STUDY OF THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

Bulletin No. 89-19

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

SEPTEMBER 1988

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LEGISLATIVE COMMISSION

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STATE OF NEVADA

SEPTEMBER 1988

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FILE NUMBER.....

ASSEMBLY CONCURRENT RESOLUTION--Directing the Legislative Commission to conduct an interim study of the Mental Hygiene and Mental Retardation Division of the Department of Human Resources.

WHEREAS, The services of the Mental Hygiene and Mental Retardation Division of the Department of Human Resources affect many people; and

WHEREAS, Most of the persons served by this division are wards of the state and are, therefore, the responsibility of the state; and

WHEREAS, The efficiency and effectiveness of the management of this division in relation to its treatment of its clients is of the utmost importance to the state; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, THE SENATE CONCURRING, That the Legislative Commission is hereby directed to conduct a comprehensive study of the Mental Hygiene and Mental Retardation Division of the Department of Human Resources, its management and its treatment of clients; and be it further

RESOLVED, That the results of the study and any recommended legislation be submitted to the 65th session of the Legislature.

19 87

SUMMARY OF RECOMMENDATIONS

This summary represents the major conclusions reached by the subcommittee. The conclusions are based upon: (1) suggestions made to the subcommittee at public hearings by representatives from the public and private sector familiar with the strengths and weaknesses of the operation of the Division of Mental Health and Mental Retardation; (2) the experience and knowledge of the members of the subcommittee; and (3) other correspondence to the members and staff of the subcommittee.

The subcommittee recommends:

1. Create a legislative committee on mental health and mental retardation (subcommittee of the Interim Finance Committee), consisting of five members, to provide ongoing legislative oversight in reviewing and evaluating the quality and effectiveness of programs provided for mentally ill and mentally retarded persons in the state.

2. Create a medical and professional advisory committee, consisting of nine members employed by the Division of Mental Health and Mental Retardation, to advise the division on matters relating to staff levels, budgets and treatment standards. Require the medical advisory committee to submit quarterly reports to the legislative committee concerning its findings.

3. That the Division of Mental Health and Mental Retardation add a training officer to the division's Central Office to plan, coordinate and implement training for all professional and paraprofessional staff within the division.

4. The subcommittee found that training throughout the Division of Mental Health and Mental Retardation is greatly deficient and funding for training should be significantly increased.

5. The Division of Mental Health and Mental Retardation should present a plan to the Legislature to begin requiring certification of all mental health technicians, mental retardation technicians and forensic technicians employed by the division, to be carried out in cooperation with the University of Nevada System. Further require that formal training of technicians begin by July 1, 1991.

6. That the Division of Mental Health and Mental Retardation submit to the legislative committee a plan to provide training for nurses employed by the division in order to satisfy their requirements for continuing education. The Division of Mental Health and Mental Retardation continues to experience problems with recruitment and retention of nurses and it is felt this will be an important benefit in assisting those recruitment efforts.

7. That the Division of Mental Health and Mental Retardation be required to submit to the legislative committee proposed ratios of staff members to in-patients, out-patients and other persons for whom services are provided or paid for by the division. This will begin to ensure that budget requests are based on a treatment oriented standard of care. It was observed the treatment should be appropriate to the needs of the individual client served because of those differentiations in mental retardation and mental health. Different types of clients require different services and levels of care.

8. That the Division of Mental Health and Mental Retardation has many programs and elements of those programs operating at or near capacity and that the division submit, as part of their budget request for the 1989 Legislative Session, a plan to eliminate all waiting lists by the end of that budget process.

9. That staffing of the Division of Mental Health and Mental Retardation's residential facilities should be sufficient to reduce overtime and to prevent back-to-back shifts being required of direct care staff.

10. Appropriate money from the state general fund to the University of Nevada Medical School for the establishment of a residency training program for psychiatrists in the State of Nevada.

11. That the requirements for psychiatric certification for psychiatrists employed by the Division of Mental Health and Mental Retardation, which currently mandates board certification after three years, be extended to five years.

12. That in-patient facilities of the Division of Mental Health and Mental Retardation meet appropriate licensing and accreditation standards by July 1992.

13. Require the Mental Health and Mental Retardation Division of the Department of Human Resources to adopt by regulation policies and procedures for defining and reporting abuse and neglect of clients of the division and to further clarify the definition of abuse and neglect.

14. Prohibit a state agency from taking any retaliatory disciplinary action against an employee of that agency on the grounds that the employee testified or submitted a complaint against the agency.

15. That the Division of Mental Health and Mental Retardation begin planning for at least a 20 bed facility to be located in Clark County to house youthful offenders with severe emotional and mental health problems.

16. Require the payment of overtime at the rate of time and one-half for all nurses employed by the State of Nevada (sunset after 4 years).

17. That consideration be given, as part of the budget process, for the hiring of more staff to lower the client/staff ratio in the community training centers. It was also identified that the staff/client ratios should be based upon the needs of the individual clients and should also include an increase in the request for payment levels.

18. That the Division of Mental Health and Mental Retardation be required to develop a five-year plan and that plan be revised on an annual basis. The plan and its annual revisions should be presented to the legislative committee. The committee also recognized that no staff at the division are specifically assigned the duties to evaluate existing services and plan for future needs. Consequently, the committee recommends that a planner be added as a member of the division staff.

19. The subcommittee recognized a gap in services for those clients who are diagnosed as both having need of mental health services as well as mental retardation services. The subcommittee supports the proposal for dual diagnosed units in Las Vegas and Reno and that those facilities are able to provide services to no less than 12 patients in Southern Nevada and 8 patients in Northern Nevada.

20. The subcommittee supports the proposal for a 50-bed secure forensic facility to be constructed in Southern Nevada during the next biennium.

21. The subcommittee identified a great need for residential group homes providing services to youths in rural Nevada. The subcommittee recommends that the Division of Mental Health and Mental Retardation, as part of their budget process, request funding for the establishment of rural group homes in Nevada.

22. The subcommittee recommends that there should be in place sufficient respite care for those families providing services to the mentally retarded and emotionally disturbed.

23. The subcommittee recommends that the Division of Mental Health and Mental Retardation request funding for a personnel officer to be located at the division's central office. It was pointed out to the subcommittee that the division has one of the highest rates of grievances of any organization within state government and that they are operating without the services of a personnel officer. It was also pointed out that many of the positions within the division are specialized and recruitment is difficult and the addition of the personnel officer should assist with recruitment efforts in addition to providing assistance in handling grievances and terminations.

24. The subcommittee is recommending the services for the chronically mentally ill population be expanded. The subcommittee received considerable testimony that the services for the chronically mentally ill adult population have been lacking in the past and currently are insufficient to meet the needs of those individuals. Statistics presented by the Division of Mental Health and Mental Retardation indicated that Nevada is providing approximately 15 beds per 100,000 population whereas the national average is 50 beds per 100,000. Need for community based housing, such as intermediate halfway houses in both the southern and northern part of the state.

25. The subcommittee recommends that inpatient facilities of the Division of Mental Health and Mental Retardation, which are required to meet licensing or accreditation standards, should have sufficient level staff to insure that those functions such as quality assurance, utilization review, and infection control are met.

26. The subcommittee recommends that the new inpatient adult psychiatric hospital in Las Vegas have sufficient pharmacy staff in order to insure this important element of treatment not be overlooked or postponed.

27. The subcommittee recommends that the budget for Southern Nevada Adult Mental Health Services include a program to serve the mentally ill geriatric population. It was pointed out to the subcommittee that the Nevada Mental Health Institute operates an 18-bed facility to serve the mentally ill geriatric population and that a similar program is not in place in Southern Nevada. With the expanding population in Southern Nevada and with the greater percentage of those individuals being at or approaching retirement age, it was felt that this important program element not be overlooked, but that planning begin immediately to assist this population.

28. The subcommittee recommends that case management services needs to be involved with clients throughout their treatment. The staffing for case management services should be sufficient to guarantee all patients are tracked and appropriate services are provided in order to insure patients are moved to a least restrictive setting as soon as possible and stabilized in that setting as long as possible.

MHMR9/r

REPORT OF THE LEGISLATIVE COMMISSION
TO THE MEMBERS OF THE 65TH SESSION OF THE NEVADA LEGISLATURE:

This report is being submitted in compliance with Assembly Concurrent Resolution No. 59 of the 64th Session of the Nevada Legislature which directs the Legislative Commission to study the Mental Health and Mental Retardation Division of the Department of Human Resources.

The legislative members of the subcommittee were:

Assemblyman James J. Spinello, Chairman
Senator Raymond D. Rawson, Vice Chairman
Senator John M. Vergiels
Assemblyman Jan Evans
Assemblyman David Humke

Legislative Counsel Bureau staff services for the subcommittee were provided by Robert A. Guernsey of the Fiscal Analysis Division (principal staff), Jan Needham of the Legal Division (legal counsel) and Nenita Martinkus of the Fiscal Analysis Division (subcommittee secretary).

The subcommittee held nine meetings and received considerable testimony concerning the operations of the division of mental health and mental retardation. The subcommittee reviewed a great deal of information and has attempted in this report to present its findings and recommendations briefly and concisely. Also, supporting documents and minutes are on file in the Fiscal Division of the Legislative Counsel Bureau. The subcommittee wishes to recognize and thank the many people who attended and participated in meetings of the subcommittee for their cooperation and assistance in providing valuable information about the operation of the state's Mental Health and Mental Retardation Division.

This report is transmitted to the members of the 1989 Legislature for consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
August 1988

* *

LEGISLATIVE COMMISSION

Senator Lawrence E. Jacobsen, Chairman
Senator Sue Wagner, Vice Chairman

Senator James I. Gibson
Senator Nicholas J. "Nick" Horn
Senator Ann O'Connell
Senator John M. Vergiels

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Assemblyman Danny L. Thompson

REPORT TO THE 65TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

I. INTRODUCTION AND BACKGROUND

The 64th Session of the Nevada Legislature, in 1987, adopted Assembly Concurrent Resolution No. 59 (File No. 155, Statutes of Nevada, 1987) which directed the Legislative Commission to study the operation of the Mental Health and Mental Retardation Division of the Department of Human Resources.

The last major study of the Division of Mental Health and Mental Retardation took place after the 1977 Legislative Session as a result of A.C.R. 55 (1977), and study Bulletin No. 79-6 was presented to the 1979 Legislature for their review. Other studies of the Division of Mental Health and Mental Retardation include a study of the problems and treatment of mentally retarded adults Bulletin No. 83-1; Mental Health Care Facilities and Programs, Bulletin No. 117, September 1974; and a major study conducted by the Rand Corporation, titled Mental Health and Mental Retardation Services in Nevada, April 1976.

The 1987 Legislature recognized the importance of the services the Division of Mental Health and Mental Retardation provides to the citizens of the state. Rapid growth of the state's population increased the division's caseload and created a need to examine the efficiency and effectiveness of the management of the division and treatment of clients.

The results of the study are to be reported for further consideration by the 65th Session of the Nevada Legislature. The subcommittee has a total of 28 recommendations.

Subcommittee Meetings

The A.C.R. 59 Subcommittee held nine meetings which took place in Las Vegas, Reno and Carson City.

Subcommittee Methodology

The A.C.R. 59 Subcommittee conducted its study through the public hearing process. The subcommittee received considerable input on the operation of the Division of Mental Health and Mental Retardation from employees of the division, the Department of Human Resources, concerned parents and relatives, practitioners in the field and from current and former clients. The subcommittee also mailed a questionnaire to all employees of the Division of Mental Health and Mental Retardation and received detailed responses from many employees (see Appendix A).

II. HISTORY AND OPERATION OF THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

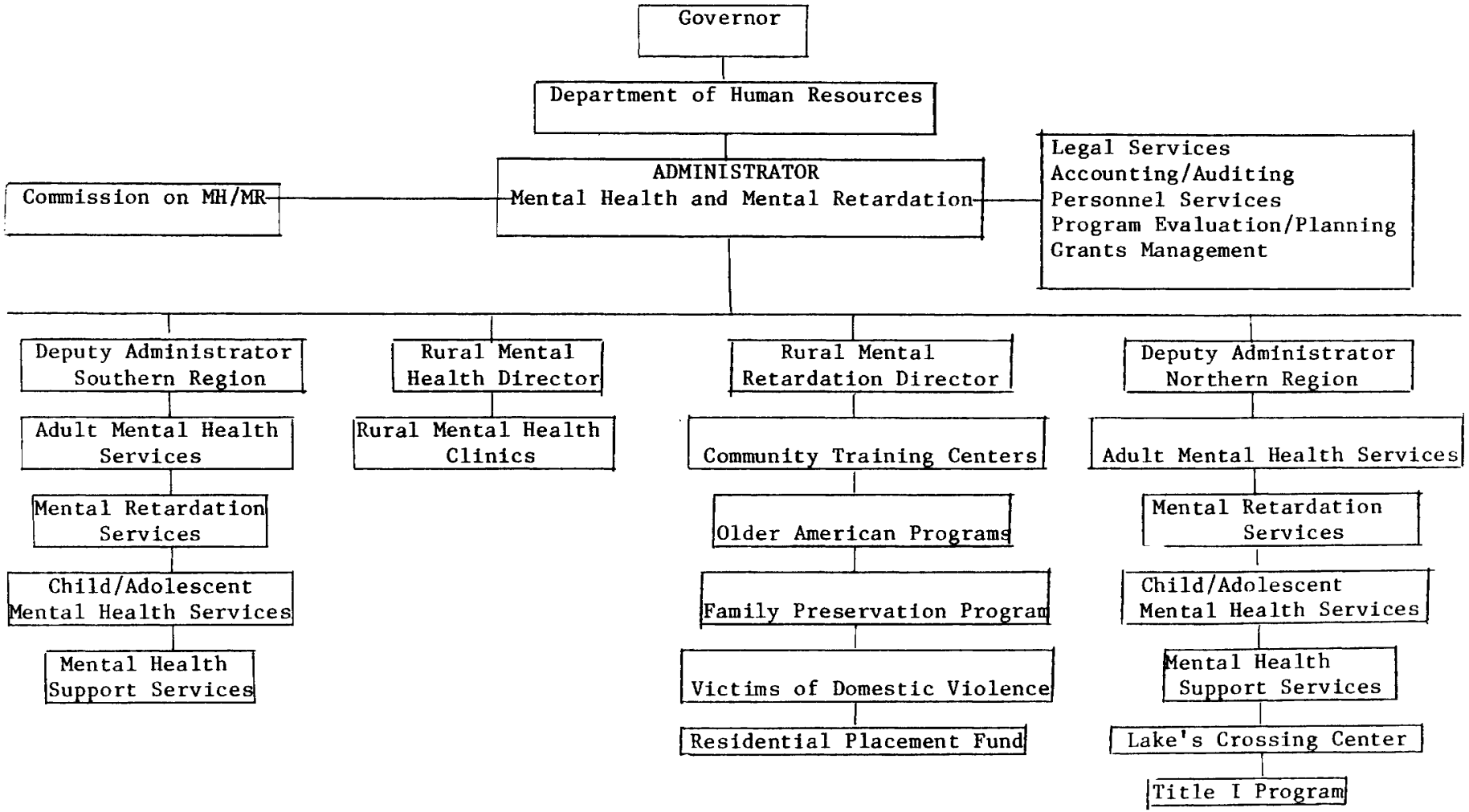
Prior to 1970, the operation of the Division of Mental Health and Mental Retardation consisted primarily of the operation of the state hospital in Sparks, Nevada. The Las Vegas area was served by a few clinicians providing services on an outpatient basis, as were services provided to rural Nevada. The framework for the current organization was implemented during the early and mid-1970's with additional programs being added to meet the growing demand for services. The Las Vegas Mental Health Center became a separate agency and new and separate services were added for children and adolescents and the mentally retarded.

Organization

The Division of Mental Health and Mental Retardation is organized as a separate division of the Department of Human Resources. Pursuant to the authority granted by Nevada Revised Statutes (NRS) 433, 433A, and 435, the Division of Mental Health and Mental Retardation is responsible for the development, administration, coordination and evaluation of treatment and training programs for mentally ill and mentally retarded citizens in the State of Nevada. The division operates inpatient facilities in Washoe and Clark counties and purchases some contract beds in other parts of the state. There is an extensive network of outpatient services and day treatment services in many parts of the state. The Division of Mental Health and Mental Retardation is divided along organization lines as displayed in the following organizational chart (Exhibit 1).

Exhibit No. 1
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Table of Organization



Prior to 1985, the division was supervised by the Department of Human Resources and had a seven-member advisory board. The 1985 Legislature, with passage of A.B. 400, created a seven-member Commission on Mental Health and Mental Retardation with policy making authority over the Division of Mental Health and Mental Retardation. The administration of the division continued to be responsible for the day-to-day administration but now would be guided in part by the policies set forth by the commission. The new mechanism was envisioned to place authority to oversee the operations and set the direction for the division in the hands of qualified and interested citizens. The organization is designed to serve as a forum for resolving problems within the state programs for mental health and mental retardation. Specific statutes concerning the operation of the Commission on Mental Health and Mental Retardation are listed in NRS 433.314, 433.316, 433.324, 433.327.

