must be gathered to efficiently administer mental health services for this special population. Given the state of Nevada growing attractiveness to retirees, this concern will increase in importance with the passage of time.

In partnership with the Division of Aging, MHDS provides outreach for seniors with SMI in the southern region through SNAMHS and in the northern region through SNAMHS. The Senior Mental Health Outreach Program provides services to adults ages 60 and older who are experiencing symptoms of mental illness, with the primary goal to identify, evaluate, and provide effective mental health care through community outreach.

Direct care services, including evaluation, counseling, and service coordination (case management), are primarily offered to seniors in their own home. Clinicians are able to complete intakes for new clients in the field. This program helps secure access to mental health care by seniors lacking in transportation or encountering

physical and medical obstacles to receiving services at traditional mental health facilities. Often community professionals, neighbors, family members, and others involved with seniors will suspect a need for mental health care and will refer the person to the program, as seniors are sometimes reluctant to go to an office to see a mental health service provider.

Integrated Treatment for Co-occurring Disorders

Co-occurring disorders refer to the diagnosis of substance abuse for people who already have a mental illness. Substance abuse is predominant in mentally ill populations and sometimes is referred to as "self-medication." Although Nevada has begun to recognize the importance of treating co-occurring disorders (e.g., mental illness and substance abuse) in a seamless manner, there is much to be done to make adequate programs available across the state.

Beyond meeting fundamental treatment needs, we have to maintain a sustained attention much remains to be done to promote productivity and other quality of life factors that Nevada consumers deserve. Adequate housing and day centers for use by the seriously mentally ill are scarce. And despite the critical needs that are yet to be met, it is not too early to begin start asking when job training job-training services will be made fully available to the economically most vulnerable segments of our population. Until these basic resources are secured, a substantial portion of Nevada's consumers of mental health services will be held back prevented from achieving their potential as productive citizens.

Interest in integrated mental health programs with substance abuse system is further evidenced in the passage in 2004 of Assembly Bill 2 that transferred the Bureau of Alcohol and Drug Abuse (BADA) into MHDS effective July 2007. Planning is underway to merge these previously separate agencies to further realize integrated services for co-occurring disorders.

Mental Health Courts

In November 2001, under the leadership of Assemblywoman Sheila Leslie, Judge Peter Breen, and advocate Rosetta Johnson, a mental

health court was established in Washoe County, through which offenders with mental illness volunteering to appear before the Court take part in a mental health treatment program instead of receiving jail time for criminal offenses. Offenders diverted to the Court have long histories of criminal offenses and hospitalization with concomitant resistance to mental health treatment. The Court is serving to assist these individuals to get the treatment they need, thereby keeping them out of jails and hospitals. Participants in the program must check in with the Court regularly. Recent data shows the Court has significantly reduced repeat arrests and hospitalizations. In December 2003, a mental health court was established in the southern region of the state to make this program available to Nevada 's largest population center.

Disaster Response and Bioterrorism Preparedness Programs

The Division of Mental Health and Developmental Services (MHDS) currently has a statewide mental health disaster response plan in place. Beginning in 1998, MHDS developed a Disaster Preparedness Program and plan for its agencies. In case of a major disaster, MHDS has a number of responsibilities dealing with officially declared disasters. Those responsibilities are identified in the Nevada Emergency Management Statewide Plan, which is coordinated and implemented by the Nevada Division of Emergency Management (DEM).

Workforce Recruitment and Retention - Especially in Rural Nevada

Retaining effective mental health professionals, especially in the rural areas, continues to be a major concern which directly affects MHDS capacity to provide services. According to a recent report (*Behavioral Health Workforce-Fact Sheet, 2006*), Nevada's rural professional staff vacancy rate is 22%. 15 of Nevada's 17 counties are designated as mental health shortages area(s). Between 2002 and 2012, Nevada's general workforce will increase by 40.7%.

To address these concerns, MHDS is joining forces with the Western Interstate Collaborative for Higher Education to develop a model

which can be used in Nevada to assist in the recruitment and retention of mental health professionals in rural and remote areas.

Data Sources and Suggested Readings

MHDS website: <http://mhds.state.nv.us>

Suicide Prevention Resource Directory (2003),
MHDS, <http://mhds.state.nv.us/admin/suicideprevent.shtml>.

Mental Health Needs Assessment Report (2004),
MHDS, <http://mhds.state.nv.us/pdfs/NeedsAssessment2004.pdf>.

Mental Health Prevalence Report (2004),
MHDS, <http://mhds.state.nv.us/pdfs/Prevalencestudy.pdf>.

Budget Highlights Report (2005),
MHDS, <http://mhds.state.nv.us/pdfs/2005BudgetHighlights.pdf>.

How Nevada Stuck Up (2005),
MHDS, <http://mhds.state.nv.us/pdfs/HowNevadaStacksUp2005.pdf>.

Legislative Council Bureau Interim Study 05-8: Nevada Mental Health Plan Implementation Commission, <http://www.leg.state.nv.us/lcb/research/05InterimReports/Bulletin05-08.pdf>.

Mental Health Rural Clinics Organization Chart 2003,
MHDS, <http://mhds.state.nv.us/pdfs/ClinicOrgChart030205.pdf>.

MHDS Decision Matrix Project for Atypical Anti-psychotics,
MHDS, <http://mhds.state.nv.us/pdfs/MHDSDecisionMatrixProject.pdf>.

MHDS Formulary, MHDS, <http://mhds.state.nv.us/pdfs/MHDSFormulary.pdf>.

MHDS General Financial Overview for Fiscal Year 2003,
MHDS, <http://mhds.state.nv.us/pdfs/MHDSFormulary.pdf>.

Monthly Report for Fiscal Year 2006,
MHDS, <http://mhds.state.nv.us/pdfs/Monthly2006.pdf>.

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MHDS, <http://health2k.state.nv.us/nihds/publications/Mental%20Health%20Report%20%20revised.pdf>.

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Pharmacy Management Allocation Plan Fiscal Year 2004,
MHDS, <http://mhds.state.nv.us/pdfs/PharmacyMAP2004.pdf>.

Strategic Plan 2004 Through 2007,
MHDS, <http://mhds.state.nv.us/pdfs/StrategicPlan2004.pdf>.

Study of Suicide Prevention from the 72nd Session of the Nevada Legislature, <http://mhds.state.nv.us/pdfs/LCBSuicidePreventionStudy.pdf>.

Study of the Feasibility of Adopting a Program of Outpatient Civil Commitment for Persons Who Are Mentally Ill, <http://mhds.state.nv.us/pdfs/LCBSuicidePreventionStudy.pdf>.

Web Site Statistical Report,
MHDS, <http://mhds.state.nv.us/pdfs/WebSiteStatisticalReport.pdf>.

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Community Resources

Adult Services:

Mental Health & Developmental Services (MHDS), 505 East King Street, Room 602, Carson City, Nevada 89701-3790. Tel. 775-684-5943, Faxes 775-687-5966 & 775-687-5964.

