Nevada Mental Health Plan Implementation Commission

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THE NEVADA MENTAL HEALTH PLAN IMPLEMENTATION COMMISSION

Senate Bill 301 (Chapter 445, *Statutes of Nevada 2003*)

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SUMMARY OF RECOMMENDATIONS

THE NEVADA MENTAL HEALTH PLAN IMPLEMENTATION COMMISSION

Senate Bill 301
(Chapter 445, *Statutes of Nevada 2003*)

This summary presents the recommendations approved by the Nevada Mental Health Plan Implementation Commission and its Subcommittee to Continue the Work of the Commission, established by the Commission at its work session on January 26, 2004. All bill draft requests were adopted by the full Commission. All other recommendations for actions were adopted by the full Commission, unless noted as an action by the Subcommittee.

RECOMMENDATIONS FOR LEGISLATION

The members of the Nevada Mental Health Plan Implementation Commission adopted the following recommendations for legislative measures:

Goal 2: Mental health care is consumer- and family-driven.

1. Request the drafting of legislation to establish a subcommittee of the Interim Finance Committee (IFC) to address housing in Nevada that is funded in whole or in part by public funds, including, but not limited to, housing for those persons who are mentally ill, elderly, disabled, low-income, or who otherwise need housing assistance, with special focus on persons reentering the community, including those from correctional institutions. Further, the creation of such a housing subcommittee of IFC would (1) establish a coordinated approach to all housing dollars entering Nevada; and (2) ensure there is a connection between housing and services. **(BDR 17-277)**

2. Request the drafting of legislation that would require consumers to be active participants in the development of their mental health treatment and care plans. **(BDR 39-280)**

Goal 3: Disparities in mental health services are eliminated.

3. Request the drafting of legislation requiring a consumer, past or present, of mental health services in the state system be included as a member of Nevada's Commission on Mental Health and Developmental Services. **(BDR 17-279)**

RECOMMENDATIONS FOR COMMISSION ACTION

The following recommendations for action were adopted by the full Commission, except where action by the members of the Subcommittee is noted.

Goal 1: Americans understand that mental health is essential to overall health.

1. Establish a subcommittee of the Nevada Mental Health Plan Implementation Commission to meet with designees appointed by the Governor, including representatives from the broadcast industry, radio, television, and newspaper publications to develop a plan for public service announcements in English and Spanish. Direct school districts to report on implementation of programs that focus on de-stigmatizing mentally ill persons. (Action by the Subcommittee)

2. Urge, in its report, the Governor to include in the Executive Budget funding for comprehensive, statewide suicide prevention and intervention programs that include survivors of suicide. Support and maintain a statewide suicide prevention plan that will include evaluation, prevention, and post-intervention services; education and training for gatekeepers, professionals, the media, and the public; youth suicide prevention in schools; and careful attention to the relationship between suicide and co-occurring disorders. (Action by the Subcommittee)

Goal 2: Mental health care is consumer- and family-driven.

3. Recommend, in its report, that the Governor provide for the development of a Comprehensive State Mental Health Plan. The plan will be designed to overcome the problems of fragmentation in the mental health delivery system and will provide important opportunities to leverage resources across multiple agencies that administer both state and federal funds. The Commission envisions a single entity coordinating the plan. The planning process should support a dialogue among all stakeholders and reach beyond the traditional state mental health agency to address the full range of treatment and support service programs that consumers and families need. The final result should be an extensive and coordinated state system of services that work to foster consumer independence and support consumers' ability to live, work, learn, and participate fully in their communities and provide for specific items such as standardized formularies to address co-occurring disorders.

4. Express, in its report, support for the concept of the Behavioral Health Plan System Redesign of the Division of Health Care Financing and Policy (DHCFP), Department of Human Resources (DHR), and urge the Executive Branch and DHR to go forward with the funding and implementation of the proposed redesign plan. The Behavioral Health Plan recommendations include, but are not limited to, standardizing the infrastructure of the system, developing specialty clinics, eliminating state-devised reimbursable codes for Nevada Medicaid, delivering targeted case management services

through state agencies, and defining mechanisms for utilization management. The recommendation includes incremental costs that may come through DHCFP and the Division of Mental Health and Developmental Services (DMHDS). (Action by the Subcommittee)

5. Recommend, in its report, that Nevada should take steps to promote, encourage, and facilitate greater access to safe and affordable community-based housing and support services by using an array of resources within the United States Departments of Housing and Urban Development (HUD), and Health and Human Services (HHS), and the Veterans Administration (VA) as leverage. To accomplish this, the Commission approved the following actions:

   - Send a letter to Nevada's Congressional delegation urging the members to support restoration of Residential Substance Abuse Treatment funds in the federal budget.

   - Include this recommendation in the Commission's report along with a statement regarding the need for housing funds specifically for mentally ill persons.

   - Request the DMHDS, DHR to update the inventory of available housing that was completed two years ago.

6. Urge, in its report, the Executive Branch to research and provide to the Interim Finance Committee recommendations for a person or firm to provide contract services for the purpose of securing grants that lead to funding mental health, housing, and other health-related services. (Action by the Subcommittee)

Goal 3: Disparities in mental health services are eliminated.

7. Urge, in its report, DMHDS to develop a rural recruitment and retention program that acknowledges difficulties in hiring and retaining qualified professionals in rural Nevada. Include rural recruitment and retention in the state's cultural competency plan.

8. Urge, in its report, all state agencies and local governments to develop a cultural competency plan for the state and urge DHR to provide effective assistance for minorities, particularly those who face cultural barriers and lack English proficiency, to receive in-patient and out-patient mental health services.

Goal 4: Early mental health screening, assessment, and referral to services are common practices.

9. Express, in its report, support for the concept of increasing medical staff at the state's mental hospital to accommodate mentally ill patients with physical health issues, and

allow DMHDS the flexibility to address the fiscal concerns in the agency's budget through contract services. (Action by the Subcommittee)

10. Express, in its report, support for the crisis triage center concept throughout the state, including the development and implementation of formalized training for staff that interacts with offenders with mental health disorders, including correctional officers and staff of the Division of Parole and Probation, Nevada's Department of Public Safety.

11. Express, in its report, support for funding of psychiatry fellows from the University of Nevada School of Medicine (UNSOM) and Adolescent Psychiatry Fellowship Training Program for the purpose of reducing the shortage of child and adolescent psychiatrists. (Action by the Subcommittee)

12. Express, in its report, support for the concept of maintenance of UNSOM's psychiatry residency training program in northern Nevada and support for the establishment of a new psychiatry residency training program in southern Nevada. (Action by the Subcommittee)

13. Express, in its report, support for the establishment of residency training, fellows, and paid internships that include alcohol and drug training to increase qualified mental health staff. To accomplish this, the Commission approved the following recommendations:

- Broaden the pool of qualified geriatric clinicians through the licensing of professional counselors in Nevada;

- Expand the scope of practice for licensed alcohol and drug counselors to assess for and oversee the treatment of Axis 2 mental health disorders;

- Require certification of professional staff working with older adults, such as completion of a Providers Certificate of Specialization in Aging offered by the Geriatric Education Center at UNSOM; and

- Enhance the state's ability to provide integrated substance abuse and mental health services to persons with co-occurring disorders.

14. Express, in its report, support for the enhancement of senior mental health services.

Goal 5: Excellent mental health care is delivered and research is accelerated.

15. Urge, in its report, the University and Community College System of Nevada (UCCSN) to assist governmental agencies with behavioral health data collection issues.

16. Urge, in its report, DMHDS to establish mechanisms to monitor the effectiveness of mental health services efforts.

17. Urge, in its report, DHR to establish funding mechanisms or incentives to implement an evidence-based practices agenda.

18. Urge, in its report, DHR to seek funding to purchase materials and train clinicians in evidence-based psychological practices.

Goal 6: Technology is used to access mental health care and information.

19. Urge, in its report, DMHDS to implement electronic medical records for all DMHDS clients and urge DMHDS and the Division of Child and Family Services (DCFS) to establish a computerized medical information system to increase coordination, communication, and continuity between and within state and private agencies.

20. Urge, in its report, DMHDS to develop telemental health capacity for rural Nevada for all disciplines, including psychiatry, psychology, social work, juvenile justice, marriage and family therapy, dually licensed (substance abuse and mental health) providers, service coordination, and nursing. Additionally, include in the final report a statement regarding the need to establish telehealth guidelines to protect the public health.

21. Urge, in its report, DCFS to establish telehealth-based psychiatric services at each of the three state-operated youth (correctional) training facilities: the Northern Nevada Youth Training Center in Elko, the Caliente Youth Center in Caliente, and the Summit View Youth Correctional Center in Las Vegas.

REPORT TO THE 73RD SESSION OF THE NEVADA LEGISLATURE BY THE NEVADA MENTAL HEALTH PLAN IMPLEMENTATION COMMISSION

I. INTRODUCTION

Senate Bill 301 (Chapter 445, *Statutes of Nevada 2003*), established the Nevada Mental Health Plan Implementation Commission (NMHPIC), charging it to determine a plan for Nevada's implementation of the recommendations of President George W. Bush's New Freedom Commission on Mental Health. The Nevada Commission must report an action plan to the Interim Finance Committee (IFC), the Legislative Committee on Health Care, and the Governor by January 1, 2005. (See Appendix A for S.B. 301 and Appendix B for the Executive Summary of the final report of the New Freedom Commission on Mental Health.)

As provided in S.B. 301, members include legislators and specific executive agency administrators and bureau chiefs. The Senate Majority Leader and the Speaker of the Assembly each appointed three members of their respective chambers. Directors or chiefs of divisions or bureaus within Nevada's Department of Human Resources (DHR) were named to the Commission *ex officio*, including the Administrator of the Division of Mental Health and Developmental Services (DMHDS), the Chief of the Bureau of Alcohol and Drug Abuse (BADA), the Administrator of the Division of Health Care Financing and Policy (DHCFP), and the Administrator of the Division of Child and Family Services (DCFS).

The following legislators served on the Nevada Mental Health Plan Implementation Commission in 2003-2004:

Senator Randolph J. Townsend, Chairman
Assemblywoman Sheila Leslie, Vice Chairman
Senator Bob Coffin
Senator Raymond D. Rawson
Assemblyman Joseph P. Hardy
Assemblyman William C. Horne

The following state administrators served on the Commission:

Jone Bosworth, Administrator, DCFS
Carlos Brandenburg, Ph.D., Administrator, DMHDS
Maria Canfield, Chief, BADA
Charles Duarte, Administrator, DHCFP

Legislative Counsel Bureau (LCB) staff services were provided by Courtney Wise, Senior Research Analyst, Carol M. Stonefield, Senior Research Analyst, Susan Furlong Reil, Principal Research Secretary, and Ricka Benum, Senior Research Secretary, of the Research Division; Leslie K. Hamner, Principal Deputy Legislative Counsel, and

Mary Alice McGreevy, Senior Deputy Legislative Counsel, of the Legal Division; and Michael J. Chapman, Program Analyst, of the Fiscal Analysis Division.

To accomplish its task, the Commission held seven meetings during the 2003-2004 Legislative Interim: five meetings at the Legislative Building in Carson City, and two meetings at the Grant Sawyer State Office Building in Las Vegas. Videoconferencing was available at the secondary site.

During its study, the Commission received expert testimony from national experts, many of whom had served on the New Freedom Commission on Mental Health, as well as from local representatives. The meetings of the Commission were organized around the six goals contained in the final report of the New Freedom Commission on Mental Health, titled *Achieving the Promise: Transforming Mental Health Care in America*.

Following the final substantive meeting on New Freedom goals, all participating constituencies were invited to recommend actions. Experts' suggestions were extracted from the minutes. The Commission publicized the list of recommendations; interested persons were invited to identify priorities under each goal. At its work session in January 2004 in Las Vegas, the Commission considered the three top recommendations in each goal.

The full Commission adopted several recommendations, deferring others projected to have a fiscal impact. (See Appendix C for the Commission's suggested legislation.) To avoid a conflict for members who were division and bureau administrators, a subcommittee consisting of the legislative members was formed to deliberate those recommendations with a fiscal impact. The NMHPIC Subcommittee to Continue the Work of the Commission acted on the deferred recommendations at its only meeting, held in Carson City in June 2004. (See Section III of this report for the Commission's recommendations for action.)

This report presents a review of national and Nevada mental health delivery systems. It also contains a summary of the Commission's efforts to fulfill its legislative responsibilities. All supporting documents and minutes of the meetings are available on the Commission's Web site at http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth. They are also on file with the Research Library of the LCB.

II. MENTAL HEALTH IN THE UNITED STATES AND IN NEVADA

A. The President's New Freedom Commission on Mental Health

President George W. Bush established the President's New Freedom Commission on Mental Health in April 2002. Directed to identify ways in which federal, state, and local governments could maximize existing resources for mental health programs, the Commission was charged to improve the overall coordination and delivery of services. Twenty-two Commissioners were appointed to analyze public and private mental health systems, conduct site visits, and review existing programs. Stakeholders from across the country were invited to participate.

After a year of study, the Commission released its final report in July 2003, concluding that the promise of a life in the community for everyone is possible. To make this promise real, the New Freedom Commission recommended addressing the current fragmented mental health system.

The Commission's recommendations are organized around the following six goals contained in its final report, titled *Achieving the Promise: Transforming Mental Health Care in America:*

- Goal 1: Americans understand that mental health is essential to overall health.
- Goal 2: Mental health care is consumer- and family-driven.
- Goal 3: Disparities in mental health services are eliminated.
- Goal 4: Early mental health screening, assessment, and referral to services are common practices.
- Goal 5: Excellent mental health care is delivered and research is accelerated.
- Goal 6: Technology is used to access mental health care and information.

The New Freedom Commission found that mental illnesses rank first among disabling illnesses in the United States, Canada, and Western Europe. In 1997, the last year for which comparable data are available, the United States spent $71 billion on treating mental illnesses. Further, in the United States the annual economic, indirect cost of mental illnesses is estimated to be $79 billion, including resulting loss of productivity due to illnesses, premature deaths, incarceration, and care-giving.

The New Freedom Commission reported that the country's mental health delivery system is not geared toward recovery. The fragmented delivery system creates gaps in care. High unemployment and disability for people with serious mental illnesses, lack of care for older

adults with mental illnesses, and lack of national priority for mental health and suicide prevention also create recovery barriers.[1]

The New Freedom Commission found that many people with mental illness go untreated; stigma impedes people from getting care; suicide presents serious challenges; better coordination is needed between mental health care and primary health care; mental health financing poses challenges; services and funding are fragmented across several programs; and financing sources can be restrictive. To better understand the importance of mental health to overall health, the New Freedom Commission recommended:

1. Implementing a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention; and

2. Addressing mental health with the same urgency as physical health.[2]

The New Freedom Commission said the complex mental health system overwhelms many consumers. Many existing social welfare programs were never intended to serve the seriously mentally ill. Individuals and families have little influence over their care program. Consumers of mental health services need employment opportunities, income supports, and affordable housing. Corrections inmates find limited mental health services. To achieve its second goal that mental health care should be consumer- and family-driven, the Commission recommends:

3. Developing an individualized plan of care for every adult with a serious mental illness and in cooperation with the family an individualized plan for every child with serious emotional disturbance;

4. Involving consumers and families fully in orienting the mental health system toward recovery;

5. Aligning relevant federal programs to improve access and accountability for mental health services;

6. Creating a comprehensive state mental health plan; and

7. Protecting and enhancing the rights of people with mental illnesses.[3]

The New Freedom Commission reported minority populations are currently under-served. Racial and ethnic minorities are under-represented in the mental health professions. Residents of rural areas enter care later, with more serious and disabling symptoms, and require more

[1] The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, page 3.
[2] Ibid., pages 19 to 26.
[3] Ibid., pages 27 to 45.

expensive and intensive treatments. To achieve its third goal, eliminating disparities in mental health services, the New Freedom Commission recommends:

8. Improving access to quality care that is culturally competent; and

9. Improving access to quality care in rural and geographically remote areas.[4]

The New Freedom Commission's fourth goal is to ensure that early mental health screening, assessment, and referral are common practices. The Commission concluded childhood disorders, left untreated, can lead to even more serious adolescent and adult mental illnesses. People with co-occurring mental and substance abuse disorders are not adequately served. Further, primary care providers often fail to diagnose or treat their patients' mental disorders. To address these findings, the Commission recommends:

10. Promoting the mental health of young children;

11. Improving and expanding school mental health programs;

12. Screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies; and

13. Screening for mental disorders in primary health care, across the life span, and connecting to treatment and supports.[5]

Expert witnesses testified that long delays exist between advances in treatment research and effective consumer treatment strategies, due in part to unsupportive reimbursement polices. Other delays are caused by the shortage of mental health workers and the lack of provider training in evidence-based practices. The Commission recommends:

14. Accelerating research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses;

15. Advancing evidence-based practices using dissemination and demonstration projects and creating a public-private partnership to guide their implementation;

16. Improving and expanding the workforce providing evidence-based mental health services and supports; and

17. Developing the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.[6]

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[4] Ibid., pages 49 to 54.
[5] Ibid., pages 57 to 65.
[6] Ibid., pages 67 to 76.

Finally, the New Freedom Commission recognized the importance of information technology to health care. A national health information infrastructure, encouraging investment in information technology, is timely. Technology may support access to care in rural areas, enhance health records transfer, and provide consumers with reliable health care information. To accomplish its last goal, the Commission recommends:

18. Using health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations; and

19. Developing and implementing integrated electronic health record and personal health information systems.[7]

To achieve its ultimate objective of enabling adults with serious mental illnesses and children with serious emotional disturbances to integrate fully into their communities, the New Freedom Commission concluded a transformation of the mental health care delivery system is needed. Cooperation among all levels of government and between public and private sector providers is necessary to accomplish this transformation.[8] (The complete final report of the New Freedom Commission on Mental Health may be found at http://www.mentalhealthcommission.gov/reports/reports.htm).

Appointed by President Bush to serve on the New Freedom Commission, Nevada State Senator Randolph J. Townsend's work served to focus on the transformation of Nevada's mental health system. Senator Townsend, sponsor of legislation to establish the NMHPIC, was subsequently elected by fellow commissioners to chair the Nevada Commission.

B. Federal Implementation of the Recommendations Made by the President's New Freedom Commission on Mental Health

At the NMHPIC's January 26, 2004, meeting, Charles G. Curie, M.A., A.C.S.W., Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services (HHS), Rockville, Maryland, noted that transforming the mental health system to promote recovery rests on two principles. First, services and treatments must be consumer- and family-driven. Second, care must focus on increasing an individual's ability to cope with life's challenges, on building resilience, and on facilitating recovery.

Mr. Curie, a member of the New Freedom Commission, said the nation must understand mental health is an integral part of overall health. Mental health disorders must be addressed with the same urgency as other medical problems. Moreover, the transformation should harness the power of health information technology to promote quality of care, access to

[7] Ibid., pages 79 to 81.
[8] Ibid., page 86.

services, and sound decision making. The country must identify ways to collaborate at the federal, state, and local levels to leverage human and economic resources.

Initially, SAMHSA will inventory current federal programs and activities that address the Commission's goals and recommendations and propose actions to advance the agenda. As this process progresses, SAMHSA will support state action agendas. In turn, state leadership will assist the federal government by providing examples of successful actions. To assist with tracking the state activities, SAMHSA has funded the National Association of State Mental Health Program Directors. Key focus areas will be collaborations between state Medicaid and mental health authorities combined with consistent and aligned communications to the states from the Centers for Medicare & Medicaid Services (CMS), HHS, and SAMHSA. Mr. Curie said that Nevada will serve as a prime example because of the work of the NMHPIC.[9]

C. Nevada's Division of Mental Health and Developmental Services

At the NMHPIC's organizational meeting on September 18, 2003, Dr. Carlos Brandenburg, Administrator, DMHDS, presented an overview of Nevada's mental health delivery system.[10] (See Appendix D for a copy of Dr. Brandenburg's presentation, *An Overview of MHDS*.) The DMHDS, located within the Department of Human Resources (DHR), is overseen by an eight-member Commission on Mental Health and Developmental Services, appointed by the Governor. Members represent disciplines including psychiatry, social work, psychology, and nursing, as well as lay members. Advisory boards in northern and southern Nevada are involved in local agency issues.

The DMHDS is organized into three regions: North, South, and Rural. In 1992, the responsibility for children's mental health services in the metropolitan areas in northern and southern Nevada was assigned to the Division of Child and Family Services (DCFS). In rural areas, DMHDS retained responsibility for children's services. Finally, DMHDS operates the Lake's Crossing Center, a maximum security forensic facility serving persons who have been adjudicated incompetent to stand trial or are not guilty of a crime by reason of insanity.

Dr. Brandenburg stated that, since 1995, DMHDS has been transforming its processes to involve stakeholders and consumers in evaluating and developing services. He suggested the NMHPIC review the Mental Health Planning Advisory Council's plan, created by a federal mandate to oversee the mental health block grant. He said that DMHDS has also developed a consumer assistance program, employing seven consumers of mental health services.

Dr. Brandenburg said DMHDS currently serves over 25,000 Nevadans as the safety net for indigent persons. Roughly 61,000 people are not receiving mental health services, however. The number of individuals whose insurance covers mental health has decreased. Because the state provides services to the severely mentally ill, those whose mental health is impaired by

[9] Curie, Commission, January 26, 2004.
[10] Brandenburg, 2003, September, *An Overview of MHDS*.

situational distress are not served. Dr. Brandenburg stated that, aside from the DMHDS plan for the federal block grant funds, no comprehensive state mental health plan exists.

D. Goal 1: Americans Understand that Mental Health is Essential to Overall Health.

1. Impact of Mental Illness on Physical Health

Ole Thienhaus, M.D., FACPsych., University of Nevada School of Medicine (UNSOM), testified to the NMHPIC that medical illness is more prevalent in people suffering from mental illness. He said that patients with major mental illness have a chronic stressful state, which exhausts the immune system. Patients with pre-existing depression have higher rates of death from heart attacks, for example. Mental illness can lead to medical problems such as anorexia. Patients with schizophrenia who chain smoke exemplify a more indirect impact of mental illness on health.

Dr. Thienhaus said separating mental illness from physical illness is a mistake. Acute psychiatric care should be delivered in health settings by people competent in discovery and treatment of medical and mental illness. Although psychiatric acute care units should be located in general hospitals, mentally ill patients in Nevada are typically segregated into separate institutions. He suggested a centralized psychiatric emergency service. Efforts should be made to help qualified patients access benefits.[11] (For a copy of Dr. Thienhaus' prepared remarks, see the minutes of the October 9, 2003 meeting of the NMHPIC, Exhibit P, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031009-823.html.)

2. Stigma Associated With Mental Illness

a. Daniel B. Fisher, M.D., Ph.D.

New Freedom Commissioner Daniel B. Fisher, M.D., Ph.D., Co-Director, National Empowerment Center, Lawrence, Massachusetts, told the NMHPIC that understanding the importance of mental health to physical health is an essential first step in transforming mental health care into a consumer-centered delivery structure.

Dr. Fisher said that a massive re-education process must be started, beginning with decision makers. People who have recovered from mental illness can be placed on wards, be involved in training, and be part of the rehabilitation of those recovering. Embracing the concept of recovery will require and result in a cultural shift at the agency and staff levels. Staff people fear they will lose their jobs if the culture shifts. States should be working to de-institutionalize people and should eliminate employment discrimination based on mental illness. Dr. Fisher said that much of mental illness is associated with a feeling of detachment.[12] (For a copy of Dr. Fisher's prepared remarks, see the minutes of the

[11] Thienhaus, 2003, October 9, *The Impact of Mental Illness on Physical Health*.
[12] Fisher, 2003, October 21, *Implementing the President's Commission on Mental Health in Nevada*.

October 21, 2003 meeting of the NMHPIC, Exhibit B1 and Exhibit B2, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031021-823.html.)

b. Dr. Frances M. Murphy, M.D., M.P.H.

New Freedom Commissioner Dr. Frances M. Murphy, M.D., M.P.H., Deputy Under Secretary for Health Policy Coordination, United States Department of Veterans Affairs, testified before the NMHPIC that this country must understand building resiliency in children and adults so they can deal with life's traumas. In the context of homelessness, Dr. Murphy identified stigma associated with mental illness as a cause of housing discrimination. Disabled people file 42 percent of all housing complaints with the United States Department of Housing and Urban Development.[13] (For a copy of Dr. Murphy's prepared remarks, see the minutes of the October 9, 2003 meeting of the NMHPIC, Exhibit D, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031009-823.html.)

c. Judge Peter Breen

District Court Judge Peter Breen, Second Judicial District Court, Washoe County, provided the NMHPIC with an overview of mental health court. The public senses that all mentally ill people are dangerous. Those who work with the mentally ill are obligated to convince the public that mental health court is not a conduit for people to escape responsibility for crimes. As a specialty court, mental health court grew out of the failure of the criminal courts to address the special circumstances of the mentally ill, who circulate from the streets to the jails to the courts and back again.[14] (For a copy of Judge Breen's Microsoft PowerPoint presentation, see the minutes of the November 20, 2003 meeting of the NMHPIC, Exhibit F, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

3. Suicide

Rena M. Nora, M.D., Commissioner, Governor's Commission on Mental Health and Developmental Services; Medical Advisor, Nevada Chapter, American Foundation for Suicide Prevention; and Clinical Professor of Psychiatry, University of Nevada School of Medicine, testified that approximately 30,000 people in the United States kill themselves every year. Nevada ranks second in the country at 21.3 per 100,000 population, double the national rate. The Nevada Center for Health Data and Research found in 2002 that 452 individuals completed suicide in Nevada, 273 of them from Clark County. Only 39 of the total suicides reported in Nevada were by non-residents. The presence of depression or other affective

[13] Murphy, 2003, October 9, *Statement of Frances M. Murphy, M.D., M.P.H., Deputy Under Secretary for Health Policy Coordination, United States Department of Veterans Affairs Before the Nevada Mental Health Commission.*

[14] Breen, 2003, Microsoft PowerPoint: *Mental Health Court, 2nd Judicial District Court*.

disorder, co-occurring disorders, and previous suicide attempts all create risks of suicide. Treating those who have attempted suicide in emergency rooms is risky, because the first 24 hours of an attempted suicide are the most crucial. Dr. Nora recommended such patients receive treatment in an appropriate setting.