Funding History

Since the early 1970's, the general fund appropriation for the division has grown dramatically from approximately $3.7 million in fiscal year 1971 to a general fund appropriation in excess of $29 million in fiscal year 1989. A history of the general fund appropriations for the Division of Mental Health and Mental Retardation from 1971 through 1989 are displayed in Exhibit No. 2.

In recognition of the problems the Division of Mental Health and Mental Retardation faced in dealing with increasing demands for services, the 1987 Legislature increased the general fund appropriation by over $8 million. This amounted to an approximate 42 percent increase in the general fund appropriation level in fiscal year 1988 over the 1987 level.

Exhibit No. 2
Division of Mental Health and Mental Retardation
History of General Fund Appropriations

Fiscal Year	General Fund Appropriation	Fiscal Year	General Fund Appropriation
1988-89	$29,127,596	1978-79	14,490,724
1987-88	28,528,283	1977-78	13,174,591
1986-87	20,083,828	1976-77	11,478,541
1985-86	19,238,070	1975-76	9,743,629
1984-85	20,213,308	1974-75	7,989,680
1983-84	18,845,520	1973-74	7,023,907
1982-83	18,192,951	1972-73	5,581,243
1981-82	17,189,738	1971-72	5,405,796
1980-81	15,764,974	1970-71	3,780,632
1979-80	14,458,480		

Exhibit No. 3 shows end of the month average caseloads for residential and community programs from fiscal year (FY) 1982 through April 1988. Prior to FY 1982, the division was keeping its data in a different format and much of the comparisons would not be valid. During the time period FY 1982 - 1988, there have been changes in the way the division records community cases. The heading "Residential" includes both inpatient and transitional beds that the division is paying for "and Community" includes all other cases such as outpatient and day treatment. During this time period, the two major adult inpatient facilities, the Nevada Mental Health Institute (NMHI) and Southern Nevada Adult Mental Health Services (SNAMHS), have experienced a significant increase in residential cases. The SNAMHS has shown a much larger increase in residential cases due to increased funding for transitional beds in the community. The community cases at SNAMHS has grown significantly from 3,980 in FY 1982 to 4,118 in FY 1988. Almost all programs have shown an increase in caseloads during this time period including Northern Nevada Mental Retardation Services (NNMRS) and Southern Nevada Mental Retardation Services (SNMRS). Due to limited residential bed capacity, those facilities have been operating at close to maximum levels, as has the Lake's Crossing facility for the mentally disordered offender. Another program showing a significant increase is the cost effective Community Training Centers (CTC) program which has grown from an average end of the month caseload of 465 in FY 1982 to almost 684 in FY 1988.

A more detailed breakout of caseload data is presented in Exhibit No. 4. The division began capturing additional caseload information in fiscal year 1985 by program sub-unit.

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
COMPARISON OF AVERAGE MONTHLY CASELOADS: RESIDENTIAL AND COMMUNITY
FY 82 THROUGH FY 88 (JULY-APRIL 88)

BUDGET #	AGENCY	FY82 EOM CASELOAD	FY83 EOM CASELOAD	FY84 EOM CASELOAD	FY85 EOM CASELOAD	FY86 EOM CASELOAD	FY87 EOM CASELOAD	FY88 EOM CASELOAD
3162	NEVADA MENTAL HEALTH INSTITUTE							
	RESIDENTIAL:	78.00	82.00	87.00	96.00	101.50	123.66	119.20
	COMMUNITY:	649.00	890.00	846.00	858.00	849.00	858.67	655.20
3161	SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES							
	RESIDENTIAL:	78.00	103.00	156.00	177.00	192.25	220.83	281.00
	COMMUNITY:	3980.00	4652.00	5095.00	5290.00	5613.58	6342.83	6118.50
3281	NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES							
	RESIDENTIAL:	31.00	36.00	38.00	38.00	42.42	41.25	41.30
	COMMUNITY:	503.00	606.00	676.00	633.00	423.09	401.09	376.60
3646	SOUTHERN NEVADA CHILD & ADOLESCENT SERVICES							
	RESIDENTIAL:	41.00	62.00	66.00	70.00	69.50	66.17	64.90
	COMMUNITY:	858.00	1065.00	1196.00	1177.00	904.67	981.24	809.60

Exhibit No. 3

BUDGET #	AGENCY		FY82 EOM CASELOAD	FY83 EOM CASELOAD	FY84 EOM CASELOAD	FY85 EOM CASELOAD	FY86 EOM CASELOAD	FY87 EOM CASELOAD	FY88 EOM CASELOAD
3645	LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER								
	RESIDENTIAL:	INPATIENT	21.00	24.00	23.00	25.00	27.08	30.17	32.50
3648	RURAL CLINICS								
	COMMUNITY:		1904.00	2055.00	2191.00	2375.00	2663.25	2803.58	2154.70
3280	NORTHERN NEVADA MENTAL RETARDATION SERVICES								
	RESIDENTIAL:		74.00	75.00	75.00	75.00	79.00	80.92	77.60
	COMMUNITY:		167.00	149.00	147.00	173.00	182.42	199.25	211.40
3279	SOUTHERN NEVADA MENTAL RETARDATION SERVICES								
	RESIDENTIAL:		81.00	86.00	91.00	93.00	93.33	89.75	91.90
	COMMUNITY:		212.00	280.00	332.00	424.00	434.25	500.58	560.20
3167	RURAL NEVADA MENTAL RETARDATION SERVICES								
	COMMUNITY:		N/A	52.00	83.00	114.00	113.58	117.08	131.10

BUDGET #	AGENCY	FY82 EOM CASELOAD	FY83 EOM CASELOAD	FY84 EOM CASELOAD	FY85 EOM CASELOAD	FY86 EOM CASELOAD	FY87 EOM CASELOAD	FY88 EOM CASELOAD
3160	COMMUNITY TRAINING CENTERS							
	COMMUNITY:	465.00	490.00	551.00	584.00	585.00	687.40	683.70
3166	FPP							
	AVERAGE # OF RECIPIENTS:				60.00	63.75	63.00	71.90

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DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
FY 85,86,87 & 88 AVERAGE EOM CASELOADS AND ADMISSIONS
06-Sep-88

AGENCY	PROGRAM MONTHLY AVERAGES	FY85 EOM CASELOAD	FY85 EOM ADMISSIONS	FY86 EOM CASELOAD	FY86 EOM ADMISSIONS	FY87 EOM CASELOAD	FY87 EOM ADMISSIONS	FY88 EOM CASELOAD	FY88 EOM ADMISSIONS
NMHI	GEN PSYCHIATRIC	60.00	92.00	63.50	99.92	77.25	105.75	72.58	99.92
	GERIATRICS	17.00	4.00	16.67	4.67	17.33	4.67	17.08	4.83
	HALFWAY HOUSE	19.00	8.00	21.33	11.75	29.00	9.50	28.17	12.58
	DAYTREATMENT	39.00	5.00	31.17	5.50	60.67	5.00	90.00	1.75
	CASEMANAGEMENT	83.00	4.00	42.75	4.58	141.75	15.56	239.50	41.58
	OUTPATIENT	736.00	71.00	775.00	65.00	656.25	71.83	343.33	41.17
SNAMHS	RESIDENTIAL	37.00	49.00	38.50	48.00	38.50	35.67	62.00	48.00
	TRANSISTIONAL	140.00	24.00	153.75	24.83	182.33	28.17	223.17	29.00
	CASEMANAGEMENT	545.00	42.00	725.92	40.00	756.17	30.42	650.75	32.25
	DAYTREATMENT	183.00	33.00	206.58	27.67	248.33	44.42	244.17	35.58
	MED SERVICES	1157.00	79.00	1555.00	74.83	1810.50	62.00	1965.25	68.67
	OUTPATIENT	1710.00	210.00	1312.00	184.58	1400.33	172.67	1425.67	197.42
	EMERG SERVICES:								
	AVER PERSO SEEN	358.00		386.92		419.67		409.58	
	AVER PHONE CONT	1337.00		1427.00		1707.83		1413.75	
NNCAS	CBS RESIDENTIAL	13.00	2.00	14.67	1.42	12.00	1.42	11.75	1.67
	CBS SCHOOL	6.00	1.00	4.25	1.33	5.25	1.50	2.75	0.75
	CBS OUTPATIENT	344.00	21.00	220.50	17.42	199.00	13.83	158.33	9.42
	CBS PRESCHOOL	65.00	12.00	78.00	13.58	76.75	12.17	90.25	13.00
	ATC RESIDENTIAL	15.00	2.00	15.33	1.91	15.67	1.33	14.17	2.25
	APW COM HOME	5.00	1.00	4.75	0.83	4.67	0.50	4.92	0.42
	REAGEN COM HOME	5.00	1.00	5.00	0.50	5.00	0.83	5.00	0.75
	ATC DAYTREATMEN	9.00	2.00	10.17	1.42	8.42	1.83	7.50	1.75
	ATC OUTPATIENT	209.00	11.00	110.17	10.55	111.67	11.00	120.00	11.42
	DESERT HILLS			2.67	1.00	3.83	0.42	4.33	0.42
	CHILD DAY CARE							5.00	5.00

Exhibit No. 4

AGENCY	PROGRAM MONTHLY AVERAGES	FY85 CASELOAD	FY85 ADMISSIONS	FY86 CASELOAD	FY86 ADMISSIONS	FY87 EOM CASELOAD	FY87 EOM ADMISSIONS	FY88 EOM CASELOAD	FY88 EOM ADMISSIONS
SNCAS	CAMPUS HOMES	30.00	4.00	32.58	3.25	27.58	3.83	31.67	4.33
	SECURE UNIT	8.00	7.00	7.50	4.92	9.17	5.08	8.25	6.83
	COMMUNITY HOMES	32.00	2.00	29.42	2.17	29.42	2.58	26.00	3.25
	DAY TREATMENT	50.00	7.00	44.00	7.92	49.08	7.83	42.08	8.67
	FAMILY OUTREACH	61.00	6.00	112.83	10.33	118.25	7.42	112.58	11.17
	OUTPATIENT	938.00	98.00	543.17	84.75	583.08	71.92	480.92	93.67
	EARLY INTERVENT	128.33	18.42	204.67	25.08	230.83	24.75	188.25	25.17
LAKES	INPATIENT	25.00	14.00	27.08	11.50	30.17	13.00	31.67	11.75
RC	TOTAL AGENCY	2301.00	330.00	2547.83	334.25	2691.75	349.00	2060.58	383.50
	INPATIENT REFER	56.00		60.25		62.67		67.67	
	DAYTREATMENT	16.00		11.67		11.83		14.92	
	EMERGENCY SERV	42.00		43.50		37.33		43.50	
NNMRS	RESIDENTIAL	75.00		79.00		80.92		77.83	
	COMMUNITY	173.00		182.42		199.25		211.75	
	WAITING LISTS:								
	FACILITY	11.00		18.33		15.83		15.17	
	COMM RESID	32.00		35.08		35.50		25.00	
SNMRS	RESIDENTIAL	93.00		93.33		89.75		91.67	
	COMMUNITY	424.00		434.25		500.58		566.08	
	WAITING LISTS:								
	FACILITY	16.00		16.25		14.83		15.17	
	COMM RESID	35.00		22.00		29.17		48.50	

AGENCY	PROGRAM MONTHLY AVERAGES	FY85 CASELOAD	FY85 ADMISSIONS	FY86 CASELOAD	FY86 ADMISSIONS	FY87 EOM CASELOAD	FY87 EOM ADMISSIONS	FY88 EOM CASELOAD	FY88 EOM ADMISSIONS
RNMRS	COMMUNITY	114.00		113.58		117.08		131.58	
	WAITING LISTS:								
	COMM RESID	24.00		13.17		16.83		9.75	
	REGIONAL	37.00		45.42		82.08		65.08	
CTC	PRESCHOOL			124.00		132.00		129.00	
	REGULAR			445.00		520.40		549.70	
	PREWORKSHOP			16.00		35.00		20.00	
FPP	AVERAGE # OF RECIPIENTS:	60.00		63.75		63.00		71.75	

* NMHI Outpatient Caseloads decreased due to transfer of on-campus OP clients to Casemanagement.

Report completed 09/01/88
DOC=ANNUAL

NOTE:
Numbers are non-duplicated within programs (e.g.,Outpatient). Duplication between programs may occur if client is receiving services in more than one program. This is most likely to occur in programs such as Medical Services (at SNAMHS) where clients from many programs receive medication treatment.

Outpatient Caseload decreases reflect Division wide audits which require terminations of clients not seen in over 90 days.

ABBREVIATIONS:

NMHI=NEVADA MENTAL HEALTH INSTITUTE

SNAMHS=SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

NNCAS=NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES

SNCAS=SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES

LAKES=LAKES CROSSING

RC=RURAL CLINICS

NNMRS=NORTHERN NEVADA MENTAL RETARDATION SERVICES

SNMRS=SOUTHERN NEVADA MENTAL RETARDATION SERVICES

RNMRS=RURAL NEVADA MENTAL RETARDATION SERVISES

CTC=COMMUNITY TRAINING CENTERS

FPP=FAMILY PRESERVATION PROGRAM

III. PROGRAM DESCRIPTIONS

Division of Administration

This budget provides for overall management of state mental health and mental retardation services. The functions of the division's Central Office are to carry out state mental health and mental retardation management and personnel policies, regulations, coordinate operations and program development statewide, guarantee quality of care provided by agencies within the division, and insure agency fiscal responsibility. The division operates under the guidance of the Commission on Mental Health and Mental Retardation established by the 1985 Legislature. Functions include establishing service and funding priorities with public input, monitoring the productivity and cost effectiveness of programs and responding to legal issues arising from service delivery. Organizational charts for individual agencies within the division are displayed in Appendix B of this report.

Nevada has the smallest number of mental inpatient beds per 100,000 of population of any of the 50 states. Exhibit No. 5 displays data for January 1974, January 1983 and January 1984. As the data indicates, all states went through a major reduction in inpatient beds during this time period with the average reduction of 58.4 percent from 1974 to 1984. During that period, Nevada's reduction in inpatient beds was 76.1 percent dropping from 81.4 per 100,000 in 1974 to 10.3 in 1984.

The utilization rates per 100,000 of state population of mental retardation beds shows Nevada lowest at 41.2 as compared to a U.S. average of 105. The comparative figures are displayed in Exhibit No. 6 of large and small ICF-MR and total residential facilities.

Southern Nevada Mental Retardation Services

The Southern Nevada Mental Retardation Services (SNMRS) budget provides services to mentally retarded and mentally disabled persons in Southern Nevada. Services include the Desert Developmental Center (DDC), a residential facility which provides mentally retarded persons 24-hour, seven days a week continuous care. DDC has 94-bed capacity and is licensed by the Bureau of Health Facilities. The SNMRS also provides community developmental private nonprofit group homes and independent living with a 126-bed capacity. These developmental home beds are licensed by the State Welfare Division. The agency also provides services which may include crisis intervention, respite care, genetic counseling, coordination of community resources, infant education programs, parent counseling, evaluation for individuals in their own homes, or residential placement for

severely retarded or behaviorally disturbed individuals without appropriate resources. The agency indicates that services are given to allow clients to obtain potential.

The Community Residential Placement Program gives emphasis to community placements for clients who can be trained and managed in specialized homes in the community. A continuum of care is provided for movement to a less restrictive environment when possible.

Southern Nevada Adult Mental Health Services

The Southern Nevada Adult Mental Health Services (SNAMHS) budget is a combination of a former Las Vegas Mental Health Center and the adult components of the former Henderson Mental Health Center. The agency offers inpatient, partial hospitalization, outpatient, emergency, case management, vocational and transitional services to clients in Clark County. Service sites are located in Henderson, Pahrump, Paradise Valley, North Las Vegas, Westside, West Charleston and University Hospital (formerly Southern Nevada Memorial Hospital).

The 1987 Session of the Nevada Legislature substantially amended the budget for SNAMHS due to a crisis situation in dealing with overcrowded inpatient conditions. The agency faced licensing and certification problems. The budget originally called for 32 new beds to come on line in September 1987 and included a request for 20 additional beds. The Legislature responded to the inpatient crisis by approving Assembly Bill 134 which provided for the construction of 88 new psychiatric beds at the Las Vegas Mental Health Center. The bill included construction of the new unit and reduction in the bed capacity of B Building. The Las Vegas Mental Health Center will have a maximum inpatient capacity of approximately 112 beds.

The 1987 Legislature agreed with a Department of Human Resources request, as contained in Assembly Bill 861, which transfers responsibility for Child Protective Services from the State Welfare Division to counties with a population of 100,000 or more, effective September 1, 1988. At that time, the state assumed responsibility for the initial commitment of mentally ill persons in exchange for the larger counties assuming responsibility for Child Protective Services. This will have a direct effect on the operation of the SNAMHS.

