Mental Health in Nevada– Vision for the Future

A position paper that focuses on the provision of community-based mental health services by the State of Nevada for persons with severe and persistent mental illness

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Mental Health in Nevada – A Quick Overview

The State of Nevada needs to look at a statewide, comprehensive, community-based mental health system including the following points, which will provide a continuum of care for persons with a serious mental illness.

- State-of-the-art, web-based communication system to enable 24-hour a day access to all records, with electronic medical recording and adequate privacy safeguards
- Integrated crisis and emergency system, 24 hours a day/7 days a week
- Programs for Assertive Community Treatment (PACT) for the most seriously ill, including high-risk populations such as the jail population
- Medication evaluation and maintenance services with state-of-the-art medications
- Residential services for all who need them, ranging from apartment living to intensive, long-term residential care
- Case management system for all other clients
- Intensive forensic services including crisis intervention and case management for persons involved with the justice system, including seamless transition to non-forensic services
- Counseling services appropriate to the needs of the client
- Day treatment, vocational services and partial care programs
- Senior services
- In-home services for families providing support to a family member with mental illness
- Seamless transition from juvenile services to adult mental health services
- Justice Courts of Special Jurisdiction to assure strict adherence to individual liberties and the protections of the law, due process and the dignity of the individual with mental illness

Such a comprehensive system will provide the most cost-effective method of providing an appropriate level of treatment to every individual with serious and persistent mental illness, allowing each person to live in the least restrictive environment and enjoy the maximum quality of life.

On a national level, increased emphasis is being placed on mental health. The 1990s were declared the Decade of the Brain. The 1999 White House Conference on Mental Health called for a national anti-stigma campaign and the Surgeon General issued a Call to Action on Suicide Prevention that year as well. A historic event occurred when the Surgeon General released the first-even Report on Mental Health[1] which highlighted mental health as a national priority. Nevada must place equal emphasis on this topic.

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

Executive Summary

For the past several Legislative Sessions, members of the Southern Nevada Legislative Task Force, in conjunction with members of the Northern Nevada Mental Health Coalition, have issued papers for the purpose of educating our elected officials as to the status of the mental health system in Nevada.

In past papers we covered the history of the system, and recommended badly needed services such as the Programs for Assertive Community Treatment [PACT] teams, state-of-the-art medications and increased residential services.

This year, for the first time, we have created a statewide vision, involving advocates from across the state and incorporating their needs and issues, in order to present our blueprint for a better mental health system

We are not demanding instant implementation of everything suggested here – instead we are attempting to offer a look at a comprehensive mental health system that would increase services to consumers, both in quantity and quality. As we have studied the system over the past 10 years or so, we have consistently noted the lack of a long-term vision. Therefore, we are providing our view of gaps in the system and changes that would improve services.

Recent History:

Since the 1997 Legislative session, a statewide coalition of mental health advocates and consumers, business owners, law enforcement officials and knowledgeable legislators has been successful in adding approximately $45 million to the mental health budget. This infusion of funding has contributed new resources to mental health care. For example, two new medication clinics were added in the Las Vegas area, bringing the total there to four. Rural services have also expanded to include clinical and medication services in Mesquite, Pahrump, Silver Springs, Battle Mountain, Fernley and Lovelock, Programs for Assertive Community Treatment (PACT) for intensive case management were added . There has been a marginal increase in available housing supports and small increases in case management services.

Equally important is the fact that, during the seven year period since 1991 (the year before the budget cuts) the state¹s population growth has ranged between 3.5 and 6.7% per year for a total of 47%. In addition, during this same time period inflation has eroded the purchasing power of the mental health dollar by approximately 23.8%. Since mental illness affects a fixed percentage of the population each year, the combination of inflation and population growth since 1992 actually yields current purchasing power that is ***17.8% less*** than the level of service available to Nevada¹s mentally ill in 1991.

Even with heroic legislative effort in the past two sessions, for which we, as advocates, are very grateful, Nevada¹s mental health system hasn¹t managed to hold its own.

