# DISCLAIMER

STATE OF NEVADA
COMMISSION ON
MENTAL HEALTH AND DEVELOPMENTAL SERVICES
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KENNY C. GUINN
Governor

DAVID WARD
Chair

February 14, 2003

Honorable Members of the Nevada State Legislature
Capitol Complex
Carson City, Nevada 89710

Dear Honorable Legislator,

The Mental Health and Developmental Services Commission was created by the Nevada State Legislature to provide an independent review of services offered to Nevadans with mental illness and developmental disabilities, and to help determine policies within the MHDS division. We represent a diverse group of professionals working in the field, as well as public representatives with special interest in MHDS. We are grateful for the opportunity to serve Nevada and clients of the MHDS Division. One of the Commission's key responsibilities is to provide an annual report to the Governor, and a bi-annual report to the Legislature, outlining our perspective regarding these services. This letter is intended to meet that responsibility.

Since our last report, we have continued to review services provided by the Division, along with those provided by DCFS and private hospitals and organizations serving Nevadans with mental illnesses or developmental disabilities. We have placed special focus on *the critical issue of suicide in Nevada*, and have tried to encourage greater coordination of efforts in prevention. We have sought out and received feedback from clients, and their families, as well as from staff and professionals working with these populations. We have reviewed and approved policy within the division, and are pleased to report our finding that the division administration and staff are fully committed to providing the best service possible with available resources.

We have noted a marked improvement in services provided during the last six years. This includes, but is not limited to, the addition of innovative community-based and emergency services, significant reductions in waiting lists and the construction of a beautiful, new mental health hospital in Northern Nevada. As you know, the MHDS Division has enjoyed funding increases greater than most other areas within the state budget. We know these increases were difficult to provide, and we recognize the leadership role our Legislature played in obtaining them. Those recent gains helped make important progress toward reversing the some of the adverse effects caused by the tremendous funding and service reductions that occurred within the division during the early 1990's.

We strongly supported the creation of task forces to more systematically evaluate needs for health care and services for Nevadans with disabilities, authorized during the last session.

We're very cognizant of the enormous and mounting fiscal crisis that our state faces, and we recognize that our Legislature is determined to find both short and long term solutions for that crisis. Within that context it is somewhat uncomfortable, yet arguably even more critical, for us to provide you with our honest appraisal of the state of services currently being provided to these populations in Nevada.

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We are encouraged by the dedication, skill, and patience of countless health care professionals and workers who serve these populations on a daily basis. They face the daunting challenge of a rapidly growing client base, coupled with severe understaffing brought about by our budget shortfall. In spite of their best efforts, Nevada's needs are many:

- A new mental health hospital in southern Nevada.
- An increase in suicide awareness, and suicide prevention programs, while streamlining data collection to improve identification of suicide risk.
- Increased funding and treatment for early Autism intervention.
- Maintain the Psychiatry Residency Program of the University of Nevada School of Medicine in Northern Nevada at NNAMHS and extend it to SNAMHS in Southern Nevada, since it is a very cost effective method of providing much needed professional services.
- Increase communication, coordination, and continuity between and within state and private agencies to provide seamless services to children, adults and seniors. A new MIS system is an essential element of this.
- One or more MHDS division grant writers to secure available Federal funds for services.
- Full funding of medication needs of the mentally ill, and full implementation of the state's medication algorithm plan.
- Appropriate funding for private providers to enable them to hire and retain qualified staff. Until we do, our providers will not be able to provide adequate quality or continuity of service.
- Full funding of the Mental Health Court and expansion to Southern Nevada.
- Hiring to fill the very large number of vacancies in division staff.
- Expanded access and availability of emergency and community-based services throughout the state.
- Continue to increase training to reduce the need for seclusion and restraint.

The preceding list of needs is not intended to ignore or diminish the good work currently being done throughout the State. In spite of gains in recent years, Nevada's per capita funding for services to these populations remains very low, while our statewide suicide rate continues to rank first or second nationally. Nevadans suffering from mental illness are forced to endure unreasonable waits to receive medication. Upon release from mental health hospitals, they are required to wait up to six weeks for an initial outpatient visit with a physician. It would be unconscionable overlook the sometimes fatal effects of these delays.

