Mental and Behavioral Health Needs Assessment

GENERAL POPULATION SURVEY

Prepared for:
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Executive Summary

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Overview and Background of the Study

The Lincy Institute collaborated with the Cannon Survey Center (CSC) to implement a survey of Southern Nevada residents. A total of 609 surveys were collected by telephone between October 14 and November 3, 2013 from randomly selected households in the area. Respondents were adults (18 and over), and interviews typically lasted about 10 minutes.

Random-digit-dialing (RDD) techniques were used to select respondent households located throughout the target area (Clark County) using the most current telephone exchange data available. Survey Sampling Inc. (SSI) maintains a database of “working blocks” which are verified to contain residential numbers, and then phone numbers are randomly generated from each block. This allows the inclusion of unlisted numbers and newly listed numbers. The RDD methodology was augmented with a cell phone frame to catch young adults (18-34) who lack a land-based line. Approximately 20% of the completed interviews were completed with members of the cell phone frame.

The questionnaire was constructed by an outside contractor based on existing health-based instruments, reviewed and revised by professionals, and tested for reliability using a test-retest method using a convenience sample of 15 university students. Reliability was assessed with a Pearson’s correlation test for each student, resulting in statistically significant (p <.05) correlation coefficients ranging from .88 to .99. When comparing all first administration survey scores to all second administration scores, the correlation coefficient was .92.

Data was collected using computer-assisted telephone interviewing (CATI) methodology. Interviewers used individual computer stations to record answers and information in files as
Interviews occurred. Up to eight call attempts were made on each number and fell within multiple call times to increase the likelihood of reaching each number. Respondent participation was voluntary, consent was implied by continued participation, and respondents could withdraw at any time. Respondents were also able to decline questions and proceed by skipping to the next question. Data were stored electronically, and any personal identifying information was removed prior to analysis.

All interviewers completed Human Subject Research training as provided online by Collaborative Institutional Training Initiative (CITI). Prior to fieldwork, the CSC staff of experienced telephone interviewers attended a refresher session that covered multiple topics and received detailed training regarding the specifics of this survey. The centralized phone-bank setting allowed continuous supervision by trained supervisors, thus permitting ongoing assessments and allowing the supervisors to respond immediately to questions. Response rates and cooperation rates were all established using disposition codes that are defined by the American Association of Public Opinion Researchers (AAPOR). The overall response rate for the survey was 10.0%. To combat inherent bias and nonresponse in telephone interviews, the use of weights, specifically iterative raking using the anesrake package (Pasek, 2010), was used. Weights are numerical adjustments for the effects of sample design and differential nonresponse, or observed demographics being different from standard sources like the Census. The worst case un-weighted margin of error (95% confidence level) for the data is +/- 3.97% based on an observed sample size of 609 (Lenth, 2006-9). The weighted worse case margin of error was +/- 4.74 based on a design effect of 1.43 and an effective sample size of 428. Data were analyzed using SPSS 19 software. Frequency distributions were presented in table form for all survey items. Cross-tabulations of all survey items by age, gender, and combined race/ethnicity were conducted with Pearson’s chi-square tests, Fisher’s exact tests, and Monte Carlo methods.

**Results**

Ninety four-percent (94.9%) of participants indicated some level of importance (ranging from important to very important) in regards to mental health treatment as a focus among politicians, researchers, and families in Southern Nevada. Female respondents were more likely than males
to rate this as very important (72.9% to 49.8%), while males were more likely to give any other response. Black/African American respondents were more likely to rate the issue as very important (73.2%), while respondents of “other” racial backgrounds were least likely to do so (56.4%). Differences between respondents on the basis of age, gender, and race/ethnicity were statistically significant (p <.05).

The majority of respondents indicated the mental health issues are more important than dissatisfaction with the government (68.9%) and immigration (63.5%). This was followed by 41.7% who agreed that mental health was more important than unemployment, 32.8% felt that it is more important than crime, and 19.2% that felt it was more important than education or general health care respectively.