Significant portions of the recent budget increases were earmarked for purchase of new generations of atypical antipsychotic medications. This represents a significant improvement in one medical aspect of treatment for many mentally ill individuals. Also, the two new PACT's have proven effective despite underfunding, understaffing and overwhelming demand. PACT programs ultimately improve the care provided for at least 140 Nevadans most seriously impaired by persistent mental illness. These programs must be expanded to address the needs of the much larger population who would benefit from their services.

Beyond these changes, the balance of the new resources has been directed to re-instituting programs that existed prior to the 1992 cuts. Programs in this category include re-established sub-acute residential treatment, enhanced levels of residential care and expanded case management.

State of Services Today

Currently, services vary somewhat throughout Nevada. We can divide the State up into three regions:

- South
- North
- Rural

Most of the issues and gaps detailed in these pages are found throughout the State. Gaps in services that occur in mainly one area are identified as such.

In Southern Nevada, a major problem is caused by the constant growth in population. Since Nevada's Legislators meet every two years to prepare the budget, a great deal of forecasting must be done to assure that the provision of services matches the growing need. A no-growth budget in Southern Nevada is equal to constantly diminishing services.

In Northern Nevada, a key factor compromising patient care is seen as the lack of organizational coherence across the service system. As a consequence, the community of consumers and advocates is now working closely with the Nevada Mental Health Institute to foster improved internal administration. The focus is particularly on the transition from inpatient to community-based care services. The perspective in the North is that the recent infusion of resources has not led to improved care. Without streamlining administrative procedures, internal continuum of care will remain a critical area of systemic dysfunction.

Because of the make-up of Rural Nevada, which consists of small communities often located many miles from the next small community, there are several critical issues not shared by the large cities. The rural areas suffer from a lack of registered nurses, social workers, psychologists and contract psychiatrists to staff existing clinics. Waiting times for medication clinics, counseling and housing, which sometimes exceed 28 days, are continuing to grow. Some areas of rural Nevada are growing rapidly; Elko County and Nye County are projected to grow to 60,000 and 58,000 respectively by 2010. Housing has been and remains a critical unmet need throughout rural Nevada.

Rural Clinics is the only mental health agency currently serving children. While this paper does not cover children's mental health services in detail, we recognize the overall inadequacy of the services provided. The entire area is poorly funded, and this lack guarantees a future with too many adults requiring intensive mental health care. Early intervention is the wisest, most humane and least costly solution.

In the Rural Clinics, the bifurcated system results in little or no statewide planning for children and adolescent services.[2] Program development at a system level is needed to properly serve adolescents in the juvenile justice system whose primary problem is mental-health based. This requires collaboration by schools (early intervention), mental health and juvenile justice. This collaboration is largely absent and results in serious and irrevocable trauma to too many Nevada children.

[2]The Federal Government addressed children's mental health issues with the "Children's Health Act of 2000" which was enacted by the Senate and House of Representatives on January 24, 2000.

Recommendations

The following recommendations are expanded on in the detailed list of services and gaps that follows:

- *We recommend* **increasing basic funding** based on increasing need as it relates to **population growth**. This is especially important in Southern Nevada.
- *We recommend* **streamlining emergency psychiatric services,** with a triage system to identify true crisis cases and more efficient processing of new clients.
- *We recommend* **continuation of existing PACT's** and addition of new PACT's for other populations at high risk of hospitalization, e.g., the jail population, the highest users of in-patient resources.
- *We recommend* increased funding for the adequate supply of the **newer medications.**
- We recommend the availability of **additional suitable housing** to assure all clients are able to live in the least restrictive setting.
- *We recommend* the availability of **adequate case management** and **forensic case management** to cover all clients who desire case management services but are not served by PACT's.
- *We recommend* **updating the Division's computer system** to take full advantage of today's Internet capabilities. An effective computerized system is integral to the efficiency and success of the system.
- *We recommend* instituting **Police Crisis Intervention Teams** throughout the State, based on the Memphis, Tennessee model.
- *We recommend* expansion of **vocational and day treatment programs**, centered around a Clubhouse Model. **Clubhouses** should be built in partnership between the State and outside agencies. Every person with mental illness should have a constructive and focused day time activity: work, school or volunteering in support of community service programs.
- *We recommend* expansion of **services for seniors** with diagnoses of mental illness.
- *We recommend* instituting **In-Home Services** that offer support for families who are providing support to a family member with mental illness.
- *We recommend* improvement of **Child and Adolescent Mental Health Services** to bolster the currently inadequate services offered in both the community and inpatient settings.
- *We recommend* effective coordination of services devoted exclusively to **seamless transition from juvenile to adult services**, both with respect to inpatient medical facilities and community-based mental health services.
- *We recommend* instituting **Justice Courts of Special Jurisdiction** to assure strict adherence to individual liberties and the protections of the law, due process and the dignity of the individual with mental illness.
- *We recommend* **selective privatization** throughout the system, when appropriate, monitored by the Division, and with the necessary mechanism in place to ensure that clients of non-profit or for-profit private providers are afforded appropriate and effective grievance procedures, appeal and due process rights consistent with those required under the conditions

of participation and applicable laws and regulations mandated by the legal requirements governing the payor source; payor sources may include but are not limited to Medicaid, Medicare, Managed Care Organizations, Health Management Organizations or private insurance.

- *We recommend* the necessary revision or amendment to Nevada statutes to comply with the aforementioned **important client rights and protections.**

On the following pages, we provide our vision of an overview of the components of a comprehensive system for community-based service delivery and identify the gaps existing in the availability of services in Nevada today. This gives us a plan for creating a better system over the next few years.

Communication System

Comprehensive Services

- A state-of-the-art networked computer system, Intranet-based, that would be accessible only by authorized personnel through protective passwords, using commercially available software.

  A Virtual Private Network would be set up for this purpose, and would allow statewide integration of all records. The system would track medication appointments and prescriptions, case management, residential, billing, pharmacy and all other services provided to the clients. In an instant, personnel working with the client would be able to information. For instance, if someone goes to the Crisis Unit in the middle of the night, the doctor will know when he had his last medications appointment, whether he filled his prescription and any other pertinent medical information. A case manager, would be able to access information relative to the client's day-to-day needs such as daily living arrangements, appointments, etc., as well as notes on the prior case management services he has received. Missed appointments would be rescheduled immediately and the case manager notified by e-mail that same day. Files would no longer be "in transport" for hours at a time.

  It is essential that appropriate releases will have been signed by the clients and that they will have given knowing consent to the disclosure of the foregoing information. Applicable laws and regulations regarding confidentiality of medical records must be strictly adhered to.

Gaps in Nevada

- The current computer system consists of the mainframe-based AIMS system which has been functioning in an inefficient manner for several years. Limited stand-along computers exist, with no Internet or e-mail access. Most of the computers are obsolete and cannot run state-of-the-art software. The only way to proceed is to scrap this system and provide all key personnel with state-of-the-art PCs and Internet access (with security firewalls in place). Even taking into account the expense of data conversion from the old system, this would be much more cost effective than the old AIMS system. In addition, the AIMS system is not accessible to most contracted providers.

Using the Internet would allow outside agencies that contract with the Division to access and upload information related to the services they provide, on a need-to-know basis.