Dr. Nora testified that 1999 was a significant turning point in suicide prevention when the U.S. Surgeon General issued a national call to action to prevent suicide. The Nevada Legislature funded the suicide prevention hotline that year. In 2003, the Legislature enacted Senate Bill 49 to create the statewide suicide prevention program in DHR.[15] (For a copy of Dr. Nora's Microsoft PowerPoint presentation, see the minutes of the October 9, 2003, meeting of the NMHPIC, Exhibit O, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031009-823.html.)

E. Goal 2: Mental health care is consumer- and family-driven.

1. Consumer-Driven Care

a. Dr. Daniel Fisher

In addition to his comments about stigma, Dr. Daniel Fisher provided a national perspective on Goal 2 of the New Freedom Commission, mental health care is consumer- and family-driven. The present delivery system is inert; it robs people of their hope. People with mental illness have been told, directly or indirectly, that they are not to expect a full life.

Dr. Fisher said that recovery is a big part of the New Freedom Commission report. In the present mental health care delivery system, people with sufficient supports are not necessarily labeled mentally ill; they retain control of their lives, enter the cycle of healing, and maintain community presence. If the supports are not there, people are excluded by society, are labeled mentally ill, are no longer considered responsible for their actions, and are unable to secure employment. Recovery then takes many more resources and more time.

Control and coercion interfere with recovery, said Dr. Fisher. People are not motivated by someone else's treatment plan. They must be involved in the planning. Dr. Fisher said that the idea of a system driven by consumers and families is controversial. Professional collaboration and power equalization are critical in realizing the goals of people labeled as mentally ill.

Dr. Fisher said that consumers have the greatest stake in recovery and the least stake in maintaining the status quo. He recommended states legislate consumer participation in developing their own care plans. Consumers working as providers have the extra motivation to help others. Consumer-run organizations assist with integration into the community, which is difficult for professionals to do because integration occurs around

[15] Nora, 2003, October, Microsoft PowerPoint: *Nevada Suicide*.

building peer relationships.[16] (For a copy of Dr. Fisher's prepared remarks, see the minutes of the October 21, 2003 meeting of the NMHPIC, Exhibits B1 and B2, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031021-823.html.)

b. Alyce Thomas

Alyce Thomas, Statewide Coordinator, Consumer Services Assistance Program, DMHDS, Las Vegas, summarized Nevada's current efforts to achieve Goal 2 of the Presidential Commission's Final Report. These efforts include establishing a consumer-run drop-in center at Northern Nevada Adult Mental Health Services, advocating the inclusion of a consumer on the Mental Health Commission, working to secure certification for peer counselors, organizing a Walk to Recovery in southern Nevada, and holding a conference to celebrate Mental Health Awareness Month.[17]

2. Behavioral Health Plan System Redesign

Commission member Charles Duarte, Administrator, and Mary Wherry, Deputy Administrator, Division of Health Care Financing and Policy, DHR, summarized the proposed Behavioral Health Plan System Redesign. Mr. Duarte indicated the proposed redesign would change revenue flows for mental health services to ensure more and better community-based care. Ms. Wherry said that the current focus is on delivery of higher level services with associated higher expenditures, which is inconsistent with the rehabilitative concept for outpatient services. Developing specialty clinics opens the delivery of lower level services to additional qualified providers, thus reaching a larger number of mental health consumers. She also highlighted areas in which the proposed plan integrates with the goals of the New Freedom Commission, including the focus on recovery, continuum of care, integration of family and peer support, and early mental health treatment.[18] (For a copy of Mr. Duarte's Microsoft PowerPoint presentation and prepared remarks, see the minutes of the December 18, 2003, meeting of the NMHPIC, Exhibits M and N, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031218-823.html.)

3. Systems Integration

Rosetta Johnson, President and Chief Executive Officer, Human Potential Development, Reno, said that Nevada's mental health system is fragmented, a patchwork relic of disjointed reforms and policies. Fragmented systems are like silos working independently of one another, creating isolation and dissidence. Obstacles to achieving mental health systems integration include the vested interests of the stakeholders who benefit from the status quo, inertia of long-standing practices, poor understanding of new systems, and mistrust among

[16] Fisher, Ibid.
[17] Thomas, Commission, October 21, 2003.
[18] Duarte and Wherry, 2003, Microsoft PowerPoint: *DHCFP 2003 Behavioral Health Plan for System Redesign*.

people who need to collaborate. Inadequate resources available to some existing programs and the lack of coordination among complementary services and programs are also obstacles to establishing evidence-based practices.

Human Potential Development is attempting to overcome those obstacles through the formation of systems integration pilot projects in housing, substance abuse, and the criminal justice system. Preliminary results of this effort should be available by December 2004. Emphasizing her desire to strengthen existing programs and services through systems integration and coordination, Ms. Johnson offered recommendations for the Commission's consideration, including the creation of an office to monitor, evaluate and assist systems integration activities. She cautioned against modifications to Medicaid, such as a reduction in funding, or restrictions to medications through preferred drug lists, prior authorization, or *fail first* policies.[19] (For a copy of Ms. Johnson's Microsoft PowerPoint presentation, see the minutes of the December 18, 2003, meeting of the NMHPIC, Exhibit G, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031218-823.html.)

4. Housing and Services for the Homeless

a. Dr. Frances M. Murphy

Dr. Frances M. Murphy, U.S. Department of Veterans Affairs, provided background information on homelessness in the United States. In addition to stigma, Dr. Murphy identified four other key factors that must be understood and addressed to eradicate homelessness. These include the: (1) affordability of housing; (2) burden of mental illness; (3) supply of housing units, and (4) complexity of the system. Approximately 637,000 people are homeless in this country; nearly half of whom suffer from mental illness or substance abuse.

The symptoms of mental illness increase the vulnerability to homelessness; people with severe mental illness have incomes about 18 percent of the median income. Their monthly Supplemental Security Income (SSI) payments are not large enough in most instances to purchase housing. Moreover, both mental health systems and housing systems are extremely complex, highly competitive, and hard to access.

Dr. Murphy recommended the mental health system access government housing programs at the state and local level and develop stronger expertise about housing programs. The states need to enforce rigorously federal fair housing standards.[20] (For a copy of Dr. Murphy's prepared remarks, see the minutes of the October 9, 2003, meeting of the NMHPIC, Exhibit D, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth-20031009-823.html.)

[19] Johnson, 2003, December 18, Microsoft PowerPoint: *Systems Integration: A Nevada Project: Fixing Fragmented Systems*.
[20] Murphy, Ibid.

b. Shawna Parker

Shawna Parker, Management Analyst, Clark County Resources Management, also provided the Commission with information about Clark County's annual survey, *Stand Down for the Homeless*. Approximately 2,000 homeless people were interviewed. The most recent data show: 10 percent have been diagnosed with mental illness; 14 percent have attempted suicide; and 20 percent are depressed. Most homeless people live in isolation. Further, the 1999 University of Nevada, Las Vegas Homeless Demographic Survey found that only 65 percent of those diagnosed with mental illness are receiving SSI benefits.

Ms. Parker cited housing first as a best practice. In this approach homeless persons are first moved into housing, after which the underlying problems are addressed. Key is continuation of intensive case management of the issues leading to homelessness. An example of this approach is the Pathways to Housing program in New York, estimated to cost about $17,000 per person. Before participation, each person used about $40,000 in services annually, including time spent in jail and in temporary hospitalizations. Ms. Parker said that placing homeless persons into permanent housing is cheaper than placing them in transitional housing.

Another best practices example is the Creative Home Initiative in Tennessee. The State of Tennessee appropriated about $2 million which it leveraged for another $29 million. Drop-in centers provide services for mentally ill persons.[21] (For a copy of Ms. Parker's Microsoft PowerPoint Presentation, see the minutes of the October 9, 2003 meeting of the NMHPC, Exhibit I, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031009-823.html.)

F. Goal 3: Disparities in mental health services are eliminated.

1. Access to Services in Rural Areas

Dennis Mohatt, Senior Program Director, Mental Health Program, Western Interstate Commission on Higher Education (WICHE), Boulder, Colorado, told the NMHPIC that the federal government lacks a consistently applied definition of rural America. Yet this term must be defined in order to focus resources. More attention must be given to the differences in this country's rural areas.

Mr. Mohatt listed issues facing rural Americans, including:

- Accessibility: Rural Americans travel further to provide and receive services, are less likely to have mental health insurance benefits, and are less likely to recognize mental illnesses and understand their care options.

[21] Parker, 2003, October, Microsoft PowerPoint: *Mentally Ill and Homeless: Needs, Gaps, and Project Suggestions*.

- Availability: Rural areas suffer from chronic shortages of mental health professionals, specialty providers are likely unavailable as are comprehensive services, and consumers often delay care.

- Acceptability: Few programs train professionals to work competently in rural areas, rural people often lack choice of providers, stigma is attached to seeking mental health care, and urban models are assumed to work in rural areas.

In addition to a number of policy recommendations for action at the national level, Mr. Mohatt said that the most viable alternative for providing mental health professionals is to encourage rural people to receive the training they need to serve their communities.[22] (For a copy of Mr. Mohatt's Microsoft PowerPoint presentation, see the minutes of the October 21, 2003, meeting of the NMHPIC, Exhibit D, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth-20031021-823.html.)

2. Cultural Competency

a. Josie T. Romero

Josie T. Romero, M.S.W., L.C.S.W., President, Board of Directors, National Latino Behavioral Health Association, Gilroy, California, said that language barriers impede information about sources of care and restrict communication with a therapist. She defined cultural competency as a set of behaviors and attitudes within the operation of a system that respects and considers the consumer's cultural background, beliefs and values, incorporating them into the delivery of health care services.

Eliminating disparities in services is cost-effective. Most costs lay currently in the utilization of emergency medical and psychiatric services. The National Academies' Institute of Medicine found that minorities tend to receive lower quality health care even when they have insurance.[23] (For a copy of Ms. Romero's Microsoft PowerPoint presentation, see the minutes of the November 4, 2003 meeting of the NMHPIC, Exhibit C, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031104-823.html.)

b. Sherrada James

Sherrada James, Executive Director, Nevada Indian Commission, Carson City, noted that the experience of living and being confined to reservations has increased mental illness among Native Americans. She said mistrust of mental health services is an important deterrent to minorities seeking treatment.

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[22] Mohatt, 2003, October 21, Microsoft PowerPoint: *The Rural Picture: Challenges and Opportunities, Caring for the Country*.
[23] Romero, 2003, November, Microsoft PowerPoint: *Behavioral Health Disparities by Latinos and Other Ethnic Communities: Proactive Actions Will Save the State $$$*.

Ms. James said that few American Indians and Alaska Natives are included in controlled clinical studies. Further, they are not typically included when programs, services, and resources are considered to address health care and mental health care issues. Mental health care is provided through the Indian Health Services, an agency within the U.S. Department of Health and Human Services. When funds are exhausted, services are provided only on a priority basis, meaning that the health situation must be critical. Because of intermarriage, many children do not qualify for health benefits through the Indian Health Services, even if they reside on a reservation. In Nevada, the tribal health clinic may provide counseling, but the individual is not referred to a state institution if funds are unavailable.

Ms. James suggested the state's mental health plan should include Nevada's Native American population in outreach, networking, and information dissemination. The tribes should be included in statewide health forums, programs, and funding on a continual basis. The myth that the federal government provides all health care services to Native Americans should be dispelled.[24] (For a copy of Ms. James' Microsoft PowerPoint presentation, see the minutes of the October 21, 2003, meeting of the NMHPIC, Exhibit G, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031021-823.html.)

3. Criminal Justice and Mental Illness

a. William Emmet

William Emmet, Project Director, National Association of State Mental Health Program Directors, Arlington, Virginia, testified that people with mental illness are over-represented in the criminal justice system. Adequate treatment is lacking in the prison setting, resulting in longer jail stays, lesser likelihood of parole, inadequate discharge planning, and higher rates of recidivism.

Mr. Emmet said that the cost to provide mental health and substance abuse treatment in correctional facilities is significantly higher. Many of the individuals with mental illness in the criminal justice system are repeat offenders. He suggested that coordinated efforts between mental health and criminal justice systems would ensure a better use of resources.[25] (For a copy of Mr. Emmet's Microsoft PowerPoint presentation, see the minutes of the December 18, 2003 meeting of the NMHPIC, Exhibit C, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031218-823.html.)

b. Jackie Crawford and Dr. Ted D'Amico

[24] James, 2003, October, Microsoft PowerPoint: *Nevada Native American Mental Health Care Issues*.
[25] Emmet, 2003, December 18, Microsoft PowerPoint: *Mental Illness and the Criminal Justice System*.

Jackie Crawford, Director, and Dr. Ted D'Amico, Medical Director, Department of Corrections (DOC), Carson City, testified that Nevada has 10,442 inmates, estimating that 13.69 percent of whom are mentally ill. The initial diagnosis, assessment, and testing occur at intake. Dr. D'Amico said that the DOC provides both inpatient and outpatient services. Special programs include an extended care unit for the chronically mentally ill and a re-entry program to assist with the transition to the community.

Ms. Crawford said that transitioning back into the community may be difficult due to the dual stigma of emotional problems and ex-offender status. Some families do not want the offender back. She said that S.B. 90 (Chapter 238, *Statutes of Nevada 2003*) permits DOC to exchange medical and mental health information with DMHDS to facilitate evaluations and ensure continuity of care. Many of the severely mentally disabled are placed at the Lake's Crossing Center, DMHDS, Sparks, Nevada, as a transitional step. Many of them, however, expire their time, becoming homeless. The prison can give a former inmate enough medications for a 30-day period. At which time, the person could be admitted into one of DMHDS's facilities, if accepted.[26] (For a copy of Ms. Crawford's Microsoft PowerPoint presentation, see the minutes of the October 21, 2003 meeting of the NMHPIC, Exhibit F, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031021-823.html.)

G. Goal 4: Early mental health screening, assessment, and referral to services are common practices.

1. Children with Serious Emotional Disturbances

New Freedom Commissioner Jane Adams, Ph.D., Executive Director, Keys for Networking, Inc., Topeka, Kansas, presented an overview of children's mental health needs. Dr. Adams emphasized the importance of providing consumer-driven peer support for families of mentally ill children. Referencing a publication titled *A New Wave of Evidence: The Impact of School, Family, and Community Connections on Student Achievement*, she also urged the Commission to consider the impact of family involvement on child outcomes.

Dr. Adams testified that finding mental health services for children is more complex than for adults. Different eligibility requirements govern 40 separate funding streams for children's services. She testified that the cost of untreated children's serious emotional disturbances (SED) is great: 50 percent drop out of high school; 66 percent to 75 percent of youths entering juvenile justice systems have SED; of the 500,000 children in foster care, approximately 85 percent have emotional/behavioral problems or substance abuse problems. The problem is disproportionately worse for minority children, who tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or mental health settings.

[26] Crawford and D'Amico, 2003, October 21, Microsoft PowerPoint: *An Overview of Mental Health Services in the Nevada Department of Corrections*.

Dr. Adams testified that maternal depression impacts the child's academic performance; mental disorders are a leading cause of school failure. She recommended developing an individualized plan of care for every child with SED. She also recommended creating a comprehensive state mental health plan that included ending the practice of trading child custody for mental health care.

To achieve Goal 4, Dr. Adams recommended early and appropriate screenings across the life span. Screenings should be conducted in multiple settings, coupled with connections to treatment and supports. Mental health programs in schools should be improved and expanded, in particular for young children. She suggested that primary health care providers screen for mental disorders and that research into children's mental health be accelerated.[27] (For a copy of Dr. Adams' Microsoft PowerPoint presentation, see the minutes of the December 18, 2003 meeting of the NMHPIC, Exhibit B, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031218-823.html.)

2. Geriatric Mental Health Issues

Laurie Moore, M.S.G., L.A.S.W., Director, Senior Mental Health Outreach Program, DMHDS, DHR, North Las Vegas, Nevada, offered recommendations to meet geriatric mental health needs. Many elderly people have one or more physical impairments. They need in-home services. Ms. Moore recommended that mental health services be provided to senior citizens in a continuum of care. Among her recommendations for actions, Ms. Moore urged the reduction of dumping of older clients. This occurs when a person, who exhibits certain symptoms, is transferred to a private facility and then is refused readmission by the referring facility when the person is stabilized. She also emphasized overcoming the stigma associated with accepting mental health services and stressed the importance of education to mental health professionals without a background in gerontology.[28] (For a copy of Ms. Moore's prepared remarks, see the minutes of the October 21, 2003 meeting of the NMHPIC, Exhibit I, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031021-823.html.)

3. Co-occurring Disorders

a. Dr. Steven Graybar

Steven Graybar, Ph.D., Clinical Psychologist, Counseling and Testing Center, University of Nevada, Reno, and member, Board of Psychological Examiners, Reno, said co-morbidity is so common that it must be viewed as the rule rather than the exception. People do not exhibit simple mental health issues or simple substance abuse issues often enough to justify two separate systems.

[27] Adams, 2003, December, Microsoft PowerPoint: *Transforming Mental Health Care for Children and Families*.
[28] Moore, 2003, October 21, *Addressing the Needs of Older Nevadans with Mental Illness*.

Dr. Graybar offered a number of suggestions to improve treatment of individuals who suffer from co-occurring disorders. Treatment for the mental health disorder and the substance abuse should be integrated. In addition, a continuing care model similar to that for treating chronic physical ailments characterized by periods of remission and exacerbation, such as diabetes, should be adopted. Dr. Graybar also stressed the importance of mental health and substance abuse agencies and professionals working together as equal partners to serve individuals with co-occurring disorders.[29]

b. Dr. David A. Rosin

David A. Rosin, M.D., Statewide Medical Director, DMHDS, Carson City, noted that with the exception of one program established to treat felons released from Nevada's DOC, the DMHDS has no program designed to treat clients with co-occurring disorders. Further, he cited statistics indicating most clients served through DMHDS in Fiscal Year 2003 suffered from co-occurring disorders: of the 12,454 clients, 8,700 had co-occurring disorders. Two reasons to be concerned about persons with co-occurring disorders are: (1) the addiction to drugs or alcohol contributes to violence, and (2) the possibility of suicide increases.[30]

c. Maria Canfield

Maria Canfield, a Commission member and the Chief of Bureau of Alcohol and Drug Abuse, Health Division, DHR, submitted an overview of BADA. She presented survey information indicating the use of alcohol, tobacco, and marijuana by Nevada residents exceeds the national average. Other survey results include:

- Seven and a half percent of Nevada residents were estimated to have used illicit drugs in the past 30 days, translating to approximately 114,000 individuals;

- An approximate 3.2 percent of Nevada residents were estimated to have used some illicit drug other than marijuana in the past 30 days, translating to about 49,000 individuals;

- An estimated 9.11 percent of Nevada's youth from 12 to 17 years of age are likely to have an alcohol or drug substance dependence or abuse problem, translating to 17,199 individuals; and

- Of Nevada's total population, 6.4 percent were estimated to have an alcohol or drug substance dependence or abuse problem, translating to 156,838 individuals.

The report also provides BADA's treatment strategies. These include coalitions, safe and drug free schools, a state incentive grant to facilitate the development of additional coalitions, and a grant from the Fund for a Healthy Nevada, (*Nevada Revised Statutes* [NRS] 439.625), to

[29] Graybar, Commission, November 4, 2003.
[30] Rosin, Commission, November 4, 2003.

implement a tobacco prevention program.[31] (For a copy of Ms. Canfield's prepared report, see the minutes of the November 4, 2003, meeting of the NMHPIC, Exhibit O, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031104-823.html.)

4. Crisis Triage and Emergency Room Services

a. Kathryn Landreth and Frank Pascoe

Kathryn Landreth, Legal Counsel, Las Vegas Metropolitan Police Department, and Chair, Southern Nevada Adult Mental Health Coalition, Las Vegas, provided a brief overview of the triage system and Crisis Intervention Team (CIT) in Clark County, Nevada. Referencing a Coalition report produced in 2002 titled *The Criminal Justice Mental Health Consensus Project*, Ms. Landreth identified four recommendations that, if implemented, would assist in providing appropriate access to mental health services to mentally ill persons at risk of committing criminal offenses:

- Ensure ease of access to mental health services;
- Establish a user-friendly mental health system;
- Provide priority service to mentally ill persons at risk of offending; and
- Secure adequate federal, state, and local funding.[32]

Officer Frank Pascoe, Las Vegas Metropolitan Police Department, also provided the following statistics: about 86,000 people with severe mental illness live in Nevada; an estimated 45,000 of them live in Las Vegas; and about 10,000 homeless people live on the streets of Las Vegas. Approximately 80 percent of the homeless are mentally ill. For psychiatric beds available in state mental health facilities, the national average is 33 per 100,000 population. Nevada has about 4.5 beds per 100,000. A "Legal 2000" mentally ill patient can spend anywhere from 36 hours to nine days in an emergency room.[33]

b. Dr. Rick Henderson and Dr. Gary Goldberg

In conjunction with the information about a crisis triage center, the Commission heard testimony regarding the overcrowding in emergency rooms of hospitals. Rick Henderson, M.D., Saint Rose Dominican Hospital, Henderson, said if the emergency room beds are full when mentally ill persons are brought to the emergency room by ambulance, the ambulance must wait for hours to unload them. Once the persons are in the emergency room, they can stay for up to five days. They are often treated by personnel who are not trained in mental

[31] Canfield, 2003, November, *An Overview of BADA*.
[32] Landreth, Commission, October 9, 2003.
[33] Pascoe, Commission, October 9, 2003.

health care. Gary Goldberg, M.D., Associate Medical Director, Sunrise Hospital and Medical Center, Las Vegas, said that mentally ill patients are sent to hospitals to be medically cleared prior to transfer to a psychiatric facility. After medical screening, they are placed on a 72-hour hold. They cannot be placed on a second such hold, so they may be deprived of their rights if the hospital cannot release them to a psychiatric facility within that time.[34]

H. Goal 5: Excellent mental health care is delivered and research is accelerated.

1. Evidence-Based Practices

New Freedom Commissioner Anil G. Godbole, M.D., Chairman, Advocate Illinois Masonic Medical Center, and Commissioner, President's New Freedom Commission on Mental Health, Chicago, Illinois, explained that while the concept of cure is not yet practical, scientific advances and research allow humankind to envision a time when early detection and cure of mental illness will be possible. Dr. Godbole defined evidence-based practices (EBP) as the integration of best research evidence with clinical expertise and patient values. He outlined eight recommended courses of action to implement science in the field and to provide feedback from providers to researchers. These include developing steadily the science base, overcoming the stigma, improving awareness of effective treatments, ensuring the supply of evidence-based services and providers trained in EBP, ensuring delivery of state-of-the-art treatment, tailoring treatment to the individual, facilitating entry into treatment, and reducing financial barriers to treatment. He said that the current delivery model contains no penalties for failure to use EBP, nor any incentives to use them. In addition, he noted that scientific research and examination of effective delivery systems are equally important.[35] (For a copy of Dr. Godbole's Microsoft PowerPoint presentation, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit B, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth-20031120-823.html.)

2. Implementation of EBPs

At the same meeting, Vijay Ganju, Ph.D., Director, Center for Mental Health Quality and Accountability, National Association of State Mental Health Program Directors, Arlington, Virginia, reported that the Center was established to promote EBPs and performance measurement initiatives. Dr. Ganju identified the most important steps if a state is to advance an EBP agenda. Among these are funding mechanisms, development and integration of infrastructure, training, consensus building, human resource development, outcome measures, and technical assistance. Dr. Ganju said that Nevada has system leadership and an organizational culture to move forward with statewide EBP implementation. He said Nevada must address capacity for human resources and information technology, policies, funding, and measures of integration with performance.[36] (For a copy of Dr. Ganju's Microsoft PowerPoint

[34] Henderson and Goldberg, Commission, October 9, 2003.
[35] Godbole, 2003, November, Microsoft PowerPoint presentation (untitled).
[36] Ganju, 2003, November 20, Microsoft PowerPoint: *Implementing Evidence-Based Practices: A National Perspective*.

presentation, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit C, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

I. Goal 6: Technology is used to access mental health care and information.

1. Telemental Health

Stephen W. Mayberg, Ph.D., Director, California Department of Mental Health, Sacramento, California, asserted that lack of knowledge inhibits access to mental health care and offered several recommendations on how to better provide information to consumers and providers. Among the new but underutilized health care technologies identified by Dr. Mayberg, a member of the New Freedom Commission, are electronic personal health records, telemedicine and other treatment related technologies, and use of the Internet for communications and self-help.[37] (For a copy of Dr. Mayberg's Microsoft PowerPoint presentation, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit D, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

2. Oregon's Implementation of Telemental Health

Catherine Britain, President, Telehealth Alliance of Oregon, La Grande, Oregon, discussed that state's experience in implementing telehealth and telemental health services. Ms. Britain reported the most cost-effective telemental health programs are those that reside on multiuse networks. She acknowledged the lack of existing outcome studies that measure the effectiveness of telehealth and telemental health services, noting that conducting such studies involves more time and funding than is available to most states.[38] (For a copy of Ms. Britain's Microsoft PowerPoint presentation, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit H, http://www.leg.state.nv.us/72nd/Interim/Statom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

3. Nevada's Rural Clinics Implement Telemental Health

a. Dr. Larry Buel

Larry Buel, Ph.D., Agency Director, Rural Clinics Community Mental Health Services, DMHDS, Carson City, reported that in October 2003, Rural Clinics initiated an ongoing telemental health project in its Silver Springs, Nevada, office. Among the potential benefits of utilizing telemental health services in rural Nevada, Dr. Buel cited collaboration with the University of Nevada School of Medicine to use sophisticated

[37] Mayberg, 2003, November 20, Microsoft PowerPoint: *National Implications for State and Local Mental Health Reform.*

[38] Britain, 2003, November 20, Microsoft PowerPoint: *Using Telehealth in the Provision of Mental Health Services.*

videoconferencing equipment placed in rural hospitals.[39] (For a copy of Dr. Buel's prepared remarks, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit L, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

b. Gerald Ackerman and Dan Tone

Gerald Ackerman, Associate Director, Office of Rural Health, and Dan Tone, Telemedicine Coordinator, both of the University of Nevada School of Medicine (UNSOM), Reno, summarized the activities of the Office of Rural Health and discussed the potential benefits of utilizing its telehealth sites to provide telemental health services. Telemedicine consultations currently available in Nevada include Alzheimer's, cardiology, dermatology, endocrinology, neurology, and psychiatry. In the future the system is going to provide services to the state mental hospital.