Lakes Crossing Center For The Mentally Disordered Offender, 500 Galletti Way, Sparks, Nevada 89431-5573; Tel. 775-688-1900, Fax 775-688-1909.

Northern NV Mental Health Services (NNAMHS), 480 Galletti Way, Sparks, Nevada 89431-5573. Tel. 775-688-2001, Fax 775-688-2092.

Southern Nevada Adult Mental Health Services (SNAMHS), 6161 West Charleston Boulevard, Las Vegas, Nevada 89146-1126. Tel. 702-486-6000, Fax 702-486-6248.

SNAMHS - Henderson Office, 98 East Lake Mead Drive, Henderson, Nevada 89015. Tel. 702-486-6700, Fax 702-486-708.

SNAMHS - North Las Vegas Office, 2121 North Las Vegas Boulevard, North Las Vegas, Nevada 89030. Tel. 702-486-5750. Fax 702-486-5769.

SNAMHS - Southeast Office, 1820 East Sahara Avenue, Ste 109, Las Vegas, Nevada 89104-3736. Tel. 702-486-8289. Fax 702-486-8295.

Rural Clinics Community Mental Health Centers- Admin Ofc., 503 N. Division St., Carson City, NV 89703. Tel. 775-687-1000.

Rural Clinics:

Battle Mountain Mental Health Center, 101 Carson Road, Suite #1/P.O. Box 50, Battle Mountain, NV 89820-0050. Tel. 775-635-5753, Fax 775-635-8028.

Hawthorne Mental Health Center, 1000 "C" Street/P. O. Box 12, Hawthorne, NV 89415-0012. Tel. 775-945-3387, Fax 775-945-2307.

Carson Mental Health Center, 1330 South Curry Street, Carson City, NV 89703-5202. Tel. 775-687-4195 and 775-687-5103.

Lovelock Mental Health Center, 775 Cornell Ave. Suite #C, Lovelock, NV 89419-1046. Tel. 775-273-1036, Fax 775-0273-1109.

Dayton Mental Health Center, 120 Pike Street/P.O. Box 1597, Dayton, NV 89403-1597. Tel. 775-246-5240, Fax 775-246-5364.

Mesquite Mental Health Center, 61 N Willow Suite 4 /P.O. Box 3567, Mesquite, NV 89024 . Tel. 702-346-4696, Fax 702-346-4699.

Douglas Mental Health Center, 1538 HWY 395 N, Gardnerville, NV 89401-5239 (P.O.Box 1509, Minden, NV 89423-1509). Tel. 775-782-3671, Fax 775-782-6639.

Pahrump Mental Health Center, 1840 S. Pahrump Valley Blvd., Pahrump, NV 89048. Tel. 775-751-7406, Fax 775-751-7409.

Elko Mental Health Center, 1515 7th Street, Elko, NV 89801-2558. Tel. 775-738-8021, Fax 775-738-8842.

Silver Springs Mental Health Center, 3595 Highway 50 East, Springs, NV 89429-1136. Tel. 775-577-0319, 775-577-9571.

Ely Mental Health Center, 1665 Avenue F/P.O. Box 151107, Ely, NV 89315. Tel. 775-289-1671, Fax 775-289-1699.

Tonopah Mental Health Center, 825 S Main P.O. Box 494, Tonopah, NV 89049-0494. Tel. 775-482-6742, Fax 775-482-3718.

Fallon Mental Health Center, 151 North Main Street, Fallon, NV 89406-2909. Tel. 775-423-7141, Fax 775-423-4020.

Winnemucca Mental Health Center, 3140 Traders Way/P.O. Box 230, Winnemucca, NV 89446-0230. Tel. 775-623-6580, Fax 775-623-6584.

Fernley Mental Health Center, 115 West Main Street/P.O. Box 2314, Fernley, NV 89408-2314. Tel. 775-575-0670, Fax 775-575-0672.

Yerington Mental Health Center, 310 Surprise Avenue, Yerington, NV 89447-2542. Tel. 775-463-3191, Fax 775-463-4641.

Laughlin Mental Health Center, 3650 So. Pointe Circle, Suite 208, Laughlin, NV 89028. Tel. 702-298-5313.

Mojave Mental Health Services. Nonprofit outpatient services (formed in collaboration with the University of Nevada School of Medicine), www.mojave.org. 6375 W. Charleston Blvd., Las Vegas, NV 89146. Tel. 702-968-4000.

Montevista Hospital. Private psychiatric facility with residential and outpatient services. 5900 W. Rochelle Ave., Las Vegas, NV 89103. Tel. 702-364-1111.

NAMI of Nevada. Education and support group for consumers of mental health services and their families. 1170 Curti Dr, Reno, NV 89502; Tel. 775-329-3260; Southern Nevada, Tel. 702-363-9584.

The Salvation Army. Nonprofit offering behavioral and rehabilitation services. 35 W. Owens, Las Vegas, NV; Tel. 702-649-8240; 1932 Sutro St., Reno, NV 89512. Tel. 775-688-4555.

Veterans Affairs Administration. Facilities .

Hospital/Ambulatory Clinic. Statewide: Tel. (800) -827-1000; 1000 Locust St, Reno, NV 89502. Tel. 775 -786-7200; 4700 N. Las Vegas Blvd, Nellis AFB, Las Vegas, NV 89146. Tel. 702-653-2222; 6 Steptoe Circle, Ely, NV 89301. Tel. 775-289-3612.

WestCare. Nonprofit behavioral healthcare with residential and outpatient services, <http://www.westcare.com>; 5659 Duncan Drive, Las Vegas, NV 89108. Tel. 702-385-2020. WestCare Community Triage Center, Las Vegas. Tel. 702 -383-4044.

West Hills Hospital. Private psychiatric facility with residential and outpatient services. 940 E. Ninth St ., Reno, NV 89512. Tel. 775-323-0478.

Children Services:

Nevada Division of Child & Family Services . State children's mental health agency, <http://dcfs.state.nv.us>, 711 E. 5th St, Carson City, NV 89701. Tel. 775 -684-4400; Southern Nevada Child and Adolescent Services, 6171 W. Charleston Blvd, Bldg 8, Las Vegas, NV 89146. Tel. 702 -486-6120.

Northern Nevada Child and Adolescent Services, 2655 Enterprise Rd, Reno, NV 89512. Tel. 775-688-1600.

Desert Willow Treatment Center, 6171 W. Charleston Blvd, Bldg 17, Las Vegas, NV 89146. Tel. 702-486-8900.

Montevista Hospital. Private psychiatric facility with residential and outpatient services. 5900 W. Rochelle Ave., Las Vegas, NV 89103. Tel. 702 -364-1111.

Nevada PEP. Nonprofit educational and support center for children with disabilities, <http://www.nvpep.org>; statewide tel. 800-216-5188; 2355 Redrock St, Suite 106, Las Vegas, NV 89146. Tel. 702 -388-8899; 4600 Kietzke Lane, Suite O-269, Reno, NV 89502. Tel. 775-448-9950.

Spring Mountain Treatment Center. Behavioral health treatment for children and adolescents, www.springmountaintreatmentcenter.com, 7000 Spring Mountain Rd, Las Vegas, NV 89117. Tel. 702-873-2400, www.springmountaintreatmentcenter.com.