Integrated Crisis and Emergency System

Comprehensive Services	Gaps in Nevada
• Crisis unit which is separate from system intake, with triage system to separate new clients from true crisis cases, and to reduce inappropriate admissions. Triage personnel would interview all persons entering the crisis unit, and would schedule intake appointments and medications appointments, referring only true crisis cases on to the crisis personnel.	• Crisis unit currently is the main system intake gateway. This results in long waiting periods for both patients in crisis and persons seeking access to outpatient services, as well as potential exacerbation of patient's existing psychological/medical condition. The resulting public impression of the system is frequently one of chaos. No true, effective triage system exists.
• Services available for patients in crisis should include a formalized structure for evaluation and treatment, same-day crisis intervention availability, same-day medication evaluation and appropriate screening for involuntary commitment and acute inpatient hospitalization..	
• Part of interconnected, web-based system for rapid access of records, with appropriate confidentiality and disclosure safeguards that comply fully with State and Federal laws in place.	• The current method of retrieving files on existing patients is manual. Since these files are kept in the main office, it is impossible to retrieve them outside of office hours. This results in a lack of pertinent, up-to-date information which is necessary for timely and effective diagnosis and treatment.
• Medical clearance on-site. The existing memorandum of understanding between Clark County and the Southern Nevada Adult Mental Health Services should be expanded to provide the acceptance of patients who are delivered by the police to the crisis unit without requiring the officer to wait for the results of the evaluation. Current Nevada law appears to require the medical clearance to be done at the County Hospital. It may be necessary to modify the existing statutes to allow for on-site medical clearance.	• Medical clearance is currently being conducted off-site, usually at the County Hospital's Emergency Room, in what often times is a very uncomfortable, time-consuming process. This results in patients often walking out and failing to receive treatment, unless they are restrained. The application of such physical or chemical restraints can often violate patients' rights. Staff members at emergency rooms are often not adequately trained in psychiatric disorders. • If a patient has been brought in by the police, the police currently have to wait

for completion of the evaluation and therefore are inclined to take them to the jail where there is no wait required.

- Mobile unit attached to Crisis Unit to provide emergency services and identify persons for subsequent intake
- No state-provided mobile unit exists.

Programs for Assertive Community Treatment (PACT) for the most seriously mentally ill

Comprehensive Services	Gaps in Nevada
• PACTs supply a very effective means for providing a seamless continuum of care for many persons who suffer from a serious mental illness. In a PACT, a team consisting of case managers, nurses, psychologists, psychiatrists and occupational therapists work to provide wrap-around services to a group of clients. The concept is a proven success, reducing hospitalizations, incidents of police intervention and jail time, and increasing the security, health and well-being of its clients	• One PACT, known as PACT I, exists in Southern Nevada, with the capacity to serve 72 clients. PACT I's outcome measures prove the success of the program.
• PACTs should eventually be available to every severely and persistently mentally ill person who wants and needs the program. • The number of PACTs should be increased over time to provide adequate services to meet the need • A forensic PACT should be added Incarcerated persons with mental illness make up the highest percentage of individuals with significant mental health needs that very often go untreated while in jail..	• Only one PACT exists at this time. Current case management services do not allow for the flexibility to intervene in a timely and effective manner with patients. The lack of timely intervention results in patient decompensation and increased need for acute levels of care. The increased need for hospitalizations and incarcerations taxes both the mental health and jail system.
• Evaluate the feasibility of privatization of the PACTs. Strict quality assurance measures and guidelines that tie into the Federal and State funding streams must be an important component of a privatized PACT system.	• PACT is currently funded as part of the State mental health system. Generally, a private agency is more cost-effective and less susceptible to factors such as hiring freezes that seriously impact services. A non-profit organization generally is run with an administrative cost of less than 10% of program costs, as compared to State administrative costs which could be as high as 35% to 40%. Non-profit organizations allow for competition

among providers, which generally will increase quality, lower costs and ensure accountability.

Case management system for all other clients

Comprehensive Services

- Case management should be available to those clients who may feel they do not need the level of "wrap-around" care provided by a PACT, or who may feel the PACT concept is too intrusive. The array of available case management services should include:
- Advocacy
- Case identification
- Family and individual support services, including coordination of medical appointments, assistance with residential placements and help with interaction with agencies such as Social Security, Welfare for Food Stamps, etc.
- Outreach and referral to rehabilitation, treatment and support services
- Case management services are also a candidate for privatization.

