Testimony
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On behalf of NAMI Nevada, the state chapter of the National Alliance on Mental Illness, I would like to offer our views on Nevada's Mental Health Needs.

I just have to make sure that everyone really understands that all the data that you received earlier in this meeting are reported statistics. Most Addiction and Mental Health issues are suffered in silence, in the dark. The stigma related to these issues does not lend itself to bright light. How many people listening to this have had some form of anxiety and depression during COVID? How much of what we are seeing in our youth is from that time frame? Mental health is a continuum that we are all on and we can be anywhere on that continuum at any time dependent on what we are going through at any particular moment. Whether chronic or acute. The only time it really becomes a statistic is when it's a crisis. Very simply what I have seen is at least 1 in 4 or more people deal with the issues we are looking at today. I would hazard a guess that if you look to your right and you look to your left either they have lived with it or its you. 78% of people with an addiction issue are probably self-medicating. Once people are addicted 100% have a mental health issue because of the substance.

I find it interesting that Mental Health is so in vogue and it seems we are much more willing to talk about this topic when we relate it to law enforcement, first responders and military veterans. I come from a military family, I'm an air force brat so I certainly don't want to diminish those needs. In fact our 2024 Education Conference coming up May 18th is dedicated to Veteran issues. Mental Health issues affect our brain. Our brain is part of

our body. We need to treat mental health issues on par with any other physical health problem for everyone.

I once had a Governor yell at me to stop saying this, it's so negative….I'll stop saying it when its no longer true. Nevada is typically ranked dead last when it comes to Mental Health services in this State compared to the rest of the nation. Where we are not ranked last you will find an asterisk saying some states were not able to report (Covid) or don't compare this with past reports because the baseline was changed.

Nevada has had studies, workgroups and anything else we could come up with that doesn't cost money. Now is the time to invest at the front end so that we save crisis dollars on the back end. We need to spend money to save money. We need to recognize that the money we save will not be in the same fund as the money we spend. This investment in our citizens will save law enforcement costs, Indigent expenses for local governments, and most importantly lives.

Our advocacy issues are developed based on the number of issues brought up in conversations, helpline, warmline and teen text/chat line calls but they generally fall into 5 groups. Housing, Medication Barriers, Criminalizing Mental Health, Lack of providers, Parity and the need to increase service for those living with mental health conditions especially for youth and the Elderly.

HOUSING

As you are aware, Nevadans suffer from an extreme lack of affordable housing. This is a truly urgent issue for Nevada's very low-income seniors, individuals, and families. *It is a crisis for the mentally ill,* the substance-addicted, and those with co-occurring disorders, many of whom are homeless. We receive more calls about housing for loved ones more than anything else.

I do this work in my retirement because my mother lived with what we would call today Schizoaffective disorder The only time she was stable was in her sixties when a county bought an old hotel, renovated it to studio apartments . They provided services on the lower floor and a cafeteria and housing above. As our economy moves more and more to online, all these empty buildings can be used; at least one in each county, to supportive housing.

For someone with a mental health condition, the basic necessity of a stable home can be hard to come by. The lack of safe and affordable housing is one of the most powerful barriers to recovery. When this basic need isn't met, people cycle in and out of homelessness, jails, shelters and hospitals. Having a safe, appropriate place to live can provide stability to allow you to achieve your goals.

You may run into housing issues after being discharged from an inpatient care unit or jail and find that you have no home to return to. Even if you haven't been hospitalized, finding an affordable home can be difficult. Many people with a serious mental illness live on Supplemental Security Income (SSI), which averages just 18% of the median income and can make finding an affordable home near impossible.

Finding stable, safe and affordable housing can help you on your journey to recovery and prevent hospitalizations, homelessness and involvement in the criminal justice system.

What Should You Look For In Housing?

A good housing match is one that meets four key needs.