The vast majority of respondents (85.5%) indicated that they believe that they have a lot of influence on their physical wellbeing. A majority (81.8%) also indicated that they believe that they have a lot of influence on their mental wellbeing. On these topics, differences between respondents on the basis of age, gender, and race/ethnicity were statistically significant (p < .05).

Fifty four-percent (54.3%) of participants indicated having a friend, while 53.3% indicated having an acquaintance, co-worker, or neighbor, who currently or previously had mental health problems. Forty seven-percent (47.2%) had cared for a relative with mental health problems. Twenty one-percent (21.5%) indicated having experienced mental health problems themselves. Eleven percent (11%) of respondents work in the mental health field.

Female respondents were more likely than males to indicate having experienced mental health problems themselves (27.4% vs. 15.7%). White respondents were more likely than others to indicate having an acquaintance, co-worker, or neighbor with mental health problems, while Hispanic respondents were least likely to indicate as such. Respondents age 18 to 24 and age 55 and older were less likely than other respondents to indicate having an acquaintance, co-worker, or neighbor with mental health problems, and were also less likely to indicate having a friend.
with mental health problems. Differences between respondents on the basis of age, gender, and race/ethnicity were statistically significant (p = <.05).

The majority of respondents (83.1%) indicated that their physical health is good or better, and a larger majority (92.2%) indicated that their mental health is good or better.

Eighteen percent (18.5%) of participants indicated being bothered by little interest or pleasure in doing things during the past two weeks more than half the days or nearly daily. This was followed by 14.5% who indicated having this trouble on several days during the past two weeks. Seventy percent (70.2%) of respondents indicated not feeling down, depressed, or hopeless during the past two weeks, but 20.8% did on several days during the past two weeks. Nine percent (9%) had trouble more than half the days or nearly daily.

Seventy six- percent (76.5%) indicated not feeling bad about themselves, or feeling that they are a failure, or have let themselves or their families down during the past two weeks. This was followed by 16.4% that indicated being bothered by this on several days during the past two weeks, and 7.1% who indicated feeling this way more than half the days or nearly daily. Respondents age 18-24 were more likely than older respondents to indicate feeling this way for several days of the past two weeks. Respondents age 35-54 were more likely to indicate feeling this way nearly every day. Differences between respondents on the basis of age were statistically significant (p = <.05).

Seventy six-percent (75.8%) indicated that they never have six drinks or more on one occasion; 95.6% indicated that they have never failed to do what was normally expected from them because of drinking in the last year. Male respondents were more likely to indicate having more than six drinks on one occasion monthly or more frequently, while females were more likely to indicate never doing so. Respondents under 35 were least likely to say they never drink six or more drinks on one occasion, and were more likely to do so monthly or more frequently. Differences between respondents on the basis of age and gender were statistically significant (p = <.05).
Sixty two-percent (61.9%) gambled at least once. White respondents and respondents of “other” racial backgrounds were most likely to have gambled, while Hispanic respondents were least likely to have done so. Differences between respondents on the basis of age and race/ethnicity were statistically significant (p = <.05).

Ninety one-percent (91.0%) have never experienced a two or more-week period of time with a lot of time spent thinking about gambling experiences, planning future gambling, or thinking or ways to get money to gamble with. The majority (94.6%) have never experienced periods when they needed to gamble with increasing amounts of money or with larger bets in order to get the same feeling of excitement. Ninety five-percent (94.6%) have also never felt restless or irritable when trying to curb gambling, and slightly fewer 92.8% reported that they have never tried and not succeeded when trying to curb gambling. Eight eight-percent (88.2%) have never gambled to escape personal problems or relieve uncomfortable feelings.

Although the vast majority of respondents (85.9%) have not asked anyone for help about feelings or behaviors in the last two weeks, 14.1% have. Hispanic respondents were most likely to have asked for help (21.2%), while White respondents were least likely to have done so (10%). Respondents age 18-24 were at least twice as likely as older respondents to have asked for help about feelings or behaviors in the last two weeks. Differences between respondents on the basis of age and race/ethnicity were statistically significant (p <.05).