WestCare. Nonprofit behavioral healthcare with residential and outpatient services, 5659 Duncan Drive, Las Vegas, NV 89108. Tel. 702-385-2020, <http://www.westcare.com>.

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Special thanks are due Kevin Crowe, Ed.D, Chief of Planning and Evaluation, Nevada Division of Mental Health and Developmental Services, for his valuable suggestions and additions to this report.

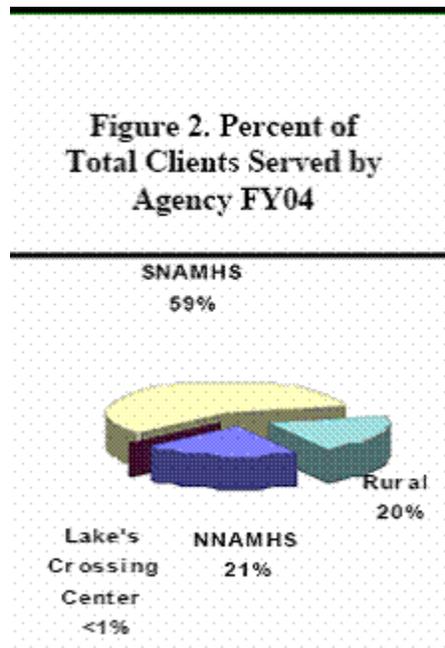
Supplementary Materials

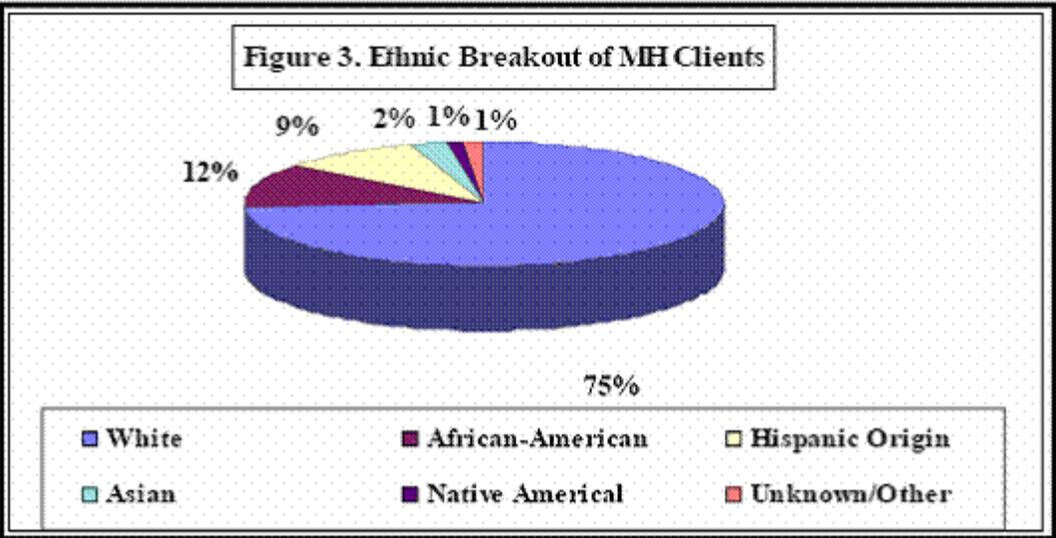
**2004 Biennial Report, State of Nevada,
Division of Mental Health and Development Services**

**Table 1. Unduplicated Clients Served:
Percent Growth**

	FY03	FY04	%change
Lakes*	449	683	+52%
NNAMHS	5192	5669	9%
SNAMHS	13374	15779	18%
Rural Clinics	4934	5465	11%
TOTAL	23949	27596	15%

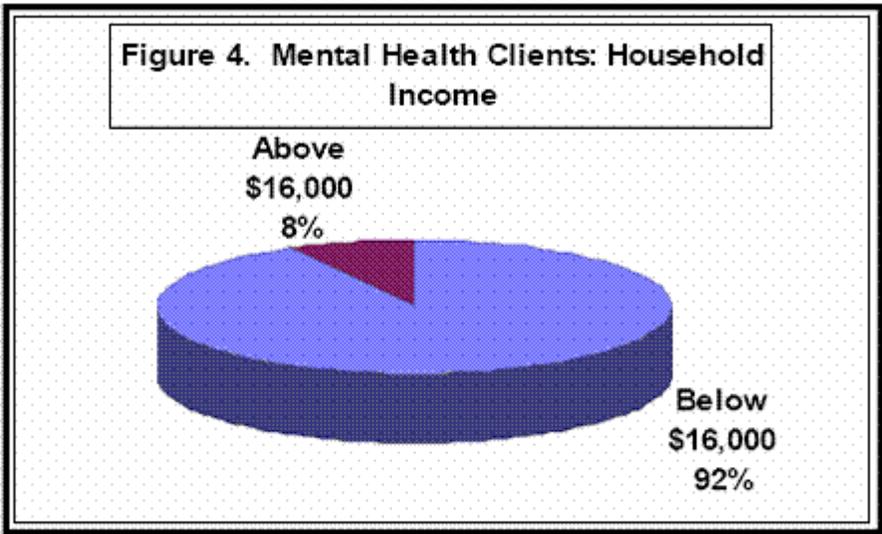
** Includes outpatient services which will be counted in future "persons served totals".*





Note, although included, Hispanics are an ethnicity, not a race. MHDS Rural data included in breakout comparison.

3. Division Demographics are based on FY2004 data analysis .



Note: This data excludes the unknown category

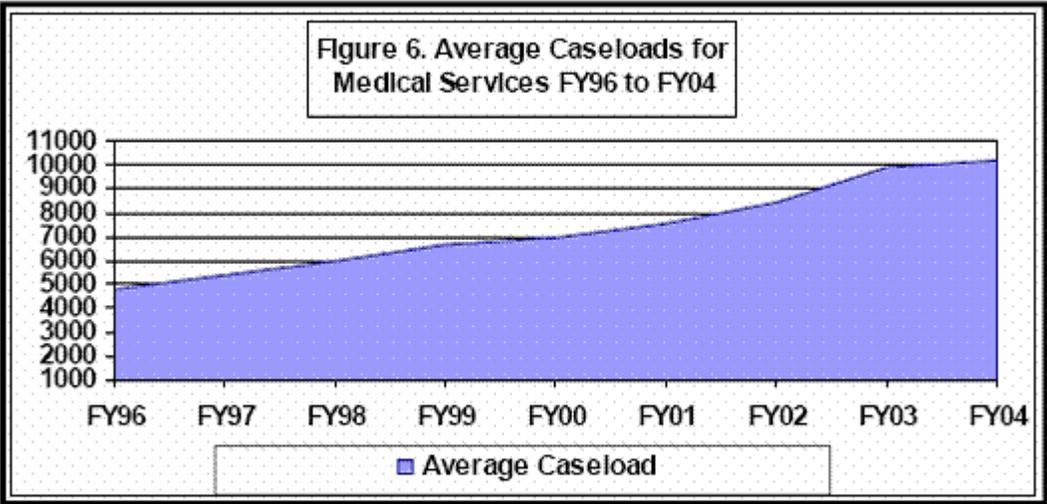
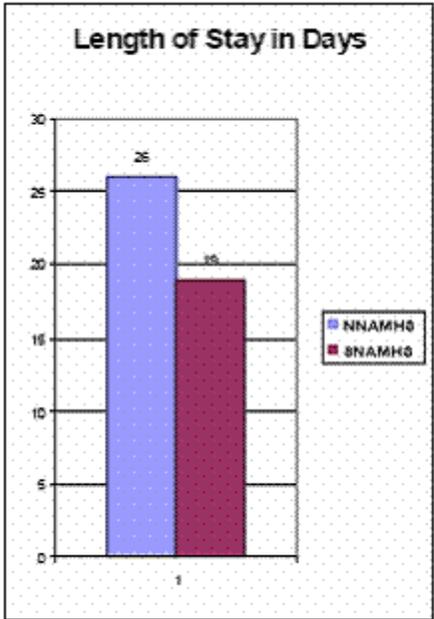