Housing should be affordable. Ideally, this means you would have to pay no more than 30% of your income for housing costs. Having to pay more may make it hard to afford needs like health care, food or clothing. Many people with mental illness may have low incomes. To meet housing costs they may need additional financial assistance, like government-funded rental assistance or rental subsidies.

Housing should offer the right amount of independence. An important part of housing is the freedom to choose where and what type you want. Different types of housing can offer someone living with mental illness different levels of independence and care, so it's important to determine which type would work best for you.

Housing should meet your physical needs. If you have a mental illness and a physical disability you may need housing features like ramps or alarms with blinking lights. Many people with mental illness also may not drive and therefore would need a home close to treatment providers and community resources, as well as public transportation.

Housing should be discrimination-free. The Fair Housing Act bars discrimination in rental housing based on disability. This means that landlords and property owners cannot refuse to rent to you because of a disability. They must also make reasonable accommodations and allow for modifications to fit your needs.

Types Of Housing

Housing options range from completely independent living to 24/7 care. The type of housing that is right for you can depend on whether you need assistance paying your bills, cleaning, making appointments or require no assistance at all. Choose a type of housing that fits your individual needs so your recovery can be your priority.

Supervised Group Housing

This type of housing provides the most support for its residents. Trained staff members are present 24/7 to provide care and assistance with things like medication, daily living skills, meals, paying bills, transportation and treatment management. These group homes provide their residents with their own bed, dresser and closet space, and shared bathrooms and common areas. This is the best type of housing for people experiencing a serious mental illness which may affect their ability to perform their daily tasks.

Partially Supervised Group Housing

Some support is provided for the residents, but staff isn’t there 24 hours a day. The residents can be left alone for several hours and are able to call for help if needed. People who choose to stay in these group homes can perform their daily living tasks independently or semi-independently, help with cooking and cleaning and may even hold a part-time job or participate in a day program.

Supportive Housing

Supportive housing provides very limited assistance. The residents of these homes live almost independently and are visited by staff members infrequently. However, they do have someone to call and resources available to them if a problem does arise.

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Medication Barriers

NAMI Nv believes that the decision to prescribe medication to patients with a mental health condition should be based on the clinical judgement of the treatment providers. Research has shown that prior authorizations, and denials for psychiatric populations results in poor outcomes which include increased utilization of ER's, higher incarceration, and higher usage of mental health inpatient hospitalizations. All these outcomes cost more money than what is saved in prescription costs.

Antipsychotic and antidepressant medications are not interchangeable, or therapeutically equivalent if the patient can't take them and providers must be able to select the most appropriate, clinically indicated medication for their patients.

- While psychiatric medications may have similar effectiveness overall, they are unique in their mechanisms of action and affect each person and a range of symptoms differently. Patients respond differently to different antidepressant and antipsychotic medications, and it often requires multiple trials and many months to find an appropriate drug regimen that stabilizes an individual's condition.

- For people with serious and persistent mental illness or those suffering from co-morbid conditions, providers must be able to select from a full range of drug options to maximize treatment efficacy, minimize side effects, and avoid drug-to-drug interactions.

Where We Stand

NAMI believes that public policies should be guided by credible, evidence-based research. NAMI supports public policies and laws that facilitate research into the benefits and risks that Schedule I drugs have for people with mental health conditions.

Why We Care

Current federal law places various substances in one of five schedules based on their medical use, potential for misuse, safety, and risk for dependence. Schedule I drugs, substances or chemicals are defined as

drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs include lysergic acid diethylamide (LSD), marijuana (cannabis), methylenedioxymethamphetamine (ecstasy), methaqualone, peyote and psilocybin ("magic mushrooms" or psychedelics).

Federal law prohibits the manufacture, distribution, dispensation and possession of Schedule I substances except for federal government-approved research studies. As a result, U.S. researchers face regulatory hurdles to studying any Schedule I drugs. This situation has limited the development of robust scientific research, particularly as it relates to potential benefits or risks for people with mental health conditions.