The under-funding of programs such as emergency or community-based services for the mentally ill or the early intervention of autism not only results in unnecessary human suffering, but is fiscally counter-productive as well.

We fully recognize that it is much easier to point out these needs than to find ways to fund them. In view of that, we offer two funding suggestions for your consideration. First, we believe the addition of one or more dedicated grant writers would generate considerable funds (a large multiple of the cost involved). Secondly, we would suggest levying *a special assessment on tobacco and alcohol* to be specifically targeted to provide funding for mental health and disabilities. This assessment could be over and above any increases earmarked toward balancing the budget. The logic of a special assessment seems clear: alcohol and tobacco use during pregnancy frequently cause retardation and ADHD; chronic self-medication by a vast majority of the mentally ill compounds the damage done by their illnesses; abuse of tobacco and alcohol by the general population significantly increases Nevada's health costs. We suggest that such a levy could fund most, if not all, of the needs we identified. As a commission we were pleased to see Governor Guinn specifically include most of these identified needs among his budget recommendations.

We would welcome the opportunity to meet with you or a designated member of your staff at your convenience to further discuss the contents of this letter or other subjects of interest to you.

Once again, thanks for the opportunity to serve as commissioners and to provide you with input on MHDS. More detailed information outlining the rationale for a new Southern Nevada Mental Health Hospital and early Autism intervention is attached for your review.

Respectfully Submitted by the Commission,

David Ward
Chair, MHDS Commission

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# REGARDING NEED FOR A NEW SOUTHERN NEVADA MENTAL HEALTH HOSPITAL

1) Currently there is daily congestion in all eight Southern Nevada area hospitals' emergency rooms. They are assessing and trying to treat copious numbers of local psychiatric patients. These patients are so many in number that when there are no psychiatric facility beds in the city, they remain in the local Emergency Departments for as long as eight or nine days on some occasions. In the past three weeks this situation has occurred at Sunrise Hospital on at least two occasions. Sixteen patients were there six to eight days. When this occurs, the patients do not get psychiatric treatment after being medically cleared as there are no psychiatrists on staff at Sunrise. They do get assessed for transfer to psychiatric facilities. They are then on waiting lists to SNAMHS, Valley Hospital Geriatric, Lake Mead Hospital or Monte Vista Hospital.

2) They cannot be admitted to the hospitals where they are to relieve the stress on the E. R..as they do not meet medical criteria for admission into a medical bed. In addition, there are not enough nurses on the medical floors to currently treat the medical patients already admitted. In fact, medical patients are already being held in the emergency rooms as well, while available medical beds remain empty as there are no nurses on those floors to treat them.

3) Depletion of emergency department staff services to maintain, feed, toilet and provide security for these patients. There is such a drain on ER staff that they do not have the time to care for medical emergency patients. These situations cause staff burn out by nurses and technicians impacting existing staff shortages.

4) Physicians are attempting to treat psychiatric patients for a longer period after the original emergency assessment and this is out of their scope of practice. They are not psychiatrists. This heightens their already vigilant concerns over malpractice issues. They are threatened with malpractice often by these patients and their families when they are kept on hold for days on end.

Reduction in Homelessness:

Patients who cannot get treatment in hospitals locally go between the emergency rooms, (often UMC) and the shelters for support of all their needs. When they cannot be treated at a psychiatric hospital they bounce between these facilities. This causes an impact on the already overburdened emergency rooms and shelters. The cycle continues until the patient is arrested over behavioral issues or is held for a long period in an emergency room. They occasionally get admitted to a psychiatric facility for treatment. The unrealized suffering and daily life style of these patients is often taken to be voluntary when it is, in fact survival only and many do not survive. After multiple cycles of this activity many attempt suicide to get into a hospital. They are often willing to take these chances to stop the cycle.

Reduction in illegal drug use:

Patients who are not receiving treatment in hospitals are not being referred for treatment of their co-morbid health conditions including alcohol and drug dependence. They are instead involved in survival cycles as mentioned above where their behavior is more dangerous to themselves and to others due to different phases of intoxication, altered mental status and withdrawal. The need for a facility which has a separate unit to treat patients with dual diagnosis which are psychiatric and chemical dependency, is understood by all professionals in Las Vegas.

