

NEVADA DISABILITY ADVOCACY & LAW CENTER

Nevada's Federally-Mandated Protection and Advocacy System for Individuals with Disabilities

Report On The Mental Health Crisis In Southern Nevada

February 2005

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EXECUTIVE SUMMARY

Nevada Disability Advocacy and Law Center's investigation into the Southern Nevada Mental Health crisis determined the following:

- Individuals on involuntary mental health holds wait on average four days in hospital emergency rooms because state law requires they must be medically screened. The state psychiatric hospital, administered by Southern Nevada Adult Mental Health Services, does not have the equipment or personnel to conduct such screenings. While individuals are being held in community hospital emergency rooms, they receive little to no psychiatric care.
- State law mandates the State of Nevada provide psychiatric care. They, along with Clark County, are responsible to adhering to the Olmstead decision. In Olmstead, The United States Supreme Court determined that unjustified institutional isolation of individuals with disabilities, including those with mental illness, is discrimination. In accordance with the Olmstead decision, any unnecessary institutionalization or isolation of individuals with mental illness must be eliminated.
- Southern Nevada Adult Mental Services should be given the resources to provide medical screenings, as required under state law, so more individuals can receive proper psychiatric care. However, with the rapid growth of Clark County, other avenues should be explored. Private community hospitals should be encouraged to assist in providing psychiatric care, but the State must increase the Medicaid reimbursement rate for inpatient psychiatric stays. The rate in Nevada is currently at 460 dollars per day. In other Western states, the average is 600 dollars a day. The community hospitals also must be trained in the proper techniques in handling psychiatric patients.
- Inpatient services are not enough. Proper community-based services must be instituted to help prevent individuals with mental illness from seeking assistance through the community hospitals' emergency rooms. Southern Nevada Adult Mental Health Services' community-based services are lacking. In one of the community-based services, the walk-in clinic, it has been estimated that 40% of those who check in on a daily basis leave out of frustration without receiving services.
- Proper supportive housing, in which the individual has safe, affordable housing coupled with needed social services, is beneficial to the individual and the community at large. Supportive housing in other metropolitan areas produced a combined cost savings of more than 30% for state and local governments. One study showed that individuals in supportive housing reduced their emergency room visits by 56% and their inpatient stays to virtually zero.

NEVADA DISABILITY ADVOCACY & LAW CENTER'S REPORT ON THE MENTAL HEALTH CRISIS IN SOUTHERN NEVADA

A. INTRODUCTION

This report presents Nevada Disability Advocacy & Law Center's investigation into the mental health crisis in Southern Nevada. Nevada Disability Advocacy & Law Center (NDALC) is a private, nonprofit corporation, which is the federally mandated and governor-designated protection and advocacy agency for the State of Nevada, pursuant to 42 U.S.C. 15001 et seq. and 42 U.S.C.10801 et seq. NDALC investigated the Southern Nevada Mental Health Crisis pursuant to its federal statutory authority to investigate allegations of abuse and neglect in treatment and care facilities.

Individuals interviewed:

James Osti, MPH, Clark County Health District
Dr. Jonna Triggs, Director of Southern Nevada Adult Mental Services
Lauri Carlson, Business Development Director, Montevista Hospital
Michael Howie, Executive Director, Mojave Mental Health Services
Jim Parcels, Chief Operations Officer, Mojave Mental Health Services
Joanne Lujan, Director, Community Triage Center, Westcare
Natalie Sieber, Emergency Department Director, MountainView Hospital

B. BACKGROUND FACTS

On July 9, 2004, Clark County issued a state of emergency after an overflow of the mentally ill who were on involuntary holds in the emergency rooms reached critical mass. Out of the 342 beds used for emergency care, more than 102 were used to care for the mentally ill who were awaiting transfer to Southern Nevada Adult Mental Services (SNAMHS), the local state mental health provider.¹ In response to the state of emergency, NDALC decided to investigate the issue and make recommendations to help alleviate the crisis.