Mr. Ackerman said that the system has over 150 sites, including clinics and hospitals. Under Medicare's rules, physicians and hospitals are eligible for reimbursement, but a mental health center does not qualify for reimbursement. When the telemedicine system was started, however, the main requests were for mental health services. Rural mental health patients frequent emergency rooms because of the lack of professional services.[40] (For a copy of Mr. Ackerman and Mr. Tone's Microsoft PowerPoint presentation, see the minutes of the November 20, 2003, meeting of the NMHPIC, Exhibit M, http://www.leg.state.nv.us/72nd/Interim/StatCom/MentalHealth/Minutes/IM-MentalHealth-20031120-823.html.)

[39] Buel, 2003, November 20, *Telemental Health Services in Rural Clinics*.
[40] Ackerman and Tone, 2003, November, Microsoft PowerPoint: *Telehealth in Nevada*.

III. RECOMMENDATIONS

At its December 18, 2003, meeting, Chairman Townsend reviewed the compiled list of recommendations submitted by participants in the Commission's meetings and offered by expert witnesses through their testimony. He invited all interested people to identify their priorities from which a final list of recommendations was assembled. That list may be found at the Commission's Web site, http://www.leg.state.nv.us/72nd/Interim/StatCom/, by clicking on the work session documents link. Because the Commission had been charged by S.B. 301 to devise a plan to implement the goals and recommendations of the President's New Freedom Commission on Mental Health, its requests for legislation and its recommended actions are organized accordingly.

During its work session, the Commission concluded that some possible recommended actions may affect the 2005-2007 biennial Executive Budget. Since the Commission membership included four division or bureau administrators, the Commission approved the request to the Legislative Commission to recognize and form the Nevada Mental Health Plan Implementation Commission Subcommittee to Continue the Work of the Commission. The Legislative Commission subsequently approved the request on February 18, 2004, authorizing the Subcommittee to hold one additional meeting to consider the fiscal impact of work session items deferred by the Commission on January 26, 2004. The Subcommittee met on June 28, 2004, to consider those deferred items.

All recommendations presented in this section are those of the full Commission unless noted as an action by the Subcommittee.

A. Legislation

At its meeting on January 26, 2004, the Commission adopted three bill draft requests (BDR). These proposals are submitted for consideration by the 2005 Legislature. Appendix C contains the BDRs. The following section explains the Commission's recommendations for legislation.

Goal 2: Mental health care is consumer- and family-driven.

Housing

During its meeting on October 9, 2003, the Commission heard testimony from Dr. Frances M. Murphy, Deputy Undersecretary for Health Policy, U.S. Department of Veterans Affairs. Dr. Murphy had reminded the Commission that, in order to eradicate homelessness, key factors must be addressed, including: (1) the stigma associated with homelessness, (2) the affordability of housing, (3) the mental health of many homeless people, (4) the supply of housing units, and (5) the complexity of the federal housing system. She recommended that the mental health system access government housing programs and develop stronger expertise to navigate the complex programs.

During its work session on January 26, 2004, Gail Hutchings, M.P.A., Special Assistant to the Administrator, Office of the Administrator, SAMHSA, said a new federal initiative is evolving around the "housing first" model, which places people with serious disabling illnesses into permanent housing accompanied by the support services they need to maintain their independence there. Dorothy Nash Holmes, Nevada's Department of Corrections, provided statistics on the housing needs of prison inmates as they reenter the community. Shawna Parker, Clark County Community Resources Management, suggested Nevada could use state revenues to leverage other federal money for low income individuals through the U.S. Department of Housing and Urban Development (HUD). Also at the work session, Charles L. Horsey, III, Administrator, Housing Division, Nevada's Department of Business and Industry, said that a goal of the division is to leverage the state's money as much as possible with HUD programs.[41]

To address the housing issues for low-income individuals, with special concern expressed for housing for the mentally ill, the members of the Commission agreed to the following action:

1. **Request the drafting of legislation to establish a subcommittee of the Interim Finance Committee (IFC) to address housing in Nevada that is funded in whole or in part by public funds, including, but not limited to, housing for those persons who are mentally ill, elderly, disabled, low-income, or who otherwise need housing assistance, with special focus on persons reentering the community, including those from correctional institutions. Further, the creation of such a housing subcommittee of IFC would (1) establish a coordinated approach to all housing dollars entering Nevada; and (2) ensure there is a connection between housing and services. (BDR -277)**

Consumers

The New Freedom Commission on Mental Health wrote that most of the consumers of mental health services who testified before the Commission expressed the need to participate in their plan for recovery. It went on to note that adults with serious mental illness and parents of children with serious emotional disturbances have limited influence over the care they or their children receive. The New Freedom Commission concluded that increasing opportunities for consumers to choose their providers and allowing consumers and families to have greater control over funds spent on their care facilitates personal responsibility, creates an economic interest in recovery, and shifts the incentives to a system that promotes learning, self-monitoring, and accountability.[42]

At its work session the Commission discussed the guidelines resulting from legislation in Michigan requiring consumers to be active participants in developing their own treatment or care plans. Ms. Hutchings said at the national level SAMHSA is creating templates as technical assistance to states to show the structure of an adult individual consumer recovery

[41] Commission, January 26, 2004.
[42] New Freedom Commission, Pages 27 to 29.

plan. She suggested combining money resources on one end of a continuum with individual plans of recovery on the other end.[43]

To address the issue of consumer-centered plans for recovery, the members of the Commission agreed to the following action:

2. Request the drafting of legislation that would require consumers to be active participants in the development of their mental health treatment and care plans. (BDR -280)

Goal 3: Disparities in mental health services are eliminated.

The Commission on Mental Health and Developmental Services (*Nevada Revised Statutes* 232.303) is appointed by the Governor. The members include: a psychiatrist, a psychologist, a physician who has experience with mental retardation, a social worker who has experience with mental illness or mental retardation, a registered nurse who has experience with mental retardation or mental illness, a marriage and family therapist, a representative of the general public with an interest in mental health, and a representative of the general public with an interest in mental retardation.

At the Commission's work session, Dr. Carlos Brandenburg, Administrator, DMHDS, said the Commission on Mental Health and Developmental Services does not include a consumer of mental health services. Ms. Hutchings said that the nature of the disease of mental illness is cyclical. She urged including someone who understands the process from a consumer's point of view.

To further the recommendation of the New Freedom Commission that mental health services be consumer- and family-driven, the Commission agreed to the following action:

3. Request the drafting of legislation requiring a consumer, past or present, of mental health services in the state system be included as a member of Nevada's Commission on Mental Health and Developmental Services. (BDR –279)

B. Actions

Senate Bill 301 provides that the NMHPIC shall determine Nevada's plan for implementing the recommendations of the President's New Freedom Commission on Mental Health to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn and participate fully in their communities. To accomplish this, the Commission recognized that a number of actions will involve federal, state, and local governmental entities. It also recognized that some actions must be taken within or between executive departments, and in conjunction with interested parties in the private sector.

[43] Commission, January 26, 2004.

Organized by the goals of the New Freedom Commission, the following section of this report presents the Commission's recommended actions to implement those goals.

Goal 1: Americans understand that mental health is essential to overall health.

Stigma

A number of expert witnesses addressed the stigma associated with mental illness as a barrier to treatment and reentry into the community. Others spoke of language barriers as obstacles. For example, at its October 21, 2003, meeting, New Freedom Commissioner Daniel Fisher told the Commission that if recovery from mental illness is the goal then a massive re-education campaign must be undertaken. New Freedom Commissioner Frances M. Murphy identified stigma as an underlying cause for housing discrimination, at its October 9, 2003, meeting. Washoe County District Court Judge Peter Breen, on November 20, 2003, told the Commission that the public senses mentally ill people are dangerous. Dennis Mohatt, WICHE, told the Commission on October 21, 2003, that stigma prevented rural residents from seeking assistance until their mental illnesses were more advanced, requiring longer and more expensive treatment.

To address the issue of reducing the stigma associated with mental illness, the Subcommittee of the Commission took the following action:

1. **Establish a subcommittee of the Nevada Mental Health Plan Implementation Commission to meet with designees appointed by the Governor, including representatives from the broadcast industry, radio, television, and newspaper publications to develop a plan for public service announcements in English and Spanish. Direct school districts to report on implementation of programs that focus on de-stigmatizing mentally ill persons.** (Action by the Subcommittee)

Suicide Prevention

The Legislature enacted S.B. 49 (Chapter 437, *Statutes of Nevada 2003*) to establish a statewide suicide prevention and intervention program. The fiscal note for S.B. 49 indicated that no source of revenue was determined, although at the time of its enactment, revenues realized from savings from other programs was cited as the funding source. Because the savings were not realized, the program was never implemented.

At its October 9, 2003, meeting, the Commission received testimony from Dr. Rena Nora, Medical Advisor, Nevada Chapter, American Foundation for Suicide Prevention. She provided statistics and discussed Nevada's consistently high ranking among the states for its rate of suicides per 100,000 population. She added that treating suicide attempts in emergency rooms is risky. The New Freedom Commission had also recommended swift action to prevent suicide.

The Commission deferred action on this item to the Subcommittee. On June 28, 2004, the Subcommittee of the Commission took the following action to address this issue:

2. **Urge, in its report, the Governor to include in the Executive Budget funding for comprehensive, statewide suicide prevention and intervention programs that include survivors of suicide. Support and maintain a statewide suicide prevention plan that will include evaluation, prevention, and post-intervention services; education and training for gatekeepers, professionals, the media, and the public; youth suicide prevention in schools; and careful attention to the relationship between suicide and co-occurring disorders.** (Action by the Subcommittee)

Goal 2: Mental health care is consumer- and family-driven.

Systems Integration

The New Freedom Commission identified fragmented delivery of mental health services as a major recovery obstacle. The Commission recommended Comprehensive State Mental Health Plans to facilitate new partnerships among the federal, state, and local governments to better use existing resources for people with mental illness. Encouraging states and localities to develop comprehensive strategies to respond to needs and preferences of consumers or families is the intended outcome.

At the December 18, 2003, meeting, Ms. Rosetta Johnson, Human Potential Development, recommended the Commission consider supporting the concept of system integration to address the funding silos and disjointed policies resulting from a patchwork approach to mental health delivery systems. Ms. Pam Becker, Washoe County Children's Mental Health Consortium, reminded the Commission during its work session that any systems integration resulting from a comprehensive state mental health plan must be consumer- and family-driven.

The Commission also discussed developing a team approach to primary care physicians, especially in rural areas. Training in linkages with mental health should be provided to primary care physicians. At the work session, Gail Hutchings, SAMHSA, said the vast majority of people who commit suicide see their primary care doctor within 30 days before they act. Little or no screening occurs in those interviews. The Commission discussed partnering with the University of Nevada School of Medicine to develop a training curriculum for primary care physicians emphasizing identification assessment instruments.

It also discussed the fragmentation of services for co-occurring disorders, gambling addiction, and the crisis triage services. Standardized formularies were cited as important when treating co-occurring disorders, as well. The Commission took the following action to address all of these concerns:

3. **Recommend, in its report, that the Governor provide for the development of a Comprehensive State Mental Health Plan. The plan will be designed to overcome**

the problems of fragmentation in the mental health delivery system and will provide important opportunities to leverage resources across multiple agencies that administer both state and federal funds. The Commission envisions a single entity coordinating the plan. The planning process should support a dialogue among all stakeholders and reach beyond the traditional state mental health agency to address the full range of treatment and support service programs that consumers and families need. The final result should be an extensive and coordinated state system of services that work to foster consumer independence and support consumers' ability to live, work, learn, and participate fully in their communities and provide for specific items such as standardized formularies to address co-occurring disorders.

Behavioral Health Plan System Redesign

At its December 18, 2003, meeting, the Commission considered the proposal to redesign the behavioral health system. The Commission was told that the driving forces for change included a 2001 letter of intent to DHR, directing it to review the feasibility of including private providers in targeted case management. Mr. Charles Duarte, Administrator, DHCFP, said DHR interpreted that request to include opening up other services to the private mental health care providers. Further, he said Assembly Bill 513 (Chapter 541, *Statutes of Nevada 2001*) appropriated funds to DHR to develop four long-term strategic plans relating to health care needs. Resulting questions were raised specific to mentally ill adults and children.

The Commission was informed that the DHCFP proposal would include components to be funded not just in Medicaid but also in the DCFS and DMHDS. The proposal would go forward under DHCFP's regular budget request to the Governor.

The Commission deferred this item until it could consider the fiscal impact. The Subcommittee of the Commission took the following action to address the proposal:

4. Express, in its report, support for the concept of the Behavioral Health Plan System Redesign of the Division of Health Care Financing and Policy (DHCFP), Department of Human Resources (DHR), and urge the Executive Branch and DHR to go forward with the funding and implementation of the proposed redesign plan. The Behavioral Health Plan recommendations include, but are not limited to, standardizing the infrastructure of the system, developing specialty clinics, eliminating state-devised reimbursable codes for Nevada Medicaid, delivering targeted case management services through state agencies, and defining mechanisms for utilization management. The recommendation includes incremental costs that may come through DHCFP and the Division of Mental Health and Developmental Services (DMHDS). (Action by the Subcommittee)

Housing

At its work session, the Commission heard testimony from Dorothy Nash Holmes, Nevada's DOC, that the Residential Substance Abuse Treatment (RSAT) funds were cut from the Fiscal Year 2004 Federal Budget. The first community-based correctional program in southern Nevada is a transition center for inmates in their last four to six months of custody. The RSAT provided therapeutic funds in a correctional setting that is not eligible for SAMHSA funding.[44]

Further, Dr. Brandenburg said that, under the Governor's Homeless Families with Children Policy Academy Committee, an inventory of available housing was completed two years ago. The Commission also discussed the specialized housing needs of the mentally ill. The Commission indicated that it wished to record its purpose is to ensure a linkage between housing dollars and treatment services.

In addition to the adoption of a BDR, the Commission took the following actions to address the lack of affordable housing to enable recovering mentally ill individuals to reenter their communities:

5. Recommend, in its report, that Nevada should take steps to promote, encourage, and facilitate greater access to safe and affordable community-based housing and support services by using an array of resources within the United States Departments of Housing and Urban Development (HUD), and Health and Human Services (HHS), and the Veterans Administration (VA) as leverage. To accomplish this, the Commission approved the following actions:

- **Send a letter to Nevada's Congressional delegation urging the members to support restoration of Residential Substance Abuse Treatment funds in the federal budget.**

- **Include this recommendation in the Commission's report along with a statement regarding the need for housing funds specifically for mentally ill persons.**

- **Request the DMHDS to update the inventory of available housing that was completed two years ago.**

Grant Writer

In the context of housing for homeless persons, the Commission heard testimony from Dr. Frances M. Murphy, Deputy Under Secretary for Health Policy Coordination, U.S. Department of Veterans Affairs, at its October 9, 2003, meeting. Dr. Murphy reported on various housing programs of the federal government through the Department of Veterans Affairs and other departments.

[44] Commission, January 26, 2004.

At its work session, the Commission discussed Nevada's efforts to assist disabled persons to move from institutional to community placements. The key is integrated affordable housing. Categorical funding streams from the federal government are difficult to access. Currently, Nevada funds housing with state General Fund dollars. Those funds could be maximized with federal dollars. Ms. Hutchings, SAMHSA, further urged the Commission to take action on this item because she said the federal government is likely to incentivize the states to develop comprehensive state mental health plans.[45]

On January 26, 2004, the Commission requested the DHR to investigate the costs associated with retaining one or more grant writers in the Department's grants management unit to secure federal and other grants relating to mental health needs of adults and children. Subsequently, the Subcommittee further considered expanding the grant writer's responsibilities to realize the state's goals in obtaining grants for various health care and mental health purposes. On June 28, 2004, the Subcommittee of the Commission took the following action:

6. **Urge, in its report, the Executive Branch to research and provide to the Interim Finance Committee recommendations for a person or firm to provide contract services for the purpose of securing grants that lead to funding mental health, housing, and other health-related services.** (Action by the Subcommittee)

Goal 3: Disparities in mental health services are eliminated.

Recruitment and Retention of Professionals in Rural Areas

Dennis Mohatt, WICHE, testified before the Commission on October 21, 2003, on services to rural residents. Mr. Mohatt advocated recruiting and training rural residents to serve those areas. The cultural differences, facing professionals from urban areas, create difficulties in resettling them to rural areas. Establishing paraprofessional staffing configurations often results in strong opposition from the professional guilds, which express concern about quality of care. Mr. Mohatt suggested the development of a rural strategy that is developed with the guilds as partners.

The Commission took the following action to address this issue:

7. **Urge, in its report, DMHDS to develop a rural recruitment and retention program that acknowledges difficulties in hiring and retaining qualified professionals in rural Nevada. Include rural recruitment and retention in the state's cultural competency plan.**

Cultural Competency

At the January 26, 2004, work session, Gail Hutchings, SAMHSA, said that from the perspective of the New Freedom Commission, cultural competency relates to underserved

[45] Commission, January 26, 2004.

populations. She suggested viewing this concept as a matrix with one side representing rural issues and services; all of the telehealth, telemedicine, telepsychiatry programs; and racial and ethnic issues such as access and language. The other side of the matrix represents workforce issues as well as training, retention, and recruitment issues. Ms. Hutchings also said one of the shortcomings of evidence-based practices is the lack of research based on racial and ethnic monority populations. She suggested that the University of Nevada School of Medicine collaborate with the DMHDS to collect data, ensuring a representative sample size that reflects the people to be served.[46]

The Commission took the following action to address this issue:

8. **Urge, in its report, all state agencies and local governments to develop a cultural competency plan for the state and urge DHR to provide effective assistance for minorities, particularly those who face cultural barriers and lack English proficiency, to receive in-patient and out-patient mental health services.**

Goal 4: Early mental health screening, assessment, and referral to services are common practices.

Professional Staffing Levels

The DMHDS has recognized that it needs to increase the medical capacity of its mental facilities. The DMHDS operates the Joint Committee on Accreditation of Healthcare Organizations (JCAHO), accredited acute psychiatric hospitals and psychiatric emergency services in Reno through the Northern Nevada Adult Mental Health Services, and in Las Vegas through the Southern Nevada Adult Mental Health Services. Each system is currently staffed medically by one senior physician. While acute medical illnesses are not within the scope of practice at either facility or program, psychiatric patients with stable chronic medical illnesses are admitted to receive acute psychiatric services. Recently JCAHO has ruled that all patients admitted into the psychiatric observation unit of the emergency services must receive a complete medical history and physical examination within the first 24 hours of admission. Prior to this ruling, only patients admitted to the acute inpatient hospital received this service. To meet JCAHO requirements and the needs of a growing psychiatric population, additional medical resources are needed.[47]

The Commission deferred action on this item to the Subcommittee. On June 28, 2004, the Subcommittee of the Commission took the following action to address this issue:

9. **Express, in its report, support for the concept of increasing medical staff at the state's mental hospital to accommodate mentally ill patients with physical health issues, and allow DMHDS the flexibility to address the fiscal concerns in the agency's budget through contract services.** (Action by the Subcommittee)

[46] Commission, January 26, 2004.
[47] DMHDS Fiscal Note, B/A 3161 and B/A 3162.

Crisis Triage Center and Crisis Intervention Training

On October 9, 2003, the Commission received information about the crisis in Clark County emergency services. The information included an overview of the triage system and Crisis Intervention Team (CIT) training, which the staff from the Las Vegas Metropolitan Police Department received in Memphis, Tennessee.

The Commission heard testimony at its October 9, 2003, meeting that about 45,000 severely mentally ill people live in Las Vegas and about 10,000 homeless people live on the streets of the city. Estimates of the percentage of mentally ill among the homeless run about 80 percent. Nevada has about 4.5 psychiatric beds per 100,000 population. The time in an emergency room for a indigent mentally ill patient can range from 36 hours to nine days.

At its October 21, 2003, and December 18, 2003, meetings, the Commission received presentations on mentally ill inmates in state prisons, the lack of training among correctional officers to work effectively with mentally ill inmates, and the difficulties in transitioning mentally ill inmates back into the community.

The Commission took the following action to address all of these concerns:

10. Express, in its report, support for the crisis triage center concept throughout the state, including the development and implementation of formalized training for staff that interacts with offenders with mental health disorders, including correctional officers and staff of the Division of Parole and Probation, Nevada's Department of Public Safety.

Child and Adolescent Psychiatrists

The State of Nevada has historically suffered from a shortage of child and adult psychiatrists. In 1991, the University of Nevada School of Medicine (UNSOM), Department of Psychiatry began an adult psychiatry residency training program in Reno. Through Northern Nevada Adult Mental Health Services, the DMHDS has participated actively in training. This program has resulted in an excellent recruiting source of adult psychiatrists for the state mental health system as well as to the population as a whole. In the next biennium, UNSOM is beginning a two-year child fellowship that will train child and adolescent psychiatrists. The DMHDS will participate by using Sierra Regional Center as a training site for first-year child fellows in treating developmentally disabled children and adolescents.

Because of the increasing need, UNSOM has created a second program for training second, third, and fourth year adult psychiatric residents in Las Vegas. The programs began in July 2004. This package includes DMHDS participation using Southern Nevada Adult Mental Health Services, beginning in fiscal year 2006-2007. A child fellowship has been considered for Las Vegas as well, possibly beginning as early as fiscal year 2007.[48]

[48] DMHDS, Fiscal Note, B/A 3168.

At its work session on January 26, 2004, the Commission discussed the need to provide incentives to recruit for the residency program both within Nevada and in other states. Dr. Brandenburg reported that research has shown that there is a greater likelihood that a resident will stay in the same location where he or she receives his or her residency.

The Commission deferred action on this item to the Subcommittee. On June 28, 2004, the Subcommittee of the Commission took the following action to address this issue:

11. **Express, in its report, support for funding of psychiatry fellows from the University of Nevada School of Medicine (UNSOM) and Adolescent Psychiatry Fellowship Training Program for the purpose of reducing the shortage of child and adolescent psychiatrists**. (Action by the Subcommittee)

Psychiatry Residency in Southern Nevada

The Commission also deferred action to the Subcommittee on the recommendation to increase the number of psychiatry residents by supporting the establishment of a new program in southern Nevada. Based on the same information relating to the shortage of child and adolescent psychiatrists, the Subcommittee took the following action to address the establishment of a new psychiatry residency training program in southern Nevada:

12. **Express, in its report, support for the concept of maintenance of UNSOM's psychiatry residency training program in northern Nevada and support for the establishment of a new psychiatry residency training program in southern Nevada.** (Action by the Subcommittee)

Increasing and Integrating Qualified Mental Health Workers

One recurring theme of the New Freedom Commission report was that recovery is impeded by fragmentation of services. During its hearings, the Commission received testimony regarding the shortage of professionals working in rural areas and among certain populations. Another issue addressed by Dr. Stephen Graybar, member of Nevada's Board of Psychological Examiners, was the occurrence of co-morbidity, which he said is so common that it must be viewed as the rule rather than the exception. In his presentation to the Commission on November 4, 2003, Dr. Graybar recommended integrated treatment for the mental health disorder and the co-occurring disorder. At that same meeting, Commission member Maria Canfield presented BADA's treatment strategies, which include building coalitions.

At its work session, the Commission discussed supporting collaborative efforts among the Legislature, the universities, and the professional licensing boards to increase the number of qualified mental health staff. It was apprised by Debra Scott, R.N., Executive Director, Nevada State Board of Nursing, that some elderly and psychiatric disordered consumers are being treated by advance practice nurses. She also cautioned the Commission to ensure that an

expanded scope of practice for licensed alcohol and drug counselors be available only to master's level counselors because Axis 2 mental health disorders are the hardest to treat.[49]

The Commission took the following action to address these concerns:

13. Express, in its report, support for the establishment of residency training, fellows, and paid internships that include alcohol and drug training to increase qualified mental health staff. To accomplish this, the Commission approved the following recommendations:

- **Broaden the pool of qualified geriatric clinicians through the licensing of professional counselors in Nevada;**
- **Expand the scope of practice for licensed alcohol and drug counselors to assess for and oversee the treatment of Axis 2 mental health disorders;**
- **Require certification of professional staff working with older adults, such as completion of a Providers Certificate of Specialization in Aging offered by the Geriatric Education Center at UNSOM; and**
- **Enhance the state's ability to provide integrated substance abuse and mental health services to persons with co-occurring disorders.**

Enhancement of Senior Mental Health Services

On October 21, 2003, the Commission considered the mental health needs of older Nevadans. Suggestions for action made at the meeting include enhancing the ability to provide mental health treatment in a non-traditional setting, ensuring that nurses and psychiatrists have geriatric training and experience, improving geriatric mental health services to address needs of residents as well as staff in group care facilities and skilled nursing facilities, and publicize the need for identification, clinical assessment and treatment of pathological gambling and prescription drug and alcohol abuse in older Nevadans.

The Commission took the following action to address these concerns:

14. Express, in its report, support for the enhancement of senior mental health services.

Goal 5: Excellent mental health care is delivered and research is accelerated.