There is a significant need to understand the impact these drugs have on people with an existing mental health condition or those at risk of developing a mental health condition. While research on the effects of these drugs is limited, SAMHSA's National Survey on Drug Use and Health consistently shows that people with mental illness are more likely to use illicit drugs than people without a mental illness. Some people with a mental health condition use these substances as a form of self-medication to positively impact some of their symptoms.

While still evolving, research on the effects of Schedule I drugs is currently insufficient, particularly as it relates to people with mental illness. For example, several studies have documented a correlation between marijuana and the onset of schizophrenia or other psychotic conditions. Heavy use of marijuana and related products during teen and young adult years can particularly increase the risk of triggering the onset of schizophrenia and psychosis. Yet, preliminary studies suggest that cannabidiol (CBD), a compound found in marijuana, may have potential positive effects for some mental health symptoms. Similarly, studies have shown that psychedelic treatment with psilocybin relieved major depressive disorder symptoms in adults; yet, other studies have shown psilocybin can cause distressing hallucinations or feelings of panic and anxiety in some individuals, especially at high doses.

As more states legalize the use of marijuana and other Schedule I drug products, it is essential that credible, evidence-based research is available

to fully understand the risks and potential benefits these products have on people with mental health conditions.

How We Talk About It

- People with mental health conditions report using some drugs at higher rates than people without mental health conditions.
- Drug use by a person with a mental health condition may be to manage the symptoms of their condition as a form of “self-medication.”
- Some drugs fall into a category known as “Schedule I drugs,” which limits researchers' ability to conduct research on the risks and benefits of these drugs for people with mental health conditions.
- As a result, we lack sufficient research to fully understand the impact of using Schedule I drugs on the brain. For example, while conclusions vary, some studies have found that marijuana and psychedelics use may trigger the appearance of symptoms like psychosis or hallucinations, respectively.
- At the same time, other preliminary studies have shown that CBD and psilocybin may reduce certain mental health symptoms.
- We believe the federal government should remove barriers so that we can rapidly accelerate research that helps us understand the possible positive and negative impacts of Schedule I drugs on people with mental health conditions.

Access to the full spectrum of psychiatric medications is a critical component of community-based care. This is an opportunity to provide open access and increase adherence to medication in populations with serious mental illness by removing prior authorization barriers.

NAMI Nevada requests that they ALL remain available to providers and patients without restriction. Again, an opportunity to increase adherence to medication in populations with serious mental illness?

How many years of your life, or the life of your child are you willing to give up to save money?

Decriminalizing Mental Health

Where We Stand

NAMI believes in minimizing justice system response to people with mental illness, while ensuring that any interactions preserve health, well-being and dignity. NAMI opposes laws and public policies that perpetuate the criminalization of people with mental illness.

Why We Care

People with mental illness are overrepresented in our nation's jails and prisons. About 2 million times each year, people with serious mental illness are booked into jails. Nearly 2 in 5 people who are incarcerated have a history of mental illness (37% in state and federal prisons and 44% held in local jails). Many people with mental illness who are incarcerated are held for committing non-violent, minor offenses related to the symptoms of untreated illness (disorderly conduct, loitering, trespassing, disturbing the peace) or for offenses like shoplifting and petty theft.
Many factors have contributed to the criminalization of people with mental illness, including:

- Policies, such as "zero tolerance" policing, nuisance laws and mandatory sentences for drug offenses
- Assumptions that people with mental illness are violent
- The lack of a robust mental health crisis response infrastructure

Jails and prisons have become America's de-facto mental health facilities. However, they are not built, financed or structured to provide adequate mental health services. Only 3 in 5 people (63%) with a history of mental illness receive mental health treatment while incarcerated in state and federal prisons, and less than half of people (45%) with a history of mental illness receive mental health treatment while held in local jails.
Public policies should invest in solutions that are evidence-based and help people with mental illness get on a path of recovery. For example, instead of charging people who are experiencing homelessness with crimes, we support policies that address the underlying need, such as providing supportive housing programs.