1. The legal hold process

The process of an involuntary mental health hold under the Nevada Revised Statutes (N.R.S.) 433A.150, grants the right to detain any individual alleged to be mentally ill and who is a danger to himself or others for period not to exceed 72 hours for evaluation, observation and treatment. The involuntary mental health hold is commonly referred to as a “Legal 2000.” The individual may be detained at any public or private mental health facility or hospital. Once admitted to the facility the individual must be evaluated by a psychiatrist, psychologist or physician. Each such emergency admission must be approved by a psychiatrist. N.R.S. 433A.160. During the 72-hour time period for an emergency admission, a petition for an involuntary court admission must be filed with the District Court with a statement signed by a physician that the individual in question is mentally ill beyond a reasonable degree of medical certainty, the person poses an imminent harm to himself or others and involuntary admission is medically necessary to prevent the person from harming themselves or others. N.R.S. 433A.210. Once the clerk of the district court receives any petition, a hearing must be set within five judicial days. N.R.S. 433A.220. If during the hearing, there is clear and convincing evidence that the person held is mentally ill and because of the illness is likely to harm himself or others, the court may order an involuntary admission, but for no longer than six months at a time. N.R.S. 433A.310

1. Las Vegas Review Journal, 7/10/04, Emergency declared as mentally ill flood ER's

2. Why are individuals on involuntary mental health holds in hospital emergency rooms?

N.R.S. 433A165 states that before an allegedly mentally ill person may be transported to a public or private mental health facility under N.R.S. 433A.160, the person must be examined by a licensed physician or physician's assistant or advanced practitioner of nursing to determine whether the person has a medical problem, other than a psychiatric problem. Currently, the facility at SNAMHS does not have the staff or equipment to do medical screenings. All medical screenings are done at the various community hospitals. When individuals are screened by the hospital, they often cannot be transferred back to SNAMHS because the state facility is regularly at its capacity of 131 beds. This causes the backlog of individuals in the hospital emergency rooms. When the crisis was declared by the county on July 9, there were 95 individuals on involuntary holds in 11 hospital emergency rooms awaiting transfer to SNAMHS.²

C. ISSUES/CONCERNS

1. What are the collective legal responsibilities of the local hospitals, Clark County and the State of Nevada in providing mental health services?

The State of Nevada and Clark County can be held liable for federal civil rights violations under 42 U.S.C. 1983 for improper Legal 2000's because they are considered to be state actors. The private community hospitals can be accountable for federal civil rights as well if an employee of the hospital initiates a Legal 2000 under N.R.S. 433A.160, because restraint of persons against their will under a statutory grant of power constitutes state action for the purposes of 42 U.S.C. 1983. Cummings v. Charter Hosp. of Las Vegas, Inc., 896 P.2d 1137. (1995)

The State of Nevada and Clark County are also subject to the Olmstead decision. In 1999, the Supreme Court of the United States in Olmstead v.L.C., held that unjustified institutional isolation of people with disabilities is a form of discrimination. The court further held that states are required to provide community-based services when the placement is appropriate and the placement can be reasonably accommodated. The decision affects states and state actors, including Clark County and the county-affiliated hospital, University Medical Center, (UMC).

². Data presented to the Southern Nevada Adult Mental Health Coalition, August 2004

In 2002, the State of Nevada drafted the Nevada Strategic Plan for People with Disabilities to implement the Olmstead mandate. The plan was done at the behest of disabled community with the full support of Governor Kenny Guinn and the Nevada State Legislature. The plan has 94 identifiable goals that are to be implemented by 2011. The State of Nevada's future decisions must conform with these goals.

Clark County also must be cognizant of the Olmstead decision and help to eliminate any unnecessary institutionalization or isolation of individuals with mental illnesses at U.M.C.

2. What are the legal responsibilities of the state to provided mental healthcare?

N.R.S chapter 433 states the Division of Mental Health and Developmental Services (MHDS) is the official state agency responsible for developing and administering mental health and developmental services. It is also authorized to operate subunits for the care, treatment and training of clients under NRS 433.094. SNAMHS is a division of MHDS.

Nevada state law also recognizes the need for community-based services. NRS 433.003 (2) charges MHDS with recognizing their duty to act in the best interests of their respective clients by placing them in the least restrictive environment. N.R.S. 436.123 designates the MHDS as the official state agency for developing and administering preventive and outpatient mental health services.

3. What are the legal responsibilities of the private hospitals in the community?

There are no state or federal statutes that mandate private hospitals provide substantive mental health treatment. However, all hospitals that receive Medicare funding, which includes almost all hospitals, fall under the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA was enacted to prevent hospitals from refusing to provide care to uninsured patients in their emergency rooms. It requires that a person presenting to a hospital's dedicated emergency department must be screened for an emergency medical condition and if one is found, stabilize before discharge or transfer. The term, "stable" in terms of a psychiatric context is described as, "when he/she is no longer considered to be a threat to him/herself or others." 68 Fed Reg 53247. Psychiatric treatment is not required.