Exhibit No. 5

Number of Inpatient Beds per 100,000 Civilian Population and Percent Change in Bed Rate, State, and County Mental Hospitals, by State: United States, January 1974, 1983, and 1984

State	Inpatient Beds per 100,000 Civilian Population			Percent Change in Bed Rate	
	Jan. 1974	Jan. 1983	Jan. 1984	1983-1984	1974-1984
Alabama	139.1	56.8	57.9	1.9	−58 4
Alaska	65.1	34.7	35.7	2.9	−45.2
Arizona	42.6	12.0	14.2	18.3	−66.7
Arkansas	82.3	16.4	16.6	1.2	−79 8
California	52.7	27.4	26.0	−5.1	−50 7
Colorado	64.5	32.4	29.3	−9.6	−54.6
Connecticut	121.5	76.2	76.5	0.4	−37.0
Delaware	242.5	103.7	88.1	−15.1	−63.7
Dist. of Columbia	472.9	335.6	258.6	−23.1	−45.3
Florida	119.8	44.2	43.2	−2.3	−63.9
Georgia	188.0	85.4	75.6	−11.5	−59.8
Hawaii	28.4	24.3	24.9	2.5	−12.3
Idaho	44.6	26.8	23.1	−13.8	−48.2
Illinois	92.3	36.1	35.7	−1.1	−61.3
Indiana	140.1	55.5	46.7	−15.9	−66.7
Iowa	55.1	36.8	33.1	−10.1	−39.9
Kansas	86.8	56.1	53.5	−4.6	−38.4
Kentucky	60.1	24.4	25.3	3.7	−57.9
Louisiana	108.6	48.5	43.3	−10.7	−60.1
Maine	127.3	59.3	57.5	−3.0	−54.8
Maryland	169.5	81.6	80.4	−1.5	−52.6
Massachusetts	139.6	48.3	48.1	0.4	−65.5
Michigan	88.8	46.8	48.7	4.1	−45 2
Minnesota	114.9	52.4	38.9	−30.0	−68.0
Mississippi	217.7	81.2	79.7	−1.8	−63.4
Missouri	106.4	48.2	47 8	−0.8	−55.1
Montana	174.5	50.4	49.9	−1.0	−71.5
Nebraska	66.1	44.5	41.8	−6.7	−31.8
Nevada	81.4	20.3	10.3	−49.3	−76.1
New Hampshire	198.2	33.8	55.3	−63.6	−88.0
New Jersey	192.7	68.0	65.3	−4.0	−68.4
New Mexico	33.1	19.4	20.6	6.2	−37.9
New York	271.0	144.7	151.5	4.7	−44.1
North Carolina	129.3	57.2	40.2	−29.7	−68.9
North Dakota	151.7	114.9	111.4	−3.0	−26.5
Ohio	137.3	49.9	44.3	−11 2	−67.7
Oklahoma	124.9	51.9	47.6	−8.3	−61 9
Oregon	74.2	35.8	34.8	−2.8	−53.1
Pennsylvania	182.6	84.5	85.7	1.4	−53.1
Rhode Island	201.8	73.2	46.9	−36.0	−76.8
South Carolina	215.5	113.7	101.8	−10.5	−52.8
South Dakota	171.2	65.4	62.4	−4.6	−63.6
Tennessee	134.8	49.7	43.8	−11.9	−67.5
Texas	99.3	44.0	41.1	−6.6	−58.6
Utah	28.4	20.0	19.5	−2.5	−31.3
Vermont	142.5	50.0	35.0	−30.0	−75.4
Virginia	176.1	91.3	72.5	−20.6	−58.8
Washington	62.0	28.5	31.2	9 5	−49.7
West Virginia	230.1	79.9	34.7	−56.6	−84.9
Wisconsin	149.4	25.9	24.4	−5.8	−83.7
Wyoming	117.0	68.5	78.1	14.0	−33.2
Totals	**132.4**	**58.1**	**55.4**	**−5.2**	**−58.4**

Source: "State and County Mental Hospitals, US 1982-83 and 1983-84," *Mental Health Statistical Note*, no. 176 (September 1986).

Exhibit No. 6

Utilization Rates Per 100,000 of State Population: Large and Small
ICF-MR and Total Residential Facilities

State	7/1/85 State Pop. (100,000)	ICF-MR Residents 15-	ICF-MR Residents 16+	ICF-MR Residents Total	ICF-MR 15- and Waiver	Total ICF-MR and Waiver	ICF-MR and Non-ICF-MR 15-	ICF-MR and Non-ICF-MR 16+	ICF-MR and Non-ICF-MR Total
ALABAMA	40.2	.8	33.2	33.9	39.8	72.9	16.5	37.6	54.1
ALASKA	5.2	7.7	11.3	19.0	7.7	19.0	41.5	15.8	57.3
ARIZONA	31.9	.0	.0	.0	.0	.0	43.7	21.1	64.8
ARKANSAS	23.6	.0	58.1	58.1	.0	58.1	18.6	63.8	82.4
CALIFORNIA	263.7	5.5	30.2	35.7	16.8	46.9	59.9	44.7	104.6
COLORADO	32.3	.0	40.7	40.7	39.6	80.3	50.2	40.7	91.0
CONNECTICUT	31.7	19.7	16.5	36.2	19.7	36.2	65.6	84.5	150.1
DELAWARE	6.2	9.8	63.5	73.4	22.4	86.0	46.5	63.5	110.0
D.C.	6.3	48.6	45.2	93.8	48.6	93.8	91.1	45.2	136.3
FLORIDA	113.7	.4	28.2	28.5	62.0	90.1	27.4	43.7	71.0
GEORGIA	59.8	.0	33.1	33.1	.0	33.1	21.5	37.9	59.4
HAWAII	10.5	2.7	21.0	23.7	6.9	27.9	44.0	26.6	70.6
IDAHO	10.1	9.9	36.5	46.4	12.4	48.9	35.0	80.8	115.7
ILLINOIS	115.4	2.9	74.7	77.6	7.6	82.3	21.7	94.7	116.5
INDIANA	55	26.4	49.6	76.0	26.4	76.0	34.8	49.6	84.5
IOWA	28.8	1.3	68.7	70.0	1.3	70.0	45.3	115.4	160.7
KANSAS	24.5	6.8	80.4	87.2	13.8	94.3	20.8	92.4	113.2
KENTUCKY	37.3	.0	31.9	31.9	13.8	45.8	11.0	40.0	51.0
LOUISIANA	44.8	20.3	104.2	124.4	20.3	124.4	29.0	105.2	134.2
MAINE	11.6	29.3	33.1	62.4	59.7	92.8	116.8	45.9	162.8
MARYLAND	43.9	.3	50.2	50.5	10.9	61.0	52.1	51.7	103.8
MASSACHUSETTS	58.2	5.1	59.1	64.2	14.2	73.2	74.6	63.4	138.0
MICHIGAN	90.9	15.2	21.2	36.5	15.2	36.5	52.9	33.8	86.7
MINNESOTA	41.9	65.7	97.8	163.5	79.3	177.1	97.6	99.6	197.2
MISSISSIPPI	26.1	.0	60.2	60.2	.0	60.2	17.2	85.6	102.7
MISSOURI	50.3	2.1	39.4	41.5	2.1	41.5	43.8	74.4	118.2
MONTANA	8.3	1.1	31.0	32.0	24.2	55.2	98.6	31.0	129.5
NEBRASKA	16.1	.0	53.5	53.5	.0	53.5	96.3	53.5	149.8
NEVADA	9.4	1.6	17.7	19.3	13.1	30.7	23.5	17.7	41.2
NEW HAMPSHIRE	10.0	5.0	22.1	27.1	55.4	77.5	79.1	22.1	101.2
NEW JERSEY	75.6	.0	51.3	51.3	26.4	77.7	44.2	73.1	117.2
NEW MEXICO	14.5	9.3	33.2	42.6	26.1	59.4	46.4	33.2	79.7
NEW YORK	177.8	29.9	66.3	96.2	29.9	96.2	80.4	67.5	147.8
NORTH CAROLINA	62.6	3.4	46.2	49.6	8.6	54.9	14.7	52.8	67.5
NORTH DAKOTA	6.9	63.9	63.3	127.2	131.0	194.3	171.3	70.4	241.7
OHIO	107.4	8.5	64.0	72.5	9.3	73.3	36.8	64.2	101.1
OKLAHOMA	33	.0	90.9	90.9	1.1	92.0	19.5	90.9	110.4
OREGON	26.9	.8	57.8	58.6	22.1	79.9	49.3	52.3	101.6
PENNSYLVANIA	118.5	4.4	60.9	65.3	8.9	69.9	47.6	74.2	121.8
RHODE ISLAND	9.7	59.0	34.5	93.5	59.0	93.5	87.7	37.7	125.5
SOUTH CAROLINA	33.5	9.9	81.7	91.6	9.9	91.6	24.6	81.7	106.3
SOUTH DAKOTA	7.1	23.4	70.0	93.4	93.5	163.5	115.9	70.0	185.9
TENNESSEE	47.6	2.0	48.7	50.7	2.0	50.7	22.2	49.7	71.9
TEXAS	163.7	8.0	65.6	73.6	8.4	74.0	11.7	69.4	81.1
UTAH	16.4	.9	77.7	78.7	.9	78.7	31.6	77.7	109.3
VERMONT	5.3	12.5	36.8	49.2	56.6	93.4	92.1	36.8	128.9
VIRGINIA	57.1	1.6	53.9	55.5	1.6	55.5	10.4	56.1	66.5
WASHINGTON	44.1	3.1	55.7	58.8	23.7	79.4	43.7	79.3	123.1
WEST VIRGINIA	19.4	.5	13.1	13.7	2.8	16.0	38.7	31.1	69.8
WISCONSIN	47.8	.0	75.7	75.7	2.6	78.3	50.2	75.7	125.9
WYOMING	5.1	.0	.0	.0	.0	.0	45.5	89.4	134.9
U.S. Total	2387.7	8.7	51.5	60.2	18.4	69.9	43.3	61.7	105.0

Southern Nevada Child and Adolescent Mental Health Services

Southern Nevada Child and Adolescent Mental Health Services (SNCAMHS) provides assessment, diagnosis and treatment services to approximately 2,168 children and adolescents per year. These children exhibit some kinds of emotional and/or behavioral disturbance. Children and families are referred to the agency by schools, child care centers, physicians, social services and the courts. The goal of the agency is to provide a continuum of service to the child ranging from the least restricted modality such as counseling to more restrictive modality such as inpatient care. The comprehensive range of direct mental health therapy includes individual child and parent therapy, family therapy, groups, in-home therapy sessions, developmental therapy for young children, social skills development, therapy training for autistic - psychotic children, day treatment, family style residential treatment and short-term mental health hospitalization for youths who are dangerous to themselves and/or others. The facility has an inpatient 14- bed capacity. In addition, they have on campus residential homes totaling 38 beds and community based home beds totaling 34. The agency provides services in Southern Nevada from the following locations: Children's Behavioral Services (CBS) on West Charleston, Westside Counseling Center, Valley Counseling Center, North Las Vegas Counseling Center, Henderson Counseling Center, the Crisis Unit at the University Medical Center and finally, at the University of Nevada, Las Vegas for a preschool program.

Northern Nevada Mental Retardation Services

Northern Nevada Mental Retardation Services (NNMRS) provides a full range of services to mentally retarded clients from Washoe County and the rural Nevada Mental Retardation Services region. The services provided include training to develop each person's full potential and the teaching of skills necessary to adapt in society. The largest component of NNMRS is the Sierra Developmental Center (SDC) which has an 84-bed capacity. In addition, the case management and community staff provide recruitment training and supervision of those clients placed in community beds in Northern Nevada. Currently, the agency supports 79 licensed community beds. In addition, the staff provides support and training to families maintaining mentally retarded dependents at home and provide a full range of clinical services including medical, nursing, psychological and training services to clients and their families. The agency also provides temporary respite care for the families of clients residing at home.

Nevada Mental Health Institute

The Nevada Mental Health Institute (NMHI) is an accredited institution serving mentally ill clients primarily from Northern

Nevada. The institute offers services which includes inpatient, transitional living, partial hospitalization, outpatient, limited community living services and emergency care to adults. The agency also provides statewide backup and psychiatric inpatient services when local resources are inadequate or not available. During the 1985-87 biennium, the Nevada Mental Health Institute had a number of clients transported from Clark County to the institute due to an insufficient number of inpatient beds at SNAMHS. The institute has two approximately 40-bed inpatient units. One is primarily designated for intensive care for those clients requiring closer observation and intervention. The second 40-bed unit is a resocialization unit for patients partially remitted. In addition, the institute provides services to the geriatric population with an 18-bed inpatient unit. Finally, the agency has two 16-bed cottages providing residential services for persons who continue to require ready access to more intensive services than are available in the community. A number of these patients also attend the day treatment program at the institute. The 1987 Legislature began a new treatment program for transitional living to add continuity of care for those inpatients moving out into the community and to provide housing for persons with little or no income.

Lake's Crossing Center

The Lake's Crossing Center in Washoe County is Nevada's only program for the mentally disordered offender. The agency provides statewide residential services to individuals who have been evaluated as not guilty by reason insanity, incompetent to stand trial, or requiring mental health services in a secure setting. Such services require a full coordinated effort as responsibilities for treatment, evaluation and consultation delegated to Lake's Crossing must meet a wide range of needs for a diversified population. The agency primarily provides services to those clients committed to the facility pursuant to an evaluation to stand trial order (NRS 178.415), being adjudicated and incompetent to stand trial (NRS 178.425) or being found not guilty by reason of insanity (NRS 175. 521). The facility also accepts short-term treatment inmates from the Washoe County jail who require a period of intensive mental health care which cannot be provided at the jail facility. The Lake's Crossing facility has a maximum of 32 residential beds available. During the past fiscal year, it has been running at or over capacity. The facility opened in February 1976 and as of August 1988 has served over 900 individuals.

Northern Nevada Child and Adolescent Services

Northern Nevada Child and Adolescent Services (NNCAS) provides mental health services to children, adolescents and their families in Washoe County and Northern Nevada. The agency is combination of the former Children's Behavioral Services and Reno

Mental Health Center. The agency provides residential services in a variety of settings to both children and adolescents and also provides day treatment, outpatient and emergency services. The NNCAS also provides evaluation and treatment for adolescent sexual offenders. The residential capacity of the program elements are as follows: adolescent beds - 16, sexual offender beds - 5, children's beds at CBS - 16, and, finally, community beds - 10.

Rural Clinics

The Rural Clinics Program provides an array of mental health services to residents of Nevada's 15 rural counties. Seven main satellite offices have been established and are located in Carson City, Hawthorne, Douglas/Lyon, Fallon, Winnemucca, Elko and Ely. The agency also operates with a number of sub-satellite offices which are staffed on an intermittent basis. In the mid-1970's, a federal staffing/operations grant was secured to increase and improve the services to the citizens residing in rural Nevada. The eight-year grant had a declining participation level each year by the federal government and after eight years, the State of Nevada was entirely responsible. In fiscal year 1987, the Rural Clinics Program served over 6,000 clients and this amounted to 36,000 hours of care compared to 34,000 hours in fiscal year 1985. In fiscal year 1988, admissions to the Rural Clinics Program consisted of approximately 76 percent of ages 18 and over and approximately 24 percent of those ages zero through 17 years of age. Approximately 74 percent of the admissions had an annual income of under $20,000.

Community Training Centers

The Community Training Centers (CTC) Program provides aid to mentally retarded persons not being served by other programs. This is done through a program of subsidizing qualified Community Training Centers which provide care and training to the clients. The support funding flows from the CTC budget, the Sierra Developmental Center budget and the Desert Developmental budget to the various programs. During the current biennium, each certified enrollee receives funding under one of the following categories:

	Per Day
Regular Adult	$15.25
Pre-workshop	24.75
Preschool	16.85

Minimum funded centers serving five to ten enrollees are paid as if they serve ten. Minimum funded centers serving fewer than five enrollees receive pro-rated amounts based on actual enrollments. Allocations from the Division of Mental Health and Mental Retardation to the various Community Training Centers for

FY 1989 are detailed in Appendix C. Included in the data are the average number of clients receiving service by training center and the dollar amounts budgeted per center going into the fiscal year. As of July 1988, the CTC program served 551 regular adults, 20 pre-workshop and 129 preschool enrollees. A total of 917 different individuals received services during the year. In addition, the Sierra Developmental Center contracted and budgeted for services for 70 adults and Desert Developmental Center contracted and budgeted for services for 74 adults.

Resident Placement Program

The Resident Placement Program provides financial resources for the placement of noninstitutional mentally retarded individuals outside their natural family home. It is anticipated that 228 clients will be in community residential programs at an average cost of $676 per month by June 1989. The program is supported through the use of collections from families, third party payment, Supplemental Security Income, collections from Social Services, Medicaid, Title 19 (waiver) and a general fund appropriation.

Family Preservation Program

The Family Preservation Program, formerly known as Mental Retardation Homecare, was established with passage of A.B. 119 by the 1981 Legislature. The program provides financial assistance to parents or relatives of profoundly retarded persons who are cared for at home. The purpose of the assistance is to prevent institutional placements of mentally retarded persons whose families might otherwise be able to care the client in their home. The program is supported entirely through a general fund appropriation. As of December 1986, the program was serving 64 families receiving an average assistance of $209 per month. The average number of recipients has increased from 62.92 in FY 1987 to 71.83 in FY 1988.