The report of the New Freedom Commission on Mental Health identified the delay in the application of research to practice. It estimated that the lag between discovering effective new

[49] Commission, January 26, 2004.

treatments and incorporating those treatments into routine patient care is 15 to 20 years. The report further identified four areas that have not been studied enough: disparities in mental health research, long-term use of medications, the impact of trauma, and acute care.[50]

At its work session on January 26, 2004, Dr. Brandenburg said that training programs for clinicians in evidence-based practices for the treatment of depression, panic disorder, and obsessive-compulsive disorder are readily available. Material costs are minimal. Gail Hutchings, SAMHSA, also suggested that the UNSOM collaborate with the DMHDS to collect data.[51]

The Commission took the following actions to address these concerns as they manifest in Nevada:

15. Urge, in its report, UCCSN to assist governmental agencies with behavioral health data collection issues.

16. Urge, in its report, DMHDS to establish mechanisms to monitor the effectiveness of mental health services efforts.

17. Urge, in its report, DHR to establish funding mechanisms or incentives to implement an evidence-based practices agenda.

18. Urge, in its report, DHR to seek funding to purchase materials and train clinicians in evidence-based psychological practices.

Goal 6: Technology is used to access mental health care and information.

The New Freedom Commission urged the increased use of technology to improve access to care and to integrate health records in a personal health information system for providers and patients. The Commission received information about the use of technology in mental health services at its November 20, 2003, meeting. Dr. Stephen Mayberg, Director, California Department of Mental Health, cited among the new technologies electronic personal records, telemedicine, and the use of the Internet for gathering information. Ms. Catherine Britain, President, Telehealth Alliance of Oregon, acknowledged, however, the lack of outcome studies that measure the effectiveness of telehealth services. A presentation from the UNSOM Office of Rural Health provided information on the telemedicine system currently operating at 150 sites throughout Nevada.

At its work session on January 26, 2004, the Commission discussed the need for care when using technology to deliver psychiatric services because of liability and privacy. Ms. Canfield suggested setting guidelines to ensure protection of the public.

[50] New Freedom Commission, pages 69 to 71.
[51] Commission, January 26, 2004.

With regard to services at the three state-operated youth training facilities, Jone Bosworth, Administrator, DCFS, said that the Division currently contracts with a psychiatrist who commutes between the two facilities. That may not provide enough management of medications, however. The DCFS facilities must have adequate psychiatric consultation to ensure that the inmates' medications are maintained when youth enter the facilities. This is an issue separate from the mental health counselors.[52]

The Commission took the following actions to address these concerns:

19. Urge, in its report, DMHDS to implement electronic medical records for all DMHDS clients and urge DMHDS and the Division of Child and Family Services (DCFS) to establish a computerized medical information system to increase coordination, communication, and continuity between and within state and private agencies.

20. Urge, in its report, DMHDS to develop telemental health capacity for rural Nevada for all disciplines, including psychiatry, psychology, social work, juvenile justice, marriage and family therapy, dually licensed (substance abuse and mental health) providers, service coordination, and nursing. Additionally, include in the final report a statement regarding the need to establish telehealth guidelines to protect the public health.

21. Urge, in its report, DCFS to establish telehealth-based psychiatric services at each of the three state-operated youth (correctional) training facilities: the Nevada Youth Training Center in Elko, the Caliente Youth Center in Caliente, and the Summit View Correctional Center in Las Vegas.

[52] Commission, January 26, 2004.

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APPENDIX A

Senate Bill 301 (Chapter 445, *Statutes of Nevada 2003*)

Senate Bill No. 301–Senator Townsend

CHAPTER 445

AN ACT relating to mental health; creating the Nevada Mental Health Plan Implementation Commission to develop an action plan for implementing the recommendations of the President's New Freedom Commission on Mental Health in this state; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. 1. The Nevada Mental Health Plan Implementation Commission is hereby created.

2. The Commission consists of:

(a) Three members of the Senate who are appointed by the Majority Leader of the Senate;

(b) Three members of the Assembly who are appointed by the Speaker of the Assembly;

(c) The Administrator of the Division of Mental Health and Developmental Services of the Department of Human Resources, or his designee;

(d) The Chief of the Bureau of Alcohol and Drug Abuse within the Health Division of the Department of Human Resources, or his designee;

(e) The Administrator of the Division of Health Care Financing and Policy of the Department of Human Resources, or his designee; and

(f) The Administrator of the Division of Child and Family Services of the Department of Human Resources, or his designee.

3. At its first meeting, the members of the Commission shall elect a chair from among its members.

Sec. 2. 1. The members of the Nevada Mental Health Plan Implementation Commission serve on the Commission for 6 months beginning on the day the President's New Freedom Commission on Mental Health Report is made public.

2. A vacancy occurring in the membership of the Commission must be filled in the same manner as the original appointment.

3. The Commission shall meet at the times and places specified by a call of the Chair of the Commission.

4. A majority of the members of the Commission constitutes a quorum for the transaction of business, and a majority of a quorum present at any meeting is sufficient for any official action taken by the Commission.

Sec. 3. 1. Except during a regular or special session of the Legislature, for each day or portion of a day during which a member of the Commission who is a Legislator attends a meeting of the Commission or is otherwise engaged in the work of the Commission, he is entitled to receive the:

(a) Compensation provided for a majority of the members of the Legislature during the first 60 days of the preceding session;

(b) Per diem allowance provided for state officers and employees generally; and

(c) Travel expenses provided pursuant to NRS 218.2207.

The compensation, per diem allowances and travel expenses of the legislative members of the Commission must be paid from the Legislative Fund.

2. Members of the Nevada Mental Health Plan Implementation Commission who are not Legislators serve without compensation, except that a member of the Commission is entitled, while engaged in the business of the Commission, to receive the per diem allowance and travel expenses provided for state officers and employees generally.

3. Each member of the Commission who is an officer or employee of the State of Nevada or a local government must be relieved from his duties without loss of his regular compensation so that he may prepare for and attend meetings of the Commission and perform any work necessary to carry out the duties of the Commission in the most timely manner practicable. A state agency or local governmental entity shall not require an officer or employee who is a member of the Commission to make up the time that he is absent from work to carry out his duties as a member of the Commission or to use annual vacation or compensatory time for the absence.

Sec. 4. 1. The Nevada Mental Health Plan Implementation Commission shall:

(a) Determine how Nevada will implement the recommendations of the President's New Freedom Commission on Mental Health to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn and participate fully in their communities; and

(b) Develop an action plan for implementing the recommendations in this state.

2. The Commission shall submit a report setting forth the action plan developed pursuant to this section to the Interim Finance Committee, the Subcommittee to Study Mental Health Issues of the Legislative Committee on Health Care and the Governor on or before January 1, 2005.

Sec. 5. This act becomes effective on July 1, 2003, and expires by limitation on January 1, 2005.

APPENDIX B

Executive Summary.
Achieving the Promise: Transforming Mental Health Care in America.
Final Report. New Freedom Commission on Mental Health.
United States Department of Health and Human Services

THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

EXECUTIVE SUMMARY

FINAL REPORT
JULY 2003

President's New Freedom Commission on Mental Health
Achieving the Promise: Transforming Mental Health Care in America

Executive Summary

Vision Statement

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

In February 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. The Initiative also promotes increased access to assistive and universally designed technologies and full access to community life. Not since the Americans with Disabilities Act (ADA) - the landmark legislation providing protections against discrimination - and the Supreme Court's *Olmstead v. L.C.* decision, which affirmed the right to live in community settings, has there been cause for such promise and opportunity for full community participation for all people with disabilities, including those with psychiatric disabilities.

On April 29, 2002, the President identified three obstacles preventing Americans with mental illnesses from getting the excellent care they deserve:

- Stigma that surrounds mental illnesses,
- Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and
- The fragmented mental health service delivery system.

The President's New Freedom Commission on Mental Health (called *the Commission* in this report) is a key component of the New Freedom Initiative. The President launched the Commission to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks.

In his charge to the Commission, the President directed its members to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers,

can implement. Executive Order 13263 detailed the instructions to the Commission. (*See the Appendix.*)

The Commission's findings confirm that there are unmet needs and that many barriers impede care for people with mental illnesses. Mental illnesses are shockingly common; they affect almost every American family. It can happen to a child,[a] a brother, a grandparent, or a co-worker. It can happen to someone from any background - African American, Alaska Native, Asian American, Hispanic American, Native American, Pacific Islander, or White American. It can occur at any stage of life, from childhood to old age. No community is unaffected by mental illnesses; no school or workplace is untouched.

In any given year, about 5% to 7% of adults have a serious mental illness, according to several nationally representative studies.[1-3] A similar percentage of children - about 5% to 9% - have a serious emotional disturbance. These figures mean that millions of adults and children are disabled by mental illnesses every year.[1; 4]

President Bush said,

> "... Americans must understand and send this message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

Over the years, science has broadened our knowledge about mental health and illnesses, showing the potential to improve the way in which mental health care is provided. The U.S. Department of Health and Human Services (HHS) released *Mental Health: A Report of the Surgeon General*,[5] which reviewed scientific advances in our understanding of mental health and mental illnesses. However, despite substantial investments that have enormously increased the scientific knowledge base and have led to developing many effective treatments, many Americans are not benefiting from these investments.[6; 7]

Far too often, treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity. For instance, according to the Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years.[8]

In its report, the Institute of Medicine (IOM) described a strategy to improve the quality of health care during the coming decade, including priority areas for refinement.[9] These documents, along with other recent publications and research findings, provide insight into the importance of mental heath, particularly as it relates to overall health.

In this *Final Report*...

Adults with a serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R *(Diagnostic and Statistical Manual for Mental Disorders)*[10], that has resulted in functional impairment[b] which substantially interferes with or limits one or more major life activities.

A serious emotional disturbance is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.[11]

Mental Illnesses Presents Serious Health Challenges

Mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe.[12] This serious public health challenge is under-recognized as a public health burden. In addition, one of the most distressing and preventable consequences of undiagnosed, untreated, or under-treated mental illnesses is suicide. The World Health Organization (WHO) recently reported that suicide worldwide causes more deaths every year than homicide or war .[13]

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount - approximately $63 billion - reflects the loss of productivity as a result of illnesses. But indirect costs also include almost $12 billion in mortality costs (lost productivity resulting from premature death) and almost $4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care.[14]

In 1997, the latest year comparable data are available, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57%, compared to 46% of overall health care expenditures. Between 1987 and 1997, mental health spending did not keep pace with general health care because of declines in private health spending under managed care and cutbacks in hospital expenditures.[15]

In 1997, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses.

The Current Mental Health System Is Complex

In its *Interim Report to the President*, the Commission declared, "... the mental health delivery system is fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration." The report described the extent of unmet needs and barriers to care, including:

- Fragmentation and gaps in care for children,
- Fragmentation and gaps in care for adults with serious mental illnesses,
- High unemployment and disability for people with serious mental illnesses,
- Lack of care for older adults with mental illnesses, and

- Lack of national priority for mental health and suicide prevention.

The *Interim Report* concluded that the system is not oriented to the single most important goal of the people it serves - the hope of recovery. State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs.

The Commission recognizes that thousands of dedicated, caring, skilled providers staff and manage the service delivery system. The Commission does not attribute the shortcomings and failings of the contemporary system to a lack of professionalism or compassion of mental health care workers. Rather, problems derive principally from the manner in which the Nation's community-based mental health system has evolved over the past four to five decades. In short, the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on. It needs to integrate programs that are fragmented across levels of government and among many agencies.

Building on the research literature and comments from more than 2,300 consumers,[c] family members, providers, administrators, researchers, government officials, and others who provided valuable insight into the way mental health care is delivered, after its yearlong study, the Commission concludes that traditional reform measures are not enough to meet the expectations of consumers and families.

To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America. The goals of this fundamental change are clear and align with the direction that the President established.

To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America.

The Goal of a Transformed System: Recovery

To achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services. Advances in research, technology, and our understanding of how to treat mental illnesses provide powerful means to transform the system. In a transformed system, consumers and family members will have access to timely and accurate information that promotes learning, self-monitoring, and accountability. Health care providers will rely on up-to-date knowledge to provide optimum care for the best outcomes.

When a serious mental illness or a serious emotional disturbance is first diagnosed, the health care provider - in full partnership with consumers and families - will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing *who*, *what*, and *how* appropriate health care will be provided:

- Choosing which mental health care professionals are on the team,
- Sharing in decision making, and
- Having the option to agree or disagree with the treatment plan.

The highest quality of care and information will be available to consumers and families, regardless of their race, gender, ethnicity, language, age, or place of residence. Because recovery will be the common, recognized outcome of mental health services, the stigma surrounding mental illnesses will be reduced, reinforcing the hope of recovery for every individual with a mental illness.

In this *Final Report*...

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations.[16] Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care.[5] Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

As more individuals seek help and share their stories with friends and relatives, compassion will be the response, not ridicule.

Successfully transforming the mental health service delivery system rests on two principles:

- **First, services and treatments must be consumer and family centered**, geared to give consumers real and meaningful choices about treatment options and providers - not oriented to the requirements of bureaucracies.

- **Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience,** not just on managing symptoms.

Built around consumers' needs, the system must be seamless and convenient.

In this *Final Report*...

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members.

Transforming the system so that it will be both consumer and family centered and recovery-oriented in its care and services presents invigorating challenges. Incentives must change to encourage continuous improvement in agencies that provide care. New, relevant research findings must be systematically conveyed to

front-line providers so that they can be applied to practice quickly. Innovative strategies must inform researchers of the unanswered questions of consumers, families, and providers. Research and treatment must recognize both the commonalities and the differences among Americans and must offer approaches that are sensitive to our diversity. Treatment and services that are based on proven effectiveness and consumer preference - not just on tradition or outmoded regulations - must be the basis for reimbursements.

The Nation must invest in the infrastructure to support emerging technologies and integrate them into the system of care. This new technology will enable consumers to collaborate with service providers, assume an active role in managing their illnesses, and move more quickly toward recovery.

The Commission identified the following six goals as the foundation for transforming mental health care in America. The goals are intertwined. No single step can achieve the fundamental restructuring that is needed to transform the mental health care delivery system.

Goals: In a transformed Mental Health System ...

Goal 1	**Americans Understand that Mental Health Is Essential to Overall Health.**
Goal 2	**Mental Health Care Is Consumer and Family Driven.**
Goal 3	**Disparities in Mental Health Services Are Eliminated.**
Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**

Achieving these goals will transform mental health care in America.

The following section of this report gives an overview of each goal of the transformed system, as well as the Commission's recommendations for moving the Nation toward achieving it. In the remainder of this report, the Commission discusses each goal in depth, showcasing model programs to illustrate the goal in practice and providing specific recommendations needed to transform the mental health system in America.

Goal 1 - Americans Understand that Mental Health Is Essential to Overall Health

In a transformed mental health system, Americans will seek mental health care when they need it - with the same confidence that they seek treatment for other health problems. As a Nation, we will take action to ensure our health and well being through learning, self-monitoring, and accountability. We will continue to learn how to achieve and sustain our mental health.

The stigma that surrounds mental illnesses and seeking care for mental illnesses will be reduced or eliminated as a barrier. National education initiatives will shatter the misconceptions about mental illnesses, thus helping more Americans understand the facts and making them more willing to seek help for mental health problems. Education campaigns will also target specific audiences, including:

- Rural Americans who may have had little exposure to the mental health service system,
- Racial and ethnic minority groups who may hesitate to seek treatment

in the current system, and

- People whose primary language is not English.

When people have a personal understanding of the facts, they will be less likely to stigmatize mental illnesses and more likely to seek help for mental health problems. The actions of reducing stigma, increasing awareness, and encouraging treatment will create a positive cycle that leads to a healthier population. As a Nation, we will also understand that good mental health can have a positive impact on the course of other illnesses, such as cancer, heart disease, and diabetes.

Improving services for individuals with mental illnesses will require paying close attention to how mental health care and general medical care systems work together. While mental health and physical health are clearly connected, the transformed system will provide collaborative care to bridge the gap that now exists.

Effective mental health treatments will be more readily available for most common mental disorders and will be better used in primary care settings. Primary care providers will have the necessary time, training, and resources to appropriately treat mental health problems. Informed consumers of mental health service will learn to recognize and identify their symptoms and will seek care without the fear of being disrespected or stigmatized. Older adults, children and adolescents, individuals from ethnic minority groups, and uninsured or low-income patients who are treated in public health care settings will receive care for mental disorders.

Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses.

The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a recovery-oriented system of care.

To aid in transforming the mental health system, the Commission makes two recommendations:

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Goal 2 - Mental Health Care Is Consumer and Family Driven

In a transformed mental health system, a diagnosis of a serious mental illness or a serious emotional disturbance will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care. This detailed roadmap - a personalized, highly individualized health management program - will help lead the way to appropriate treatment and supports that are oriented toward recovery and resilience. Consumers, along with service providers, will actively participate in designing and developing the systems of care in which they are involved.

An individualized plan of care will give consumers, families of children with serious emotional disturbances, clinicians, and other providers a valid

opportunity to construct and maintain meaningful, productive, and healing relationships. Opportunities for updates - based on changing needs across the stages of life and the requirement to review treatment plans regularly - will be an integral part of the approach. The plan of care will be at the core of the consumer-centered, recovery-oriented mental health system. The plan will include treatment, supports, and other assistance to enable consumers to better integrate into their communities; it will allow consumers to realize improved mental health and quality of life.

In partnership with their health care providers, consumers and families will play a larger role in managing the funding for their services, treatments, and supports. Placing financial support increasingly under the management of consumers and families will enhance their choices. By allowing funding to follow consumers, incentives will shift toward a system of learning, self-monitoring, and accountability. This program design will give people a vested economic interest in using resources wisely to obtain and sustain recovery.

The transformed system will ensure that needed resources are available to consumers and families. The burden of coordinating care will rest on the system, not on the families or consumers who are already struggling because of a serious illness. Consumers' needs and preferences will drive the types and mix of services provided, considering the gender, age, language, development, and culture of consumers.

The plan of care will be at the core of the consumer-centered, recovery-oriented mental health system.

To ensure that needed resources are available to consumers and families in the transformed system, States will develop a comprehensive mental health plan to outline responsibility for coordinating and integrating programs. The State plan will include consumers and families and will create a new partnership among the Federal, State, and local governments. The plan will address the full range of treatment and support service programs that mental health consumers and families need.

In exchange for this accountability, States will have the flexibility to combine Federal, State, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice systems.

Increased flexibility and stronger accountability will expand the choices and the array of services and supports available to attain the desired outcomes. Creative programs will be developed to respond to the needs and preferences of consumers and families, as reflected in their individualized plans of care.

Giving consumers the ability to participate fully in their communities will require a few essentials:

- Access to health care,
- Gainful employment opportunities,
- Adequate and affordable housing, and
- The assurance of not being unjustly incarcerated.

Strong leadership will need to:

- Align existing programs to deliver services effectively,
- Remove disincentives to employment (such as loss of financial benefits or having to choose between employment and health care), and
- Provide for a safe place to live.

In this transformed system, consumers' rights will be protected and enhanced. Implementing the 1999 *Olmstead v. L.C* decision in all States will allow services to be delivered in the most integrated setting possible - services in communities rather than in institutions. And services will be readily available so that consumers no longer face unemployment, homelessness, or incarceration because of untreated mental illnesses.

No longer will parents forgo the mental health services that their children desperately need. No longer will loving, responsible American parents face the dilemma of trading custody for care. Families will remain intact. Issues of custody will be separated from issues of care.

In this transformed system, stigma and discrimination against people with mental illnesses will not have an impact on securing health care, productive employment, or safe housing. Our society will not tolerate employment discrimination against people with serious mental illnesses - in either the public or private sector.

Consumers' rights will be protected concerning the use of seclusion and restraint. Seclusion and restraint will be used only as safety interventions of last resort, not as treatment interventions. Only licensed practitioners who are specially trained and qualified to assess and monitor consumers' safety and the significant medical and behavioral risks inherent in using seclusion and restraint will be able to order these interventions.

The hope and the opportunity to regain control of their lives -often vital to recovery - will become real for consumers and families. Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery.

To aid in transforming the mental health system, the Commission makes five recommendations:

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

2.4 Create a Comprehensive State Mental Health Plan.

2.5 Protect and enhance the rights of people with mental illnesses.

Goal 3 - Disparities in Mental Health Services Are Eliminated

In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. Mental health care will be highly personal, respecting and responding to individual differences and backgrounds. The workforce will include members of ethnic, cultural, and linguistic minorities who are trained and employed as mental health service providers. People who live in rural and remote geographic areas will have access to mental health professionals and other needed resources. Advances in treatments will be available in rural and less populated areas. Research and training will continuously aid clinicians in understanding how to appropriately tailor interventions to the needs of consumers, recognizing factors such as age, gender, race, culture, ethnicity, and locale.

Services will be tailored for culturally diverse populations and will provide access, enhanced quality, and positive outcomes of care. American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans will not continue to bear a disproportionately high burden of disability from mental health disorders.[1] These populations will have accessible, available mental health services. They will receive the same high quality of care that all Americans receive. To develop culturally competent treatments, services, care, and support, mental health research will include these underserved populations. In addition, providers will include individuals who share and respect the beliefs, norms, values, and patterns of communication of culturally diverse populations.

In rural and remote geographic areas, service providers will be more readily available to help create a consumer-centered system. Using such tools as videoconferencing and telehealth, advances in treatments will be brought to rural and less populated areas of the country. These technologies will be used to provide care at the same time they break down the sense of isolation often experienced by consumers.

Mental health education and training will be provided to general health care providers, emergency room staff, and first responders, such as law enforcement personnel and emergency medical technicians, to overcome the uneven geographic distribution of psychiatrists, psychologists, and psychiatric social workers.

> ***In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location.***

To aid in transforming the mental health system, the Commission makes two recommendations:

> **3.1 Improve access to quality care that is culturally competent.**
>
> **3.2 Improve access to quality care in rural and geographically remote areas.**

Goal 4 - Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

In a transformed mental health system, the early detection of mental health problems in children and adults - through routine and comprehensive testing and screening - will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from

escalating. For example, a child whose serious emotional disturbance is identified early will receive care, preventing the potential onset of a co-occurring substance use disorder and breaking a cycle that otherwise can lead to school failure and other problems.

Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems. Both children and adults will be screened for mental illnesses during their routine physical exams.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders.

Early detection of mental disorders will result in substantially shorter and less disabling courses of impairment.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening.

To aid in transforming the mental health system, the Commission makes four recommendations:

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

Goal 5 - Excellent Mental Health Care Is Delivered and Research Is Accelerated

In a transformed mental health system, consistent use of evidence-based, state-of-the art medications and psychotherapies will be standard practice throughout the mental health system. Science will inform the provision of services, and the experience of service providers will guide future research. Every time any American - whether a child or an adult, a member of a majority or a minority, from an urban or rural area - comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works. That care will be delivered according to the consumer's individualized plan.

Research has yielded important advances in our knowledge of the brain and behavior, and helped develop effective treatments and service delivery strategies for many mental disorders. In a transformed system, research will be used to develop new evidence-based practices to prevent and treat mental

illnesses. These discoveries will be immediately put into practice. Americans with mental illnesses will fully benefit from the enormous increases in the scientific knowledge base and the development of many effective treatments.

Also benefiting from these developments, the workforce will be trained to use the most advanced tools for diagnosis and treatments. Translating research into practice will include adequate training for front-line providers and professionals, resulting in a workforce that is equipped to use the latest breakthroughs in modern medicine. Research discoveries will become routinely available at the community level. To realize the possibilities of advances in treatment, and ultimately in prevention or a cure, the Nation will continue to invest in research at all levels.

Knowledge about evidence-based practices (the range of treatments and services of well-documented effectiveness), as well as emerging best practices (treatments and services with a promising but less thoroughly documented evidentiary base), will be widely circulated and used in a variety of mental health specialties and in general health, school-based, and other settings. Countless people with mental illnesses will benefit from improved consumer outcomes including reduced symptoms, fewer and less severe side effects, and improved functioning. The field of mental health will be encouraged to expand its efforts to develop and test new treatments and practices, to promote awareness of and improve training in evidence-based practices, and to better finance those practices.

Research discoveries will become routinely available at the community level.

The Nation will have a more effective system to identify, disseminate, and apply proven treatments to mental health care delivery. Research and education will play critical roles in the transformed mental health system. Advanced treatments will be available and adapted to individual preferences and needs, including language and other ethnic and cultural considerations. Investments in technology will also enable both consumers and providers to find the most up-to-date resources and knowledge to provide optimum care for the best outcomes. Studies will incorporate the unique needs of cultural, ethnic, and linguistic minorities and will help ensure full access to effective treatment for all Americans.

To aid in transforming the mental health system, the Commission makes four recommendations:

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6 - Technology Is Used to Access Mental Health Care and Information

In a transformed mental health system, advanced communication and information technology will empower consumers and families and will be a tool for providers to deliver the best care. Consumers and families will be able to regularly communicate with the agencies and personnel that deliver treatment and support services and that are accountable for achieving the goals outlined in the individual plan of care. Information about illnesses, effective treatments, and the services in their community will be readily available to consumers and families.

Access to information will foster continuous, caring relationships between consumers and providers by providing a medical history, allowing for self-management of care, and electronically linking multiple service systems. Providers will access expert systems that bring to bear the most recent breakthroughs and studies of optimal outcomes to facilitate the best care options. Having agreed to use the same health messaging standards, pharmaceutical codes, imaging standards, and laboratory test names, the Nation's health system will be much closer to speaking a common language and providing superior patient care. Informed consumers and providers will result in better outcomes and will more efficiently use resources.

Electronic health records can improve quality by promoting adoption and adherence to evidence-based practices through inclusion of clinical reminders, clinical practice guidelines, tools for clinical decision support, computer order entry, and patient safety alert systems. For example, prescription medications being taken or specific drug allergies would be known, which could prevent serious injury or death resulting from drug interactions, excessive dosages or allergic reactions.