Gaps in Nevada

- Currently, there are not enough case managers to serve clients, and waiting lists exist which consist of about 125 clients, or a waiting time of 1-1/2 years. Too heavy caseloads result in some clients being shortchanged. In addition, there is often a wasteful doubling up of services where a client receiving State case management services, also receives case management services connected to his residential placement, for example, with the Salvation Army's programs.
- **RURAL**: There are not enough case managers to provide adequate levels of psychosocial rehabilitation and the intensive case management needed by many rural citizens with mental illness. Intensive case management is needed to prevent, or at least reduce, the need for hospitalization.

Intensive forensic crisis intervention and case management system for persons involved with the justice system

Comprehensive Services	Gaps in Nevada
• Forensic case management to provide intensive, uninterrupted services to clients who may have pending court matters. This should include case identification and referral to medical management, rehabilitation, treatment and support services, and family and individual support services.	• Southern Nevada currently has four social workers and one psychologist dedicated to this population. At this time, when a person is incarcerated, there is a disruption in services and medications may be cut off or changed. When released, the client may not resume services with the same treatment providers, resulting in a discontinuity of services. In many instances, a forensic PACT that would interface with the jails could be a solution to this problem. In other instances, there should be a mechanism in place to assure that the client's current case manager can interface with the jail system, and facilitate his transition upon discharge.
• Seamless transition from correctional facilities to inpatient medical facilities or community-based mental health services should also be provided, to assure continuity of the provision of mental health services, especially rapid access to appropriate medications.[3]	• Prescriptions written by doctors in correctional facilities and private practice doctors are not accepted at the Crisis Unit. Clients often wait up to 3 weeks for a medications appointment for a new prescription, by which time the client has often decompensated to the point of required re-institutionalization.
• Police Crisis Intervention Team (CIT) based on the Memphis, Tennessee model should be established. This model involves the creation of a team of uniformed patrol officers within the police force who volunteer and are selected to receive 40 hours of training from mental health	• No CIT exists, with the result that individuals with mental illness are generally taken directly to jail for committing minor infractions that could be effectively dealt with at the mental health crisis unit.

[3] In September 2000, Congress approved money for pilot programs that emphasize supervision and treatment rather than prison sentences for the mentally ill who commit nonviolent crimes. Funds will be available to create up to 100 programs to help the mentally ill in the criminal justice system.

providers, family members, and consumers. In the event of a non-violent crime or disturbance being created by a mentally ill person, the nearest CIT police officer is dispatched to the scene to take charge, defuse the situation, and divert the individual to the mental health crisis unit in lieu of incarceration. The existing memorandum of understanding between Clark County and the Southern Nevada Adult Mental Health Services should be modified to incorporate this process and define the reimbursement arrangements.

Medication evaluation and maintenance services incorporating recently developed medications

Comprehensive Services	Gaps in Nevada
• Individual and group medication visits with a psychiatrist or nurse-practitioner	• Medications clinics exist. However, in order to eliminate waiting lists, more sites and personnel are needed
• Scheduling at reasonable intervals	• The scheduling system is archaic, revolving around a crisis-unit based system intake with no computerized internal communication
• Recently developed, more effective atypical antipsychotics and SSRI (selective serotonin re-uptake inhibitors) anti-depressants that are more cost-effective than older formulary medications.	• Budget must be maintained and expanded to assure that each person with serious mental illness can receive the best, most appropriate medication. • When prescribing medications, a cost-consciousness should be reinforced in a way that is consistent with professional judgment. We are concerned that external influence by pharmaceutical companies may result in the wholesale use of the newest, most costly and not necessarily most effective medications. This is observed on a national level. It is essential to balance optimum patient outcomes with conservation of fiscal resources.
• A consistent, systematic method for evaluating new medications as they are introduced on the market, to assure a high standard of care in Nevada regarding state-of-the-art medications	
• Accessible and cost-effective purchase and distribution system	• The distribution system is currently limited to a few private and State-owned and operated pharmacies. We recommend the State complete an evaluation of purchase and distribution practices.
• Sites located in various areas to facilitate easier accessibility	• Currently there are not enough sites.
• Mobile medications van with satellite computer link to server to provide around-the-clock crisis intervention services in the community	• No mobile medications van exists.