Early intervention, comprehensive community mental health care and a robust crisis response system are essential to reduce justice involvement. In addition, investment in diversion strategies, like mental health courts, alternatives to incarceration, and giving judges, prosecutors, and police the discretion to not criminally charge an individual with mental illness, can help reduce the criminalization of people with mental illness.

How We Talk About It

- People with mental illness deserve help, not handcuffs. Yet, people with mental illness are overrepresented in the criminal justice system.
- Policies, such as “zero tolerance” policing, nuisance laws and mandatory sentences for drug offenses have contributed to the criminalization of mental illness.
- About 2 in 5 people who are incarcerated have a history of mental illness, resulting in jails and prisons becoming de-facto mental health facilities.
- Too many people wrongly believe that people with mental illness are violent. However, people with mental illness are more likely to be victims of crime than to perpetrate violent crime.
- The criminal justice system is ill-equipped to meet the complex needs of people with mental illness. We need a mental health response to people experiencing symptoms, not a law enforcement response.
- Communities should invest in policies and solutions that are evidence-based and help people with mental illness get on a path of recovery.
- NAMI believes that public policies should focus on investments in early intervention, comprehensive community mental health, robust crisis response systems and diversion strategies to decriminalize people with mental illness and connect people to care.

Lack of Providers

The Census Bureau reported that **30% of American adults had symptoms consistent with an anxiety or depression diagnosis**. While the pandemic has exacerbated underlying mental health issues for many Americans, barriers to receiving mental health care have existed for years.

A central issue is the lack of mental health care professionals. The Health Resources and Services Administration tracks health professional shortage areas, which are geographic areas, population groups, or health care facilities designated as having a shortage of health providers. Areas are designated as having a shortage if they meet certain criteria: the ratio of mental health providers (e.g., psychiatrists, clinical social workers, therapists, etc.), the poverty rate, the proportion of the area that is either young or elderly, the prevalence of alcohol and substance abuse, and travel time to a facility.

An estimated 122 million Americans, or 37% of the population, lived in 5,833 mental health professional shortage areas as of March 31. The nation needs an additional 6,398 mental health providers to fill these shortage gaps.

Mental health shortages range in severity across the country. Two-thirds of shortage areas are in rural or partially rural parts of the country. Wyoming and Utah have the largest proportion of population living in mental health shortage areas, at 96.4% and 83.3%, respectively. Nevada is 77%. New Jersey and Massachusetts have the lowest proportions, at 0.4% and 4.0%, respectively.

Overview of Mental Health Workforce Shortage Each year, millions of Americans with mental illness do not receive any mental health treatment. According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) annual National Survey on Drug Use and Health (NSDUH), in 2021, among the 57.8 million adults with mental health conditions, 52.8% (31.3 million) did not receive any mental health services. Lack of treatment is particularly acute in marginalized populations. For example, 60% of LGBTQ youth who wanted mental health care in the past

year were not able to get it. Additionally, the percentage of adults with a mental health condition in the past year who received mental health services was lower among Asian (25.4%), Hispanic or Latino (36.1%), or Black or African American adults (39.4%) than among White (52.4%) or Multiracial adults (52.2%). Barriers to accessing mental health care in the U.S. are numerous and multifaceted.

Access to mental health care is dependent on having appropriately skilled providers available to provide care, yet data consistently shows that there is a shortage of all types of MH/SUD providers across the country. In 55% of U.S. counties, there is not a single practicing psychiatrist, and 160 million people live in a designated Mental Health Professional Shortage Area.