Reduction in Crime:

Crime occurs when patients who would normally be admitted are on the streets or at home without resources. Many are involved in a cycle of no treatment or intermittent treatment during which they decompensate and search for relief in criminal activity.

Addendum notes:

### PRIVATE INSURANCE/HMO PATIENTS

Questions arise about state facilities making contracts with private insurance companies/HMOs for treatment of their patients who are also languishing in emergency rooms while awaiting beds in local private facilities who are consistently full.

### SHORTAGE OF PSYCHIATRISTS AND PSYCHIATRIC NURSES:

Any existing facility or new facility has a growth plan and as part of that plan:

1) The residency program for psychiatrists should be active in the North and South divisions concurrently.

2) The facilities need improved plans for training nurses. Goal to offer insight into the need and future desirability of becoming psychiatric nurses is critical. A brief rotation is not satisfactory but instead an internship which results in certification as a Psychiatric R.N. Any internship should by contractual agreement offer employment and career advancement for them. Further, a training program for advanced practice nurses, i.e. Nurse Practitioners or Clinical Specialists in Psychiatry would produce a new source of primary psychiatric care in all of the facilities. These mid-level providers can practice independently with collaboration with a psychiatrist, prescribe medications, and develop treatment plans for patients. This would also reduce the need for as many psychiatrists whom we are having difficulty finding. Two mid-level providers can be hired for the cost of one psychiatrist. One psychiatrist is able by Nevada law to collaborate with five Nurse Practitioners.

Recruitment of out-of-state Mid-level providers in the psychiatric field should be considered and instituted to relieve the workload of Psychiatrists currently practicing in our facilities. There are only five currently licensed mid-level providers in psychiatry in Las Vegas employed and practicing.

REGARDING THE BENEFITS OF EARLY INTERVENTION FOR AUTISM

No one has found a cure for autism, the neurological disorder that leads to lifelong impairments in a child's ability to speak, respond to others, share affection and learn. But there is a growing consensus that intensive early intervention is both effective and essential - the sooner after diagnosis, the better.

Early intervention, which involves many hours of therapy with one or more specialists, does not help every autistic child to the same degree. It is best started no later than age 2 or 3, and for reasons that are unclear, it does not help some children at all. But for those who are helped, their parents say, the changes are miraculous.

Yet the success of early intervention is posing a painful predicament for schools and families - a predicament made more immediate by a rising tide of diagnoses of autism. Last week, researchers reported that the number of autistic children in California had risen more than six-fold since 1987, and other states and the federal government have also noted sharp increases.

By federal law, public schools must provide appropriate education for children with disabilities, starting at age 3. But the treatment is so expensive - averaging $33,000 a year, according to research published in the journal Behavioral Intervention - that many families cannot persuade their school districts to pay for it.

Brian and Juliana Jaynes of Newport News, Va., can testify to that. As a baby, their son, Stefan, developed normally, if not ahead of the curve. By age 2, his vocabulary was well over 100 words. He knew his address and his colors, and he spoke in short sentences. But soon after his second birthday, he started to regress, forgetting the words he once knew.

His parents suspected a neurological disorder. A specialist confirmed their suspicions, telling them Stefan was severely autistic and urging them to get intensive therapy for him.

Instead, school officials placed Stefan in a special-education preschool, where, the Jayneses say, he rapidly regressed. (The school district says the placement was appropriate.) After the neurologist told the frantic couple that their son might have to be institutionalized, they removed him from the preschool and began 40 hours a week of behavior therapy at home.

It cost them more than $100,000 over three years. Today, Stefan, 11, attends a school for autistic children and has vastly improved his language, social and self-help skills. He can say some simple sentences and communicate his needs; perhaps most important, he spends more and more time interacting with his family, and less time in his own world. The behavior therapy, his father said, "has brought about an awakening in this little boy's personality that is truly a miracle."

In recent years, four leading institutions - the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the Surgeon General and the National Academy of Sciences - have called for early intervention, including one-on-one therapy, for children with autism. A panel of experts convened by the academy last year recommended a minimum of 25 hours a week, 12 months a year.