The Older Americans Program

The Division of Mental Health and Mental Retardation serves as the sponsor agency for two older American volunteer programs. Those programs are the Senior Volunteer Program and the Foster Grandparent Program. Both programs provide extensive services to state and local government agencies. During FY 1988, the R.S.V.P. Program provided 185,000 hours in human services with more than 76 hours provided in governmental agencies. Thirteen state agencies received over 44,000 hours of services at a minimum wage value of $147,000. The Foster Grandparent Program hires senior citizens ages 60 and over, who work for four hours a day, 20 hours per week and are paid an hourly stipend of $2.20. The income is exempt and does not effect their benefits. Foster

grandparents receive a hot meal at their work site, transportation reimbursements and an annual physical. As of October 1988, there were 90 foster grandparents, providing over 93,000 hours of services annually.

Domestic Violence Program

The Division of Mental Health and Mental Retardation serves as the responsible agency for administering the funds for Aid to Victims of Domestic Violence Program. Revenue for the program is provided by $7 marriage license surcharge. This surcharge is deposited in the State Treasury by all counties. The Division of Mental Health and Mental Retardation is charged with the responsibility of awarding grants from the account for the Aid of Victims of Domestic Violence, assuring compliance with rules and regulations in NRS, quarterly monitoring a program effectiveness and financial status, and providing biennial reports. In fiscal year 1987, $567,704 was collected. The 1987 Session of the Nevada Legislature raised the surcharge from $5 to $7 and it is anticipated that the division will collect $822,825 in fiscal year 1988 and approximately $830,000 in fiscal year 1989. The allocation of funds for fiscal year 1989 from the Division of Mental Health and Mental Retardation is detailed in Appendix D.

IV. MEDICAL AND HEALTH SERVICES SURVEY

At the request of the A.C.R. 59 Subcommittee, the Department of Personnel was asked to conduct a selected medical and health services survey indicating where the State of Nevada ranks in reference to salary and fringe benefits. The survey also asked for what additional options may be considered to assist in the recruitment efforts of selected classes.

The Department of Personnel has had great difficulty in recruiting certain classes as displayed in Exhibit No. 7. The Department of Personnel conducted a national survey of state governments to obtain salary information for classes involved with medical and health services. The department also included a survey questionnaire for psychiatrists and psychiatric registered nurses regarding pay practices, benefits and recruiting practices. That data is also presented in Appendix E. The salary comparison for the senior psychiatrist, range C, which is the board certified psychiatrist indicates that the weighted average of all responding states has a average monthly salary of $6,889. Nevada's comparison to that is $6,300 which places the state below the average salary of 6,503. The salary comparisons for psychiatric social worker II, shows Nevada salary level is higher than the minimum salary comparisons, the maximum salary and the average salary. The comparisons for the psychologist V position shows Nevada being below both the minimum average and the maximum average salary of other states. The salary comparisons for psychiatric nurses shows Nevada being below the weighted national average at both the minimum and maximum salary levels. The comparative data shows Nevada's payment level at $1,715 versus a weighted average of $1,802. The maximum level of Nevada's payment is at $2,311 versus $2,401.

The A.C.R. 59 Subcommittee felt there may be other reasons in addition to salary concerns for the difficulty in recruiting psychiatrists in Nevada. The Department of Personnel had 13 questions in their questionnaire and a summary of those is as follows:

In reference to the payment of malpractice insurance - 27 states responded. The majority of those states indicated that the psychiatrists are covered by the states self-insurance program as is Nevada.

In reference to psychiatrists being allowed to have a private practice on the side - 36 states responded. The majority indicated that psychiatrists are allowed to have a private practice which is similar to the State of Nevada.

The responses in reference to providing reimbursements of costs of continuing education varied among the states. This was an area that the A.C.R. 59 Subcommittee felt that Nevada could significantly improve the attractiveness of the staff psychiatrist positions in Nevada. Funding for training for psychiatrists and most other professional positions within the Division of Mental Health and Mental Retardation has been limited.

In reference to offering sabbaticals to psychiatrists, 11 states reported a policy of providing sabbaticals for psychiatrists.

In reference to offering cash bonuses to employees who recruit psychiatrists, there were no affirmative answers.

In reference to offering new recruits a cash bonus for completing a given period of time, only two states responded. Both states indicated that it was a negotiable provision.

In reference to offering a pay differential by geographic location, eight states reported a pay differential for psychiatrists. However, only North Carolina indicated a set amount with ten percent for the eastern or western part of the state. It should be noted that recruiting psychiatrists in certain parts of Nevada has been difficult. Providing psychiatric coverage for rural Nevada has been through contract arrangement with psychiatrists traveling from the major metropolitan areas to rural Nevada on a regular basis.

The Department of Personnel also explored what other states are utilizing in their recruitment efforts for psychiatrists with most states indicating the majority were advertising through professional journals, newspapers, etc. Nevada has discussed the possibility of utilizing professional recruiting services and seven states responded that they have used such service with quoted prices being $5,900 - $20,000 per placement. Only two states reported placements in the survey.

In reference to possible direct mail of recruitment information to psychiatrists, ten states indicated that they utilize the direct mail format with four states reporting that it was a cost-effective measure.

Exhibit No. 7

MH/MR
PSYCHIATRIST AND NURSE
VACANCY REPORT

TITLE OF POSITION	AREA	# FILLED	# VACANT	TOTAL
MEDICAL DIRECTOR	South	1	0	1
	North	1	0	1
	TOTAL:	2	0	2
SENIOR PSYCHIATRIST	South	3	6	9
	North	6	1	7
	Rural	0	1	1*
	TOTAL:	9	8	17
DIRECTOR OF NURSING	South	1	0	1
	North	1	0	1
	TOTAL:	2	0	2
PSYCH. NURSE III	South	5	0	5
	North	5	0	5
	TOTAL:	10	0	10
PSYCH. NURSE II	South	16	4	20
	North	14	1	15
	TOTAL:	30	5	35
PSYCH. NURSE I	South	16	5	21
	North	15	2	17
	Rural	1	0	1
	TOTAL:	32	7	39

* Agency does not wish to fill - contracted out due to extensive travel

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Responses to Psychiatric Nursing Survey Questionnaire

The Department of Personnel also requested that states fill out a survey questionnaire in reference to salary and recruitment efforts for psychiatric nurses. The details of that survey are attached as part of Appendix E. In reference to whether the state's reimburse costs for continuing education, 34 states reported a policy of reimbursing for continuing education. Nevada has reimbursed for some costs in the past, however, the expenditures for education of professionals and para-professionals within the Division of Mental Health and Mental Retardation has been very limited. Only the State of Connecticut reported a policy of paying for licensing fees for nurses. In reference to recruiting efforts of providing cash bonuses to employees who recruit another nurse, no states indicated positively in response to that. However, four states did report offering a cash bonus to new nurses for completion of a given period of service. In reference to whether nurses are hired at an accelerated rate, contingent on experience and/or education, 31 states responded in a positive manner. The State of Nevada has for a number of years brought in all nurses at an accelerated rate within the Division of Mental Health and Mental Retardation. The Department of Personnel also asked whether a shift differential for nurses was different from other employees, 22 states indicated that they provide a shift differential that is different than other employees. Of those reporting a fixed amount, an average of .75¢ is paid for the second shift and .83¢ for the third shift.

V. FINDINGS AND RECOMMENDATIONS

The A.C.R. 59 Subcommittee received considerable input from concerned individuals and groups regarding the operation of the Division of Mental Health and Mental Retardation. The subcommittee felt the division was performing an admirable task under sometimes very adverse conditions and many times with a lack of sufficient manpower and resources. Almost every agency within the division was experiencing waiting lists for services. The inpatient facilities of the divisions have had critical evaluations from both state and federal surveyors. At a number of times during the past biennium, the division has had to approach the Interim Finance Committee for additional staff and resources due to threat of the loss of license or certification.

The Division of Mental Health and Mental Retardation has been suffering from a lack of long-term planning and with the expanding population of the State of Nevada (see Exhibit No. 8) has been operating in almost a crisis management mode. The inpatient facilities are operating at capacity and most of the day treatment and outpatient programs are also at capacity with long waiting lists for services. At the request of the A.C.R. 59

Subcommittee, the Division of Mental Health and Mental Retardation did a projection of future needs through fiscal year 1995 and attempted to indicate what their ideal staffing would be to meet deficiencies, expanding demand for services and anticipated costs (please see Exhibit No. 9). Due to the length of that report, it will not appear in entirety as part of this subcommittee report. However, it is available at the Fiscal Analysis Division for any parties that may wish to review it.

Preliminary Nevada Population Forecasts
By County
1980 through 2010

County	1980[a]	1985[b]	1990	1995	2000	2005	2010
Carson City	32,022	35,400	39,962	45,514	51,123	56,940	63,031
Churchill	13,917	15,450	17,095	18,477	20,624	22,864	25,215
Clark	463,087	572,140	715,377	879,878	1,069,430	1,290,330	1,548,770
Douglas	19,421	23,200	30,071	37,096	45,277	54,858	66,140
Elko	17,269	22,850	26,290	29,323	33,293	37,522	42,052
Esmeralda	777	1,380	1,410	1,425	1,472	1,515	1,555
Eureka	1,198	1,450	1,780	1,972	2,420	2,936	3,541
Humboldt	9,449	11,880	14,038	14,876	15,750	16,609	17,451
Lander	4,076	4,500	4,981	5,230	5,469	5,704	5,929
Lincoln	3,732	4,200	4,031	4,179	4,312	4,438	4,557
Lyon	13,594	17,050	19,636	21,863	24,723	27,768	31,027
Mineral	6,217	6,030	5,443	4,856	4,499	4,216	4,000
Nye	9,048	14,850	17,519	23,186	28,439	34,623	41,944
Pershing	3,408	3,610	3,968	4,023	4,053	4,082	4,107
Storey	1,503	1,780	2,052	2,376	2,723	3,097	3,502
Washoe	193,623	224,420	264,398	311,227	364,171	423,009	488,567
White Pine	8,167	7,560	8,727	8,733	8,709	8,687	8,668
Statewide	800,508	967,750	1,176,778	1,414,234	1,686,487	1,999,198	2,360,056

a) Department of Commerce, U.S. Bureau of the Census, April 1, 1980.
b) 1985 numbers represent the State of Nevada's revised population estimates for July 1985.

SOURCE: University of Nevada-Reno, Bureau of Business and Economic Research in cooperation with the Governor's Office of Community Services.

Exhibit 9

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
SUMMARY OF PROJECTED NEED BY AGENCY:

MENTAL HEALTH ADULT:

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY95
NMHI	Geriatrics/Inpatient:	Beds	19.11		21.48	22.83	24.87
3162		Cost	$1,006,838		$1,068,746	$1,136,340	$1,237,732
	Halfway/Residential:	Beds	32.75		34.76	36.96	40.26
		Cost	$537,776		$592,072	$629,519	$685,688
	Gen. Psych./Inpatient:	Beds	80.00	87.41	92.78	98.65	107.45
		Cost	$4,021,586	$4,152,148	$4,407,453	$4,767,302	$5,388,805
	Transitional/Residential:	Beds	26.00		83.00	140.00	236.60
		Cost	$85,800		$217,320	$270,700	$457,483
	Recreational Therapy:	Staff	3.00	13.94	15.00	15.74	16.94
	(serves inpat.&commun.)	Cost	$108,625	$540,174	$581,527	$609,957	$656,479
	Occupational Therapy:	Staff	3.50	6.84	7.38	7.78	8.46
	(serves inpat.&commun.)	Cost	$136,014	$258,339	$278,082	$293,671	$318,814
	Outpatient Services:	Staff	7.00		7.53	8.06	8.86
		Cost	$428,640		$461,099	$464,425	$482,333
	Daytreatment Services:	Staff	2.00	6.43	6.92	7.41	8.15
		Cost	$71,170	$230,810	$248,288	$265,879	$292,264
	Casemanagement Services:	Staff	10.00		10.42	11.09	12.09
		Cost	$352,468		$367,334	$391,217	$427,042
	Medical Services:	Staff	1.50		3.02	3.24	3.56
		Cost	$45,512		$72,095	$77,202	$84,864
		TOTAL:	$6,814,429	$7,658,505	$8,294,016	$8,906,212	$10,031,504
	FY 88 ADDITIONAL NEED:			$844,076			

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY95
SNAMHS	Gen. Psych./Inpatient:	Beds	70.00	97.05	105.19	114.87	129.38
(3161)		Cost	$3,593,477	$4,157,073	$4,724,797	$5,159,381	$5,811,264
	Transitional/Residential:	Beds	189.81	219.20	227.92	248.89	280.33
		Cost	$1,317,107	$1,664,913	$1,729,693	$1,888,789	$2,127,436
	Casemanagement Services:	Staff	17.50	21.77	23.51	25.58	28.69
		Cost	$617,705	$768,712	$829,359	$901,421	$1,009,516
	Jail & Homeless Services:	Staff	4.00		4.00	4.00	4.00
		Cost	$139,300		$139,300	$139,300	$139,300
	Daytreatment Services:	Staff	14.00		14.09	15.39	17.33
		Cost	$487,373		$489,024	$534,004	$601,475
	Vocational Services:	Staff	3.00		3.25	3.55	4.00
		Cost	$90,449		$98,038	$107,056	$120,582
	Crisis Unit:	Staff	10.50		11.65	12.38	13.88
		Cost	$417,815		$464,813	$493,404	$553,926
	Medical Services:	Staff	4.95	8.25	9.34	10.20	11.49
		Cost	$422,564	$611,016	$663,085	$718,627	$799,019
	Outpatient Services:	Staff	22.00		24.91	27.20	30.64
		Cost	$898,742		$1,022,132	$1,116,147	$1,257,171
		TOTAL:	$7,984,532	$9,235,393	$10,160,241	$11,058,129	$12,419,689
[Page 1]	FY 88 ADDITIONAL NEED:			$1,250,861			

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
SUMMARY OF PROJECTED NEED BY AGENCY:

MENTAL HEALTH ADULT:

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY95
LAKES	Inpatient/Forensic:	Beds	29.00	34.86	37.49	40.51	45.05
(3645)		Cost	$1,781,787	$2,105,404	$2,263,855	$2,446,579	$2,720,667
	FY 88 ADDITIONAL NEED:			$323,617			
AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY95
RURAL CLINICS	Community:	staff	79.00		83.59	87.41	93.52
(3648)		cost	$3,682,612		$3,892,911	$4,068,160	$4,348,559
	MENTAL HEALTH ADULT TOTAL:		$20,263,360	$22,681,914	$24,611,023	$26,479,081	$29,520,419
	FY 88 ADDITIONAL NEED:			$2,418,554			

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DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
SUMMARY OF PROJECTED NEED BY AGENCY:

MENTAL HEALTH YOUTH:

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY9
	On-Campus/Residential:	beds	16.00		16.69	17.77	19.3
NNCAS		cost	$440,154		$496,963	$526,848	$569,68
(3281)							
	Comm. Treatment Homes:	beds	10.00	38.20	41.36	43.72	47.11
		cost	$257,531	$863,420	$932,555	$984,406	$1,058,72
	Adoles. Treatment Center:	beds	17.39	33.82	37.03	39.44	42.9
		cost	$826,410	$1,557,016	$1,699,913	$1,807,086	$1,960,70
	Desert Hills - Sexual Off	beds	5.00	9.92	10.52	11.20	12.1
		cost	$123,454	$213,754	$226,015	$240,162	$260,44
	Outpatient Services:	Staff	7.40		8.87	9.51	10.4
		cost	$332,456		$398,474	$427,152	$469,41
	Preschool Services:	Staff	1.84	1.92	2.06	2.21	2.4
		cost	$94,388	$98,362	$105,559	$113,157	$124,35
		TOTAL:	$2,074,393	$3,505,162	$3,859,479	$4,098,812	$4,443,31
	FY 88 ADDITIONAL NEED:			$1,430,769			

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY9
SNCAMHS	Inpatient Hospital:	Beds	14.00		12.11	13.22	14.8
(3646)		Cost	$577,381		$740,246	$808,333	$910,46
	Comm. Treatment Homes:	Beds	29.25	33.95	38.43	41.96	47.2
		Cost	$546,855	$686,661	$718,498	$784,586	$883,71
	On-Campus/Residential:	Beds	36.00	38.43	43.50	47.50	53.5
		Cost	$737,475	$830,432	$939,988	$1,026,447	$1,156,13
	Family Outreach/Counsel.:	Staff	5.00		5.66	6.18	6.9
		Cost	$168,135		$190,216	$207,774	$334,08
	Family Outreach/Daytreat:	Staff	2.00		2.90	3.17	3.5
		Cost	$61,124		$88,792	$96,861	$109,09
	Outpatient Services:	Staff	18.00		20.38	22.25	25.0
		Cost	$660,141		$747,325	$816,064	$919,17
	Early Intervention/Couns:	Staff	5.50	6.19	7.38	8.06	9.0
		Cost	$186,135	$227,112	$249,926	$272,914	$307,39
	Early Intervention/Daytr:	Staff	7.50		8.13	8.88	10.0
		Cost	$197,817		$214,415	$234,137	$263,71
		TOTAL:	$3,135,063	$3,408,803	$3,889,406	$4,247,116	$4,883,78
	FY 88 ADDITIONAL NEED:			$273,740			

MENTAL HEALTH YOUTH TOTAL:	$5,209,456	$6,913,965	$7,748,885	$8,345,927	$9,327,10
FY 88 ADDITIONAL NEED:		$1,704,509			

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DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
SUMMARY OF PROJECTED NEED BY AGENCY:

MENTAL RETARDATION:

AGENCY:	PROGRAM:		(actual) FY88	(need) FY88	FY90	FY92	FY95
NNMRS (3280)	ICF_MR/Residential:	Placements	81.57	97.07	106.21	113.13	123.03
		Cost	$4,515,861	$5,879,338	$6,314,667	$6,713,698	$7,285,642
	Comm Casemanagement:	Staff	10.50	11.53	13.62	15.62	18.61
		Cost	$402,498	$439,121	$517,225	$591,611	$703,189
		TOTAL:	$4,918,359	$6,318,459	$6,831,892	$7,305,309	$7,988,831
	FY 88 ADDITIONAL NEED:			$1,400,100			
SNMRS (3279)	ICF_MR/Residential:	Placements	92.24	106.82	120.85	132.00	148.74
		Cost	$4,713,031	$5,898,480	$6,652,948	$7,252,886	$8,152,794
	Comm Casemanagement:	Staff	11.50	17.13	18.47	20.09	22.50
		Cost	$503,231	$757,832	$758,856	$823,133	$919,549
		TOTAL:	$5,216,262	$6,656,312	$7,411,804	$8,076,019	$9,072,343
	FY 88 ADDITIONAL NEED:			$1,440,050			
RNMRS (3160)	Comm Casemanagement:	Staff	4.88	7.25	6.98	7.33	7.90
		Cost	$174,544	$282,549	$302,081	$314,471	$334,296
	FY 88 ADDITIONAL NEED:			$108,005			
RPF (3167)	RPF/Residential:	Placements	204.08	243.17	284.79	307.77	342.13
		Cost	$1,483,349	$1,767,474	$2,069,967	$2,237,041	$2,486,774
	Comm Habil/Resid:	Placements	62.28		72.94	78.83	87.63
		Cost	$886,522		$1,038,245	$1,122,046	$1,247,305
		TOTAL:	$2,369,871	$2,653,996	$3,108,212	$3,359,087	$3,734,079
	FY 88 ADDITIONAL NEED:			$284,124			
CTC (3160)		Days	131,109		141,056	152,441	169,459
		Cost	$2,075,523		$2,230,080	$2,406,978	$2,671,393
	MENTAL RETARDATION TOTAL:		$14,754,559	$17,986,839	$19,884,069	$21,461,865	$23,800,942
	FY 88 ADDITIONAL NEED:			$3,232,280			
	GRAND TOTAL:		$40,227,375	$47,582,719	$52,243,977	$56,286,872	$62,648,466

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The subcommittee has a total of 28 recommendations.