Many local hospitals do not have psychiatrists on staff to provide treatment. EMTALA does require that the hospitals do have psychiatrists on call but only “in accordance with the resources available to the hospital, including the availability of on-call physicians.” 68 Fed. Reg. 53262. The State of Nevada has incorporated a similar statute NRS 439B.410.

4. Treatment that individuals receive while waiting in emergency rooms.

MHDS reports on average that 62 individuals wait each day in emergency rooms awaiting transfer to SNAMHS.³ Those individuals are held in emergency rooms an average of 93 hours, equating to almost four days.⁴ While waiting in emergency rooms, individuals under involuntary holds receive little psychiatric care. Out of the 13 local hospitals, only two have a psychiatrist on staff.⁵ Many of the hospitals’ medical staffs have little psychiatric training. Only one hospital, MountainView, has taught its staff non violent de-escalation techniques.⁶ Individuals often wait in hospital hallways and corridors waiting to be transferred to Southern Nevada Adult Mental Health Services because all the designated emergency patient rooms are full. Such a practice cannot be considered to be conducive to treatment.

5. What direct services are being provided by the state to the hospitals to help alleviate the emergency room crisis?

After the state of emergency was declared by Clark County, the State of Nevada contracted with Westcare, a private substance abuse and mental health provider, to accommodate an additional 28 individuals on Legal 2000’s on a temporary basis. The state then renovated one of the older buildings on its Desert Regional Center (DRC) campus to serve as the permanent site. Once the site was completed, the 28 beds were transferred from Westcare to DRC.

The state also has a unit, the Mobile Crisis Team, that assesses and discharges those who have stabilized in the hospitals on Legal 2000’s. Dr. Jonna Triggs, the director of Southern Nevada Adult Mental Health Services, estimated the Mobile Crisis Team saw 4,200 patients in the emergency rooms and diverted 39% out of the hospital and gave them community support over the months of June, July and August of 2004.⁷ The Mobile Crisis team consists of 5.6 clinical social workers who work seven days-a week. Montevista Hospital, the private psychiatric facility in Las Vegas, performs a similar service in conjunction with SNAMHS.

3&4. As reported on the Division of Mental Health Developmental Services website, <http://mhds.state.nv.us>

5. Interview with James Osti, Clark County Health District, Jan. 2005

6. Interview with Natalie Seiber, Emergency Department Director, MountainView Hospital, Sept. 2004

7. Interview with Dr. Jonna Triggs, Director of Southern Nevada Adult Mental Health Services, Sept. 2, 2004

6. Who are the individuals who require long term psychiatric treatment?

NDALC interviewed three individuals who were receiving inpatient treatment at SNAMHS. NDALC inquired as to past treatment and the services provided to these individuals.

EW is a 38-year old man who stated that he had been to the state hospital approximately 18 to 20 times since 1983, twice in the past year. He stated that he had been in three different group homes in the past two years. During his last group home stay, he found the supportive services lacking and had to come back to the hospital because he “needed to talk to somebody,” and he wanted to stop hearing voices. EW believed if he had the proper supportive services, such as his own apartment and help with his finances, he would not have returned to the state hospital. His emergency room stays were uneventful.

ES is a woman in her mid 50’s. She has a slight physical impairment plus a mental disability. She estimated that she had been to the state hospital three times in the past 10 years. She was homeless for some time and had a difficult time at a local shelter. She told NDALC, “they kick you out in the early morning and don’t let you return until the early evening. That isn’t right in over 100 degree temperatures.” She had an incident with the police and ended up in an emergency room. She told NDALC it took eight hours for her to be examined. While at the hospital, they did not give her prescribed medications. She believes if she received supportive housing with educational and vocational programs, she would not have been in the hospital.

ST is a woman in her mid 50’s. She had been to the state hospital twice in the past six months. She told NDALC they released her too quickly the first time. Her medications had not stabilized and she could not get in contact with her mental health caseworker. As a result, she entered into a crisis and went to a hospital emergency room to receive treatment. She waited there for 96 hours before she was transferred to SNAMHS. She stated when she is released, she will be placed in a group home and was concerned about losing her own apartment in the community as a result.

D. RECOMMENDATIONS

NDALC believes the mental health crisis can be alleviated by providing more effective inpatient treatment as well as substantial increases in community-based services and supportive housing.