Figure 12. Average Caseload: Service Coordination FY96 through FY04

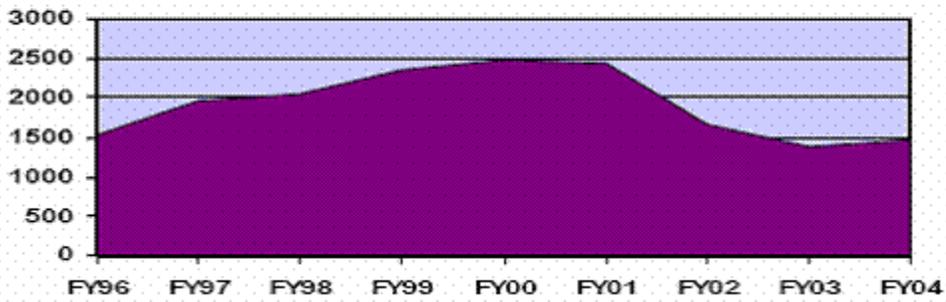


Figure 14. Outpatient Counseling: Average Caseloads by Agency

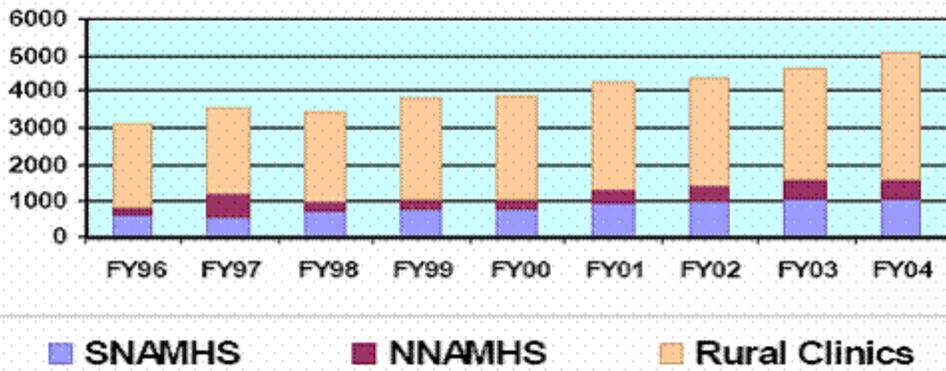


Figure 20. MHDS expenditures Mental Health Funding
Sources: Fiscal Year 2004

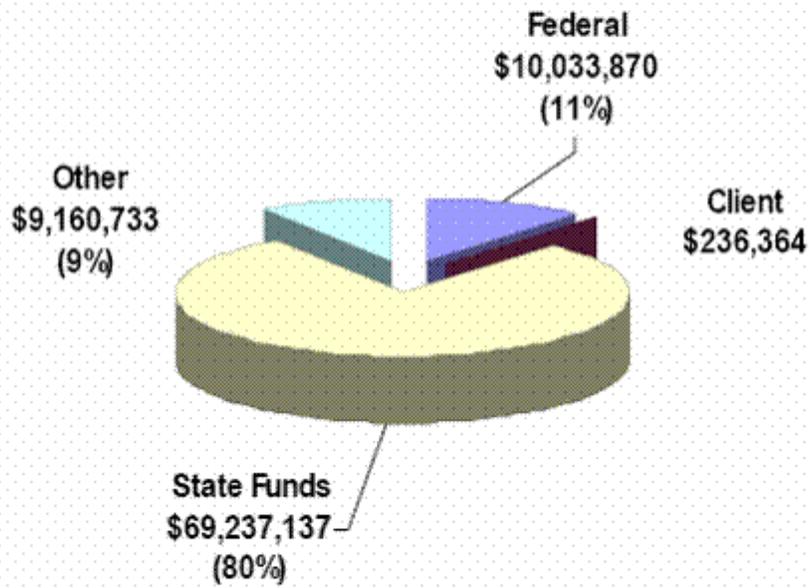


Figure 25 - Developmental Services and State Demographic Comparison by Ethnic Category