The subcommittee recommends:

1. Create a legislative committee on mental health and mental retardation (as a subcommittee of the Interim Finance Committee), consisting of five members, to provide ongoing legislative oversight in reviewing and evaluating the quality and effectiveness of programs provided for mentally ill and mentally retarded persons in the state.

   The subcommittee felt there is a need for a knowledgeable ongoing group of legislators who could devote sufficient time to examine the operation of the division because of the number of legislative studies done in the past, the additional legislative hearings during the session and growing complexity of programs. The subcommittee could provide some consistent liaison and oversight from the Legislature of the many problems which exist within the division. The subcommittee felt there was a strong need for legislative review of the operations of the division. Consequently, the subcommittee recommends that a five-member committee be formed as a subcommittee of the Interim Finance Committee. The subcommittee will provide that necessary review and evaluation of the quality and effectiveness of the programs.

2. Create a medical and professional advisory committee, consisting of nine members employed by the Division of Mental Health and Mental Retardation, to advise the division on matters relating to staff levels, budgets and treatment standards. Require the medical advisory committee to submit quarterly reports to the legislative committee concerning its findings.

   A number of medical and other professionals came forward and testified before the A.C.R. 59 Subcommittee concerning problems which exist within the operation of the Division of Mental Health and Mental Retardation. Specifically, a number of the concerns had to do with the lack of medical and other professional input into the decision making process of the division and very little medical input into the development and submittal of the biennial budget of the division. Medical staff which appeared before the subcommittee came from the University School of Medicine, psychiatrists in private practice, current psychiatrists employed by the division and finally, former psychiatrists employed by the division. Dr. Norton Roitman, former medical director of the Nevada Mental Health Institute, submitted a detailed plan to the subcommittee indicating some of his concerns and problems faced by physicians in

trying to deal with and manage the mentally ill clients served by the division. Dr. Roitman's summary report is attached in Appendix F.

In addition, Grant Miller, M.D., past president of the Nevada Association of Psychiatric Physicians testified on a number occasions before the A.C.R. 59 Subcommittee and presented a site visit report done at the Nevada Mental Health Institute in Reno and the Las Vegas Mental Health Center. The site visit was conducted by three psychiatrists at the direction of the Nevada Association of Psychiatric Physicians. Their report is attached as Appendix G. The report pointed out severe problems which existed within those two adult inpatient facilities during their site visits of April 1987.

The Division of Mental Health and Mental Retardation does not have a medical director or psychiatrist at the division level and the subcommittee felt strongly that there needed to be an increase of medical input into the decision making process of the division. The makeup of the medical advisory committee would include psychiatrists, psychologists, and nurses representing both the northern and southern parts of the state.

3. That the Division of Mental Health and Mental Retardation add a training officer to the division's Central Office to plan, coordinate and implement training for all professional and paraprofessional staff within the division.

4. The subcommittee found that training throughout the Division of Mental Health and Mental Retardation is greatly deficient and funding for training should be significantly increased.

5. The Division of Mental Health and Mental Retardation should present a plan to the Legislature to begin requiring certification of all mental health technicians, mental retardation technicians and forensic technicians employed by the division, to be carried out in cooperation with the University of Nevada System. Further require that formal training of technicians begin by July 1, 1991.

6. That the Division of Mental Health and Mental Retardation submit to the legislative committee a plan to provide training for nurses employed by the division in order to satisfy their requirements for continuing education. The Division of Mental Health and Mental Retardation continues to experience problems with recruitment and retention of nurses and it is felt this will be an important benefit in assisting those recruitment efforts.

Recommendations No. 3 through No. 6 deal with one of the most important and critical areas examined by the A.C.R. 59 Subcommittee, that being lack of orientation and training of division personnel. The subcommittee felt that training reflects recognition that staff skills in a large measure determine the quality of client care and that training resources in recent years have been deficient. Exhibit No. 10 summarizes training expenditures and personnel assigned to training and orientation for each division agency. The specific types of training types of training supported by the Regional Training budgets and training funds allocated to the two mental retardation facilities are detailed in a report which is available within the Fiscal Analysis Division of the Legislative Counsel Bureau. Due to the length of that report, it was not possible to enclose within the body of the A.C.R. Subcommittee report.

Replace this page with Exhibit No. 10 which summarizes Training Needs here.

The area where the subcommittee had some of its greatest concern was the orientation and training of mental health and mental retardation technicians. The subcommittee discussed that technicians require three basic types of training. The first is intensive to their direct care responsibilities, client rights, and fire and safety issues prior to beginning work in units. This orientation is primarily provided by supervising nurses and other qualified personnel. The second type consists of specialized direct care training of a recurrent nature in such topics as behavior management, CPR and management of assaultive clients. The third type is training necessary to promote the technician within the series.

The subcommittee felt that ongoing training could best be addressed by a combination of inservice training provided by division personnel and by on campus instruction provided by local community colleges under interagency agreements. A recourse to the community colleges would be to permit bringing in consultants, if necessary, in the short-term to develop the requisite expertise among faculty in the long-term. Following this course would gradually equip the community colleges to offer associate of arts degrees (AA) sequences. The AA degree qualifies graduates for employment in the division programs at the technician III level and creates a course of instruction parallel to that being proposed by the Nursing Board for nursing assistants.

The subcommittee feels strongly that the training of technicians is an area which should be explored and supported by the 1989 Legislative Session. It is important to help insure ongoing consistent training of all technicians since those are the staff members spending the greatest amount of time interacting and providing assistance to the clients.

The forensic specialists employed at the Lake's Crossing Facility in Washoe County and the possible new Lake's Crossing Facility to be located in Southern Nevada have somewhat different training needs than other technicians. There orientation and inservice training leading to promotion is handled by personnel at that facility. These technicians require additional formalized training such as Police Officers Standards and Training (POST) security training offered in Carson City. In addition to the POST training, it is felt that including the forensic specialists formalized course of instruction through the community colleges would provide a greater level of expertise to those staff members.

The division employs a number of psychologists, social workers and nurses who have additional training needs. The

demand for continuing education, which is necessary to maintain state licensure, which requires approximately 15 units per year per discipline. It is felt that division training opportunities and partial fulfillment of these requirements can be provided most economically under interagency agreements with professional schools at UNR and UNLV.

The subcommittee felt that it is important that training of professionals be provided in new treatment methodologies. The subcommittee discussed that many states have proven that deflecting adult mental health clients from inpatient care through mobile crisis and crisis residential services reduces immediate and later demand for hospitalization. A combination of appropriate housing, medication and management and other services can greatly assist the clients in need of service of psychiatrists. The State of Nevada is experiencing great difficulty recruiting psychiatrists to work within its agencies not only at the Division of Mental Health and Mental Retardation but also within the prison system. The subcommittee requested that the Department of Personnel continue to study in conjunction with the Division of Mental Health and Mental Retardation the training practices of other states and present a more comprehensive ongoing training package to meet the needs of psychiatrist. It is felt that psychiatrists should receive sufficient days of administrative leave and reimbursement of reasonable costs annually to attend training sessions and conferences.

The subcommittee felt that a number of agencies were doing an admirable job of providing orientation and training while some agencies were having great difficulty providing the necessary training to all staff employed within their agencies. In order to provide some consistency in training and to insure that all personnel employed by the division receive adequate orientation and ongoing training, the subcommittee strongly recommends that a training officer be employed by the Division of Mental Health and Mental Retardation. In addition to other duties, it is felt that this would be a key position within the division to coordinate and insure development of a comprehensive training package through the community college system.

The subcommittee also felt that additional providers of service to division clients such as community training centers, private residential facilities, foster care parents, etc., also be given consideration in training classes to be offered. Many of these groups and agencies provide a great deal of ongoing care and treatment of division clients and it is felt that the training officer could help facilitate training to those important facilities.

Due to the great difficulty in recruiting and retaining registered nurses, that consideration be given to paying or providing for the required training nurses must take every two years to satisfy their requirement for continuing education units. Currently, the Board of Nurses requires 30 direct contact hours of training of all licensed nurses every two years on the nurse's birthday. The subcommittee felt that nurses must be an important part of the training plan to be presented to the legislative oversight subcommittee and that the subcommittee would want to review the division's training plan on an annual basis.

7. That the Division of Mental Health and Mental Retardation be required to submit to the legislative committee proposed ratios of staff members to in-patients, out-patients and other persons for whom services are provided or paid for by the division. This will begin to ensure that budget requests are based on a treatment oriented standard of care. It was observed that treatment should be appropriate to the needs of the individual client served because of those differentiations in mental retardation and mental health. Different types of clients require different services and levels of care.

   The 1987 Session of the Nevada Legislature began working closely with the Division of Mental Health and Mental Retardation in trying to develop suitable staffing ratios to insure consistent quality treatment throughout the division agencies. The division was only able to begin work on some residential ratios which have yet to be completed and have just begun work on other types of services provided including outpatient, day treatment, case management, etc. The subcommittee felt that since many of the services being provided by the division have waiting lists and are ordered to better assist in evaluating workloads of the various agencies and their service elements, suitable ratios should be developed and recommended as part of the budget process.

8. The Division of Mental Health and Mental Retardation has many programs and elements of those programs operating at or near capacity and that the division submit, as part of their budget request for the 1989 Legislative Session, a plan to eliminate all waiting lists by the end of that budget process.

   The subcommittee felt that those individuals in need of psychiatric services should not have to be put on a waiting list for an inordinate period of time and it should be the goal of the division to eliminate waiting lists and provide the necessary treatment to individuals seeking service.

9. That staffing of the Division of Mental Health and Mental Retardation's residential facilities should be sufficient to reduce overtime and to prevent back-to-back shifts being required of direct care staff.

In testimony before the A.C.R. 59 Subcommittee, it was brought out that a number of technicians and nurses are required to staff back-to-back shifts with no breaks in between. The reasons for this varied from vacations, sick leave, to insufficient staffing within that residential facility. The subcommittee felt that staffing should be sufficient to reduce overtime and to prevent back-to-back shifts being required of direct care staff. The subcommittee felt that this could be addressed as part of the budgets submitted to the 1989 Legislative Session. It was recognized that an emergency situation will sometime exist which would require a back-to-back shift being worked but normal staffing should be sufficient that this was not necessary on an ongoing basis.

10. Appropriate money from the state general fund to the University of Nevada Medical School for the establishment of a residency training program for psychiatrists in the State of Nevada.

Appropriate money from the state general fund to the University of Nevada Medical School for the establishment of a residency training program for psychiatrists in the State of Nevada. Dr. Robert M. Daugherty, the Dean of the University of Nevada School of Medicine, testified before the A.C.R. 59 Subcommittee in reference to the critical need for psychiatrists in the State of Nevada and the possibility of establishing a residency training program within the state. Dr. Daugherty indicated that a residency training program would be an assistance with psychiatric recruitment and would have a great impact on the patient care of division facilities. Dr. Daugherty's proposal to the subcommittee is attached as Appendix H. The anticipated cost of establishing that training program during the 1989-91 biennium is $950,000. The largest part of that expenditure would be for the renovation of Building No. 6 at the Nevada Mental Health Institute which the Public Works Board estimates would cost $561,881 to renovate to provide a suitable location on the institute campus for the housing of the program. The additional $338,119 would go to the University of Nevada School of Medicine for the hiring of a residency training director in fiscal year 1989 and plus the addition of a second psychiatrist in fiscal year 1991. Additionally, anticipated expenses include malpractice insurance and some operating expenditures. The program as outlined by Dr. Daugherty would provide a four-year residency program in psychiatry with four students through

each year of the program. It is anticipated that during the first two years that the students will receive a residency training program in Northern Nevada. However, by the third and fourth year, it is anticipated that some of the students would be transferred to Las Vegas to receive additional residency training.

11. That the requirements for psychiatric certification for psychiatrists employed by the Division of Mental Health and Mental Retardation, which currently mandates board certification after three years, be extended to five years. The subcommittee also recommended that the statute be changed to allow the division to hire range B (board eligible) psychiatrists subject to approval of Interim Finance Committee.

The Division of Mental Health and Mental Retardation is having severe problems recruiting sufficient numbers of psychiatrists to fill vacant positions throughout the state. There was considerable discussion of the current requirement of requiring board certification of psychiatrists employed by the division and the possible relaxing of that requirement. In testimony before the A.C.R 59 Subcommittee, it was pointed out that only one-third of psychiatrists employed in the United States are certified. Approximately 50 percent of those who took the certification examination the first time, failed. With a limited number of psychiatrists from which to recruit and the additional requirement in the State of Nevada that a psychiatrist not only be licensed but be board certified, the A.C.R 59 Subcommittee felt that the requirement of achieving certification within three years after employment by the division, may need to be modified to five years in order to provide some additional flexibility in recruiting efforts in this hard-to-recruit classification. In addition, if a severe shortage continued to exist, an exception to the certification requirement could be evaluated on a case by case basis, as presented by the Division of Mental Health and Mental Retardation to the Interim Finance Committee. It should be pointed out that the Department of Prisons also employs psychiatrists and the requirements for that department allow them to recruit board eligible psychiatrists, in addition to board certified psychiatrists.

12. That inpatient facilities of the Division of Mental Health and Mental Retardation meet appropriate licensing and accreditation standards by July 1992.

For a number of years, in particular during the past biennium, the Division of Mental Health and Mental Retardation has received a number of critical evaluations from both state and federal surveyors. The division has had

to approach the Interim Finance Committee several times during the past biennium for additional staff and resources due to the threat of loss of licensure or certification. The A.C.R. 59 Subcommittee felt that all inpatient facilities operated by the Division of Mental Health and Mental Retardation should meet established licensing and/or accreditation standards. In order to establish a reasonable time line for the division to achieve this goal, the subcommittee further stated that the division should meet these established licensing and accreditation standards no later than July of 1992.

13. Require the Mental Health and Mental Retardation Division of the Department of Human Resources to adopt by regulation policies and procedures for defining and reporting abuse and neglect of clients of the division and to further clarify the definition of abuse and neglect.

A number of individuals testified before the A.C.R. 59 Subcommittee concerning significant problems created as a result legislation enacted by the 1987 Session of the Nevada Legislature concerning required reporting of abuse and neglect cases. The subcommittee felt that a major problem was confusion within the Division of Mental Health and Mental Retardation what constituted abuse and neglect and what written procedures there were on reporting of abuse and neglect cases. The subcommittee felt that the division should have clear policies and procedures guiding staff on the reporting of abuse and neglect cases. It was felt that more specific regulations that the agencies can follow, should help to minimize problems brought about by the changes in the reporting of abuse and neglect cases.

14. Prohibit a state agency from taking any retaliatory disciplinary action against an employee of that agency on the grounds that the employee testified or submitted a complaint against the agency.

This type of legislation is commonly known as a "whistle blower" law.

15. That the Division of Mental Health and Mental Retardation begin planning for at least a 20-bed facility to be located in Clark County to house youthful offenders with severe emotional and mental health problems.