Of those that asked for help, 78% indicated that they had asked a friend or family member, followed by a partner or spouse (47.7%), an acquaintance, neighbor, or co-worker (40.8%), a doctor or healthcare worker (29.6%), and a spiritual leader (28.3%). Male respondents were more likely to have asked a police, prison, or probation officer for help (19.2% vs. 0%). Differences between respondents on the basis of gender, and race/ethnicity were statistically significant (p = <.05).

Thirty three-percent (32.7%) were caregivers for a child or children under the age of 18. The majority of children in the household discussed (60.8%) were reported to be boys. The three age groups were 0-5 (32.7%), 6-12 (39.1%), and 13-18 (29.2%). Ninety nine-percent (98.6%) of
participants indicated that the child’s physical health was good or better. Differences between respondents on the basis of age and race/ethnicity were statistically significant (p = <.05). Ninety six-percent (95.7%) indicated that the child’s mental health was good or better. Differences between respondents in this category on the basis of race/ethnicity were statistically significant (p = <.05).

The feelings or behaviors that children may need help with that were most commonly indicated by respondents included emotional problems (16.7%), problems with family relationships (15.5%), conduct problems (12.7%), and over-activity or inattention problems (12.6%). Differences between respondents on the basis of age were statistically significant (p = <.05). Only 5.9% indicated that in the last six months someone (most commonly another family member or teacher) has suggested to them that the child may need help with feelings/behaviors. 93% of respondents indicated that they have not accessed mental health services in the last six months. 92% said they did not need them, had a lack of insurance (46.5%), didn’t know who to talk to (35.9%), couldn’t afford (27.9%), or didn’t know where to go (21.7%). Of those that had used services, most common were private practice professionals (75.8%), clinics (39.3%), medical impatient units (24.8%) and psychiatric hospitals (23.2%). Differences between respondents on the basis of age and race/ethnicity were statistically significant (p = <.05).

All respondents were asked if they knew where to go for help if they felt they needed access to mental health care. Seventy two-percent (72.1%) indicated that they did. Respondents age 18 to 24 were least likely to know where to go for help, followed by respondents age 55 and older. Differences between respondents on the basis of age were significantly significant (p < .05). Respondents were then prompted to specify who they would call if they needed help with mental health issues. The clear majority of respondents (77.1%) indicated that they would call a primary care doctor. This was followed by those who would call a friend (57.8%), look in the phone book or online (55%), call a relative (54%), and those who would call a therapist or social worker (51.9%). Black/African American respondents were more likely than others to indicate that they would seek help from a spiritual leader.
Respondent Profile

The distribution of respondent gender reflects weighting, with an equal split of male and female respondents. The largest age group was 55 and older (31.3%); the smallest was 35 to 44 (13.4%). Less than half (45.8%) estimated earning between $25,000 and $74,999 in 2012; 29.3% estimated earning more than $75,000 and 24.7% less than $25,000 in 2012. Under half (44.9%) reported being employed for wages. 33.8% have lived in the Las Vegas area for 20 or more years, followed by 26.2% who have for 11 to 20 years, 19.9% who have for one to five years, 16.3% for six to ten, and 3.9% for less than one year.

Respondents were able to select more than one category to indicate their racial background. Responses were re-coded to exclusive categories and included ethnicity to demonstrate the weighted distribution, percentages of total responses, and to exclude refusals. The weighted distribution reflects a slight majority of respondents (51.2%) are white, 25.6% Hispanic (any race), 9.8% Black or African American, 5.9% mixed race, 4.6% Asian, 1.5% American Indian or Alaska Native, and 1.4% Pacific Islander. 86.4% of respondents speak English as their primary language, 9.1% speak Spanish, and 4.6% said other.

Eight one-percent (80.7%) said they had health insurance, and 67.5% had insurance for mental health problems. These included private health insurance (77.6%), Medicare (27.9%), Medicaid (12%) and Nevada Check Up (3.3%). Hispanic respondents and those 18 to 24 were the least likely to have insurance or have mental health coverage. Age and race/ethnicity differences were statistically significant (p<.05). Under half (49.4%) indicated being aware of the Nevada Silver State Health Exchange website.