But Dr. Catherine Lord, the panel's chairwoman and a psychology professor at the University of Michigan, estimates that fewer than 10 percent of children with autism are getting the recommended level of therapy. "Almost everywhere, schools will say kids are getting services," she said. "But what they're getting varies enormously."

Because the young nervous system has a great deal of plasticity, many experts believe that early intervention enriches neural growth.

Dr. David L. Holmes, president of the Eden Institute, an autism center in Princeton, said, "If you have a child with autism who's not wired correctly, and we allow that to continue without intervention, those neuropathways will become fixed, and it becomes far more difficult to undo that tangled mess."

Autistic children lose the ability to learn by observation, something other children do constantly. Behavioral therapy is aimed at teaching these children how to learn. Teaching an autistic child to wave goodbye, for instance, can take 40 hours of repetitive lessons.

Autism Therapy Is Called Effective, but Rare. There are several kinds of therapy. The most popular - the one Stefan Jaynes receives - is applied behavioral analysis, in which a therapist asks a child to perform small tasks and then offers feedback to reinforce correct responses.

Other programs use sensory integration therapy, based on the theory that autistic children have defects in processing the messages from their five senses; auditory integration therapy, which assumes that some are oversensitive or undersensitive to sound or have problems processing sounds; speech therapy; and group programs.

The federal education law leaves decisions about therapy to professionals and parents. But administrators say parents often demand far more therapy than the experts recommend. "Is the school system going to override teachers, and substitute the teacher's decision with the parent's decision?" asked Bruce Hunter, associate executive director for public policy at the American Association of School Administrators in Arlington, Va.

The biggest obstacle is budgetary. "When you're looking at limited resources in a school district, sometimes the available resources drive what services schools will propose to offer," said David Egnor, policy director at the Council for Exceptional Children. "It's simply pragmatic."

Mr. Hunter added: "The problem all along in special ed is that you have a chronic shortage of money that is exacerbated by downturns in the economy, which is when it really gets bad. You get the joy of taking the money from one group of children and spending it on another group."

Under law, the federal government may reimburse states up to 40 percent of the extra cost of educating a child with a disability. But this year, Congress is paying just 17 percent, or $7.5 billion. President Bush has proposed adding $1 billion next year.

"The federal and state governments ought to pay attention to these children who have disabilities and need to be educated and need special treatment, and that costs money," said Representative Dan Burton, Republican of Indiana, who has an autistic grandson.

But the chairman of the House Committee on Education and the Workforce, John A. Boehner, Republican of Ohio, opposes full financing of the act until major changes are made. He and others have called for reforms in identifying students with disabilities - minority students are classified far out of proportion to their numbers - and in the daunting paperwork for the schools.

Many experts believe society would pay less in the long run if children received appropriate early intervention. An article in Behavioral Intervention in 1998 found that if 100 children were given early intensive intervention and 40 of them had only partial improvement, the public would save $9.5 million over their school years, ages 3 to 22.

Most insurance companies do not pay for therapy for developmental disorders like autism, though a few companies offer reimbursement as part of their health benefits.

Another obstacle to treatment is a lack of specialists. Public schools have a shortage of more than 12,000 special education teachers, and the number is expected to grow as many teachers retire or leave the field.

Advocates say the supply of teachers trained to deal with autism is even shorter, so schools are forced to rely on expensive outside specialists.

Even parents who decide to pay for treatment have trouble finding private specialists. Autism schools and private behavioral therapists typically have waiting lists of more than a year. This forces parents to set up their own in-home school and hire teams of people to provide the 20 to 40 hours a week of therapy. Many parents train themselves in the behavioral therapies, and then train college students, whom they can hire for considerably less money than specialists.

Yet another obstacle to early intervention is delayed diagnosis. Autism is most commonly diagnosed at 20 to 36 months, but experts say the signs often surface earlier. Many families experience delays because pediatricians often dismiss their concerns.

The growing awareness of autism may ease that problem. (Autism is now diagnosed in 1 out of 600 children, by most estimates.) But without appropriate therapy, early diagnosis does little but create frustration for parents, as Stefan's mother, Juliana Jaynes, recalled recently. "I had the doctor telling me that every moment counts," she said. "There's that horrible feeling of time slipping away and nothing being done."