1. INPATIENT TREATMENT

NDALC believes a humane and cohesive approach to inpatient treatment can be obtained by the following;

- a. Have Nevada state government provide the resources so SNAMHS' staff may perform medical screenings.
- b. Encourage private hospitals to provide acute psychiatric care.
- c. Require proper de-escalation techniques be taught to all hospital emergency staff and proper restraint procedures be utilized.

a. Medical screenings

The primary reason why individuals wait in hospital emergency rooms to be transferred is that SNAMHS does not have the medical personnel and equipment to provide medical screenings. If SNAMHS had the proper personnel and necessary equipment, individuals could be screened there, negating the need to be screened in the emergency rooms of the community hospitals.

SNAMHS has requested state government provide the necessary funding to allow medical screenings to be performed on their site. SNAMHS has estimated that if funding is approved up to 84 individuals may be medically screened at their facility.⁸

NDALC recommends medical screenings occur at SNAMHS. An individual in a psychiatric crisis needs and deserves proper care as soon as possible. SNAMHS can currently provide the proper psychiatric care, the local community hospitals cannot.

8. Dr. Jonna Triggs' presentation to the Southern Nevada Mental Health Coalition, January 6, 2005

b. Encourage private hospitals to provide acute psychiatric care

It is estimated that in 2006, SNAMHS could accommodate up to 341 inpatient beds with the building of the new state hospital and the retention the current number of beds in the existing facility.⁹ While it is hopeful that the state system could accommodate all the Legal 2000's over time, it is unlikely. James Osti, with the Clark County Health District, estimates 3,240 individuals with serious mental illness move into Clark County each year.¹⁰ If the statistics are proven to be accurate, it wouldn't be long until SNAMHS would again be over its capacity to provide acute psychiatric care.

If the private hospitals would be willing to open acute inpatient psychiatric units, it would take the burden off the state to provide these services. It also could prompt SNAMHS to concentrate in providing more comprehensive community-based mental health services.

For this to occur, the private hospitals would have to be paid a reasonable rate of reimbursement from the State Nevada Health Care Financing and Policy (Medicaid) division. At present, State Medicaid pays 460 dollars a day per person for an inpatient psychiatric stay.¹¹ It is estimated a private hospital would need at least 530 dollars per day to provide the appropriate services and not lose revenue.¹² Many other Western states reimburse at least 600 dollars per day.¹³

NDALC recommends the State of Nevada negotiate with the private community hospitals to raise the inpatient psychiatric rate to an acceptable standard. The more facilities that provide acute psychiatric care, the better.

9. Dr. Jonna Triggs' presentation to the Southern Nevada Mental Health Coalition, January 6, 2005

10. James Osti, Presentation, Southern Nevada Healthcare Overcrowding Crisis, Dec. 16, 2004

11. State of Nevada Health Care Financing and Policy website, <http://dhcfp.state.nv.us>

12. Interview w/ Lauri Carlson, Director of Business Development, Montevista Hospital, August 31, 2004

13. Reno Gazette Journal, January, 23, 2004, [Democrats seeking fix for crisis in mental care](#)

c. Require proper de-escalation techniques be taught to all hospital emergency room staff with regards to the mentally ill and proper restraint procedures be utilized.

If medical screenings occurred at SNAMHS, it is unlikely that mentally ill patients will be held under Legal 2000's at hospital emergency rooms. Nevertheless, all emergency room personnel should be required to learn proper de-escalation techniques for the safety of the patients and themselves.

The hospitals also must utilize proper restraint procedures, if necessary, while an individual is held on a Legal 2000, in accordance with The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO is a quality oversight body for health care organizations and managed care in the United States. JCAHO allows the use of restraint procedures in instances where individuals pose an immediate threat to themselves or others and if all other measures have been attempted. In these instances, individuals must be restrained safely and in a humane manner in compliance with JCAHO.

NDALC recommends State of Nevada require SNAMHS assist in providing proper de-escalation techniques to the community hospitals. NDALC also recommends that each hospital adhere to JCAHO restraint procedures.

2. COMMUNITY-BASED SERVICES

a. Increase of community-based services

The community-based services provided by SNAMHS are as follows:

Psychiatric Ambulatory Services (PAS)¹⁴ provides 24-hour emergency walk-in center service for clients in crisis. For many, this is the only reasonable way to receive services. The wait times can be lengthy. Many clients have been known to leave out of frustration. Dr. Triggs estimates that 40 percent of individuals who sign in each day leave without being seen.¹⁵ Four out of every of ten clients not receiving assistance is unacceptable.