Access to care will be improved in many underserved rural and urban communities by using health technology, telemedicine care, and consultations. Health technology and telehealth will offer a powerful means to improve access to mental health care in underserved, rural, and remote areas. The privacy of personal health information - especially in the case of mental illnesses - will be strongly protected and controlled by consumers and families. With appropriate privacy protection, electronic records will enable essential medical and mental health information to be shared across the public and private sectors.

Reimbursements will become flexible enough to allow implementing evidence-based practices and coordinating both traditional clinical care and e-health visits. In both the public and private sectors, policies will change to support these innovative approaches.

The privacy of personal health information - especially in the case of mental illnesses - will be strongly protected and controlled by consumers and families.

An integrated information technology and communications infrastructure will be critical to achieving the five preceding goals and transforming mental health care in America. To address this technological need in the mental health care system, this goal envisions two critical technological components:

- A robust telehealth system to improve access to care, and
- An integrated health records system and a personal health information system for providers and patients.

To aid in transforming the mental health system, the Commission makes two recommendations:

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

Preventing mental illnesses remains a promise of the future. Granted, the best option is to avoid or delay the onset of any illness, but the Executive Order directed the Commission to conduct a comprehensive study of the delivery of mental health services. The Commission recognizes that it is better to prevent an illness than to treat it, but unmet needs and barriers to services must first be identified to reach the millions of Americans with existing mental illnesses who are deterred from seeking help. The barriers may exist for a variety of reasons:

- Stigma,
- Fragmented services,
- Cost,
- Workforce shortages,
- Unavailable services, and
- Not knowing where or how to get care.

These barriers are all discussed in this report.

The Commission - aware of all the limitations on resources - examined realigning Federal financing with a keen awareness of the constraints. As such, the policies and improvements recommended in this *Final Report* reflect policy and program changes that make the most of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers, coupled with a strong measure of accountability. A transformed mental health system will more wisely invest resources to provide optimal care while making the best use of limited resources.
The process of transforming mental health care in America drives the system toward a delivery structure that will give consumers broader discretion in how care decisions are made. This shift will give consumers more confidence to require that care be sensitive to their needs, that the best available treatments and supports be available, and that demonstrably effective technologies be widely replicated in different settings. This confidence will then enhance cooperative relationships with mental health care professionals who share the hope of recovery.

Goals and Recommendations In a Transformed Mental Health System ...		
Goal 1	**Americans Understand that Mental Health Is Essential to Overall Health.**	
	Recommendations	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 1.2 Address mental health with the same

		urgency as physical health.
Goal 2	**Mental Health Care Is Consumer and Family Driven.**	
	Recommendations	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery. 2.3 Align relevant Federal programs to improve access and accountability for mental health services. 2.4 Create a Comprehensive State Mental Health Plan. 2.5 Protect and enhance the rights of people with mental illnesses.
Goal 3	**Disparities in Mental Health Services Are Eliminated.**	
	Recommendations	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas.
Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**	
	Recommendations	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**	
	Recommendations	**5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.** **5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.** **5.3 Improve and expand the workforce providing evidence-based mental health services and supports.** **5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.**
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**	
	Recommendations	**6.1 Use health technology and telehealth**

		to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations. **6.2 Develop and implement integrated electronic health record and personal health information systems.**

Footnotes:

a. In this Final Report, whenever child or children is used, it is understood that parents or guardians should be included in the process of making choices and decisions for minor children. This allows the family to provide support and guidance when developing relationships with mental health professionals, community resource representatives, teachers, and anyone else the individual or family invites. This same support and guidance can also include family members for individuals older than 18 years of age.

b. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities, including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts (Section 1912 (c) of the Public Health Services Act, as amended by Public Law 102?321).

c. In this Final Report, consumer identifies people who use or have used mental health services (also known as mental health consumers, survivors, patients, or clients).

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APPENDIX C

An Overview of MHDS, Carlos Brandenburg, Ph.D., Administrator.
Division of Mental Health and Developmental Services,
Nevada's Department of Human Services

An Overview of MHDS

Presented to
Nevada
Mental Health Plan
Implementation Commission
SB 301

September 2003

DIVISION ADMINISTRATOR,
CARLOS BRANDENBURG, PH.D.

DEPUTY ADMINISTRATOR
DEBBIE HOSSELKUS, LSW

COMPILED BY
KEVIN CROWE, ED.D.
CHIEF, PLANNING AND EVALUATION UNIT

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Nevada Mental Health Plan Implementation Commission 2003

The Division of MHDS provides a variety of in-patient and outpatient services to best meet the changing needs of Nevadans

Reports concerning strategic planning, medication, needs assessment and other topics can be accessed. For further information regarding the Division of MHDS and any of it's agencies, please visit our website at:

http://mhds.state.nv.us/

New Beginnings Characterized The Past Two Years

The US Congress declared the 1990's the "Decade of the Brain".

"The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a call to action for suicide prevention in 1999 as well."

"We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health."

President Bush established the "New Freedom Commission on Mental Health".
The commission was established as part of the President's agenda to ensure that American's with mental illness not fall through cracks, that lives not be lost, and that recovery be a realistic goal of treatment.

Senator Randolph J. Townsend was selected by the President to serve as a Commissioner on his New Freedom Commission on Mental Health.

It is with great pleasure that I present to the Nevada Mental Health Plan Implementation Commission (SB301) this report which is designed to give you an overview of the Division's programs, and understanding of our accomplishments and major new plans for the next two years.

Our programs can be characterized by continuing key services to Nevadan's who have mental illness or are developmentally disabled, the development of new and innovative programs and by overall increasing consumer demand.

Nowhere is this more apparent than with new programs such the mental health Consumer Assistance Program, and new intensive residential supports for use with clients who are being discharged from Nevada's legal system.

Construction was completed at Lakes Crossing Center for the Mentally Disordered Offender in Sparks NV, which increased our forensic bed capacity from 36 to 48. We also opened a new state of the art psychiatric hospital in Northern Nevada in September 2001, named the Dini-Townsend Hospital.

We made other systemic changes too; for example, the 2001 Nevada Legislature authorized renaming the old Nevada Mental Health Institute to the Northern Nevada Adult Mental Health Services (NNAMHS). This name change reflects our commitment to move Nevada's system of care forward from an obsolete institutional treatment model where people were separated from family and community in distant castle like buildings away from social events and friends to a community-based system of care.

Support from Governor Guinn and the Legislature enabled MHDS to provide new community-based mental health programs to assist those consumers who rely on our outpatient services. All MHDS programs are intended to reduce the need for hospitalization and foster consumer recovery in the community. Our programs are designed to insure we meet the intent of the *Olmstead* decision. The federal act resulting from this decision was geared to require a State to move people from an institutional setting to a community setting with all reasonable speed to accommodate the change in placement. Among these outpatient programs and special highlights are:

- Programs for Assertive Community Treatment

(P.A.C.T.) continue to provide highly specialized services for the most seriously mentally ill residing in the community setting. The PACT model has demonstrated effectiveness for the most severely mentally ill (SMI) who comprise 20 to 40 percent of the SMI population. These consumers include those who have major psychiatric symptoms that may only partially improve but who can be maintained in the community with medication and the intensive treatments offered through the P.A.C.T. program. New for this year, we added substance abuse counselors to these programs so that the unique needs of these individuals can be more effectively met. Our P.A.C.T. programs clearly have met the goal of reducing hospital recidivism.

- Supported housing services at SNAMHS currently serve 584 indigent seriously mentally ill clients. Priority is given to patients recently discharged from our inpatient psychiatric hospital. Placement levels include, among others, intensive supported living arrangements (ISLA) and special needs beds. Intensive supportive living arrangements (ISLAs) provide 24-hour awake supervision of clients who otherwise would require inpatient hospital care. These services are provided in independent apartment community settings with additional individualized support services based on client needs and choice. In addition, 'Special needs' beds provide independent apartment community settings for medically compromised mentally ill clients who require additional nursing supervision. These placements provide service to clients who otherwise would have remained in the inpatient psychiatric hospital only because self care of their medical condition is compromised by mental illness.

- Nevada's first-ever Consumer Assistance Program began in June 2002, providing the employment of six mental health consumers as state employees to facilitate consumer recovery and integrate consumers into the service delivery system.
- NNAMHS consumer classroom offered for the first time brand new computers for consumers in a classroom setting, to let them gain skills so they can return to work.

- Provided substantial funding increases from FY01 for the prescription of the newer and safer anti-depressants and antipsychotic (AAP's) medications. In FY02, the MH medication budget was $11,157,803 which was 15.70 % of the total budget. For comparison, FY01 was budgeted at $7,955,095 or 13.19% of the budget.

MHDS Strategic Plan Goal #1:

Provide and promote high quality and cost effective services in a safe environment

Data Excerpts from the NASMHPD Research Institute Report Draft:

"Funding Sources and Expenditures of State Mental Health Agencies in Fiscal Year 2001":

MHDS spent 1% of their total expenditures on Administration compared to the National average of 4.1%.

MHDS expenditures for Inpatient Services were 29% of the total expenditures Compared to the national average of 39%.

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Vision

For all Nevadans with mental illness or developmental disabilities to realize their optimal potential as individuals and as positive productive citizens of their community and state.

- A Mental Health Court was established in Washoe County, whereby certain mentally ill offenders who volunteer for the special court receive a mental health treatment program instead of jail time for minor offenses. They must check in with the court regularly. The Washoe County court has succeeded in part because judges volunteer their lunch time once a week to hear cases. Recent data shows it has reduced repeat offenders. Five of the 32, or about 15 percent of the mentally ill offenders who have participated the Washoe special court have had their probation revoked. Assemblywoman Sheila Leslie, D-Reno, sponsored the state bill that created the pilot program in Washoe County.

- We expanded our mental health program for senior citizens in Southern Nevada into Northern Nevada (Reno). This program is a collaborative effort between the Division of Mental Health and Developmental Services, the Division of Aging Services and the Bureau of Alcohol and Drug Abuse. The goal of both the Northern and Southern Senior Outreach Programs is to improve the mental health service delivery system for elder Nevadans. The target population is older adults who have undiagnosed and untreated illnesses such as depression and alcoholism. These senior outreach programs seeks to impact on the staggering rates of suicide in Nevadans aged 65 and older.

- The Division continues to update its Division wide Mental Health disaster response plan. This plan continues to be called into use, and over the past two years was utilized to provide crisis mental health services to Nevadans in emergencies as the result of wildfires and other small scale disasters;
particularly the Walker (CA) River Wildfire during the Summer of 2002, during which the tragic crash of the rescuing Forest Service air tanker into the community distressed the
population of the small town on the Nevada-California border. Our staff even worked alongside professionals from Placer County (CA) mental health to respond to the interstate needs of the Walker community.

- Over the past two years, we have all become affected by terrorism in our country. Even here in Nevada our programs were directly affected by the September 11, 2001 tragedy at the New York World Trade Center; as we were called upon to send NV mental health professionals to assist there, and placed others on standby. We <u>were</u> ready to help.

- Over the past two years we have put in place a new website, which was recognized as a national model in 2002 for its user friendliness. Visit us at http://mhds.state.nv.us.

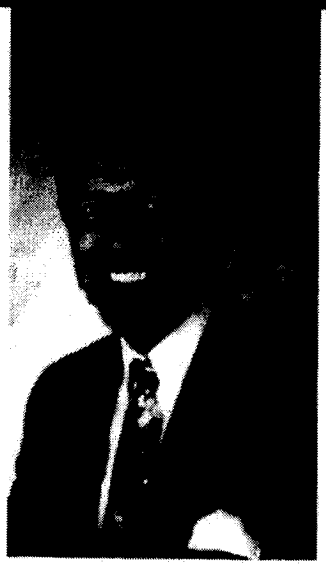
In closing, I am proud of our progress. But while these past years have seen many accomplishments, clearly the future is unfolding as a time for wise planning to meet tomorrows challenges.

Now, more than ever, the participation of our stakeholders is required to move our programs ahead cost effectively. More than ever, we need and appreciate your support.

Sincerely,

Carlos Brandenburg, Administrator

FROM THE ADMINISTRATOR



DIVISION ADMINISTRATOR, CARLOS BRANDENBURG, PH.D.

Dr. Brandenburg received his Ph.D. from the University of Nevada, Reno.
As the Administrator of the Division of Mental Health and Developmental Services, he supervises over 1100 employees and a budget of over 225 million dollars.
In 1995, when Dr. Brandenburg became the Administrator for the Division, Nevada was ranked 49th in actual dollars and per capita expenditures. As of 1999, Nevada is now ranked 35th.

MHDS MISSION

Our mission statement is an invaluable tool for directing, planning and achieving the Goals of the Division of MHDS.

In coordination with the mission statement, budgets are developed to assist with meeting the goals of the Division as well as ensure that we meet the needs of Nevada consumers.

Mission Statement for the Division of Mental Health and Developmental Services

Working in partnership with consumers, families, advocacy groups, agencies and diverse communities, the Division of Mental Health and Developmental Services provides responsive services and informed leadership to ensure quality outcomes. This mission includes treatment in the least restrictive environment, prevention, education, habilitation and rehabilitation for Nevadans challenged with mental illness or developmental disabilities. These services shall maximize each individuals' degree of independence, functioning and satisfaction.

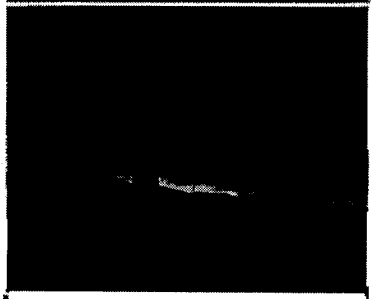
Division of Mental Health and Developmental Services Overview

The Division of Mental Health and Developmental Services (MHDS) provides services to over 25,000 Nevadans, (22,341 Mental Health clients and 3153 Developmental Services clients (total = 25,494 in Fiscal Year 2002) across 96,000 square miles of Nevada in both urban and rural areas. This is an increase of 9% from FY 2001. In addition to these direct consumers, the Division works with many stakeholders, including family members, advocates, service providers, legislators, the general public, and law enforcement. As a result of these diverse interests, the issues facing the Division in addition to being complex, are also viewed 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/developmental services system that meets the needs of Nevada's citizens.

The Division of 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. The Division 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 which 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, assure services are offered in the "least restrictive environment," base services upon individual needs, and honor consumers rights. The Division is committed to providing quality cost effective services that ensure consumer and citizen safety, are readily accessible to all persons in need, are responsive to local needs, are consumer-driven and promote self-sufficiency.

The MHDS Division is located within the Department of Human Resources. The Division Administrator, appointed by the Governor, relies on the oversight and direction of stakeholders as represented in several advisory groups. A Commission on Mental Health and Developmental Services is appointed by the Governor and "establishes policies to ensure adequate development and administration of services for the mentally ill, developmentally disabled and related conditions ..." The Commission has several powers related to the oversight of programs within the Division. Local Advisory Boards exist within each region by authority of the Commission and are involved with local agency issues. Administration and services are organized into three regions: North, South and Rural.

DIVISION OVERVIEW



"Mental disorders collectively account for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer"

Disease burden by selected illness categories in established market economies, 1990

	% of total DALYS*
All cardiovascular conditions	18.6
All mental illness **	15.4
All malignant disease	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious/ parasitic disease	2.8
All drug use	1.5

*Disability-adjusted life year. (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration. (Murray&Lopez,1996)

**Disease burden associated with mental illness includes suicide

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MHDS

MHDS
Strategic Plan
Goal #2:

Promote and support the least restrictive services possible in people's own communities while reducing reliance on institutional placement.

Strengthen community-based services to support people with multiple and complex needs.

Mental Health.

A full range of adult mental health services are provided by the Division which are categorized into the following programs by agency:

NNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services and Program for Assertive Community Treatment (PACT).

Rural Clinics: Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, and Residential Programs. Rural Clinics also provides services to children and youth.

SNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services, Intensive Service Coordination, Senior Outreach and Program for Assertive Community Treatment (PACT).

Lake's Crossing Center (LCC): Nevada's only forensic facility, providing mental health treatment for the mentally disordered offender in a maximum security setting

Since 1992, youth services have been incorporated into a separate Division of Child and Family Services within the Department of Human Resources. DCFS administers family support services, child care licensing, juvenile justice and an array of treatment services for youth in the urban areas of Clark and Washoe counties. However, in the remaining 15 rural counties, these youth services are offered via the Mental Health Division's system of rural clinics.

Since 1998, the foremost mental health service priority within the Division has been to provide services to consumers with serious mental illness (SMI). The Division in FY 97 revised the Nevada Administrative Code (NAC) to expand the state definition of seriously mentally ill. The definition for serious mental illness in the Nevada Administrative Code (NAC) reads:

> " Adults with a serious mental illness are persons 18 years of age and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that meets DSM criteria (excluding the substance abuse or addictive disorders, irreversible dementias as well as mental retardation) which has resulted in functional impairment which subsequently interferes with or limits one or more major life activities.
>
> 'Functional Impairment' addresses the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health - illness and is viewed from the individual's perspective within his environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety."

SERVICE LOCATIONS

MENTAL HEALTH & DEVELOPMENTAL SERVICES (MHDS)
505 East King Street, Room 602
Carson City, Nevada 89701-3790
Telephone (775) 684-5943
Faxes (775) 687-5966 & 687-5964
E-Mail: mhds@govmail.state.nv.us
Carlos Brandenburg, Ph.D., Administrator
Debbie Hosselkus, LSW, Deputy Administrator
David Rosin M.D., State Medical Director

SIERRA REGIONAL CENTER (SRC)
Family Support Programs
605 South 21st Street
Sparks, Nevada 89431-5599
Telephone (775) 688-1930
Fax (775) 688-1947
Dave Luke, Ph.D., Associate Administrator
For Developmental Services

RURAL REGIONAL CENTER (RRC)
625 Fairview Street, Suite 120
Carson City, Nevada 89701-5430
Telephone (775) 687-5162
Fax (775) 687-1001
Marcia Bennett, Ph.D., Clinic Director

DESERT REGIONAL CENTER (DRC)

1391 South Jones Boulevard
Las Vegas, Nevada 89146-1200
Telephone (702) 486-6200
Fax (702) 486-6334
Stan Dodd, LCSW, Clinic Director

LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER

500 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-1900
Fax (775) 688-1909
Elizabeth Neighbors, Ph.D., Director

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
480 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-2001
Fax (775) 688-2092
Harold Cook, Ph.D., Clinic Director

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)
6161 West Charleston Boulevard
Las Vegas, Nevada 89146-1126
Telephone (702) 486-6000
Fax (702) 486-6248
Jonna Triggs, Ed.D., Clinic Director

SNAMHS - North Las Vegas Office
2121 North Las Vegas Boulevard
North Las Vegas, Nevada 89030
Telephone (702) 486-5750
Fax (702) 486-5769

SNAMHS - Henderson Office
98 East Lake Mead Drive
Henderson, Nevada 89015
Telephone (702) 486-6700
Fax (702) 486-6708

SNAMHS - Southeast Office
1820 East Sahara Avenue,
Suite 109
Las Vegas, Nevada 89104-3736
Telephone (702) 486-8289
Fax (702) 486-8295

RURAL CLINICS: Administrative Office
503 North Division St.
Carson City, NV 89703-4104
Telephone (775) 687-1000; Fax (775) 687-3544
Larry Buel, Ph.D., Clinic Director

SERVICE LOCATIONS

RURAL CLINICS:

Battle Mountain Mental Health Center
101 Carson Road, Suite #1/P.O. Box 50
Battle Mountain, NV 89820-0050
(775) 635-5753; (775) 635-8028 Fax
David Dummar, MFT

Carson Mental Health Center
1330 South Curry Street
Carson City, NV 89703-5202
(775) 687-4195; (775) 687-5103 Fax
Sueann Bawden MFT, Clinic Director

Dayton Mental Health Center
120 Pike Street/P.O. Box 1597
Dayton, NV 89403-1597
(775) 246-5240; (775) 246-5364 Fax
Marilyn Newell MA, Clinic Director

Douglas Mental Health Center
1538 HWY 395 N, Gardnerville, NV 89401-5239
(P.O.Box 1509, Minden, NV 89423-1509)
(775) 782-3671; (775) 782-6639 Fax
Tom Embree Ph.D.,MFT, Clinic Director

Elko Mental Health Center
1515 7th Street
Elko, NV 89801-2558
(775) 738-8021; (775) 738-8842 Fax
Jeanne Carey, MSW, Clinic Director

Ely Mental Health Center
1665 Avenue F/P.O. Box 151107
Ely, NV 89315
(775) 289-1671; (775) 289-1699 Fax
Patty Hill, LCSW, Clinic Director

Fallon Mental Health Center
151 North Main Street
Fallon, NV 89406-2909
(775) 423-7141; (775) 423-4020 Fax
Dolly Coke, LCSW, Clinic Director

Fernley Mental Health Center
115 West Main Street/P.O. Box 2314
Fernley, NV 89408-2314
(775) 575-0670; (775) 575-0672 Fax
Marilyn Newell MA., Clinic Director

Hawthorne Mental Health Center
1000 "C" Street/P. O. Box 12
Hawthorne, NV 89415-0012
(775) 945-3387; (775) 945-2307 Fax
Dolly Coke, LCSW, Ph.D., Clinic Director

Lovelock Mental Health Center
775 Cornell Ave. Suite #C/P.O. Box 1046
Lovelock, NV 89419-1046
(775) 273-1036; (775) 273-1109 Fax
Sharon Maginnis, MFT, MH Counselor III

Mesquite Mental Health Center
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Mesquite, NV 89024
(702) 346-4696; (702) 346-4699 Fax
Kathleen Pantaze, LCSW,LADC, Clinic Director

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1840 South Pahrump Valley Blvd. Suite A
Pahrump, NV 89048
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Kathleen Settle, MSSA., Clinic Director

Silver Springs Mental Health Center
3595 Highway 50 East/P.O. Box 1136
Springs, NV 89429-1136
(775) 577-0319; (775) 577-9571 Fax
Marilyn Newell MA., Clinic Director

Tonopah Mental Health Center
825 S Main P.O. Box 494
Tonopah, NV 89049-0494
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STAKEHOLDERS

Stakeholder Values

Community Integration:
Consumers contribute to the community through positive behavior.

Consumer Involvement:
Consumers are educated about their disorders and actively involved in their treatment.

Consumer Satisfaction:
Consumers feel good about the kinds of services received.

Family Support:
Consumers' families are informed and involved.

Safety:
Consumers and the community are safe from the consumers behavior.

MHDS-MENTAL HEALTH SERVICES:

Involving Stakeholders in Planning and Evaluation

MHDS directly involves its stakeholders in the planning and quality improvement of its mental health programs. Consumers, family members, legislators, and mental health professionals, as well as representatives from the courts and correctional fields, have been formally involved in the definition of values that underlie the mission of the Division and guide the strategic planning of the mental health programs. The general community is also invited to participate in strategic planning meetings, and has been instrumental in defining the mission statements of the agencies. These stakeholders are regularly updated on the progress made toward the goals and objectives of the Division.

MHDS is excited to report that great strides have been made over the past two years in our efforts to involve consumers in the delivery of our programs. Since our last report in 2000, we have worked to ensure that consumers are active in each region. We have promoted consumer representation at most local advisory board meetings and the meetings of the Commission on Mental Health and Developmental Services, which is the statutorily authorized governing body in Nevada.

A primary way we have strengthened the involvement of consumers is by our increasing collaboration with the Nevada Mental Health Planning Advisory Council (MHPAC). The Council is a 17-member group established in 1989 with the goal of serving as an advocate for chronically mentally ill individuals, severely emotionally disturbed children and youth, and other individuals with mental illnesses or emotional problems. By federal mandate, greater than 50% of the members of the Council must be non-State representatives that include consumers of mental health services, family members, and other mental health advocates. The MHPAC works with the Division in a variety of ways, all of which are designed to involve consumers in the development and delivery of mental health services here in Nevada. Major activities of MHPAC include the following:

- The Council advises the Division of Mental Health and Developmental Services and the Division of Child and Family Services on the development of the State Mental Health Plan.
- The Council serves as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and others with mental illnesses and emotional problems.

- The Council reviews and assists with the administration of the Center for Mental Health Services (CMHS) Block Grant, which helps fund Nevada's community-based system of care.
- The Council develops education and training opportunities for consumers of mental health services and family members of consumers.
- The Council promotes awareness of mental health issues within the State, and works to positively influence the State Legislature regarding laws and budget decisions that affect consumers of mental health services.

During the last two years, the MHPAC has worked to implement an innovative new program to increase consumer involvement by directly awarding funds from the MHPAC administrative budget for consumer services. These awards total between $30,000 and $50,000 per year and are focused the following:

1. Community-based services that benefit consumers directly
2. Consumer education and training
3. Professional education and training on mental health issues

By directly funding consumer services, in 2001 the Council began to support grass-roots efforts within the state to provide services to consumers and to educate the professionals who work with consumers. The Council has partnered with both MHDS and other nonprofit organizations to provide the services and information needed to improve the quality of mental health care provided to children and adults in Nevada.

Three projects were funded by the MHPAC in 2002 for the upcoming fiscal year. One is the Nevada Recovery Guide, which is a Website that provides recovery-related resources via that Internet that includes information for mental health and recovery professionals, community service organizations, and consumers who are seeking help with a mental health or substance abuse issue. Another is the Northern Nevada Adult Mental Health Services (NNAMHS) Canteen Employment Learning Lab. This project is designed to provide consumers training in work skills, interpersonal communication, team building, basics of food service, work habits, time management, organizational skills, and customer service. The third project is the Mental Health Association (MHA) of Southern Nevada Leadership Academy Training. This training is designed for consumers to increase their well-being, their self esteem, their capabilities for self-determination, their share in the direction of the mental health system, and their understanding and incentive to contribute their skills and concern to the betterment of the larger community.

Since our last report in 2000, we are excited and proud to report that now, more than ever before, the MHPAC is dynamic, energized, and actively engaged in our programs.

CONSUMERS

Consumer feedback is greatly valued.