The A.C.R. 59 Subcommittee received considerable testimony from professionals working in the juvenile criminal justice system and from family members who have dependents who have mental health problems and who are also youthful offenders. Judge McGroarty and juvenile probation staff in Clark County indicated that there is a severe lack of appropriate bed

space in Clark County to deal with the youthful offender who has severe emotional and/or mental health problems. Sending the youthful offender to Elko where psychological and psychiatric assistance is limited proves to be a less than desirable option for the courts and juvenile probation officials. The subcommittee recognized the limitation on available beds for youthful offenders with mental health problems in Clark County and strongly recommends that planning begin for at least a 20-bed facility to be located in Clark County to serve this population.

16. Require the payment of overtime at the rate of time and one-half for all nurses employed by the State of Nevada (sunset after 4 years).

This legislation would be for a limited period of time, being four years. The chairman and members of the A.C.R. 59 Subcommittee received a number of complaints concerning the overtime pay practices of the State of Nevada in reference to registered nurses. Nurses that testified indicated that in private facilities they are paid at a rate of time and one-half regardless of their pay level and that in their capacity as registered psychiatric nurses working for the state, a number of employees who are a grade 32 and below are receiving a higher rate of pay than a supervising nurse at a grade 33 and above. Due to the problems of recruitment of nurses and the competitive nature of the marketplace not only in Clark County but throughout the nation, the A.C.R. 59 Subcommittee is recommending the classification of nurses employed by the State of Nevada be paid time and one-half for overtime regardless of their classification.

17. That consideration be given, as part of the budget process, for the hiring of more staff to lower the client/staff ratio in the community training centers. It was also identified that the staff/client ratios should be based upon the needs of the individual clients and should also include an increase in the request for payment levels.

The A.C.R. 59 Subcommittee felt that while the Division of Mental Health and Mental Retardation is developing staffing ratios for their agencies and programs, that the community training centers, which are a vital link in the services provided to mental retarded citizens in Nevada, not be overlooked in that process. The division should jointly with the community training centers examine the existing staffing ratios in those facilities and develop a reasonable staffing level to insure adequate training and treatment of those clients. The subcommittee also felt that the payment levels to the community training centers should be examined and reviewed as part of the budget process.

18. That the Division of Mental Health and Mental Retardation be required to develop a five-year plan and that plan be revised on an annual basis. The plan and its annual revisions should be presented to the proposed legislative oversight committee. The subcommittee also recognized that no staff at the division level are specifically assigned the duties to evaluate existing services and plans for future needs. Consequently, the subcommittee recommends that a planner be added as a member of the division staff.

The A.C.R. 59 Subcommittee felt that the division has consistently been behind in the planning adequate services to meet the expanding population base of the State of Nevada. The Mental Health and Mental Retardation Division is currently behind having sufficient staff in a number of areas to provide services to citizens requesting services. With the expected increase in the state population, this will only get worse and it is critical for the division to do an adequate job of planning for meeting future demands. For example, during the past biennium, the adult mental health inpatient facilities have been at capacity and this has created a tremendous hardship on clients, staff and families. It is felt that an addition of a planner at the division level, to examine not only existing programs and possible deficiencies in those programs but to start looking to the future and to develop a 5-year plan with annual revisions is the bare minimum the division should be doing to ensure their meeting demand for services.

19. The subcommittee recognized a gap in services for those clients who are diagnosed as both having need of mental health services as well as mental retardation services. The subcommittee supports the proposal for dual diagnosed units in Las Vegas and Reno and that those facilities be able to provide services to no less than 12 patients in Southern Nevada and 8 patients in Northern Nevada.

The A.C.R. 59 Subcommittee heard considerable testimony in reference to clients diagnosed as mentally retarded but also in need of extensive mental health services. Currently, dually-diagnosed clients are being inappropriately placed either in the mental retardation units or mental health units, both of which have readily testified that they are unable to provide proper treatment for these dual-diagnosed clients. Data presented by the Division of Mental Health and Mental Retardation indicated that having at least 12 beds in place in Southern Nevada and 8 beds in Northern Nevada would meet the needs of those dual-diagnosed clients for the near future.

20. The subcommittee supports the proposal for a 50-bed secure forensic facility to be constructed in Southern Nevada during the next biennium.

The Lake's Crossing Facility located in Washoe County is a 32-bed facility which can adequately handle 29 inpatients at any point in time. During the past biennium, that facility has been at or above capacity on an almost a continuous basis. Even with the expansion of six additional beds as approved by the 1987 Legislative Session, the Lake's Crossing Facility is unable to meet the growing demands for their specialized services. With well over 50 percent of the population of the state residing in Clark County and the location of Lake's Crossing in Washoe County, the facility has been unable to provide the appropriate level of services to the residents of Clark County as indicated by the population distribution. The Lake's Crossing Facility presented data which indicated one-third of their clients are coming from Clark County. With the rapid population growth in Clark County, the Division of Mental Health and Mental Retardation and the A.C.R. 59 Subcommittee feel that it is vital to have a secured forensic facility in Clark County to meet the needs of the courts and the citizens in the Southern Nevada.

21. The subcommittee identified a great need for residential group homes providing services to youths in rural Nevada. The subcommittee recommends that the Division of Mental Health and Mental Retardation, as part of their budget process, request funding for the establishment of rural group homes in Nevada.

The division has had considerable success in providing services to clients by utilizing group homes in Clark County and has recently begun developing group homes in Washoe County. However, one of the big gaps in services in rural Nevada, as testified to by the director of Rural Clinics, is the lack of rural group homes. By not having rural group homes, the rural clinics program many times has to place clients into homes in Reno or Las Vegas. Many of the placements are for children and the subcommittee felt that it would be most appropriate to provide services to those clients to be as close to their homes as possible. The subcommittee felt that the division could present this as part of their 1989 budget submittal to the next legislative session. The Division of Mental Health and Mental Retardation felt that there was critical need for having a number of small group homes in communities closer to the families of the children receiving services.

22. The subcommittee recommends that there should be in place sufficient respite care for those families providing services to the mentally retarded and emotionally disturbed.

The A.C.R. 59 Subcommittee received testimony that one of the best forms of treatment and most cost-efficient is to provide services to clients in the family's home or in a contract home. With the ongoing, 24-hour day, demand placed on the family by having a mentally retarded or emotionally disturbed client residing within the home, respite care provided by the division is of great importance to that family. Respite care provides a break for the family from providing ongoing 24-hour continuous service to the client and goes a long way to insuring a successful placement within the home setting and helps prevent numerous cases of institutionalization of clients.

23. The subcommittee recommends that the Division of Mental Health and Mental Retardation request funding for a personnel officer to be located at the division's central office. It was pointed out to the subcommittee that the division has one of the highest rates of grievances of any organization within state government and that they are operating without the services of a personnel officer. It was also pointed out that many of the positions within the division are specialized and recruitment is difficult and the addition of the personnel officer should assist with recruitment efforts in addition to providing assistance in handling grievances and terminations.

It was pointed out that many organizations of smaller size within state government have a personnel officer. The subcommittee felt that services of a personnel officer under the direction of the Department of Personnel would be of great assistance to the division in such specialized areas of recruitment for difficult and hard to recruit classifications of personnel. That personnel officer could provide training and assistance to supervisors and employees in the proper handling of grievances and possible disciplinary actions. The position of personnel officer would provide training to supervisors throughout the Division of Mental Health and Mental Retardation to insure that all supervisors know all proper personnel policies and procedures.

24. The subcommittee is recommending the services for the chronically mentally ill population be expanded. The subcommittee received considerable testimony that the services for the chronically mentally ill adult population have been lacking in the past and currently are insufficient to meet the needs of those individuals. Statistics presented by the Division of Mental Health and Mental

Retardation indicated that Nevada is providing approximately 15 beds per 100,000 population whereas the national average is 50 beds per 100,000 of population. A need was recognized for community based housing, such as intermediate halfway houses in both the southern and northern part of the state.

By not having these services in place, this creates a greater hardship on the various communities where the chronically mentally ill are residing. By not having community based housing such as intermediate halfway houses in both the north and south, there is a greater demand on the inpatient residential beds existing within the state system.

25. The subcommittee recommends that inpatient facilities of the Division of Mental Health and Mental Retardation, which are required to meet licensing or accreditation standards, should have sufficient level staff to insure that those functions such as quality assurance, utilization review, and infection control are met.

Both the Nevada Mental Health Institute and the Las Vegas Mental Health Center are licensed as psychiatric hospitals and as such, are required to carry on a number of functions performed by hospitals such as quality assurance, utilization review and infection control. By not having sufficient staff in place to provide those functions, it creates an additional hardship on the staff in place within those facilities. It is also difficult for the division to insure that these functions are being properly carried out. These are functions that should be in place and reviewed in all residential facilities by the division including services provided to the mentally retarded and children and youth.

26. The subcommittee recommends that the new inpatient adult psychiatric hospital in Las Vegas have sufficient pharmacy staff in order to insure this important element of treatment not be overlooked or postponed.

The 1987 Session of the Nevada Legislature was faced with insufficient inpatient beds in Clark County to meet the demands for services. Many clients were being transported from Southern Nevada to the Nevada Mental Health Institute in Reno, due to a limited bed capacity. The 1987 Session of the Legislature increased the number of psychiatric beds over and above that recommended by the Governor and included a place within the new psychiatric hospital for a pharmacy to provide services to all clients receiving services at the West Charleston Campus. Since pharmacy services is an important part of the treatment received by those clients, the subcommittee feels that there should be sufficient

pharmacy staff in place to insure that pharmacy services be an integral part of the treatment to all clients needing those services.

27. The subcommittee recommends that the budget for Southern Nevada Adult Mental Health Services include a program to serve the mentally ill geriatric population. It was pointed out to the subcommittee that the Nevada Mental Health Institute operates an 18-bed facility to serve the mentally ill geriatric population and that a similar program is not in place in Southern Nevada. With the expanding population in Southern Nevada and with the greater percentage of those individuals being at or approaching retirement age, it was felt that this important program element not be overlooked,

    The subcommittee felt that planning should begin immediately to insure that this population not be overlooked.

28. The subcommittee recommends that case management services needs to be involved with clients throughout their treatment. The staffing for case management services should be sufficient to guarantee all patients are tracked and appropriate services are provided in order to insure patients are moved to a least restrictive setting as soon as possible and stabilized in that setting as long as possible.

    Case management services is a key element of the treatment for clients served by the division. When they are insufficient, case managers to assist clients and insure that appropriate treatment is taking place, the end result may possibly be higher incidence of hospitalization of those clients in needs of services. Case management services not only insures that the client receives the proper treatment at the proper time but has proved to be of economic benefit to the system by insuring a client receives services before becoming a danger to themselves or others and require the more expensive hospitalization.

MHMR9/r

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Appendix A

Questionnaire

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710

DONALD A. RHODES, *Director*
(702) 885-5668

LEGISLATIVE COMMISSION (702) 885-562
LAWRENCE E. JACOBSEN, *Senator, Chairman*
Donald A. Rhodes, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 885
MARVIN M. SEDWAY, *Assemblyman, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

JOHN R. CROSSLEY, *Legislative Auditor* (702) 885-5622
ROBERT E. ERICKSON, *Research Director* (702) 885-5637
LORNE J. MALKIEWICH, *Legislative Counsel* (702) 885-56

January 4, 1988

MEMORANDUM

TO: ALL EMPLOYEES OF THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

FROM: Legislative Commission's Interim Study Committee on the Division of Mental Health and Mental Retardation (A.C.R. 59)

SUBJECT: Questionnaire

The Legislative Commission's Interim Study Committee on the Division of Mental Health and Mental Retardation (A.C.R. 59), established by the 1987 Legislature, is requesting your assistance. The subcommittee has interviewed a number of division employees, clients and concerned citizens about the operation of the division. It appears, based upon these interviews, that a number of the programs run by the division are operating at, or near capacity levels and some problems do exist. Since it is not possible for the committee members to talk individually with all division employees, it is requested that you take the time to share your thoughts about the operation of the division and what changes or additions you feel are needed in order to better serve the clients.

A return envelope is provided to ensure confidentiality.

Legislative Commission's Interim Subcommittee to
Study the Mental Health and Mental Retardation
Division (A.C.R. 59)
Questionnaire

1. How would you rate the performance of your agency and would you recommend the services to friends or family?

   A. Excellent _____ Recommend Service
   B. Average _____ Yes _____
   C. Poor _____ No _____

   Comments:

2. What are the major problems you feel are facing your agency or the division.

3. What changes do you feel should be made in order to deal with those problems?

Agency name _____

Your name (optional) _____

Job Title _____

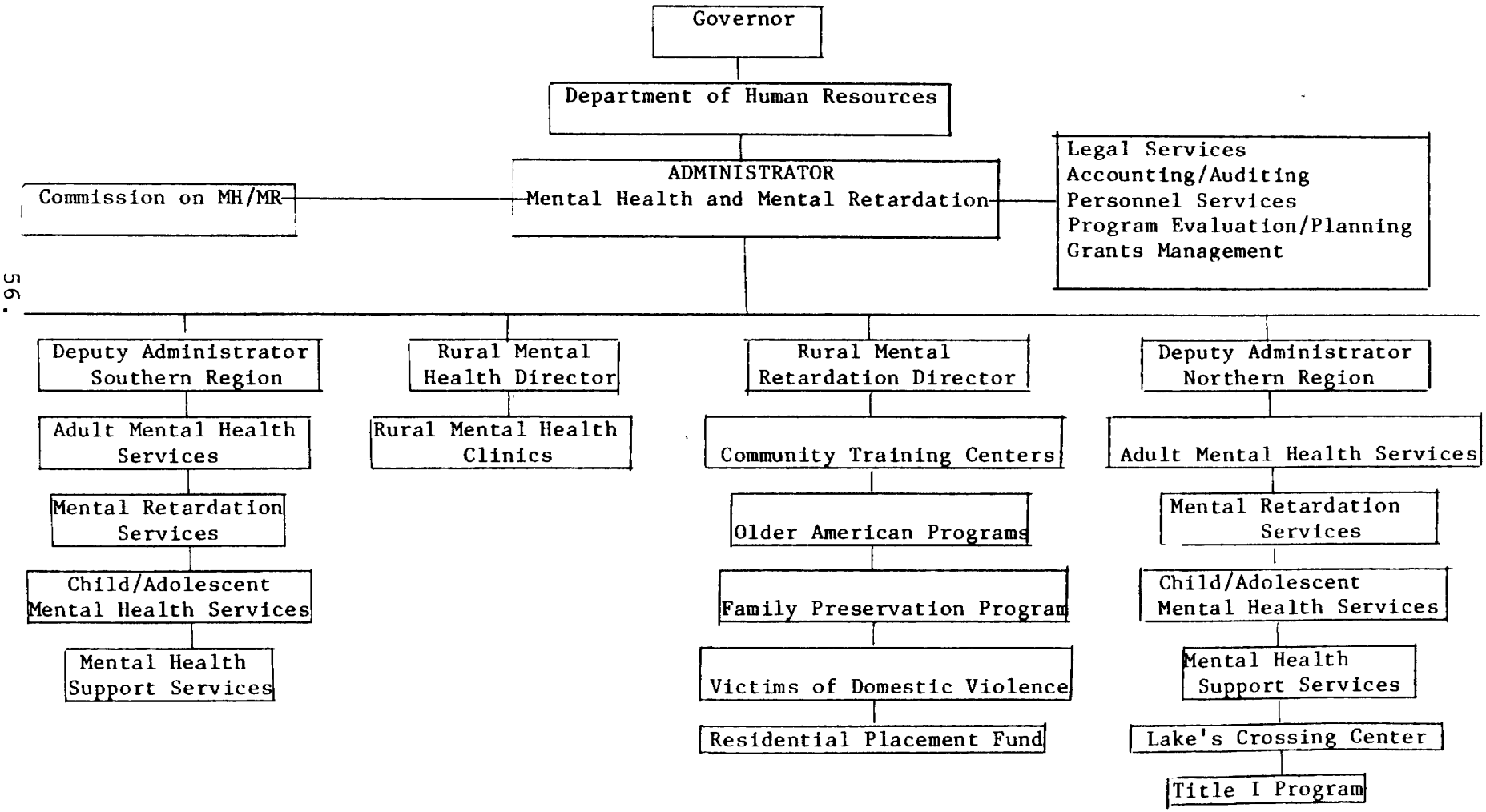
MHMR/q

Appendix B

Organizational Charts

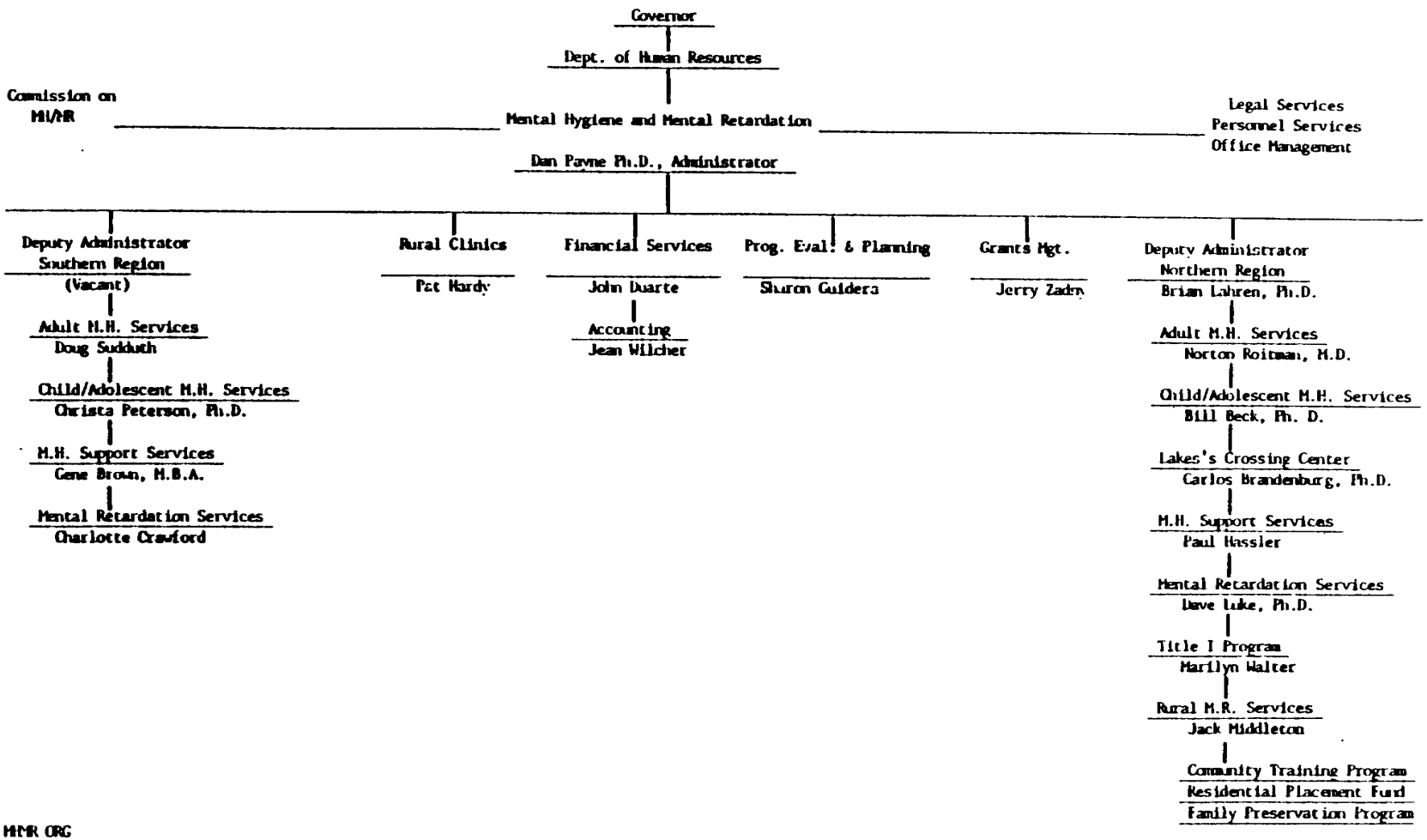
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Table of Organization



DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Table of Organization



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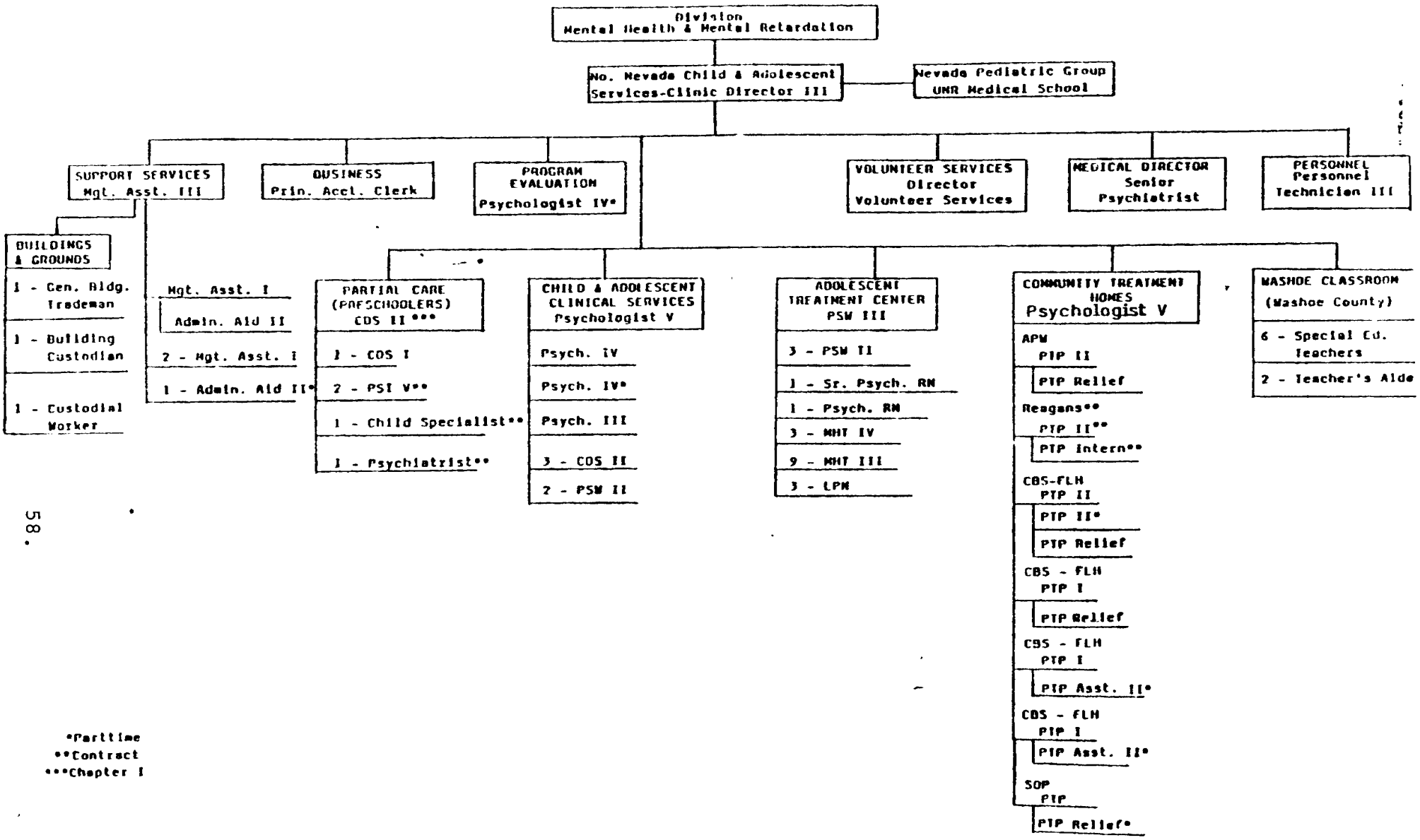
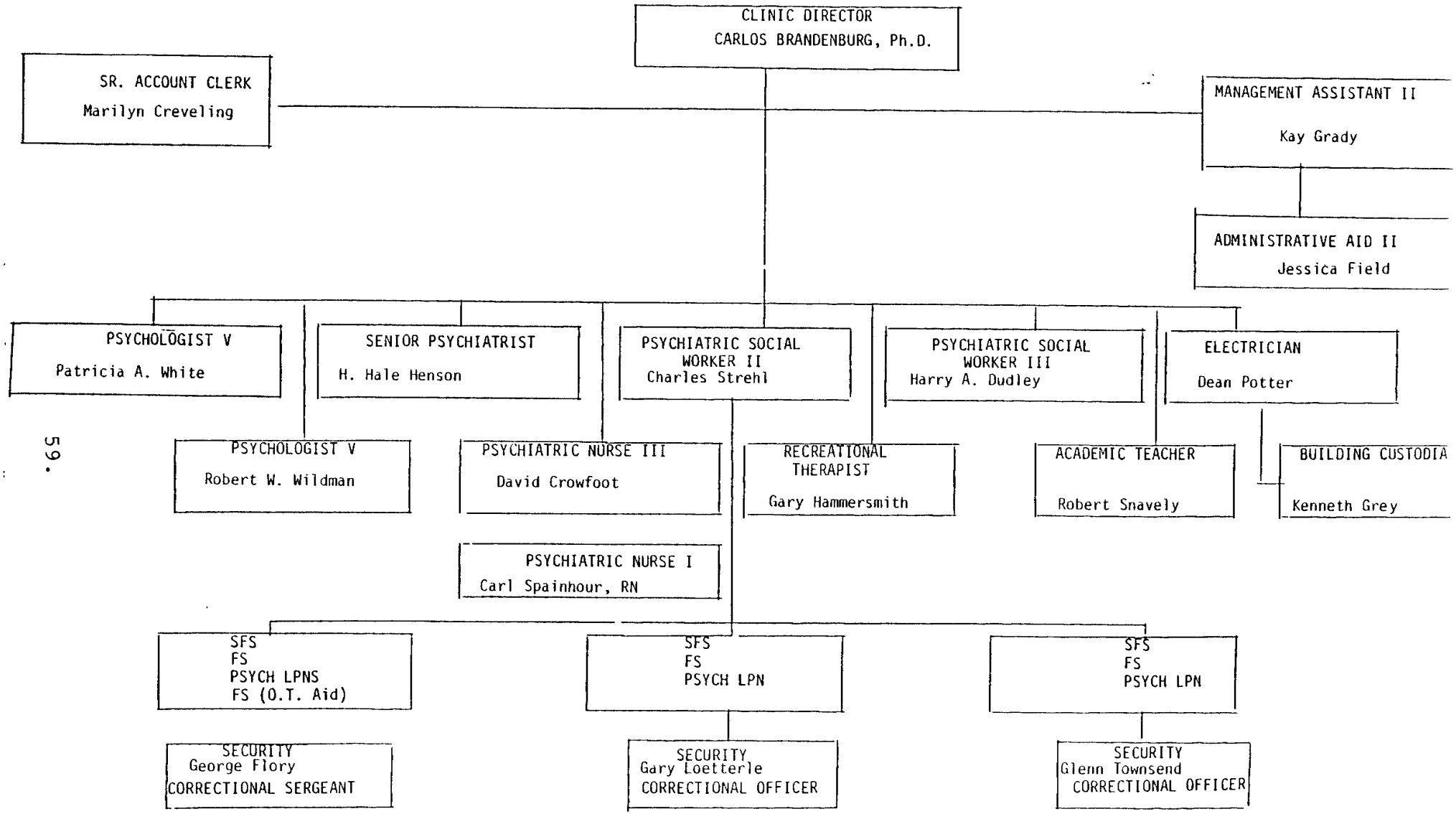
NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES

ORGANIZATIONAL CHART



*Parttime
**Contract
***Chapter I

LAKE'S CROSSING CENTER
ORGANIZATION CHART



Item No. 1

9/28/87

ORGANIZATION CHART

SOUTHERN NEVADA CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

ADMINISTRATION

Clinic Director III

CLINICAL SUPPORT SERVICES

Senior Psychiatrist, Range C

OUTPATIENT COUNSELING

Psychologist III	
Psychologist V	(4)
Psychologist III	(2)
Child Development Specialist II	(6)
Psychiatric Social Worker II	(2)
Management Assistant I	(2)
Administrative Aide II	

EARLY CHILDHOOD INTERVENTION

Child Development Specialist II	
Psychologist V	
Psychologist II	
Child Development Specialist II	(3)
Special Education Teacher I	
Public Service Intern I	
Mental Health Technician III	
Management Assistant I	
*Child Development Specialist II***	
*Mental Health Technician III***	(2)

FAMILY OUTREACH

Psychologist III	
Psychologist V	
Psychologist II	
Psychiatric Social Worker II	(2)
Child Development Specialist II	
Mental Health Technician III	

Management Assistant II (2)*

RESIDENTIAL SERVICES

Secure Youth Hospital

Psychiatric Social Worker III	(50%)
Psychologist V	
Psychiatric Nurse III	
Psychiatric Nurse I	(5)
Psychiatric LPN I	
Recreation Therapist II	
Mental Health Technician IV	
Mental Health Technician III	(8)
Administrative Aide II	

Treatment Homes

Psychiatric Social Worker III	(50%)
Psychologist III	
Professional Teaching-Parents I	(4)
Professional Teaching-Parents II	(2)
Professional Teaching-Parents Relief	(6)
Mental Health Technician III	(1.5)
Management Assistant I	

Transitional Treatment Homes

Psychologist V

PROGRAM EVALUATION

Management Assistant II

SOUTHERN AREA BUSINESS

Revenue/Patient Accounts/Fiscal Intakes

Management Analyst II
Principal Account Clerk
Senior Account Clerk

Switchboard

Administrative Aide II

Housekeeping

Senior Building Custodian	(2)
Building Custodian	(2)

Personnel

Management Assistant I

Valley Counseling Center

Clerical/Switchboard/Receptionist/Intakes/Outpatient Revenues/Medical Records Clerk

Senior Account Clerk
Administrative Aide II

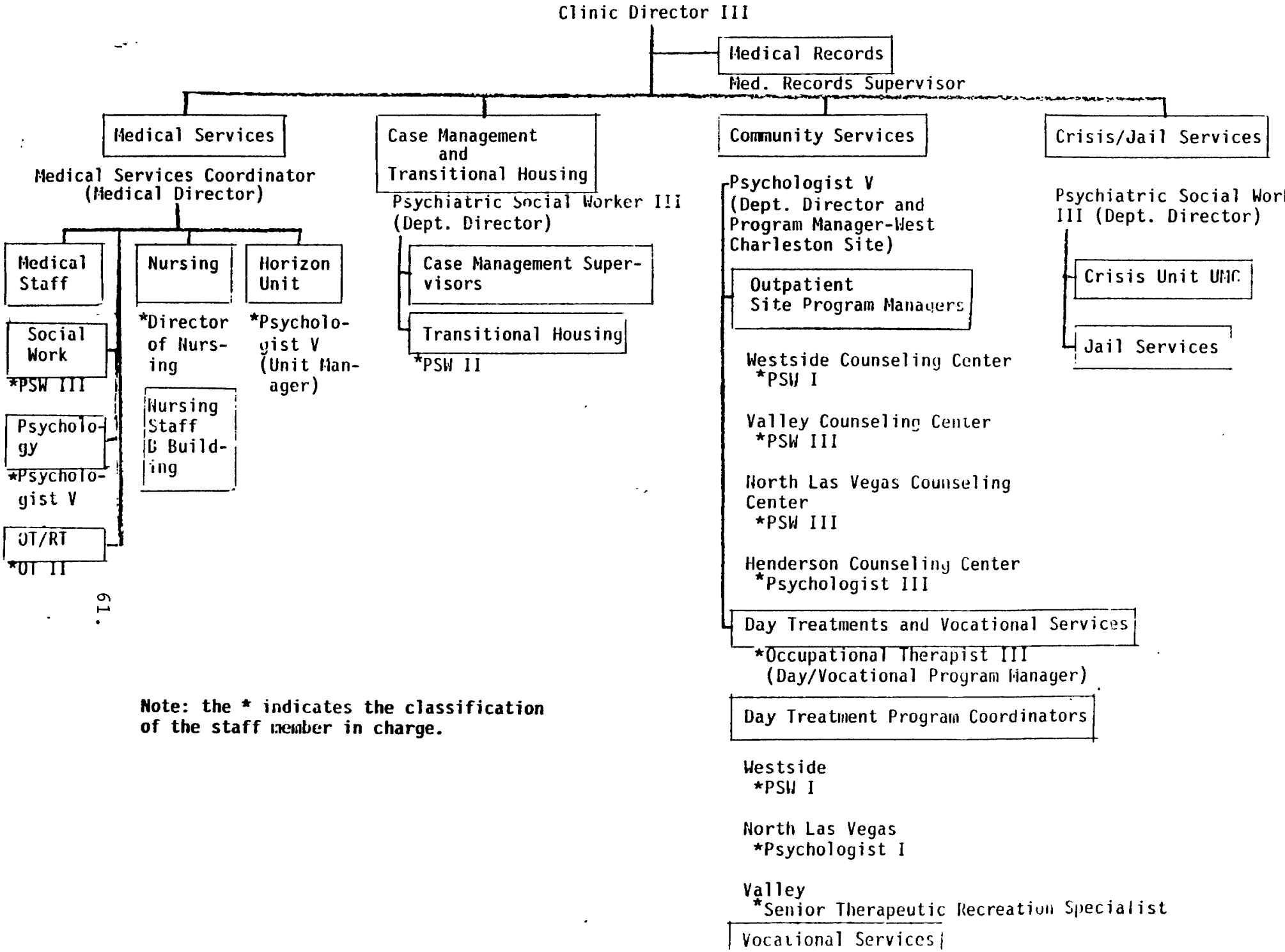
North Las Vegas Counseling Center

Clerical/Switchboard/Receptionist/Intakes/Outpatient Revenues/Medical Records Clerk

Management Assistant II

* One M.A. II provides secretarial services for the Deputy Administrator for Southern Nevada Mental Hygiene/Mental Retardation Services