The lack of providers exacerbates unmet needs and leaves more people without options for mental health care. A staggering 50% of NAMI's state leaders hear from people on a daily basis trying to access mental health care but who cannot find a provider, with more than 86% hearing from people who cannot find a provider at least weekly. One NAMI state leader wrote, "For many clients it takes more than 6 months to get through the waitlists that all locations have in this area." With more than 4 in 10 adults experiencing symptoms of depression and anxiety in recent years, the demand for mental health care has increased significantly, but the workforce gap continues to grow.

"Currently, mental health providers are ranked as some of the lowest paid positions. Many community mental health workers receive minimum wage or only slightly higher. Unlike other medical professions, there is no additional reimbursement for specialty care such as residential, trauma-informed vs. ICU nurses, etc." –NAMI leader, March 2023 NAMI workforce survey A critical challenge in the mental health workforce is reimbursement and payment for MH/SUD care – a challenge that directly translates to a lack of access to this type of care for millions of Americans.

Research has consistently demonstrated that MH/SUD providers are not paid at equal levels to counterparts in the medical field. One study, based on actual claim data in all 50 states for hundreds of health insurance plans, showed that primary care physicians received between 16.3% and 22.3% more than behavioral health care professionals for the same services. Additionally, the study showed that average reimbursements for both mental

health and substance use office visits have remained below Medicare allowed amounts over a five-year period. In 11 states, reimbursement rates for primary care providers were more than 50% more than for behavioral health providers for the same services. These disparities apply across the mental health workforce. For example, peer support specialists, a critical component to team-based models of care (as discussed below) earn an average of only $15.42 – barely above many states' minimum wage. Now lower than fast food workers in California.

National data consistently shows that over 20% of all people with untreated mental health needs say they did not get treatment because their insurance plans either did not cover mental health treatment at all or offered insufficient coverage. Roughly one-third of large employers say their networks do not have enough MH/SUD providers to ensure timely access to care. This is even more stark for children's mental health needs. A behavioral health care office visit for a child is 10.1 times more likely to be out of network than a primary care office visit, more than twice the disparity seen for adults.

Primary care providers are often inadequately trained to identify mental health needs, prescribe mental health medications, and provide mental health treatment. In integrated models of care, primary care providers work with mental health providers (e.g., psychiatrists, psychologists, licensed clinical social workers) and care coordinators, who can assist with screening, care management, coordination, patient education to promote self-management of symptoms, and links to social services. This team-based approach can take place all in the same setting or across settings, so long as there is continuous coordination, communication, and patient data sharing. Integrated care provides mental health expertise, support, and resources to primary care providers who are already providing mental health care, as well as broadening access to, and maximizing the use of, the current workforce to address mental health conditions. Moreover, solutions should consider other ways to leverage existing health care workforce t

Increase in Services, especially to youth and the elderly

Millions of people in the U.S. are affected by mental illness each year. It's important to measure how common mental illness is, so we can understand its physical, social and financial impact — and so we can show that no one is alone. These numbers are also powerful tools for raising public awareness, stigma-busting and advocating for better health care.

Fast Facts

1 in 5 U.S. adults experience mental illness each year
1 in 20 U.S. adults experience serious mental illness each year
1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year
50% of all lifetime mental illness begins by age 14, and 75% by age 24
Suicide is the 2nd leading cause of death among people aged 10-14

You Are Not Alone

DOWNLOAD INFOGRAPHIC

Millions of people are affected by mental illness each year. Across the country, many people just like you work, perform, create, compete, laugh, love and inspire every day.