- **RURAL**: While the rural areas have the same budgetary problems regarding funds for purchase of medications, in addition they need additional psychiatric and RN support to deal with waiting lists for medications appointments. RN support is needed for lower-level medication reviews between visits of traveling psychiatric consults. Medication clinic appointments are delayed by 28 days in some rural clinic sites.

Counseling services

Comprehensive Services

- Counseling services appropriate to the needs of the clients should be available, including individual and group sessions and ADL [Activities of Daily Living] training.
- Access should not be limited because of a client's ability to pay, and fees should be charged on a sliding scale ranging from free to standard rates.
- Clients should retain their right to choice of providers.
- Counseling services that are contracted with community agencies are generally more cost-effective.

Gaps in Nevada

- Limited individual counseling is available through counselors at the State facilities or its contracted provider.
- There are limited symptom management group services and limited ADL training classes.

- **RURAL**: Counseling and emergency services are seriously inadequate in the rapidly growing areas of Elko and Nye counties. There are month-long waiting lists for critical counseling services in some areas.

Residential services

Comprehensive Services

All levels of housing should be available to assure that each individual lives in the least restrictive setting appropriate to the individual's needs, ranging from

- Supported apartment living, either as an individual, or with family or compatible roommate
- Semi-supervised homes, with individual bedrooms and common living areas
- Supervised homes, with individual bedrooms, the provision of meals, support services and medications management
- Short-term crisis housing, to be accessed in emergencies or for respite
- Short-term sub-acute housing as a step between hospitalization and more independent housing
- Long-term intensive sub-acute housing as an eventual replacement for long-term hospitalization which will gradually be phased out
- Intensive support services to accompany housing

Gaps in Nevada

- Inadequate number of housing placements available
- Too many group homes that are substandard and frequently maintain poor security, hygiene and meal services. Such homes merely warehouse clients
- Monitoring of group homes should be increased
- Only 24 sub-acute residential treatment beds currently exist in Southern Nevada, 16 at Pathways, operated by the Salvation Army, and 8 at the Bruce Adams Residential Treatment Center, operated by Mojave Mental Health
- Long-term intensive residential housing as an alternative to hospitalization is much more cost-effective and permits a resident to retain a much greater independence consistent with his or her needs and level of activity
- Housing for seriously mentally ill persons over the age of 62 is almost non-existent, since adult homes and nursing homes are reluctant to, and/or legally prevented from, admitting persons with a mental illness; group homes are likewise reluctant to take older persons
- The State needs to provide reimbursement for community-based housing and support service that is adequate to support the availability of an array of community-based services and provider agencies that are appropriate to the needs of individuals living in the community.
- **RURAL**: A critical unmet need throughout rural Nevada.

Day treatment, vocational and partial care programs

Comprehensive Services	Gaps in Nevada
• All non-medical programs should have an end goal of maximizing the quality of life of individuals with mental illness. A cornerstone of this ideal is the clubhouse concept. Clubhouses, possibly patterned on the New York City Fountain House model, will provide social and vocational opportunities. The Clubhouses should include an income-generating business component which will not only provide jobs and training for Clubhouse members, but will also help assure the financial viability of the Clubhouse without relying solely on private and public grants and funding. The Clubhouses should be open extended hours, including evenings and weekends, and should encourage association among all age groups.	• The only Clubhouse in the Southern Nevada area is Arville House, which is restricted to veterans. It is entirely supported by the Veterans Administration.
• Pre-vocational and vocational services incorporating supported employment with job coaches and job training services which provide a comprehensive range of services from assistance with obtaining employment to providing appropriate supports in order to assist the individual with mental illness to enter or re-enter the job market, and in order to maintain meaningful, steady employment. Vocational services should be collaborative, with partnerships being created with the Bureau of Vocational Rehabilitation, private providers of vocational rehabilitation services under the newly enacted Federal legislation, i.e., the "Ticket to Work" and "Work Incentives Improvement Act" of 1999 TWWIIA) and private businesses. These services, or a portion of them, should be run out of the Clubhouses	• Current vocational services are almost non-existent on a State-wide level, and those that exist are understaffed, with vital coordination with other agencies not maximized. The Salvation Army has instituted several vocational programs, but limited funding restricts availability.