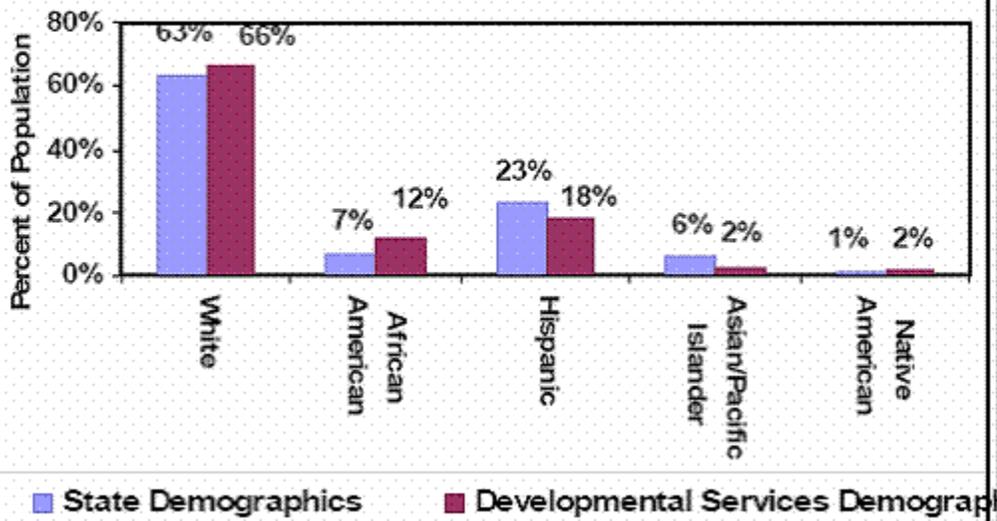
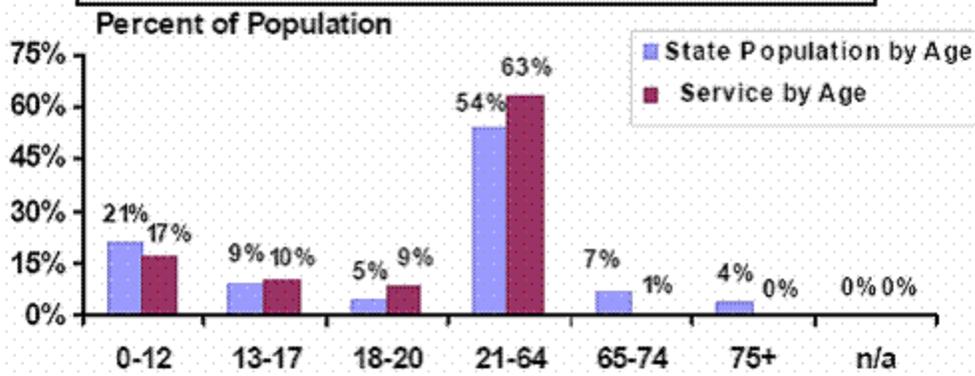
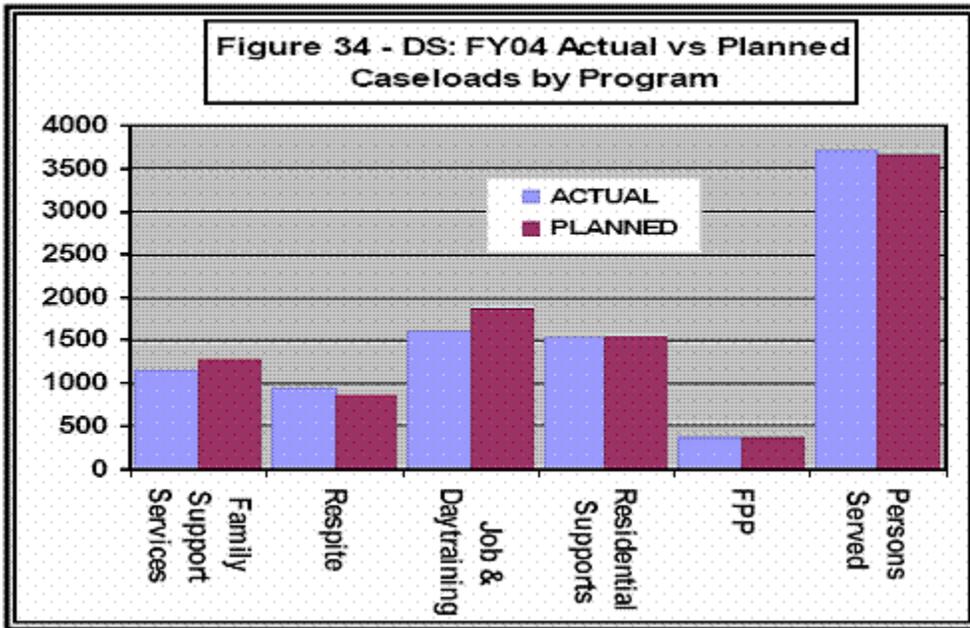
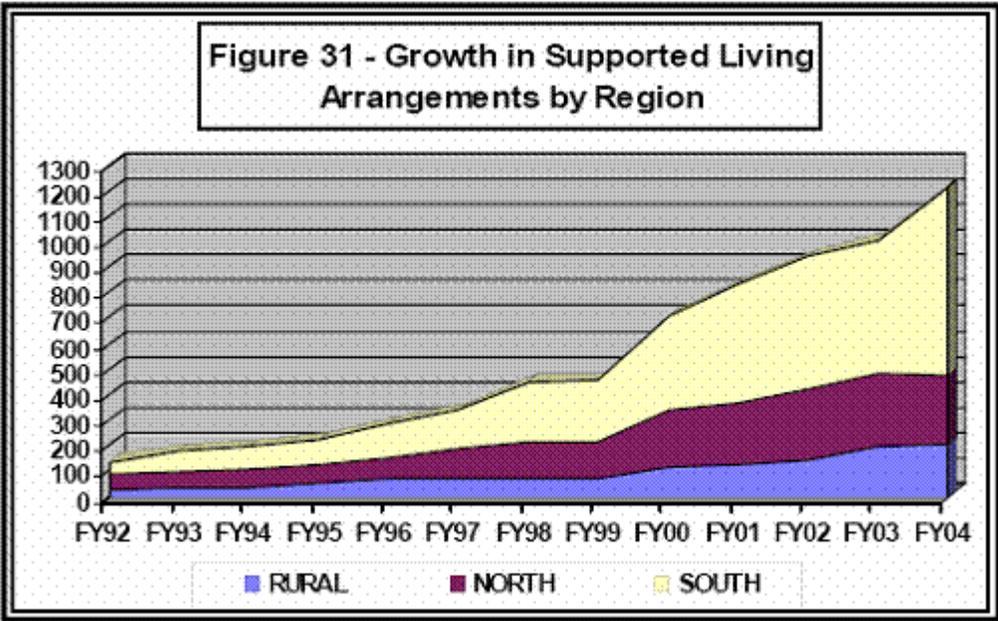


Figure 26- Service and State Demographic Comparison by Age Groupings





The above figures are produced by State of Nevada, Division of Mental Health and Development Services, Biennial Report. Compiled by Troy Williams. January 2005.