14. All descriptions of community-based services are taken from the Strategic Plan for People with Disabilities, State Department of Human Resources, October 2002

15. Report given to Southern Nevada Mental Health Coalition, Jan. 6, 2005.

SNAMHS has requested 20 more direct care staff which includes registered nurses, psychologists and psychiatrists. If approved, wait times should decreased considerably and those seeking services should receive them in a timely manner.

Medication clinics: Medication services are provided by a physician or advanced practice nurse with privileges to evaluate, prescribe and monitor medications.

The majority of the community-based services provided by Southern Nevada Adult Mental Health Services (SNAMHS) are provided by the medication clinics. Four sites provide psychiatric medication to patients. The main site is located on 6161 West Charleston. There are also sites in North Las Vegas, East Las Vegas and Henderson. As of June 2004, 6,745 individuals were receiving medications.¹⁶

As per state law, a psychiatrist must see these individuals every ninety days. NRS 433.504. Each appointment with a psychiatrist at a medication clinic is scheduled for 30 minutes. It is estimated the psychiatrists at the medication clinics currently carry a caseload of more than 700 patients.¹⁷ That is double the number of the agency's staffing ratio.¹⁸ Because of these large caseloads, there is little time for the doctor to consult the patient regarding medication regimen or symptomology.

SNAMHS has requested staff increases of 10 additional psychiatrists and 20 nurses. These increases should significantly cut down on caseloads and improve services.

SNAMHS has also requested a new medication clinic in downtown Las Vegas to provide better access for its clients.

Outpatient counseling: Group outpatient counseling services provided to clients include diagnosis and evaluation, counseling, psychotherapy, and behavioral management.

As June 2004, 1,140 individuals received outpatient group counseling, less than 18 percent of those receiving medication

SNAMHS has requested a staff increase of one counselor. If approved, 130 additional clients would receive services.¹⁹

16. All statistics for community-based services derived from Southern Nevada Adult Mental Services reports, June-August 2004.

17. Interview w/ Dr. Jonna Triggs, Sept. 2, 2004

18. Division of Mental Health and Developmental Services staffing ratios

19. All caseload increases are based on MHDS staffing ratios

Programs for Assertive Community Treatment (PACT): The program provides intensive community-based treatment and rehabilitation services to clients with serious mental illness by using a multi disciplinary mental health team approach. The focus of this team, consisting of a psychiatrist, psychologist, nurses, psychiatric case workers and a drug and alcohol counselor, is to provide a better quality of life for mental health patients. The PACT team is mobile and services are provided wherever necessary in the community. As of June 2004, 130 individuals received PACT services, less than 2 percent of those receiving medication.

Service Co-ordination: Personal service coordinators organize treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan. They help clients access essential community resources including housing, financial, employment, and transportation.

As June 2004, 691 individual received service co-ordination, less than 11 percent of those receiving medication.

SNAMHS has requested an additional 1.5 Intensive Service Co-ordinators. Intensive Service Co-ordinators provide increased service co-ordination to those individuals with serious mental illness and felony legal involvement. If approved, 23 additional clients would be eligible for services.

Psychosocial Rehabilitation: This program's focus is to help foster clients' independence in the community and prevent acute inpatient care. Services provide consumers with education and training related to employment, social relationships, living situations and wellness.

As June 2004, 173 individual received service co-ordination, less than 3 percent of those receiving medication.

SNAMHS has requested an increase of 1.5 staff members. If approved, an additional 68 clients would receive services.

Compare the percentages of SNAMHS's community-based services to Mohave Mental Health, the community mental health service provider for Medicaid eligible individuals, over the same period of time.²⁰ Of the 992 individuals to whom Mojave provides services;

20. Included in Southern Nevada Adult Mental Health statistics, June 2004-August 2004

782 received medication, more than 78% of their clients.

789 received service co-ordination, more than 79% of their clients.

513 received counseling including individual counseling, more than 51% of their clients.

337 received psychosocial rehabilitation, 34% of their clients.

If SNAMHS were to increase its community-based services to equal Mojave Mental Health, they would have to increase their services by the following number of clients;

service co-ordination by 4,637 clients.

outpatient counseling by 2,299 clients.

psychosocial rehabilitation by 2,120 clients.