Opportunities for consumer feedback include:

- Inpatient consumer survey conducted with each consumer prior to discharge from the hospital.
- Outpatient consumer survey conducted with consumers in community based programs.
- Consumer comment forms and boxes allow consumers to comment anonymously about the services that they receive at any time they wish.

CONSUMERS

MHDS Strategic Plan Goal #3:

Ensure that services address the interests, rights, and needs of each individual consumer served.

Stakeholder Values

Improved Social Functioning: Consumers make progress in work, school and relationships.

Personhood: Consumers have worth and dignity.

Skilled Coping: Consumers gain skills needed to handle the problems of life.

Symptom Reduction: Consumers symptoms are reduced, stabilized or prevented.

Over the past two years we have also made great strides to facilitate the collaboration of policy making and advisory bodies here in Nevada. To illustrate, in February, 2002, the Council met with the Nevada Commission on Mental Health and Developmental Services, which marked the first time these two primary planning and governance bodies have ever met or worked together. These initial meetings were quite successful and both bodies began collaborative legislative planning to better the provision of mental health services in Nevada. We hope to continue this endeavor in 2003.

Another great new way MHDS began to involve mental health consumers is via an exciting new program that began in 2002 called the Consumer Assistance Program (CAP).

Since the mid 1990's, the Nevada Division of Mental Health and Developmental Services (MHDS) has been interested in hiring consumers as part of transitional mental health services. Nevada's new Consumer Assistance Program began this year (2002), and is designed to assist other consumers as they become involved in the treatment process, as well as help Division personnel work more effectively with mentally ill adults.

We are pleased that we can report here that Nevada's first-ever Statewide CAP Coordinator began service as an MHDS employee in June 2002, and quickly hired the staff of six consumers as part of the new Consumer Assistance Program. During 2002, MHDS was able to set annual federal funding for this program at approximately $270,000 per federal fiscal year. With these funds, MHDS positioned seven full-time employees (FTE) across the state as part of the CAP:

- ✓ Three FTE Consumer Services Assistants at Southern Nevada Adult Mental Health Services (SNAMHS); one is the Statewide CAP Coordinator.
- ✓ Two FTE Consumer Services Assistants at Northern Nevada Adult Mental Health services (NNAMHS).
- ✓ Two FTE Consumer Services Assistants at Rural Clinics, one each in Minden and Carson City clinics.

The Consumer Assistance Program employs seven FTE and is designed so that our own consumers can work with other consumers in our system to develop work and career transitional skills. Our Consumer Assistants also mentor recently discharged consumers, and collect consumer surveys, as well as assist the Division in quality assurance efforts, and designing statewide consumer advocacy and policy development efforts. Our Consumer Assistants also work to make sure our website is as user friendly as we can make it. They develop statewide consumer flyers and social events. They also participate in various human rights boards, and review all consumer care complaints. Finally, we are pleased that our new Consumer Assistance positions were designed to afford these individuals promotional career opportunities into other permanent State positions.

We are optimistic that our existing Consumer Assistance Program is in the early stage of development, and we can report in our next biennial report that we will have added additional Consumer Assistants and further expanded this program.

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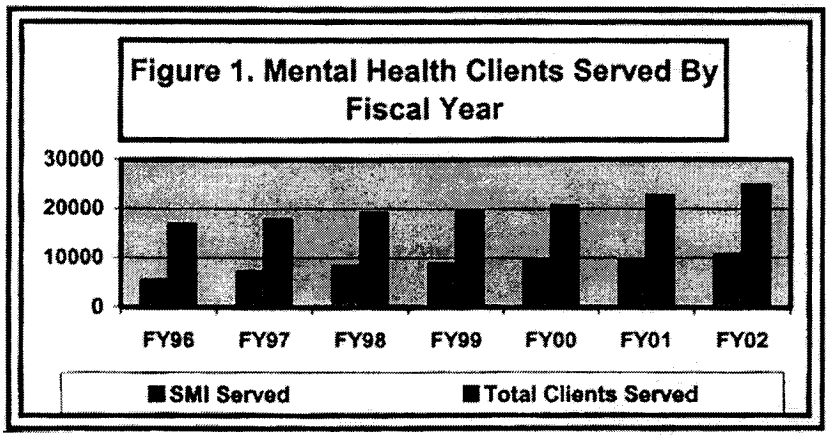
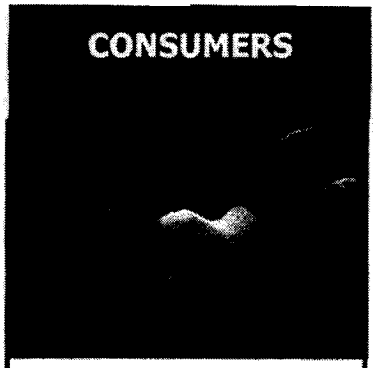
Who are the Recipients of Mental Health Services?

The Division of Mental Health and Developmental Services directly provides or coordinates the provision of contracted adult public mental health services in Nevada. MHDS Rural Clinics also provide services to children and families. A University affiliated provider, Mojave Adult, Child and Family Services in Las Vegas provides much of the regions outpatient services through referral from SNAMHS. Inpatient and outpatient programs are provided primarily on a fee for service basis since people with serious mental illness have been "carved out" of the State's managed care structure.

The Center for Mental Health Services[1] estimates that 7.2% of the population in Nevada will suffer from a severe mental illness during their life. More recently, a study [2] ranked Nevada as the number one state in the Western United States for prevalence of mental illness, estimating that as much as 23.7% of the population in Nevada will have some form of diagnosable mental disorder during their life. It also estimated that approximately 1.8% of Nevadans are currently functionally impaired because of a serious mental illness. In FY 2002, the Division's mental health programs served 22,341 people. This is an increase of 9% over last year. **Figure 1** shows the growth in individuals served over the last seven fiscal years. **Table 1** shows the breakdown by agency for FY01 and FY02. You can see that Rural Clinics caseload is down. This is because the agency is unable to recruit positions for the rural area. **Figure 2** shows percent of consumers by agency.



1 *Estimation of the 12-Month Prevalence of Serious Mental Illness*, CMHS Draft, Kessler, et al. 1997.
2 *Needs Assessment in the West: a Report on a Workshop and Subsequent Analysis* (WSDSG, 1998)



MHDS Strategic Plan Goal #4:

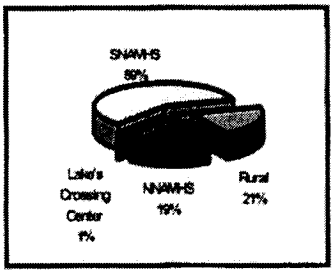
Utilize technology to improve accessibility to, and availability of services and the efficient use of resources.

MHDS Strategic Plan Goal #5:

Update and maintain a plan to respond to emergencies in Nevada in a timely and effective manner.

MENTAL HEALTH CONSUMERS

Figure 2. Percent of Total Clients Served by Agency



President George W. Bush announced the creation of The President's New Freedom Commission on Mental Health at the University of New Mexico in Albuquerque on April 29, 2002. In his address, the President stated that "our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care."

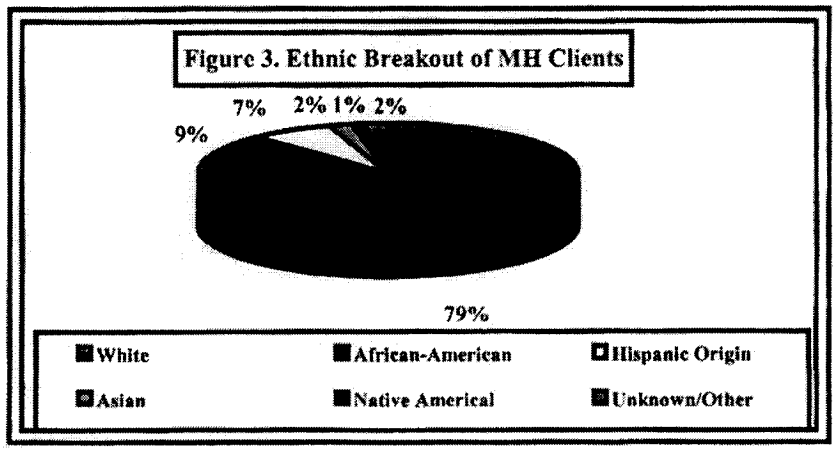
Table 1. Unduplicated Clients Served: Percent Growth

	FY01	FY02	%change
Lakes	173	191	10%
NNAMHS	4022	4485	12%
SNAMHS	11528	12996	13%
Rural Clinics	4852	4669	-4%
TOTAL	20575	22341	9%

With the exception of MHDS' forensic facility, the state demography shows an equal split between male and female and MH shows a consumer ratio of 56% female to 44% male. Around 67 percent of the consumers served by SNAMHS and 47% of Rural Clinics' consumers are between 21 and 44 years of age. MHDS only serves children through its Rural Clinics, where they comprise 30% of the client base. The demographers estimate for the percentage of children in the state is 18.4%.

Approximately one third of the consumers have never married, and most claim only themselves as a single dependent. More than one third are unemployed.

Approximately 79% of MHDS' consumers are white which is comparable to Nevada's population figure of 69% projected for FY02. **Figure 3**, details MHDS' breakout of clients by ethnicity. The largest category of racial minorities served at Nevada's urban mental health centers are African Americans. In contrast, Native Americans are the



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

3. Division Demographics are based on FY2002 data analysis .

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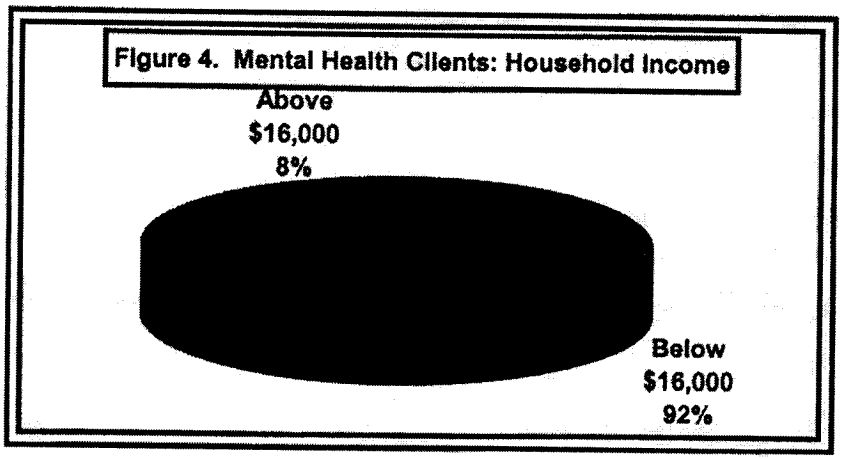
primary racial minority in MHDS rural mental health clinics. Ethnically, approximately 7% of the State's public mental health consumers are Hispanic. The state demographer estimates that Hispanics (Hispanic Origin of any race) will comprise around 19% of Nevada's population by 2003.

It is estimated that in 2002, 10.3% of all Nevadans lived below the poverty level. This contrasts sharply with the consumers of Nevada's public mental health services. As a rule, the people who come for mental health service are from lower income brackets, with approximately 92% of MHDS' consumers earning below the $16,000 per year. **Figure 4** shows percent of clients below $16,000 in income. In 1999 7.5% of Nevada families were below the poverty level.



Note: This data excludes the unknown category

Generally, people come to MHDS' locations for treatment of a few primary disorders: major depression, psychosis, bipolar or schizophrenic episodes. Outpatient consumers show a wider range of treatment needs. Seventy six percent of outpatient clients fall into several categories: adjustment disorders, mood disorders, major depression, dysthymia, and schizophrenia. Around 10% of our outpatient consumers have a dual diagnosis, suffering from both mental illness and substance abuse.

The 750 children who were served by the Division's Rural Clinics primarily sought service in FY 00 for help with depression (10.8%), attention deficit (33%), bipolar (3.3%) adjustment disorder (31.8%), and anxiety (6.9%).

MENTAL HEALTH SERVICES

Top Outpatient Diagnosis at Admission (FY00)

Mood Disorders	49%
Schizophrenia and related	17%
Substance Related Disorders	10%
Adjustment & Personality Disorders	7%
Other Disorders	20%

Top Inpatient Diagnosis at Admission (FY00)

Schizophrenia and related	43%
Mood Disorders	35%
Substance Related Disorders	10%
Adjustment & Personality Disorders	7%
Other Disorders	5%

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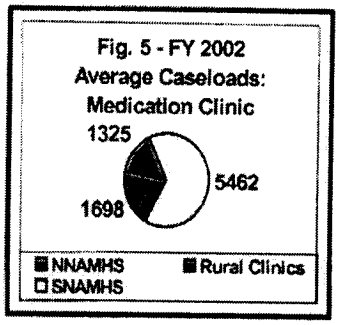
MENTAL HEALTH PROGRAMS

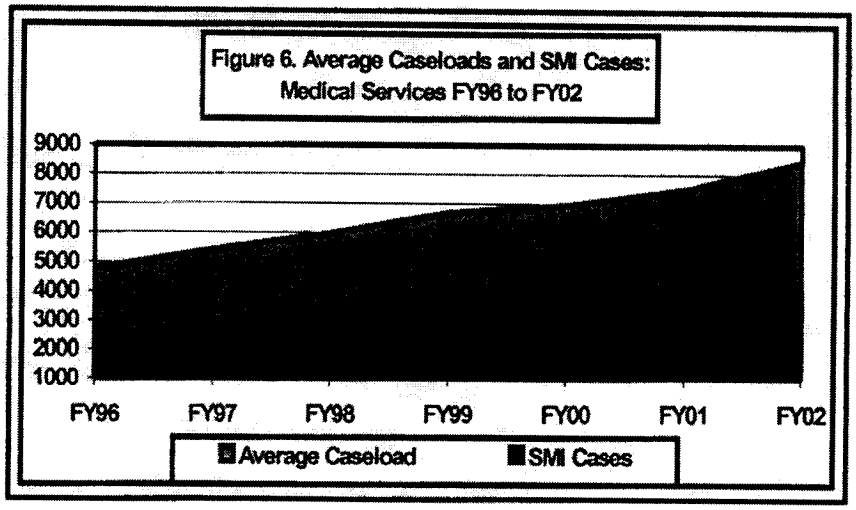
MEDICATION CLINIC

Several levels of mental health care are provided through inpatient and outpatient programs. Consumers requiring intensive care are supported by inpatient services and intensive outpatient programs. Other outpatient programs help the consumer gain greater independence, confidence and ability to function in the community.

The Role of New Medications: The Division's medical services are provided by a physician or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services may also include pharmaceutical counseling and education provided by a pharmacist. Since medication forms a foundation of treating most mental illnesses, the medication clinic is the Division's largest treatment program (**Figure 5** shows the medical services consumer served by agency. **Figure 6** shows program growth). Medication costs account for $11,157,803 or 15.70% of the FY02 Mental Health budget.

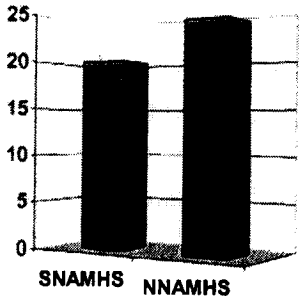
Newer antidepressant and anti-psychotic medications have had fewer negative side effects than older medications. While they cost more, they benefit consumer functioning and reduce the demand and duration of other expensive treatment forms. The Division has increased funding for these new medications so the consumers can have access to these medications.





INPATIENT SERVICES

Figure 7 - Average Length of Stay in Days (FY 2002)

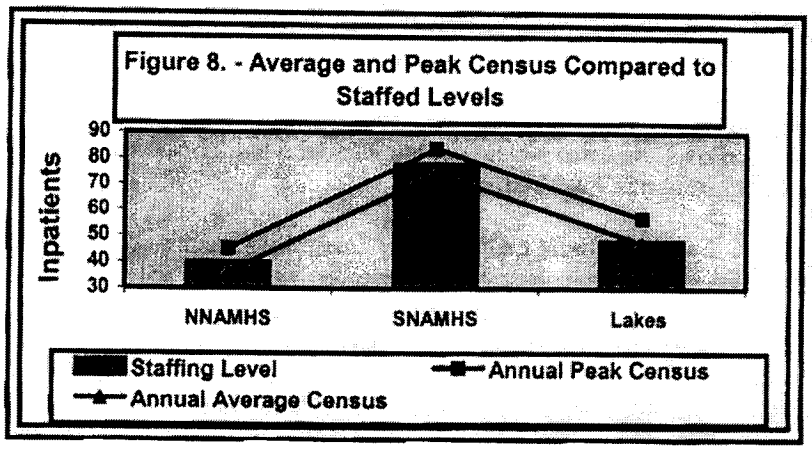


Inpatient Programs:

Inpatient facilities at the Northern Nevada Adult Mental Health Services (Dini-Townsend Hospital) and Southern Nevada Adult Mental Health Services (Muril H. Stein Hospital) focus on consumer recovery and stabilization.

For example, at SNAMHS, individuals in crisis are served by an outpatient program Psychiatric Emergency Services (PES) which has a

Psychiatric Ambulatory Unit, providing 24 hour emergency walk-in center service for clients in crisis and a Psychiatric Observation Unit (POU), a 72 hour observation unit for consumers needing short term observation, stabilization and treatment in a secure environment. The POU currently has a capacity for 20 patients. The provision of psychiatric emergency services (PES) allows consumers in crisis to be stabilized and avoid admission to the hospital. The positive effect of this program is shown by the fact that more than 82% of the consumers admitted to the SNAMHS POU are stabilized and avoid hospitalization. **Figure 7** (previous page – sidebar) compares the average length of stay between SNAMHS and NNAMHS for inpatient. **Figure 8** compares the average census and peak census for each of the mental health inpatient facilities in Fiscal Year 2002. **Figure 9** (sidebar) shows the portion of inpatient consumers served at each of the hospitals.

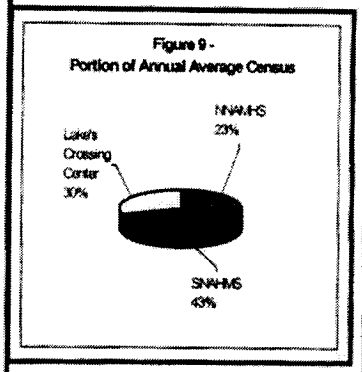


Forensic Services: Lake's Crossing Center was designed to serve the mentally disordered criminal offender, to evaluate competency to stand trial, assess criminal responsibility and/or provide recommendations for treatment. Services include clinical assessment, forensic evaluation and short or long term treatment as appropriate based on the nature of the court commitment. Ninety seven percent (97%) of the consumers are sent to the Center by the courts for treatment to establish competency to stand trial or for initial competency evaluations (see **Figure 10** – sidebar). This relationship between this agency and the court and legal system is defined in NRS Chapter 178. The 48 bed Center served 203 consumers in Fiscal Year 2000. Eighty seven percent (87%) of all admitted clients in FY 2000 were Nevada residents; Thirteen percent (13%) were from California and other states. Most of the state admissions come from urban areas (12% north, 65% south) with only 23% admitted from rural Nevada. As an average in FY 2000, client length of stay is 112 days. During Fiscal Year 2000, the census peaked above facility capacity four months out of the year. The highest peak was 23% above capacity.

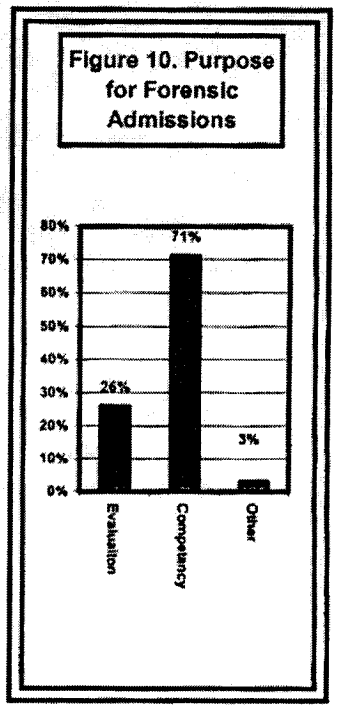
Outpatient Programs with an Intensive Care Focus:

MENTAL HEALTH SERVICES

INPATIENT SERVICES



FORENSIC SERVICES



PROGRAMS AND SERVICES

PACT

The Program for Assertive Community Treatment uses a multidisciplinary mental health team to provide customized mental health services.

ISC

Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada

Program for Assertive Community Treatment (PACT): This program provides intensive community based treatment and rehabilitation services to consumers with serious mental illness by using a multidisciplinary mental health team to provide these services. The goal of the program is to reduce debilitating symptoms and minimize or prevent recurrent acute episodes of illness. Continuous rather than time limited service and interventions tailored to each consumer characterize this program. Nationally, the PACT model has shown participants to have longer and more productive community tenure and be better able to manage their impairment upon discharge from the program.

This program started serving clients at Southern Nevada Adult Mental Health Services campus in March 1998. The program had a caseload of 73 consumers in the program June 2002 and has been undergoing planned growth of around 5 new consumers per month. For comparison; in Fiscal Year 1998 the program was serving 23 consumers. Northern Nevada Adult Mental Health Services began this program in Fiscal Year 1999.

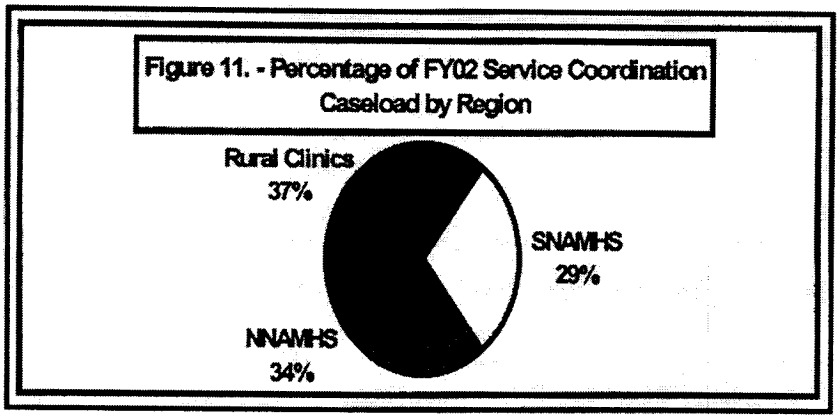
Intensive Service Coordination: Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada. This growing number of people tends to have numerous and long term hospital stays as well as extended time in jails and/or prison. Each day a patient is in the hospital ($389/day) or jail/prison (approximately $90/day) is extremely costly for the state. These patients need intensive assistance to develop independent living skills, medication compliance, social skills, employment skills, and anger management processes to reduce or eliminate violent or criminal behaviors. The goal of ISC is to assist the consumer in achieving and maintaining the highest level of independent functioning possible, while reducing time spent in either the hospital or in jail/prison. The program began serving consumers at SNAMHS in December 1997. Since that time, the average monthly caseload has more than quadrupled, growing from 11 initial consumers to 49 consumers at the end of Fiscal Year 2002. The program is budgeted to support a caseload of 45 people.

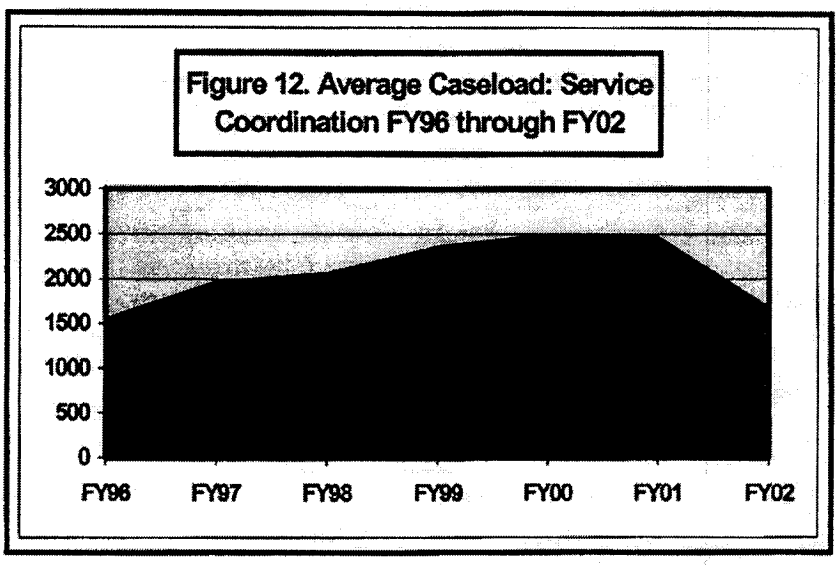
Outpatient programs focusing on increasing consumer independence:

Service Coordination : Service Coordinators coordinate treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure that consumers access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement and other essential community resources. They also help mobilize family, community, and self-help groups on the consumer's behalf. They may provide direct treatment to consumers when none is available through referrals or community agencies. MHDS' Service Coordination caseload averaged around 571 cases at NNAMHS, 609 cases at Rural Clinics and 478 cases at SNAMHS. Additionally, Mo-

jave Adult, Child and Family Services (University affiliated provider under contract to MHDS) served an average monthly caseload of 696 people. (**Figure 11** shows service coordination case distribution, **Figure 12** – caseload over last seven years).[4]

4 This does not include clients at Mojave Adult, Child and Family Service





Outpatient Counseling: Outpatient counseling services provided to individuals include diagnosis and evaluation, counseling, psychotherapy, and behavioral management. These programs focus on developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. Specialized services are provided to families and couples to facilitate communication between patients and family members. Group counseling sessions include activity therapy as well as psychotherapy to help guide consumers through interpersonal conflict and improve positive communication. Outpa-

Personal Service Coordination

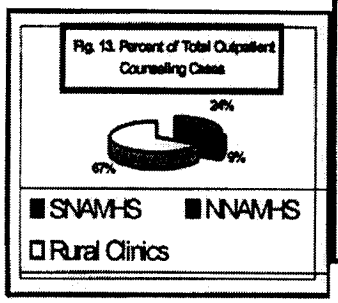
There are many models of community care for persons with mental illness.