- Every person with mental illness should have a constructive and focused day time activity: work, school or volunteering in support of community service programs. A complete menu of vocational options must be constructed if people with serious mental illness are to be integrated into the workforce. Each person needs to have responsible day activities. These should include the supports necessary to help people in pre-vocational activities, temporary sheltered employment, enclaves in industry, supported employment, job search and support of competitive employment as necessary.
- Other alternatives should include school (when focused on skills necessary for productive employment) and volunteering as a means of re-integrating into a constructive community life, when paid employment is not an option.
- Also integrated into the Clubhouse should be Peer Counseling programs which educate people in basic counseling skills, enabling them to take their place beside the professionals on treatment teams, as paid employees. Peer Counselors not only provide empathy and understanding which is made possible only through their unique experiences, but also serve as valuable team members who work on discharge planning, workplace re-entry, crisis intervention and enhancement of case management services.
- The existing fledgling Peer Counselor program suffers from unstable funding and inadequate commitment of resources, which results in under-utilization of the concept. When used properly, Peer Counselor programs benefit the bottom line. The agency involved gains valuable, committed employees who, because they are still technically in training, work for a lower salary than long-term employees. The Peer Counselors gain training, work experience, self-respect, confidence, an opportunity to contribute and opportunities to move into competitive employment if they so choose.
- Day treatment programs to familiarize persons newly diagnosed with a mental illness with the challenges of their illness. They are taught medication management,
- Since being eliminated in the budget cuts of 1992, only skeleton programs exist. Programs for consumers should include educational programs ranging

interaction with others, basic daily living skills and coping strategies. This type of program is a prerequisite to all other programs.

from high school and GED through college and vocational education and training. In addition, programs should be expanded to include family education and support.

Senior services for persons 75+

Comprehensive Services

- Services should include appropriate residential placements for all older consumers where needed. In addition to all of the services customarily provided to persons with mental illness, of special importance to older people are partial day programs and in-home services.

Gaps in Nevada

- Currently, one site provides senior mental health services to 26 persons, and 9 people waiting. Services provided include evaluation, counseling, personal service coordination and referral. Residential placements for this population are extremely limited if not non-existent. In addition, mainstream nursing homes are reluctant to take mental health consumers. In fact, most nursing homes annually screen their residents to eliminate those with a primary diagnosis of mental illness.

Seamless transition from juvenile services to adult mental health services

Comprehensive Services

- Services should include a comprehensive evaluation of children who reach the age of 17 or are in their final year of high school, whichever comes later, and are still receiving mental health services. Dialog between the School District, the Division of Child and Family Services, Nevada Medicaid and the Division of Mental Health should be ongoing at this time, along with the young adult client and his or her family and/or guardian, to determine the continuation of proper treatment and care of these children when they reach the age of 18. A comprehensive community-based system would be able to double up on case managers at this time, with each child assigned a case manager from both DCFS and MH. Ongoing coordination and communication between the case managers would assure a seamless transition into the appropriate adult services, including higher education or vocational training, as desired. An essential part of this would be the gradual switching of attitude from "taking care of the child" to empowering the young adult to be as independent as possible.

Gaps in Nevada

- In Nevada, there are limited systems in place for children under 18, and these systems are, in many cases, inadequate. Waiting lists exist and often children are sent out of state for services not existing here. Children's services are not the subject of this paper, but concern exists that, since children are cared for under a different state division than adults (those over the age of 18), there is no system of transition in place to assure that those who reach the age of 18 and who need access to continued mental health services as adults are able to obtain adequate and timely services.