Even with the proposed increases, state-supported community-based services are lacking. It is hard to imagine that the majority of the 6,745 individuals who receive medications are not in need of other community-based services. Medications alone will not prevent an individual from decompensating and spiraling into a crisis. An interaction with a health professional at a medication clinic for 30 minutes every three months is not enough.

NDALC recommends that SNAMHS increase its numbers of clients in its community-based programs by 50% in the next biennium. Roughly that equates to 570 more individuals in outpatient counseling, 326 in service co-ordination and 87 in psychosocial rehabilitation.

NDALC also recommends that the requests made by SNAMHS regarding its (PAS) services and the medication clinics are approved.

b. Increase of supportive housing

The Nevada Strategic Plan for People with Disabilities states the top housing need for those with mental illness is affordable, permanent supportive housing. The idea of supportive housing is to provide decent, affordable housing in combination with access to medical, social and psychological services.

Supportive housing has proven to be a success. Many urban areas have used supportive housing to combat homelessness while saving money. The Corporation for Supportive Housing, a non profit housing provider, commissioned two studies in two major urban areas, one in New York City, the other in San Francisco, to show the impact of supportive housing in their respective communities. In the San Francisco study, 200 men with mental illness received supportive housing and within one year of receiving services, the use of emergency rooms fell by 58 percent and the number of inpatient psychiatric stays decreased from two

and a half days to zero.²¹ In New York City, 4,679 mentally ill homeless individuals were placed in supportive housing. It was estimated that before entering supportive housing, the state of New York and the city of New York combined spent on average \$40,449 in publicly funded services for each homeless person.²² Once placed into supportive housing, a homeless mentally ill individual reduced his or her use of publicly funded services in New York by an average of \$12,145 per year, a decrease of more than 30 percent.²³

Other state mental health providers have devised new approaches in providing supportive housing. The State of Hawaii has partnered with the Bureau of Housing and Urban Development to provide supportive housing for individuals with mental illness. The State of Hawaii's rental assistance program provides housing to mental health clients for up to two years or until a Section 8 voucher through HUD is available. The state contracts with a local non profit to administer the program and provide supportive services.

In Clark County, SNAMHS currently provides housing to its clients in two categories: Group Homes and Supportive Living Arrangements.

Group Homes: These are residential programs for clients whom have been deemed not to need specialized services. Independent contractors who provide supervision and training in household duties operate group homes. Clients who live in a group home typically share a room with another resident. In June of 2004, 412 individuals were in group homes, a little more than 6% of the individuals who receive medication.²⁴

Supportive Living Arrangements: These are apartments or homes for clients who require training and support in daily living. Trainers come to the client's residence to teach living skills and provide support. In June of 2004, 270 individuals were in supportive living arrangements, about 4% of the individuals who receive medication.

SNAMHS has requested increases of 215 community beds for the next biennium. These beds are a mixture of placement in group homes and supportive living arrangements.

NDALC is pleased that SNAMHS has asked for increases in residential housing but believes the increases should be larger and focus more on supportive housing. As such, NDALC recommends that SNAMHS increase its supportive living arrangements by 50% in the next biennium. NDALC also recommends that SNAMHS start a pilot housing project similar to those currently being offered by the State of Hawaii and the Corporation of Supportive Housing.

21. Corporation for Supportive Housing, Supportive Housing and Its Impact on the Public Health Crisis of Homelessness, 2000.
22&23. Corporation for Supportive Housing, The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals, May 2001.

24. Statistics for community-based services derived from Southern Nevada Adult Mental Services reports, June-August 2004.

E. CONCLUSION

The State of Nevada, Clark County, and the community hospitals all have some responsibility in the mental health crisis, both legally and morally.

To alleviate the mental health crisis in Southern Nevada, increases in both inpatient and outpatient services need to occur. No one in crisis should wait four days to receive treatment nor should someone leave in frustration after not receiving psychiatric services in a timely manner.

NDALC hopes that the proper community-based services are implemented. Mental health consumers need these services to aid them in their rehabilitation and to prevent recurring inpatient stays. More supportive housing should be strongly considered. It has proven to be cost effective in other metropolitan areas. In supportive housing, treatable problems are addressed by service professionals. If not for supportive housing, many of these individuals who have treatable issues would have spiraled into a psychiatric crisis requiring days of needless hospitalization.

NDALC asks the State of Nevada, Clark County and the community hospitals to support our recommendations to help end this crisis. Mental health consumers deserve no less.

For additional information, contact:

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