The Division policy 3.002 defines this service as:

- *Arrange access to needed service.*
- *Assure efficient and timely coordination of services.*
- *Maximize the client's capacity to benefit from services and to function independently.*
- *Limit unnecessary restrictive treatment.*
- *Mobilize the support of family, friends and advocates.*

OUTPATIENT SERVICES

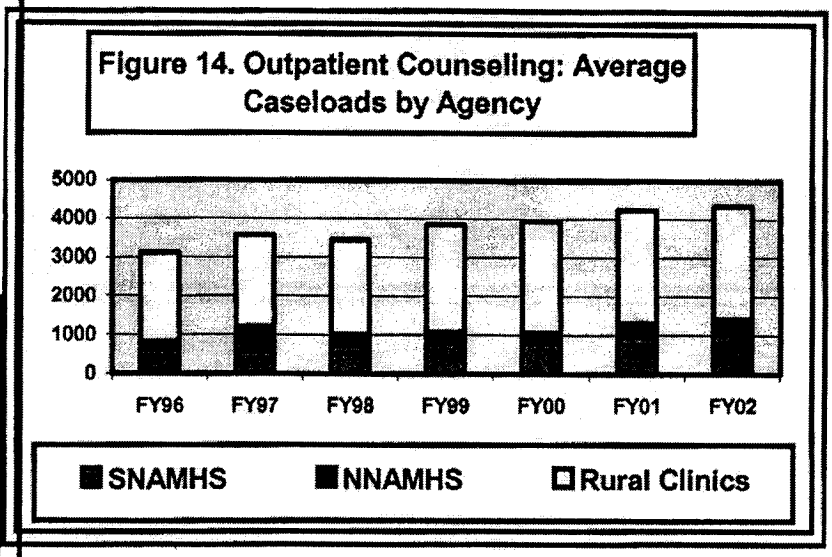
Outpatient Counseling



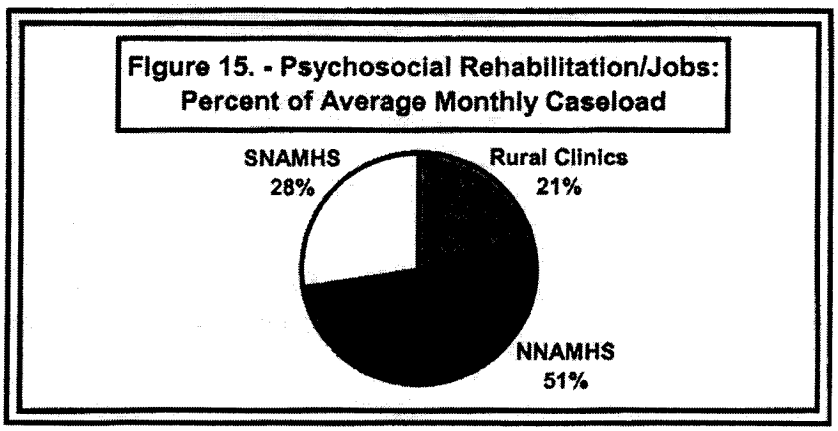
tient Counseling, Rural Clinic's primary program, serves as the foundation program for all of its consumers. NNAMHS and SNAMHS may admit consumers into other programs, such as service coordination, without first seeing a counselor. **Figure 13**-(side-bar) shows the portion of outpatient counseling consumers served by agency. **Figure 14** shows 7 years of counseling caseloads.

Psychosocial Rehabilitation and Vocational Programs:

Psychosocial rehabilitation is targeted to consumers in need of an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of



functioning in the community and to prevent acute inpatient care. Emphasis is placed on acquiring skills in the following areas: survival and adaptation, symptom and medication management, problem solving, grooming, financial management, prevocational services, and management of leisure time. Programs are individualized for the consumers. Some services are provided under contract and may take



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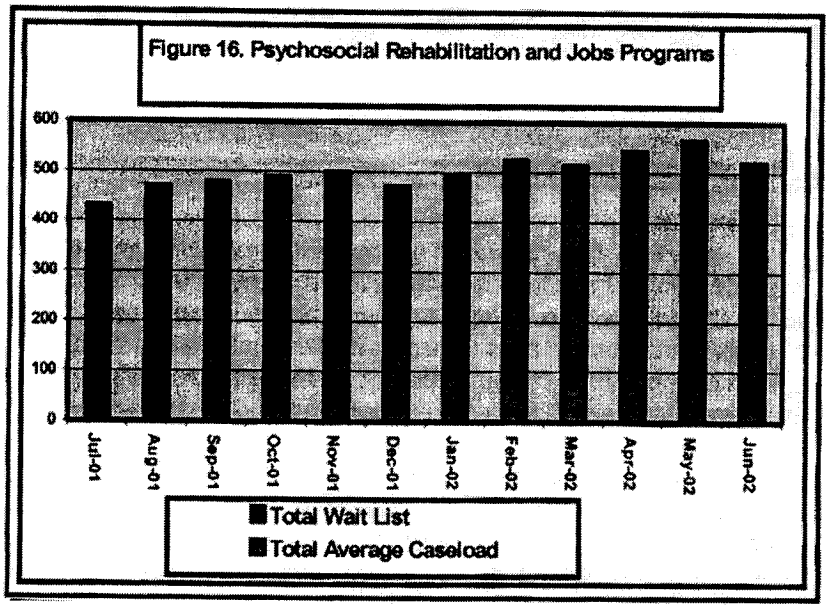
place in a classroom setting or at the consumer's residence. **Figure 15** (previous page) shows each agency's portion of the psychosocial rehabilitation caseload. **Figure 16** shows program caseload and wait list during Fiscal Year 2002.

Vocational programs include vocational guidance and counseling, and transitional planning. They also provide an array of skills training through school, peer advocacy, world of work classes through BVR and on the job training and apprenticeships. This program assists with job seeking skills and provides support during job seeking as well as thru the State's Bureau of Vocational Rehabilitation (BVR). Consumers are assisted through vocational assessment, work adjustment training and post-employment services designed to maintain employment by focusing on decision making, problem solving and establishing natural community supports. Additionally, joint efforts between MHDS and the BVR provide collaborative assistance to help consumers achieve their vocational goals.

These programs are in demand by consumers as can be seen



by their waiting lists for services (**Figure 17**). The Divisional annual average caseload (Vocational and Psychosocial Rehabilitation programs combined) in Fiscal Year 2002 was at 450 clients .

Residential Supports:

Group housing: These are group residential programs for clients who do not require specialized intensive services. The Division average annual caseload is approximately 457 clients (see **Figure 18** (following page).

Supported Living Arrangements (SLAs): These living arrangements are intended to be flexible and offer housing based on consumer choice and individualized services tailored to the

OUTPATIENT SERVICES

Psychosocial Rehabilitation And Jobs

Peer counselors, themselves prior consumers of the mental health system, work with clients in these programs by providing education, advocacy, and support.

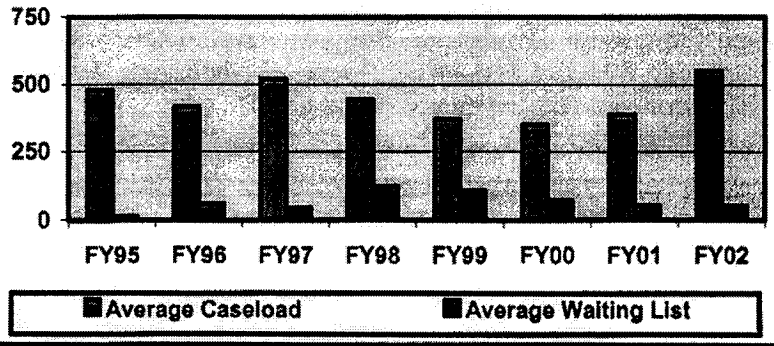
OUTPATIENT SERVICES

Helping people find employment through vocational assistance and training

A key ingredient of recovery-based services includes encouraging consumers to think about the future. There are such considerations as meaningful work activities (including volunteer activities).

consumer's needs so that services have a "wrap around" effect and encompass the capabilities of the consumer. Consumers, families and agencies collaborate in the development of a plan that will place the client in an independent setting. The program includes purchased community SLA's, contract services and the HUD Shelter Plus Care program for homeless mentally ill people. **Figure 18** compares the seven year average group housing caseloads to the average number of

Figure 17. Mental Health Vocational and Psychosocial Rehabilitation Caseloads and Waiting Lists



SLA contracts.

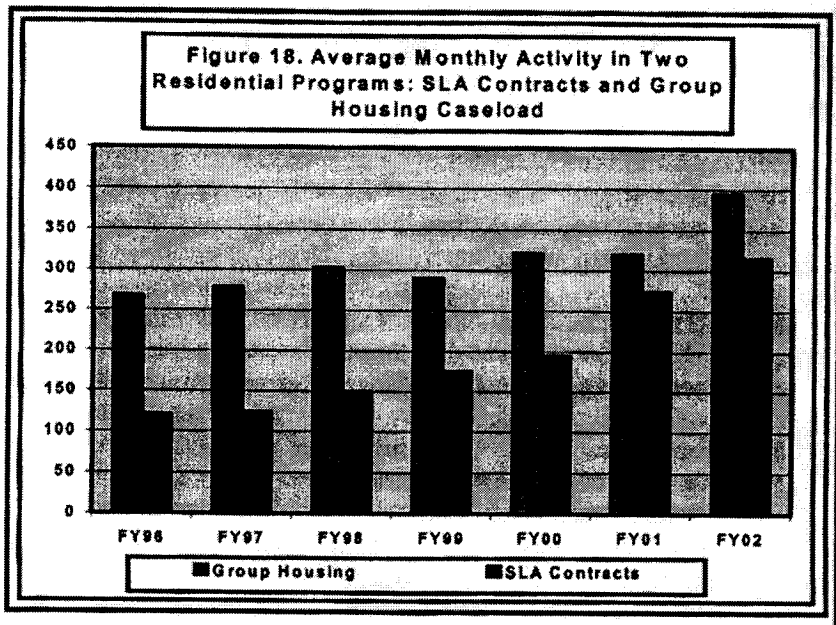
Specialized Residential - These programs provide support and/or skills training for residents with specialized service needs who also need psychiatric services. These programs include arrangements that are specially designed to meet the needs of the following individuals: people with medical problems, senior citizens requiring assistance, consumers with severe behavioral symptoms, and deaf consumers, as well as people needing treatment for substance abuse.

Intensive supportive living arrangements (ISLAs) - They provide 24-hour awake supervision of clients who otherwise would require in patient hospital care. These services are provided in independent apartment community settings with additional individualized suppor services based on client needs and choice.

Special Needs Beds—They provide independent apartment community settings for medically compromised mentally ill clients who require additional nursing supervision. These placements provide service to clients who otherwise would have remained in the inpatient psychiatric hospital only because self care of their medical condition is compromised by mental illness.

Programs for special populations:

Geriatric Services: These services are supported through grants from the Division of Aging Services and the Bureau of Alcohol and Drug Abuse to the Southern Nevada Adult Mental Health Services.



People are referred by the Division of Aging Services.

Homeless services – The Division of MHDS receives funding for programs specifically targeted for those people who are homeless and have a serious mental illness. They are:

- PATH – Projects for Assistance in Transition from Homelessness – A McKinney-Vento Act grant that provides for $300,000 that is in turn contracted to such non-profit agencies as Friends in Service Helping (FISH – Carson City), ReStart (Washoe County) and The Salvation Army (Clark County and Pahrump). Services that are provided with this money range from outreach to mental health services up to and including security deposits/rental assistance

- Shelter Plus Care – A grant from Housing and Urban Development (HUD) has provided approximately $4.5 million in tenant-based rental assistance funding to Division agencies since 1995. The grant is matched in aggregate by Division agencies with supportive services for those persons who are eligible (homeless and have a serious mental illness or other long-duration disability).

- HOPE -- Homelessness Outreach Pilot Evaluation. The Hope Project serves 100 homeless persons with serious mental illnesses and co-occurring substance abuse disorders in metropolitan Las Vegas. It provides a full continuum of substance abuse and addiction treatment services, including a broad array of health and human services, in community-based, residential, and outpatient environments. Utilizing an outreach and case management model of asser-

OUTPATIENT SERVICES

Helping clients achieve greater independence through residential programs

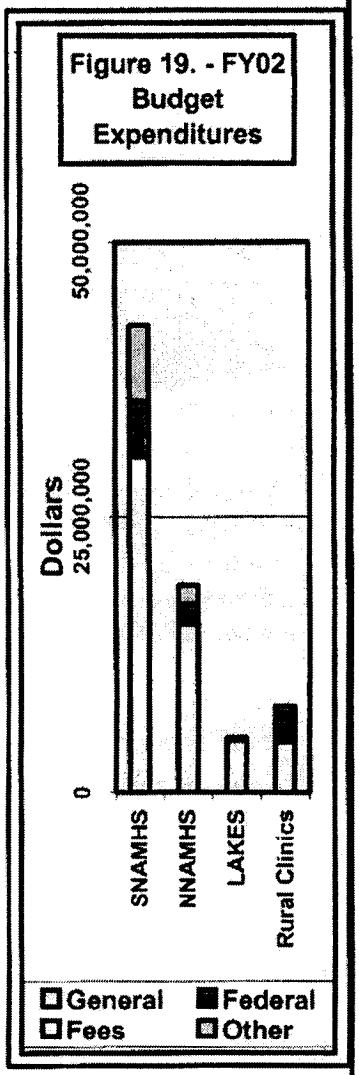
Currently there are approximately 16,049 persons statewide who are homeless and have a serious mental illness.

Housing (safe, decent and affordable) and residential supports play a crucial role in the recovery of persons with mental illness.

FUNDING AND EXPENDITURES

FUNDING SOURCES

Figure 19. - FY02 Budget Expenditures



Staffing to Meet Service Demands

Inpatient facilities are licensed and staffed to support a certain number of client beds. Other programs, such as service coordination (case management) have caseload standards or service level standards. When these are exceeded, waiting lists occur.

The Division was budgeted for 1150 staff positions in fiscal year 2002. Of these, 729 people work for mental health agencies. **Figure 21** shows the distribution of staff in MHDS' mental health agencies. Sixty seven percent of these positions are employed in direct consumers care (see **Figure 22** sidebar). If all programs are combined, there is one direct care staff for every 43 mental health consumer. However, programs differ dramatically in the intensity of service and the staffing required to provide adequate service. The Lake's Crossing Center forensic facility has a ratio of one direct care staff for every 3 consumers. Inpatient facilities at SNAMHS and NNAMHS also have small consumer to staff ratios and serve consumers around the clock. Intensive outpatient services have reduced clinical caseloads, such as one clinician or service coordinator (case manager) for every 15 consumers. Other intensive outpatient services take a team approach to help consumers reduce symptoms and develop self sufficiency. The ability to carry larger clinical or service coordinator caseloads increases as consumers become more independent and services focus more on life management needs than recovery from severe symptoms. Typically, service coordinator caseloads are one service coordinator for every 35 consumers. Many consumers are maintained and function in a stable fashion in the community, only returning for medical services. Thus, nurses providing medical oversight at the medication clinics carry larger caseloads of one nurse to every 217 clients.

Measuring Effectiveness and Performance Indicators in Mental Health Programs

The ability for state public mental health programs to monitor and assure the quality of services through consumer oriented outcomes has been driven from the Federal level through a Presidential Task Force and programs and funding through the Center for Mental Health Services. By participating in organizations such as the National Association of State Mental Health Program Directors, Nevada has shared in this national effort.

We have received funding from the Center for Mental Health Services through their Data Infrastructure Grant award. The purpose of this grant is to develop and sustain State and community data infrastructure that helps promote comprehensive, community based systems of care for all children and adults with mental illness or at risk of developing mental illness. National standardization of uniform data reporting for the States is a major goal of this grant.

These outcome areas have been further defined in Nevada through a stakeholder values clarification project. Value areas that have been addressed in the development of consumer oriented outcome measures include: Skilled Coping, Personhood, Symptom Reduction, Functioning, Community Integration, Involvement in Treatment, Satisfaction, Family Support and Safety. [5]

5 *Nevada Stakeholder's Priorities for Mental Health Outcomes*, McGuirk and Zahniser, 1996.

New Mental Health Performance Indicators

The development of new performance measures in Fiscal Year 2002 has allowed MHDS to use more meaningful indicators of service in the Fiscal Year 2002-2003 budget. New annual budget indicators include:

Performance Indicators with definition:

INPATIENT

- Percent of clients in hospital over 90 days. - Current inpatients with LOS > 90 for those discharged.
- 30 Day Readmission Rate. - Rate of readmissions to an inpatient facility that occur within 30 days of a previous discharge from the same facility.

OUTPATIENT COUNSELING

- Wait Time. - Number of days from referral to first scheduled appointment.
- OC-Only Clients admitted to the POU. - Percent of clients open only to OC who were admitted to the POU.

SENIOR MENTAL HEALTH OUTREACH

- Wait Time. - Number of days from referral to first scheduled appointment.
- Average Scale at Intake. - The average score of clients using the Geriatric Depression Scale.
- Average Scale at 3 months. - The average score of clients after 3 months using the Geriatric depression Scale.

SERVICE COORDINATION

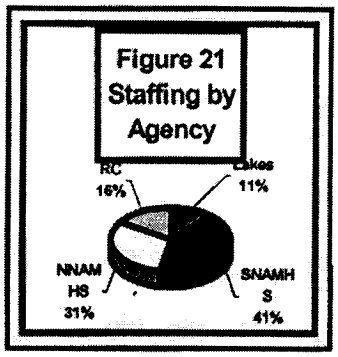
- Inpatient Days Before and After Starting Program. - Percent of time clients were in IP before and after starting to receive the program's services.
- Wait Time. - Number of days from referral to first scheduled appointment.

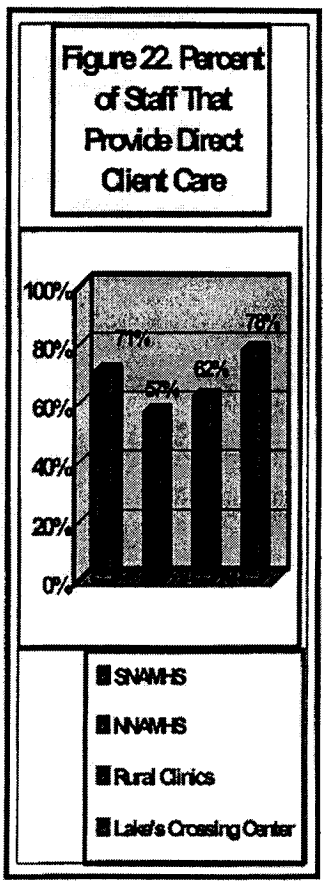
INTENSIVE SERVICE COORDINATION

- Inpatient days Before and After Starting Program. - Percent of time clients were in IP before and after starting to receive program's services.
- Re-offenses. - Number of clients that are jailed because of a

STAFFING

STAFFING PATTERNS

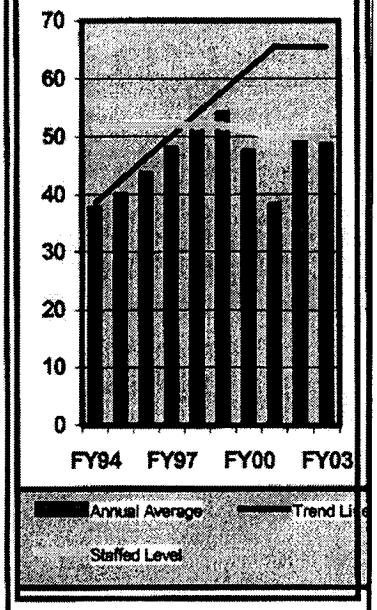




felony arrest while in the program

MENTAL HEALTH INDICATORS

Figure 23. - Projected Census at NNAMHS



Our Quarterly Performance Indicator Report can be viewed on our website for those that want to look at Data for FY02

Http://mhds.state.nv.us

MEDICATION CLINIC

- Clients Attending Their First Appointment. - Percentage of new clients attending their first scheduled appointment.
- Average Wait Time. - Average number of days from referral to first scheduled appointment.
- Wait Time. - Number of days from referral to first scheduled appointment.
- MC-Only Clients Admitted to the POU. - Percent of clients open to only MC who were admitted to POU.

MEDICATION CLINIC (MC) AND OUTPATIENT COUNSELING (OC)

- MC and OC only clients admitted to the POU. - Percent of clients open only to MC and OC who were admitted to the POU.

GROUP HOUSING

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

INTENSIVE SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

RESIDENTIAL TREATMENT PROGRAM

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

PES (Psychological Emergency Services)

- Inpatient Deflections and Admissions. - Percentage of persons receiving PES services who were deflected from IP versus those who were admitted to IP.

PACT (Program For Assertive Community Treatment)

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

LAKES CROSSING CENTER

- Evaluation of Competency. -Average length of stay. (Calculated from date of admission to date of discharge).
- Incompetent to stand trial. -average length of evaluation.

(Calculated from date of admission to date letter sent to court with findings).

- Competency Determination. - Percent of clients admitted as incompetent to stand trial. (Calculated from date of admission to date letter sent to court with findings).

Figure 23 (on previous page) shows the NNAMHS inpatient census.

RECENT MHDS ACCOMPLISHMENTS

MENTAL HEALTH PROGRAMS—STATEWIDE PROJECTS

- Statewide Accreditation of all agencies: MHDS central office has begun efforts to coordinate and centralize all agency accreditation efforts to result in national accreditation for all MHDS agencies. Staff will facilitate and maintain these accreditation activities.
- The Division updated Nevada's comprehensive statewide disaster response plan, and has begun to focus on bioterrorism preparedness. Since the plan was completed in June 2000, it has been utilized on at least six separate occasions. For example, the use of this plan has resulted in immediate and effective mental health services to Nevadans in emergencies in Dayton, Reno and an Alaska Airlines air disaster.
- Third annual statewide training conference on Service Coordination: Because Service Coordination is a critical part of delivering community-based services, MHDS has begun to provide an annual statewide training conference. This training is designed to increase the skills of Nevada Service Coordinators in providing services to adults with SMI and people with developmental disabilities. Nevada's annual training conferences are now scheduled each August. Each annual conference has provided training to over 225 MHDS Service Coordinators.
- MHDS began the new Consumer Assistant Program in collaboration with Nevada State Personnel. These new positions are staffed by former mental health program consumers who will assist other consumers, infuse consumer perspectives in performance improvement and other activities designed to increase the user-friendliness of MHDS programs.
- MHDS began an interactive website, which was designed by MHDS clients and staff, and includes the ability to make electronic applications for services, as well as access publications, agency information and links with other state and national services and referral sources.
- Completed a pharmacy policy and procedure review that addressed security, accountability, storage and dispensing, which ensures uniform medication management in all agencies.
- MHDS is a member of the Caseload Evaluation Organization (CLEO). The purpose of the organization is to have each organization in the Department provide a statistical process for the projection of caseload growth by program. This information is used by management to develop precise budgets, staffing and evaluate program needs.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

MENTAL HEALTH INDICATORS

Nevada's Mental Health Stakeholder Outcome Domains:

Symptom Reduction

Improved Functioning

Skilled Coping

Personhood

Consumer Involvement in Treatment Plan

Community Integration

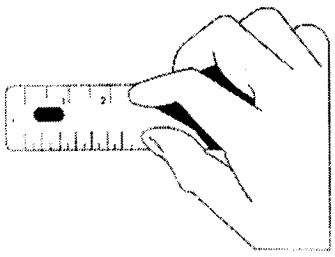
Social Functioning

Safety

Quality of Life

29

MENTAL HEALTH ACCOMPLISHMENTS



Performance indicators are instrumental in planning future services by helping predict program service demand

(SNAMHS)

- SNAMHS increased the capacity of the Psychiatric Observation Unit from 10 patients to 20 with out additional staff or resources.
- SNAMHS increased inpatient capacity from 60 beds to 68.
- SNAMHS more than doubled the psychiatrist staff from 8 to 17, leaving only one vacancy that will be filled before the end of 2002.
- SNAMHS has re-opened 2 pharmacies at the Henderson and North Las Vegas site offices.
- Despite budgetary restraints and cuts SNAMHS has managed to continue to provide a full array of services at all sites.
- SNAMHS has improved staff training compliance from 25% to 80%.
- Implemented the innovative, community based, Intensive Supported Living Arrangement program to serve 8 chronically mentally ill who would otherwise remain hospitalized.
- SNAMHS hired long-time DHR employees into key positions including the Agency Director, Director of Nursing, and Medical Director, lending stability to these crucial positions.
- Local Area Network (LAN) installed at SNAMHS.
- SNAMHS has significantly reduced overtime expenditures in all categories.
- SNAMHS has improved standards of care, in line with JCAHO accreditation
  standards, and will apply for accreditation in December 2002.
- SNAMHS hired a new director of Health Information Services who is charged with bringing the agency into compliance with HIPAA regulations.

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)

- NNAMHS opened the Dini-Townsend Hospital on September 12, 2001. This state-of-the-art psychiatric hospital provides Northern Nevada with an inpatient hospital unequaled in the State in its ability to provide contemporary, high quality treatment in a clean, open and therapeutic environment
- Initiated in July 2002 an Intensive Supported Living Arrangement program to provide community based living options for individuals with high care needs and histories of extensive hospital use. This program has provided an opportunity to discharge patients who have resided in the hospital for months or even years.
- On November 12, 2002 NNAMHS opened the consumer run canteen. This canteen will serve consumers and staff by serving a variety of snacks, light meals and soft drinks. The canteen will also serve as a vocational training program for consumers. The canteen will be self supporting, requiring no state funding.
- In January 2002 NNAMHS passed a three year accreditation survey

by the Joint Commission On Accreditation of Health Care Organizations with high marks and very few and insignificant Type I recommendations..