- 22.8% of U.S. adults experienced mental illness in 2021 (57.8 million people). This represents 1 in 5 adults.
- 5.5% of U.S. adults experienced serious mental illness in 2021 (14.1 million people). This represents 1 in 20 adults.
- 16.5% of U.S. youth aged 6-17 experienced a mental health disorder in 2016 (7.7 million people)
- 7.6% of U.S. adults experienced a co-occurring substance use disorder and mental illness in 2021 (19.4 million people)

- Annual prevalence of mental illness among U.S. adults, by demographic group:
  - Non-Hispanic Asian: 16.4%
  - Non-Hispanic Native Hawaiian or Other Pacific Islander: 18.1%
  - Non-Hispanic Black or African American: 21.4%
  - Hispanic or Latino: 20.7%
  - Non-Hispanic White: 23.9%
  - Non-Hispanic American Indian or Alaska Native: 26.6%
  - Non-Hispanic mixed/multiracial: 34.9%

    - Lesbian, Gay or Bisexual: 50.2%

- Annual prevalence among U.S. adults, by condition:
    - Schizophrenia: <1%
    - Obsessive Compulsive Disorder: 1.2%
    - Borderline Personality Disorder: 1.4%
    - Bipolar Disorder: 2.8%
    - Posttraumatic Stress Disorder: 3.6%
    - Major Depressive Episode: 8.3%
    - Anxiety Disorders: 19.1%

Mental Health Care Matters

DOWNLOAD INFOGRAPHIC

Mental health treatment—therapy, medication, self-care—have made recovery a reality for most people experiencing mental illness. Although taking the first steps can be confusing or difficult, it's important to start exploring options.

- 47.2% of U.S. adults with mental illness received treatment in 2021
- 65.4% of U.S. adults with serious mental illness received treatment in 2021
- 50.6% of U.S. youth aged 6-17 with a mental health disorder received treatment in 2016
- The average delay between onset of mental illness symptoms and treatment is 11 years
- Annual treatment rates among U.S. adults with any mental illness, by demographic group:
    - Non-Hispanic Asian: 25.4%
    - Hispanic or Latino: 36.1%
    - Non-Hispanic Black or African American: 39.4%
    - Non-Hispanic White: 52.4%
    - Non-Hispanic mixed/multiracial: 52.2%
    - Male: 40%
    - Female: 51.7%
    - Lesbian, Gay or Bisexual: 55.6%
- 10.6% of U.S. adults with mental illness had no insurance coverage in 2021
- 11.9% of U.S. adults with serious mental illness had no insurance coverage in 2021
- 164 million people live in a designated Mental Health Professional Shortage Area

The Ripple Effect Of Mental Illness

DOWNLOAD INFOGRAPHIC

Having a mental illness can make it challenging to live everyday life and maintain recovery. Beyond the individual, these challenges ripple out through our families, our communities, and our world.

PERSON

- People with depression have a 40% higher risk of developing cardiovascular and metabolic diseases than the general population. People with serious mental illness are nearly twice as likely to develop these conditions.
- 33.5% of U.S. adults with mental illness also experienced a substance use disorder in 2021 (19.4 million individuals)
- The rate of unemployment is higher among U.S. adults who have mental illness (7.4%) compared to those who do not (4.6%)
- High school students with significant symptoms of depression are more than twice as likely to drop out compared to their peers
- Students aged 6-17 with mental, emotional or behavioral concerns are 3x more likely to repeat a grade.

FAMILY

- At least 8.4 million people in the U.S. provide care to an adult with a mental or emotional health issue
- Caregivers of adults with mental or emotional health issues spend an average of 32 hours per week providing unpaid care

COMMUNITY

- 21.1% of people experiencing homelessness in the U.S. have a serious mental health condition
- Among people in the U.S. under age 18, depressive disorders are the most common cause of hospitalization (*after excluding hospitalization relating to pregnancy and birth)*
- Among people in the U.S. aged 18-44, psychosis spectrum and mood disorders account for nearly 600,000 hospitalizations each year
- 19.7% of U.S. Veterans experienced a mental illness in 2020 (3.9 million people)
- 9.6% of Active Component service members in the U.S. military experienced a mental health or substance use condition in 2021
- Across the U.S. economy, serious mental illness causes $193.2 billion in lost earnings each year

WORLD

- Depression and anxiety disorders cost the global economy $1 trillion in lost productivity each year
- Depression is a leading cause of disability worldwide

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