Chart 1

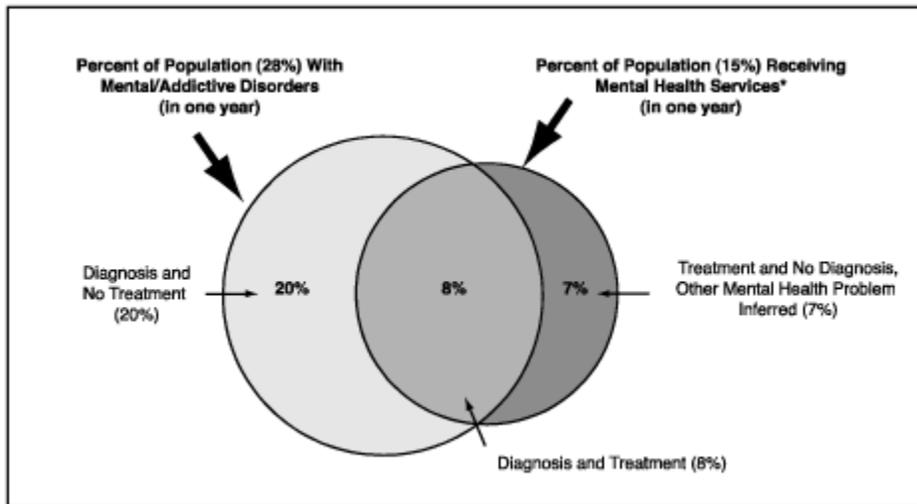
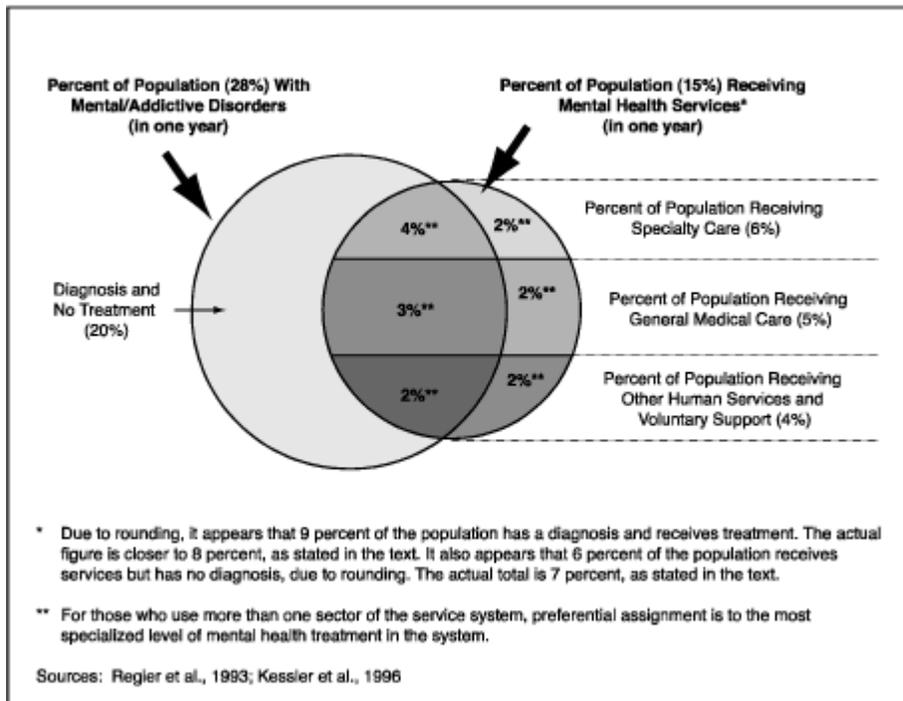


Chart 2



*U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health, 1999.

Agoraphobia	4.9	3.7	4.9
GAD	(1.5)*	3.4	3.4
Panic Disorder	1.6	2.2	1.6
OCD	2.4	(0.9)*	2.4
PTSD	(1.9)*	3.6	3.6
Any Mood Disorder	7.1	11.1	7.1
MD Episode	6.5	10.1	6.5
Unipolar MD	5.3	8.9	5.3
Dysthymia	1.6	2.5	1.6
Bipolar I	1.1	1.3	1.1
Bipolar II	0.6	0.2	0.6
Schizophrenia	1.3	—	1.3
Nonaffective Psychosis	—	0.2	0.2
Somatization	0.2	—	0.2
ASP	2.1	—	2.1
Anorexia Nervosa	0.1	—	0.1
Severe Cognitive Impairment	1.2	—	1.2
Any Disorder	19.5	23.4	21.0

*Numbers in parentheses indicate the prevalence of the disorder without any Comorbidity . These rates were calculated using the NCS data for GAD and PTSD, and the ECA data for OCD. The rates were not used in calculating the any anxiety disorder and any disorder totals for the ECA and NCS columns. The unduplicated GAD and PTSD rates were added to the best estimate total for any anxiety disorder (3.3%) and any disorder (1.5%).

**In developing best-estimate 1-year prevalence rates from the two studies, a conservative procedure was followed that had previously been used in an independent scientific analysis comparing these two data sets (Andrews, 1995). For any mood disorder and any anxiety disorder, the lower estimate of the two surveys was selected, which for these data was the ECA. The best estimate rates for the individual mood and anxiety disorders were then chosen from the ECA only, in order to maintain the relationships between the individual

disorders. For other disorders that were not covered in both surveys, the available estimate was used.

Key to abbreviations: ECA, Epidemiologic Catchment Area; NCS, National Comorbidity Study; GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; MD, major depression; ASP, antisocial personality disorder.

2. Budget Growth

<i>Budget Period</i>	<i>Budget Increase(over prior budget period)</i>	<i>Percent Increase(over prior budget period)</i>	<i>Staff Position Growth</i>
SFY 2002 – 2003	\$27,028,024	22.72%	4
SFY 2004 – 2005	\$45,249,175	30.99%	98
SFY 2006 – 2007	\$91,384,243	47.78%	449

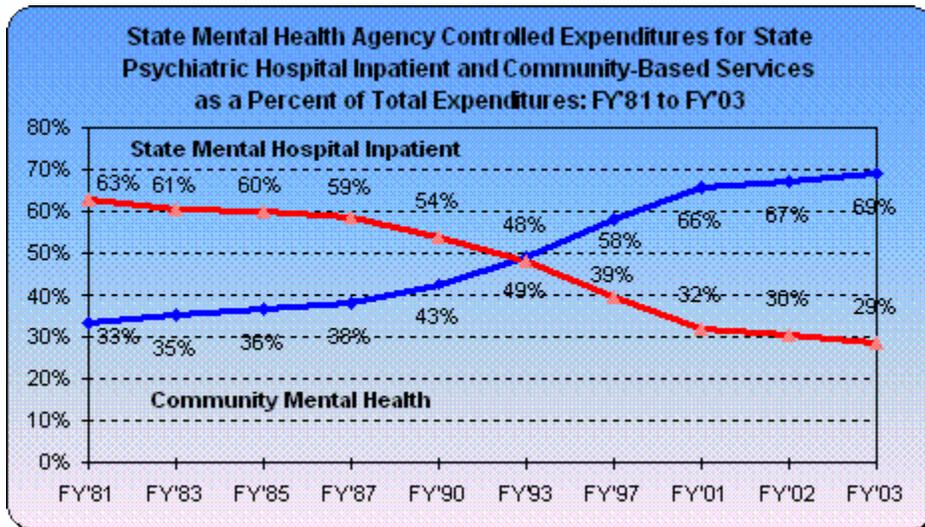
3. Funding sources

<i>Source</i>	<i>SFY 2005 Amount</i>	<i>Percentage</i>
State General Fund	78,366,602	78.46%
Federal Funding	11,337,362	11.35%
Fees, Charges	1,414,029	1.42%
Other	8,758,261	8.77%
TOTAL:	\$99,876,254	100.00%

4. Staffing

<i>Region</i>	<i>SFY 2005 Budget</i>	<i>Positions</i> (Rounded to the nearest whole number)
North (BA 3162)	25,203,646	233
South (BA 3161)	57,784,147	380
Rural (BA 3648)	11,212,454	134
Forensic (BA 3645)	5,676,007	76
TOTAL:	\$99,876,254	823