- Initiated a Family Psycho education Program. This evidence based program is designed to assist families of patients with schizophrenia to deal effectively with the symptoms manifested by their family member. NNAMHS staff received training in January, 2002 and currently have three "groups" in progress. The expected outcome for this program is a reduction in hospitalization for patients; an increase in family participation in treatment and greater support for individuals with schizophrenia to live in their own communities

RURAL CLINICS (RC)

- 6.5 new positions were funded for caseload growth plus 5.02 positions were funded to meet the existing backlog.
- The agency was budgeted to collect 1.2 million in TANF funding over the biennium, which provided a general fund savings of 1.2 million.
- Continued participation in the leukemia cluster emergency in Fallon, Nevada, including involvement in the two day workshop in July, facilitating the establishment of the Community Unity Response Team (CURT), and hiring and supervising a Service Coordinator for the affected families.
- Implementation of the Agency Suicide Intervention/Prevention Clinical Training Program.
- Utilization of videoconferencing for agency and cross agency meetings, resulting in significant cost savings in travel budget and labor.
- Successful budget presentations resulting in improving infrastructure in nursing service coordination and counseling programs. E.g., increased services to South Lake Tahoe.
- Personnel Analyst initiated collaborative effort with other agencies in rural Nevada to provide/make available mandatory training in rural Nevada, thus improving training opportunities while reducing costs.
- The Rural Nevada Continuum of Care (RNCoC)) is developing with the support of Rural Clinics stakeholders groups. Documentation of a strong well-developed rural continuum is essential if the continuum is to be successful in applying for up to $300,000 in HUD funds in May 2002.
- In December of 2001, Rural Clinics received a grant for $202,100 in BADA funds for the period January 2002 through June 2003 to develop programs in Ely, Tonopah, Hawthorne, Pahrump, Mesquite, Overton and Caliente.

LAKE'S CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER (LCC)

- The Sanity Commission process was eliminated in NRS 178 and language was changed to allow LCC staff to conduct sanity evaluations.

MENTAL HEALTH ACCOMPLISHMENTS

Highlight:

The opening in September of a new, state of the art, 60 bed Dini-Townsend Psychiatric Hospital in Sparks, NV, allows for treatment in a clean modern setting.

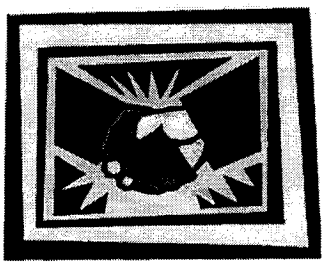
GOALS FROM THE 2003 MHDS STRATEGIC PLAN

- Provide and promote high quality and cost effective services in a safe environment
- Promote and support the least restrictive services possible in people's own communities while reducing reliance on institutional placement (strengthen community-based service to support people with multiple and complex needs).
- Ensure that services address the interests, rights and needs of each individual consumer serviced
- Utilize technology to improve accessibility to and availability of services and the efficient use of resources
- Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.

SIGNIFICANT LEGISLATION AND OTHER ACTIONS

- NRS 433A.370, 433A.380 and 433A.390 were amended to allow for persons who have been involuntary committed to a mental health facility to be placed on convalescent or conditional leave for a period not to exceed 6 months. This change in the law is designed to allow for a consumer to be evaluated by staff and be re-hospitalized if necessary.
- State legislation passed by the 1999 State Legislature, authorizes judges to consider past mentally ill behavior when determining if an individual should be involuntary committed.
- State legislation, passed by the 1999 State Legislature, allows the Division to serve not only persons with mental retardation, but also persons with conditions related to mental retardation.
- Assembly bill 346 allowed for funding of a pilot project in Las Vegas for the provision of a program of intensive and integrated community services to adults who are seriously mentally ill and homeless.
- BDR for a State of Nevada committee on homeless which came about as a result of the "Nevada Policy Academy Team of Homeless Families with Children."
- BBC Research and Consulting, contracted by the State of Nevada Dept. of Business and Industry, Housing Division, conducted a housing needs assessment of special needs population in the greater Las Vegas and greater Reno/ Sparks area. See website at: http://nvhousing.state.nv.us.

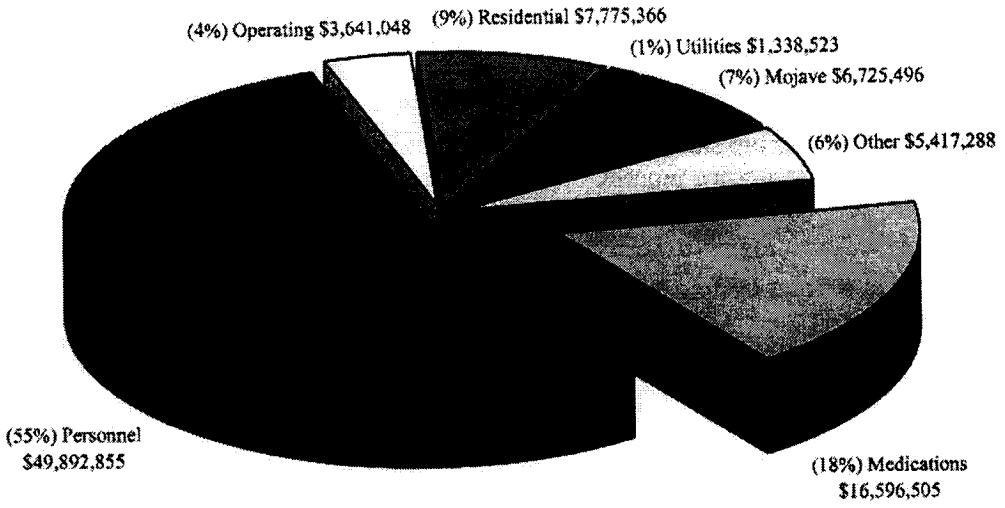
MENTAL HEALTH HIGHLIGHTS



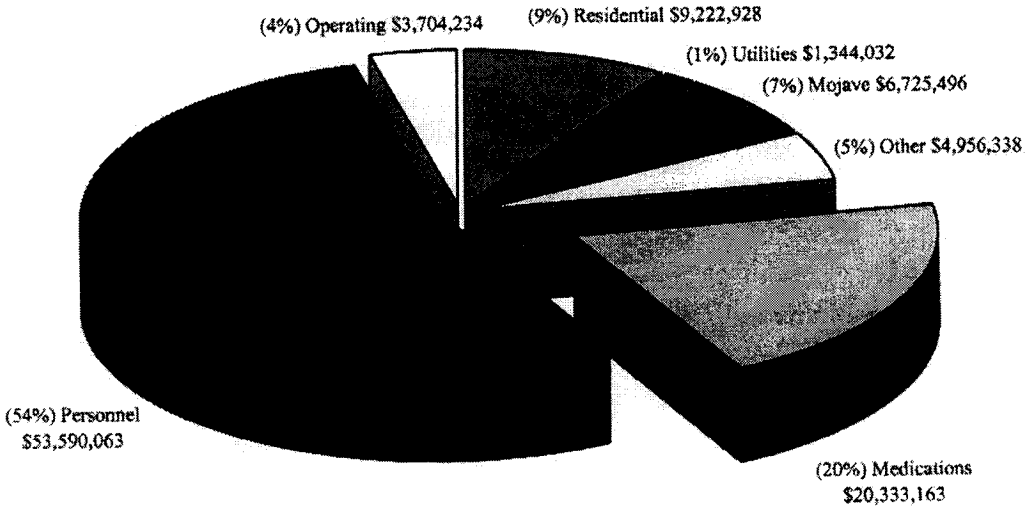
The Division of MHDS strategic planning process began in 1995. The plan was again updated in 1997 and again in 2000. The 2000 Strategic Plan addressed national standards, service gaps, budget and program planning. Additionally, the division developed a legislative planning process to reflect a timeframe in which an MHDS Needs Assessment occurs every even-numbered year, with strategic planning reports made in alternating (odd) years. Therefore legislative planning could be linked with specific FY04/05 budget efforts to findings reported in the Needs Assessment and Strategic Planning. This 2003 Strategic Plan and the upcoming 2004 Needs Assessment are being developed to assist MHDS through the FY06/07 biennium.

MH Challenges 2003-2005	*Plans for meeting the challenge*
☑ Maintain /expand funding support during state general fund budget reductions	• Reinstatement of FY03 budget reductions first priority, then budget for additional staff and resources to meet demands for programs showing the greatest need. • Apply for additional federal funding to support the expansion of Nevada's data infrastructure and programs.
☑ Involve consumers and other stakeholders in the planning and quality assurance process.	• Fully operate new Consumer Assistance Program (CAP). • Refine collection/reporting of consumer perceptions and satisfaction.
☑ Inpatient demand beyond staffing capacities	• Put into operation, increased bed capacity in Southern Nevada. • Expand PES in Southern Nevada. • Address emergency room crisis in southern Nevada hospitals.
☑ National accreditation of all MHDS agencies	• Obtain adequate staff infrastructure to under take accreditation. Train all levels of staff in planning and development to meet external standards. • Expand quality assurance program and continue to monitor program's consumer oriented outcome measures.
☑ Technology	• Replace obsolete MIS system in all MHDS agencies. • Internet connectivity for all clinical and fiscal all staff. • MHDS Website updates and improvements • Telemedicine.
☑ Maintain adequate funds for use of new generation antipsychotic medications	• Invest in newer, state of the art medications that provide consumers relief from mental health symptoms and reduce the demand for hospitalization.
☑ Improved mental health services to correction consumers	• Expand mental health courts • Assist NV correctional system in reorganization.
☑ Disaster Response Bioterrorism Preparedness	• Develop adequate infrastructure and staff development to provide crisis counseling, critical incident debriefing, and related activities. • Develop interstate linkages.

Mental Health Program Expenditures
Fiscal Year 2004



Mental Health Program Expenditures
Fiscal Year 2005



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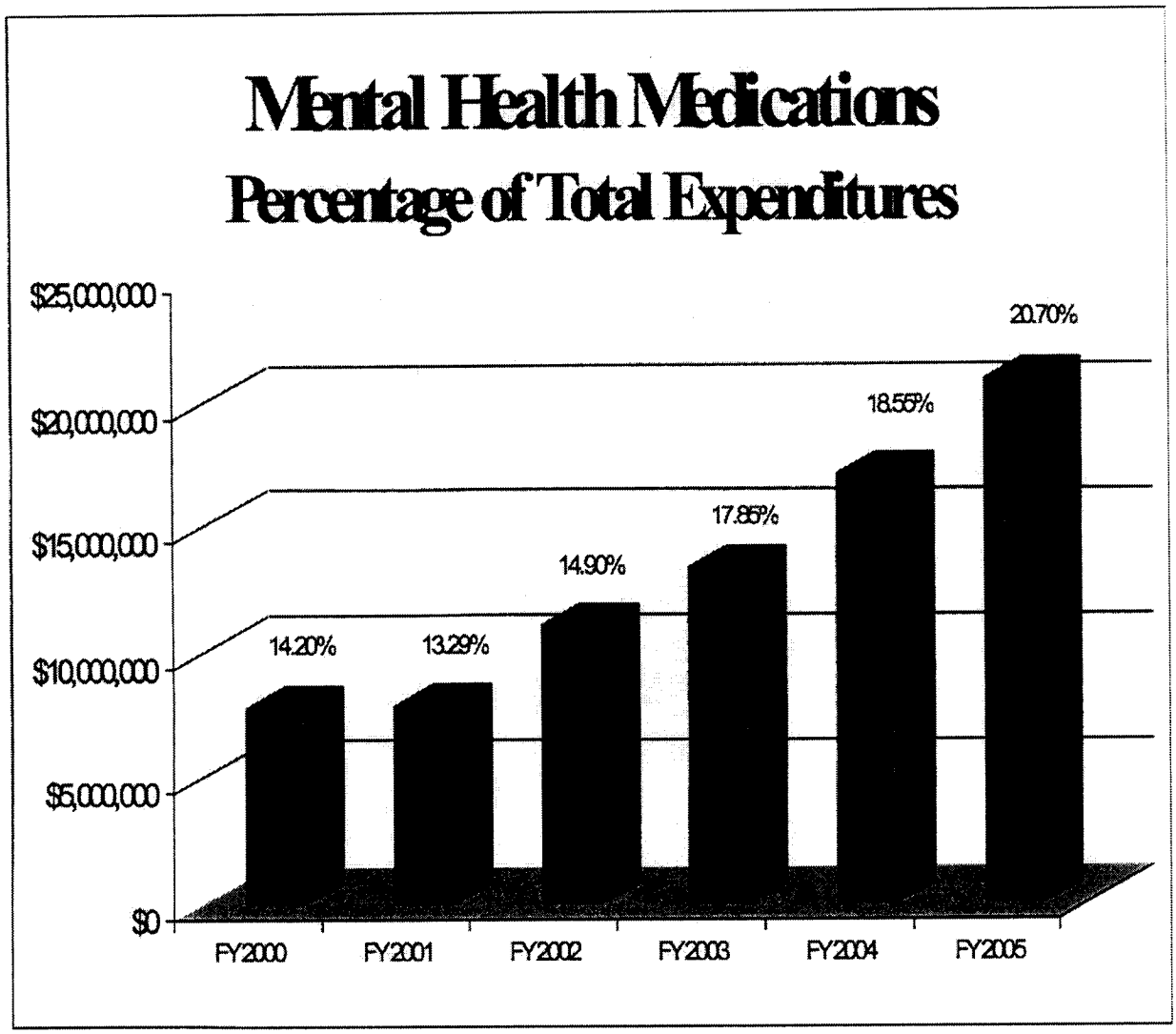
Mental Health Medications
Percentage of Total Expenditures
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
14.20%
13.29%
14.90%
17.86%
18.55%
20.70%
FY2000
FY2001
FY2002
FY2003
FY2004
FY2005

BUDGET HIGHLIGHTS
FY04-05

FY04-05 BUDGET HIGHLIGHTS
MENTAL HEALTH AND DEVELOPMENTAL SERVICES

▪ MENTAL HEALTH AND DEVELOPMENTAL SERVICES (MHDS) ADMINISTRATION

Mental Health Information System Budget

New Information System (Avatar) (M501)
Funding for this decision unit will enable MHDS to begin implementation of the new information system (Avatar). Implementation (functional migration) will commence in FY2004-05. MHDS plans to implement the new system in two phases. In Phase One, the financial/pharmacy reporting modules will be implemented statewide for mental health agencies during FY04. In Phase Two, the electronic medical records module (clinical workstation) for mental health agencies will be started in FY2004-05 and finished in FY2005-06. This budget account only includes necessary overtime for Mental Health's IT staff. The actual budget for the development of the new information system is included in budget account 1325, under the Department of Administration, decision unit M501.

	Gen Fund	Federal	Other	Total
SFY 04	1,550,966	303,813		1,854,779
SFY 05	599,099	117,356		716,455

Mental Health and Developmental Services Administration Budget

HIPAA – Health Insurance Portability (M501)
This decision unit provides for a privacy officer who oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to the organization's policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the health organization's information privacy practices.

New FTE's 1.00

	Gen Fund	Federal	Other	Total
SFY 04	50,453	8,989		59,442
SFY 05	61,486	11,008		72,494

▪ SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)

New FTEs 8.60
Caseload Growth 823 clients 14% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	834,916	49,673	4,275	888,864
SFY 05	2,338,354	100,566	8,550	2,447,470

New FTEs 2
Caseload Growth 182 clients 25% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	474,585	195,421		670,006
SFY 05	1,061,700	489,385		1,551,085

New FTEs 4
Caseload Growth 57 clients 8% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	124,114	787	339	125,240
SFY 05	230,234	1,569	666	232,469

New FTEs 7.5
Caseload Growth 182 clients 25% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	105,572	55,755		161,327
SFY 05	204,193	151,026		355,219

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	27,697	4,344		32,041
SFY 05	147,361	23,971		171,332

New FTEs 15.5
Caseload Growth 6 beds 60% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	646,163	11,891	5,070	663,124
SFY 05	847,586	12,271	5,070	864,927

New FTEs 21.2
Caseload Growth 10 beds 63% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	494,046	19,820	8,450	522,316
SFY 05	1,190,901	20,451	8,450	1,219,802

New FTEs 7.53
Caseload Growth 72 clients 100% growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	324,629	53,672		378,301
SFY 05	444,913	83,028		527,941

New FTEs 5.6
Caseload Growth New program

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	216,949	18,640	7,144	242,733
SFY 05	344,136	18,640	7,938	370,714

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	71,241			71,241
SFY 05	6,001			6,001

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	13,309			13,309
SFY 05	40,517			40,517

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	18,232			18,232
SFY 05				0

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	166,532		18,162	184,694
SFY 05	157,621		18,443	176,064

- **NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)**

Medication Clinic Services - (M200)
For FY04/05, NNAMHS requested: 1 psychiatrist, 1.5 Advance Practice Nurses, 3.5 psychiatric registered nurses to accommodate the caseload growth of more than 700 clients in the Medication Clinic. In addition, an increase of $3,600,000 for the newer and safer medications was also included in the agency request. The Governor's Budget includes all of these requests. These increases will substantially increase the ability of NNAMHS to provide community standard psychiatric services.

New FTE's	7.02			
Caseload Growth	767	clients	xxx	percent growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	1,288,281	52,936	42,150	1,383,367
SFY 05	2,223,943	87,075	68,355	2,379,373

Outpatient Counseling Services - M203)
NNAMHS requested 2 FTE Mental Health Counselor IV's to supplement outpatient counseling services. These two positions would be post doctoral interns who would provide state-of-the-art outpatient counseling to the rapidly expanding caseload for this service. The Governor's Budget included both these positions.

New FTE's 1.75
Caseload Growth 182 clients xxx percent growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	44,652		19,568	64,220
SFY 05	74,764		36,211	110,975

Community Residential Services - (M201) (E601)
NNAMHS requested funding for an additional 5 SLA's to accommodate caseload growth and 15 SLA's by converting funding for the 8-bed Residential Treatment Program to SLA funding as part of the restoration of the 3% cuts. The Governor's budget included funding for these 20 SLA's. These additional SLA's will allow NNAMHS to significantly reduce the severity of the homeless, indigent mentally ill problem in Washoe County by providing housing and support for these individuals.

M201
New FTE's 0
Caseload Growth 5 clients xxx percent growth

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	38,764	2,650		41,414
SFY 05	55,920	3,824		59,744

Service Provider Rate Increase - (E350)

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	23,120		4,499	27,619
SFY 05	104,743		21,164	125,907

Mental Health Court Support Services - (E351)
NNAMHS requested funding for 30 SLA's and contract intensive service coordination for up to 45 clients to support the Mental Health Court. The Governor's Budget included funding for both items. Mental Health Court is a valuable addition to the array of services in Northern Nevada and will prove to be an increasingly effective method to prevent seriously mentally ill clients with criminal histories from re-offending and from being re-hospitalized.

New FTE's 0
Caseload Growth
Residential 30 clients xxx percent growth

Caseload Growth
Contract 45 clients

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	253,743		19,494	273,237
SFY 05	336,660		30,132	366,792

Caseload Growth 275 Clients 21.7 percent growth
Wait List 58 Clients

Expansion Cost	General Fund	Federal	Other	Total
FY04	$ 587,594	$ 0	$ 72,624	$ 660,218
FY05	$ 782,562	$ 0	$ 68,049	$ 850,611

Psychosocial Rehabilitation – These services are targeted toward those persons with serious mental illnesses who need an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community at the least restrictive level of care and prevent inpatient treatment. Emphasis is placed on developing skills and a supportive environment. The Governor recommended funding to continue the existing program and to fund projected caseload growth.

New FTE's 2.75
Caseload Growth 58 Clients 34.7 percent growth

Expansion Cost	General Fund	Federal	Other	Total
FY04	$ 93,898	$ 0	$ 23,474	$ 117,372
FY05	$ 143,540	$ 0	$ 47,847	$ 191,387

Residential Supports – This program provides services to homeless or nearly homeless persons with mental illnesses. It is designed to provide a secure domicile for our clients and to cultivate their efforts toward independent living within their community. Rural Clinics currently arranges for 40 to 45 persons to live in their own or shared apartments with supportive monitoring and training/teaching of independent living skills through the service coordination and psychosocial rehabilitation programs where a full range of services are available. The Governor supported continuation of this program, to fund projected caseload increases and to clear the existing wait list.

New FTE's 1.50
Caseload Growth 32 Clients 82.1 percent growth
Wait List 11 Clients

Expansion Cost	General Fund	Federal	Other	Total
FY04	$ 114,438	$ 90,230	$ 15,405	$ 220,073
FY05	$ 214,353	$ 149,282	$ 19,139	$ 382,774

Service Coordination – This program provides supportive services to help persons obtain and utilize resources and services and to support them in their individual treatment plan. The Governor supported continuation of this program at its existing level. The costs shown below relate to decision unit changes that should be spread across all programs (e.g. inflation, fringe benefits, budget reductions).

New FTE's 0.00
Caseload Growth 0 Clients

Expansion Cost	General Fund	Federal	Other	Total
FY04	$ 45,775	$ 0	$ <1,761>	$ 44,014
FY05	$ 44,658	$ 0	$ <2,126>	$ 42,532

- **LAKE'S CROSSING CENTER (LCC)**

Lake's Crossing Center for the Mentally Disordered Offender

Total - Lake's Crossing Center	General Fund	Other	Total
SFY 04	$5,522,274	$101,566	$5,623,840
SFY 05	$5,574,740	$101,267	$5,676,007

Expansion of Staff Training and Programming:

	General Fund	Other	Total
SFY 04	$18,900		$18,900
SFY 05	$ 2,100		$ 2,100

Lake's Crossing Center asked for minimal changes in funding. One request that was a change from the past, included an additional $18,900 for training for the clinical staff. This request was made because this facility does a very specialized service for the state. That service requires staff be trained over and above their initial licensure requirements. The mnies will assure that the staff are supported in these requirements and that they complete these requirements so that the facility is in a better position to seek licensure.

In addition to training support for staff, this training money will allow for the establishment of several new programs that are specifically designed to work with mentally disordered offenders. This increase in programming will be especially important in the wake of new laws passed that may send some clients to the facility who are found not guilty by reason of insanity and who will require a different type of programming than pre-trial detainees.

Changes in positions:

	General Fund	Other	Total
SFY 04	$28,000		$28,000
SFY 05	$28,000		$28,000

A psychiatric resident rotation was established at Lake's Crossing by designating some of the professional services monies for this purpose. The resident will assist the in-house psychiatrist in caring for the clients' medication needs and in completing competency assessments. This new position/program is also hoped to provide potential candidates for recruitment when the present doctor retires.

Total - Lake's Crossing Center	General Fund	Other	Total
SFY 04	$22,031		$22,031
SFY 05	$21,972		$21,972

A .25 position was requested to be added to a .75 position being transferred into the 3645 (Lake's Crossing Center) budget account from budget account 3168 (Mental Health and Developmental Services Administration). This additional resource would allow for meeting increased demands by the Sex Offenders panels, community tier notification appeals and the sex offender risk assessments requested through the Washoe County Interposal agreement. These requests are all generated out of statutorily required assessments.

Replacement Equipment:

	General Fund	Other	Total
SFY 04	$5,020		$5,020
SFY 05	$0		$0

Some requests for new safety equipment were proposed and those were granted. The legislature mandated that the spending be moved from the second year of the biennium to the first. We have observed that the population at this facility has changed over the years and additional security equipment is required.

Other than these items there are no new requests in the Lake's Crossing Center Budget.

Replacement Equipment (E710 & E711)
NNAMHS requested funding to replace computers, carpeting, furniture, and other necessary equipment to run a large, 24-hour operation which currently has old and outmoded equipment. The Governor included all of these requests in his budget.

Cost of Expansion	Gen Fund	Federal	Other	Total
SFY 04	250,907			250,907
SFY 05	33,440			33,440

- **RURAL CLINICS (RC)**

RURAL CLINICS COMMUNITY MENTAL HEALTH CENTERS

Funding is provided to support a variety of community-based mental health services at 16 clinics throughout rural Nevada. In total, the support is increased by 32% over the biennium relative to the FY02/03 biennium. This increase will allow Rural Clinics to provide services to meet projected caseload growth and reduce the wait list time.

Funding increases are related to outpatient services, medication clinic, psychosocial rehabilitation, residential supports, and service coordination, as well as, the anticipated increased costs for modern medications. Total funding for Rural Clinics Community Mental Health Centers is:

Total RC Services	General Fund	Federal	Other	Total
FY04	$ 6,656,963	$ 2,815,456	$ 953,796	$ 10,426,215
FY05	$ 7,218,270	$ 2,985,946	$1,008,238	$ 11,212,454

Outpatient Counseling – This program provides therapeutic interventions needed to decrease the impact of mental illness on client's lives and relationships, and to assist in responding to mental health crises within the community. The Governor recommended increased funding in the rural communities to ensure sufficient services are available to meet the projected caseload growth needs and to satisfy existing unmet need.

New FTE's 8.77
Caseload Growth 382 Clients 13.2 percent growth

Expansion Cost	General Fund	Federal	Other	Total
FY04	$ 340,379	$ 0	$ 85,095	$ 425,474
FY05	$ 454,864	$ 0	$ 204,359	$ 659,223

Medication Clinics – This program provides evaluation, prescription and medication monitoring services. Licensed contract Psychiatrists and Psychiatric Nurse provide these services. Rural Clinics has a program to assist clients in accessing medication scholarships or samples. The indigent medication program purchases medications for clients who are unable to afford them and who are not eligible for Medicaid. The Governor has continued support of this program including the use of newer and safer anti-psychotic and anti-depressant medications, caseload increases and clearing the wait list.

New FTE's 5.27

APPENDIX D

Suggested Legislation

The following Bill Draft Requests will be available during the 2005 Legislative Session, or can be accessed after "Introduction" at the following Web site: http://www.leg.state.nv.us/73rd/BDRList/page.cfm?showAll=1.

BDR 17-277 Creates a Subcommittee of the Interim Finance Committee to address public housing issues in Nevada.

BDR 18-279 Adds a consumer of mental health services as a member of the Commission on Mental Health and Developmental Services.

BDR 39-280 Requires consumers of health care services to be active participants in their treatment plans.