5. Institutional vs. Community Based Services, United States Las Vegas Metropolitan Police Department



6. Prevalence of SMI and SPMI in Nevada

County	July 1, '03 Population	2003 SMI/SED		Number Population Served **	Unmet Need **	Penetration Rate
		Prevalence*	Percent of Population			
Nevada Statewide	2,296,566	92,563	4.03%	23,759	31,969	42.6%
Carson						
City/County	55,220	2,287	4.14%	729	1,558	31.9%
Churchill	25,808	1,058	4.10%	297	761	28.1%
Clark	1,620,748	35,042	2.16%	14,497	20,545	41.4%
Douglas	45,603	1,678	3.68%	560	1,118	33.4%
Elko	45,805	2,055	4.49%	166	1,889	8.1%
Esmeralda	1,116	44	3.91%	0	44	0.0%
Eureka	1,420	61	4.30%	0	61	0.0%
Humboldt	16,457	722	4.39%	297	425	41.1%
Lander	5,277	240	4.56%	133	107	55.3%
Lincoln	3,749	175	4.66%	27	148	15.5%
Lyon	41,244	1,755	4.25%	1,005	750	57.3%
Mineral	4,687	192	4.10%	108	84	56.2%
Nye	36,651	1,452	3.96%	184	1,268	12.7%

Pershing	6,967	350	5.02%	69	281	19.7%
Storey	3,736	137	3.68%	0	137	0.0%
Washoe	373,233	8,087	2.17%	5,616	2,471	69.4%
White Pine	8,842	392	4.43%	71	321	18.1%

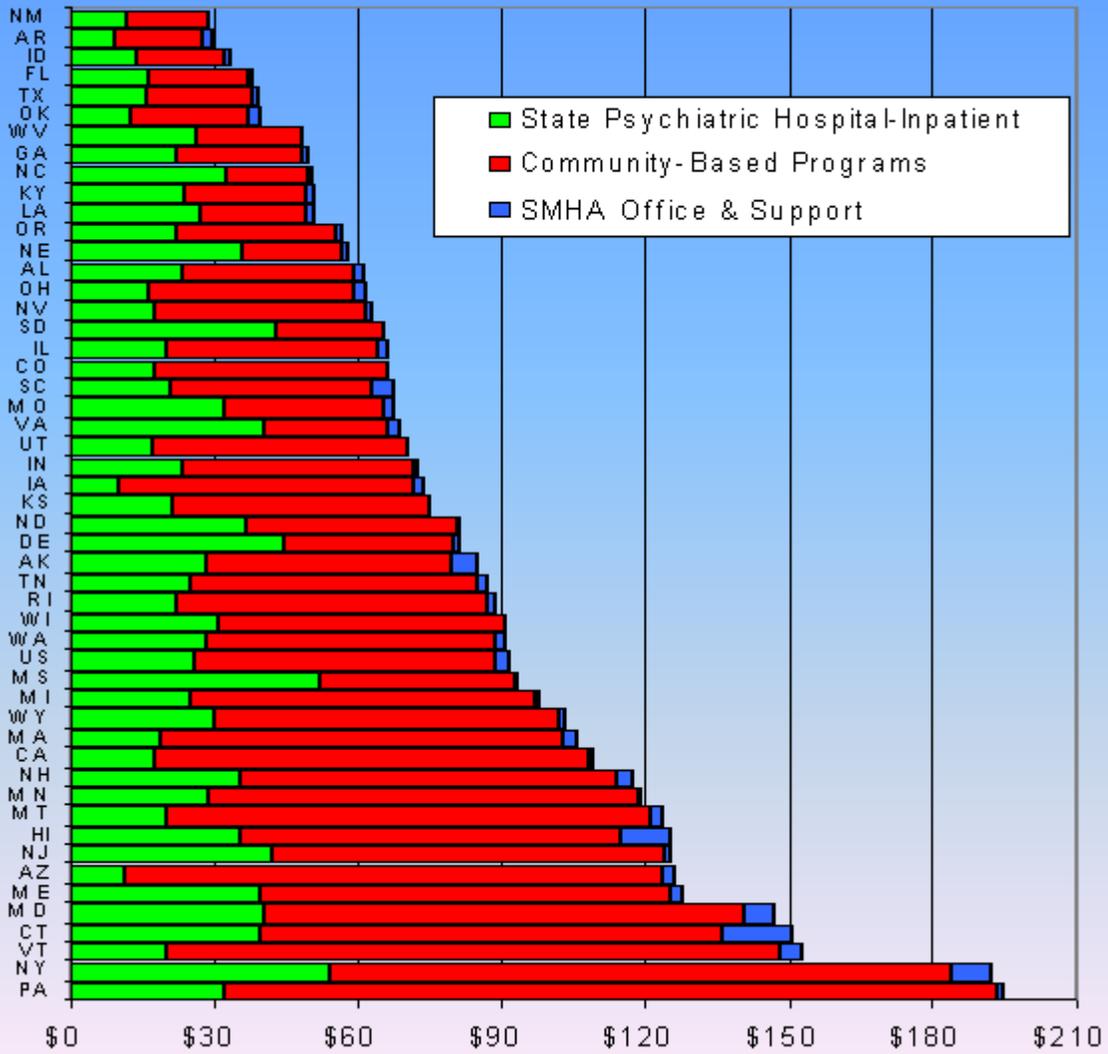
7. Financial comparative statistics

	SFY 2003Actual	SFY 2004Actual	SFY 2005 Actual
7.1: Funding committed to community-based services	40.58%	45.18%	42.34%
<i>Numerator:</i>	\$30,407,436	\$39,640,656	\$42,289,209
<i>Denominator:</i>	\$74,939,453	\$87,739,916	\$99,876,254
 7.2: Mental health expenditures per person served			
	\$3,408	\$3,423	\$4,084
<i>Numerator:</i>	\$74,939,453	\$87,739,916	\$99,876,254
<i>Denominator:</i>	21,991	25,631	24,456
 7.3: Mental health expenditures per capita			
	\$32.72	\$37.08	\$40.91
<i>Numerator:</i>	\$74,939,453	\$87,739,916	\$99,876,254
<i>Denominator:</i>	2,290,436	2,366,314	2,441,079

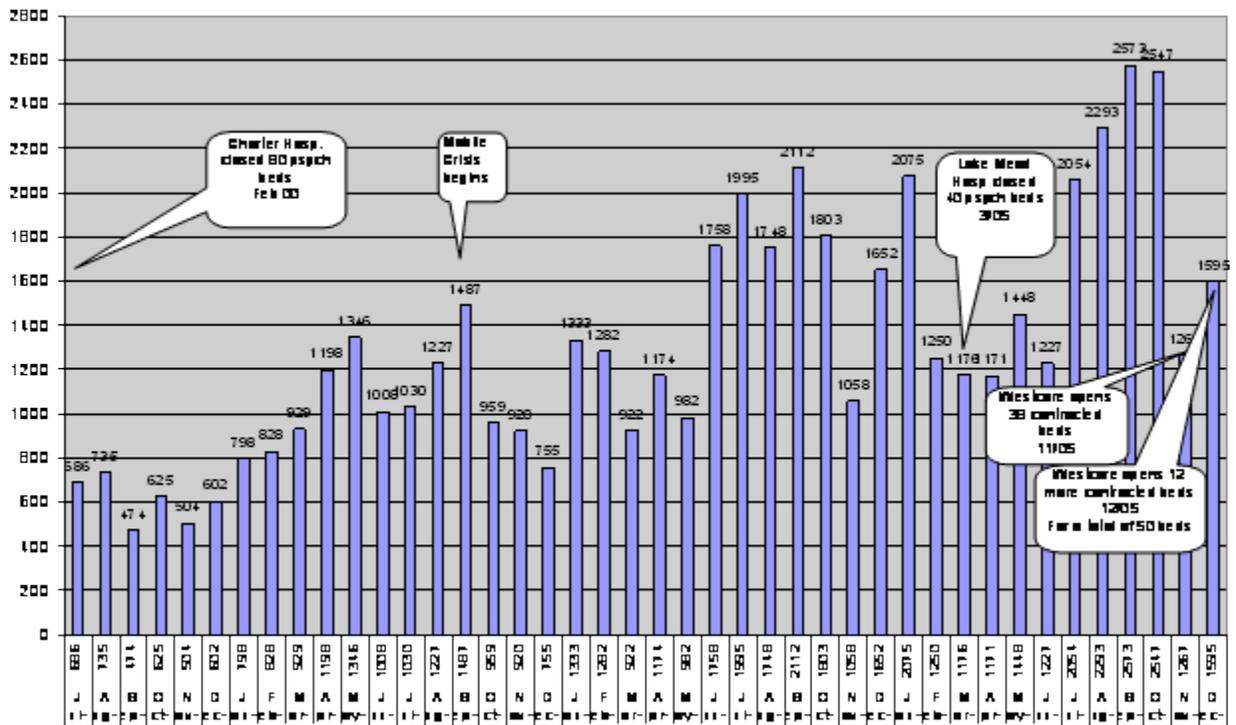
DATA NOTES: Funding committed to community-based services shows a decrease in SFY 2005 because of funds allocated to retrofit Building 1300 and recruit additional staff at SNAMHS to provide 38 emergency inpatient beds to help alleviate the emergency room wait time crisis discussed in prior and current grant applications under criterion one. However, actual funding committed to community-based services has increased based on the numerator.

8. National Rankings (Per capita expenditures for MH)

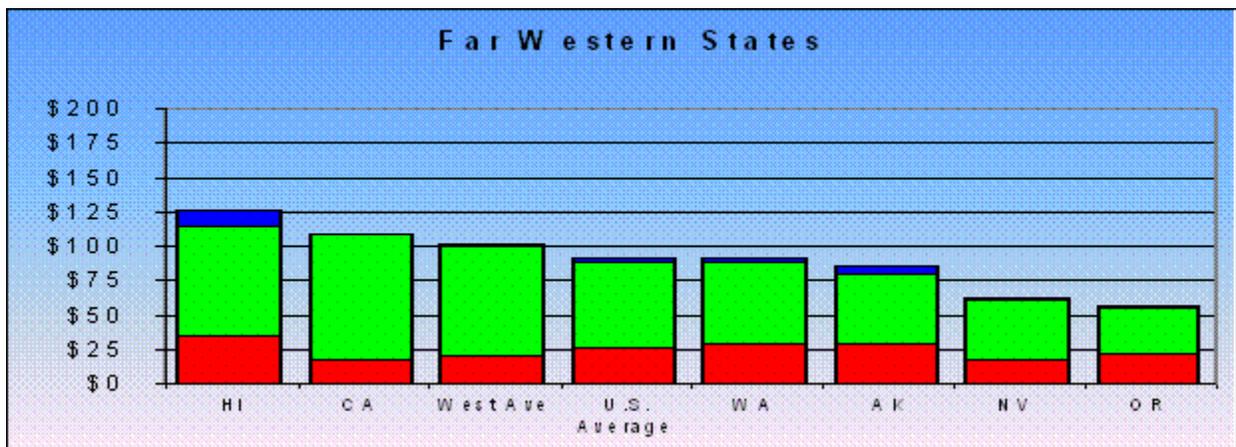
Fiscal Year 2003 SMHA-Controlled Per Capita Expenditures For Mental Health Services



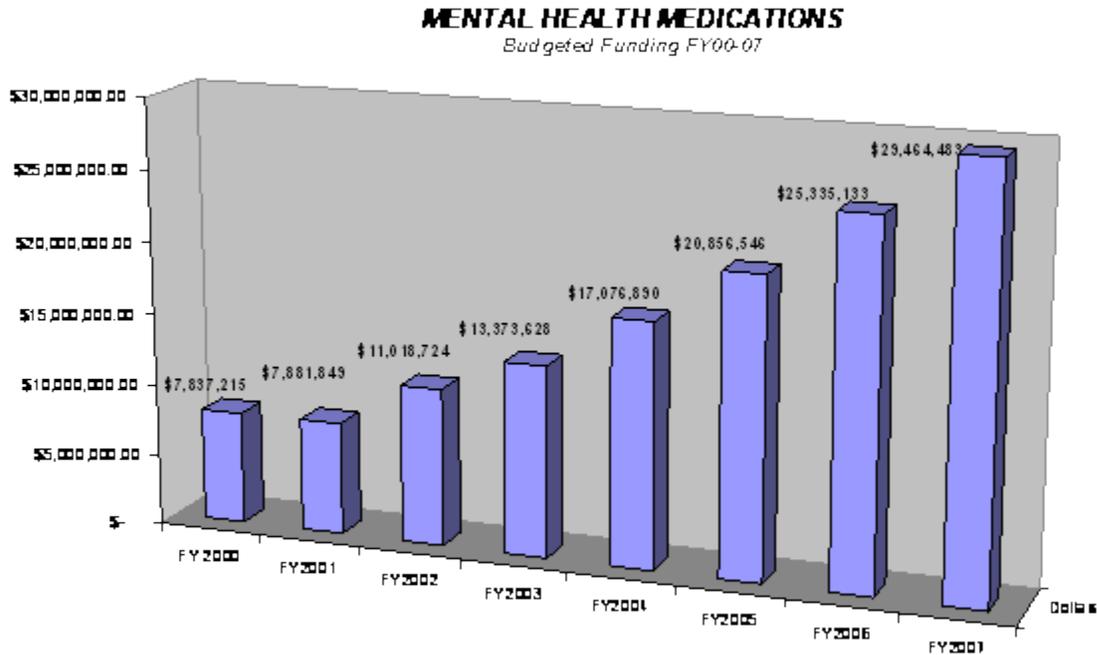
Monthly Total of People Waiting in Clark Co. ER's for Services from SNAMHS
July 2002-December 2005



9. Regional Comparisons of Per Capita Expenditures for MH



10. NV Expenditures for MH Medications



*This report stems from the Justice & Democracy forum on the Leading Social Indicators in Nevada that took place on November 5, 2004, at the William S. Boyd School of Law. The report, the first of its kind for the Silver State, has been a collaborative effort of the University of Nevada faculty, Clark County professionals, and state of Nevada officials. The Social Health of Nevada report was made possible in part by a Planning Initiative Award that the Center for Democratic Culture received from the UNLV President's office for its project "Civic Culture Initiative for the City of Las Vegas." Individual chapters are brought on line as they become available. For further inquiries, please contact authors responsible for individual reports or email CDC Director, Dr. Dmitri Shalin shalin@unlv.nevada.edu.