** These positions are effective as of 1/88



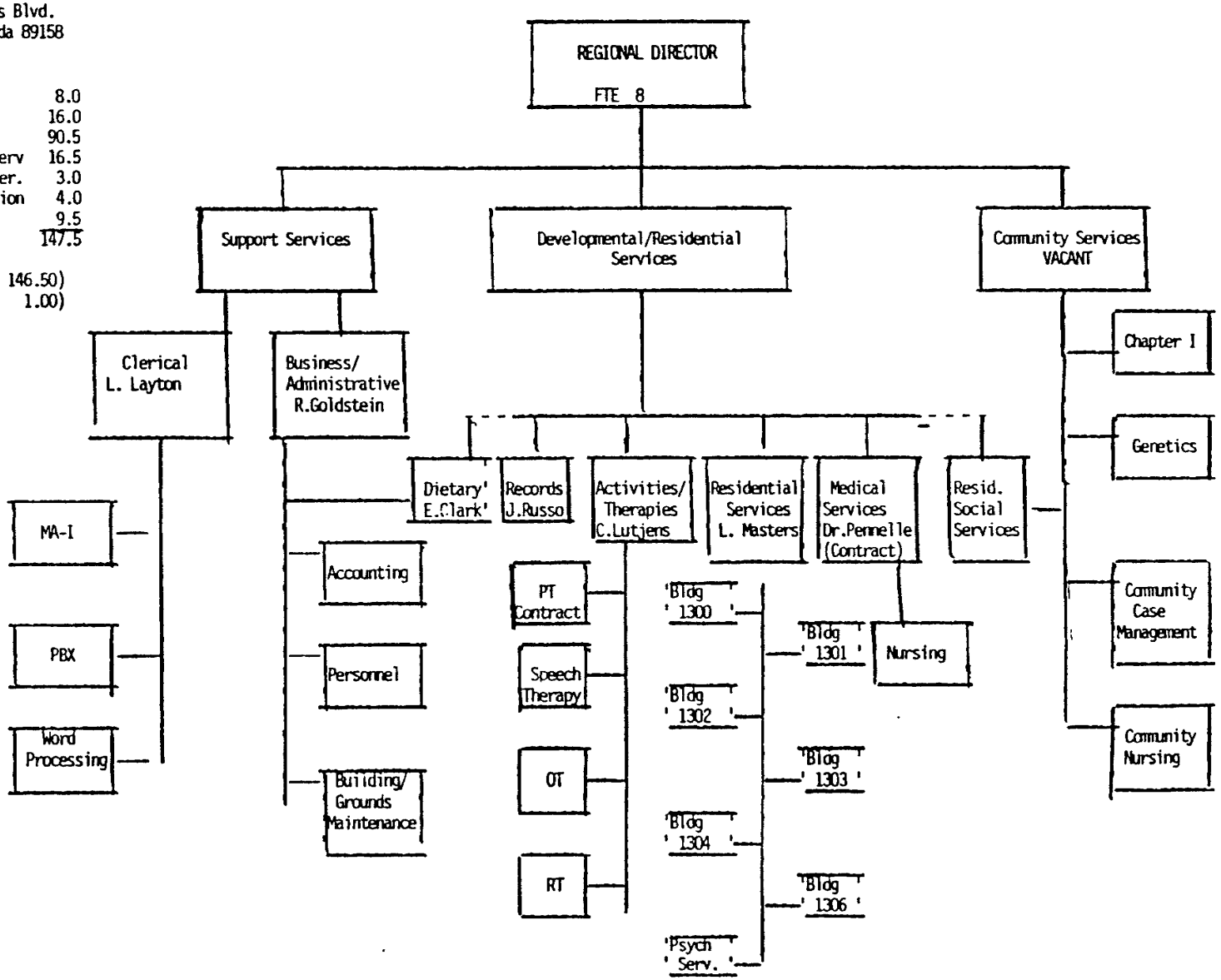
Note: the * indicates the classification of the staff member in charge.

SOUTHERN NEVADA MENTAL RETARDATION SERVICES
1300 South Jones Blvd.
Las Vegas, Nevada 89158

FTE By Section:

Director	8.0
Bus. Mgr	16.0
Residential	90.5
Community Serv	16.5
Activity Ther.	3.0
Administration	4.0
Nursing	9.5
	147.5

(Budget 3279 - 146.50)
(Budget 3159 - 1.00)



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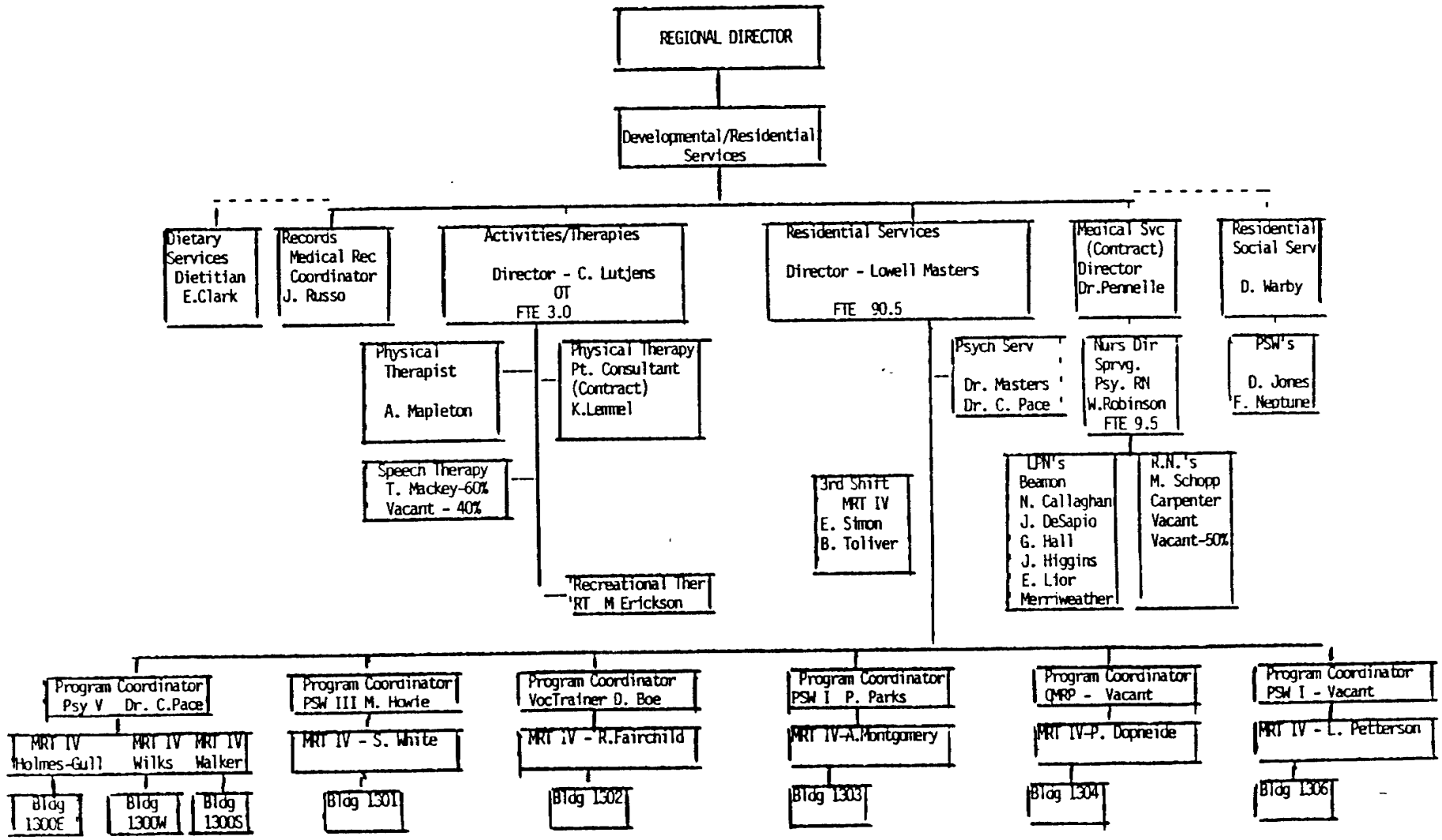
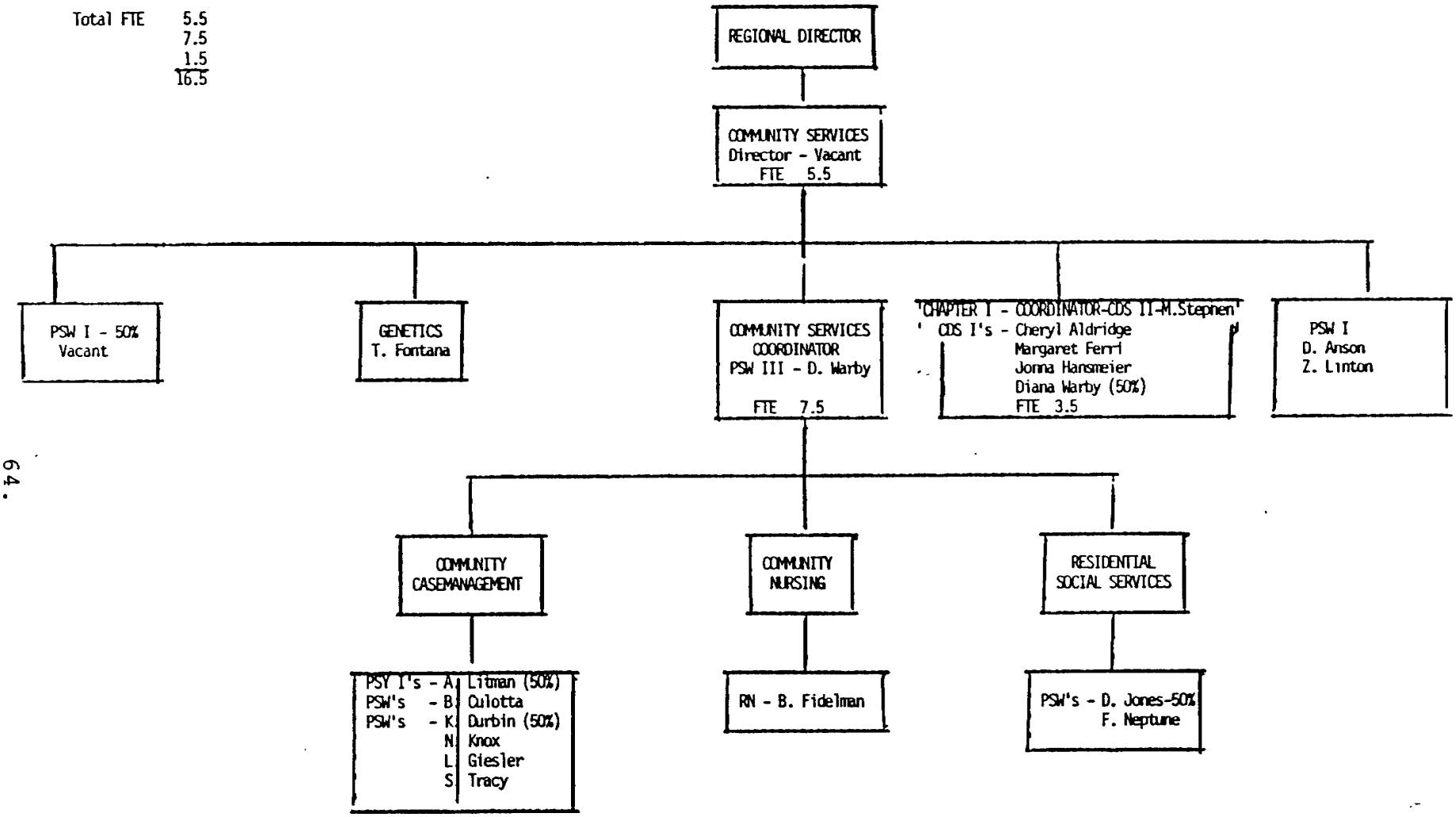

REGIONAL DIRECTOR
Developmental/Residential Services
Dietary Services Dietitian E.Clark
Records Medical Rec Coordinator J. Russo
Activities/Therapies Director - C. Lutjens OT FTE 3.0
Residential Services Director - Lowell Masters FTE 90.5
Medical Svc (Contract) Director Dr.Pennelle
Residential Social Serv D. Warby
Physical Therapist A. Mapleton
Physical Therapy Pt. Consultant (Contract) K.Lemmel
Speech Therapy T. Mackey-60% Vacant - 40%
Recreational Ther RT M Erickson
Psych Serv Dr. Masters Dr. C. Pace
Nurs Dir Sprvg. Psy. RN W.Robinson FTE 9.5
PSW's D. Jones F. Neptune
3rd Shift MRT IV E. Simon B. Toliver
LPN's Beamon N. Callaghan J. DeSapio G. Hall J. Higgins E. Lior Merriweather
R.N.'s M. Schopp Carpenter Vacant Vacant-50%
Program Coordinator Psy V Dr. C.Pace
MRT IV Holmes-Gull
MRT IV Wilks
MRT IV Walker
Bldg 1300E
Bldg 1300W
Bldg 1300S
Program Coordinator PSW III M. Howie
MRT IV - S. White
Bldg 1301
Program Coordinator VocTrainer D. Boe
MRT IV - R.Fairchild
Bldg 1302
Program Coordinator PSW I P. Parks
MRT IV-A.Montgomery
Bldg 1303
Program Coordinator QMRP - Vacant
MRT IV-P. Dopneide
Bldg 1304
Program Coordinator PSW I - Vacant
MRT IV - L. Petterson
Bldg 1306

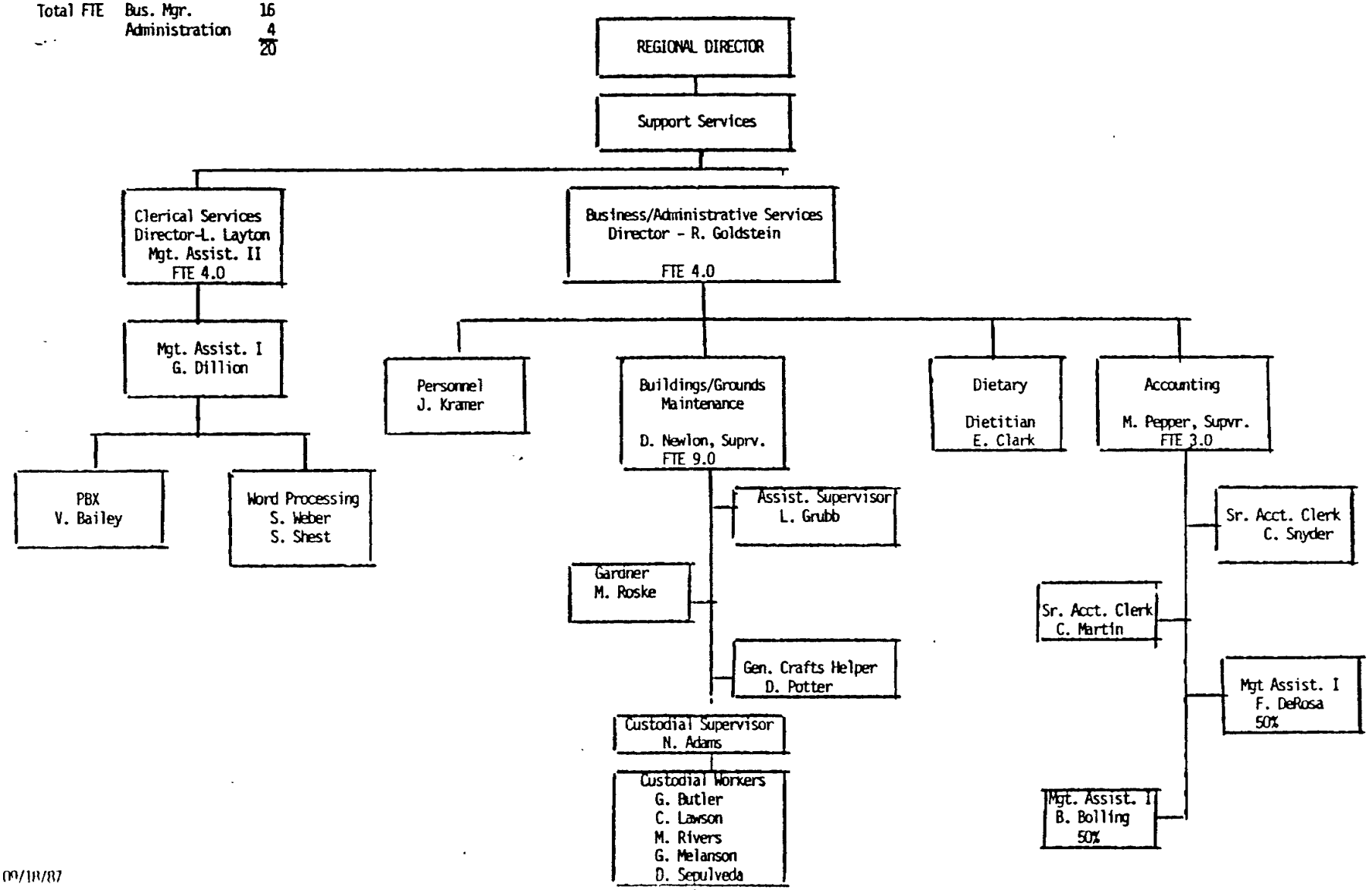
09/18/87

Total FTE 5.5
7.5
1.5
16.5



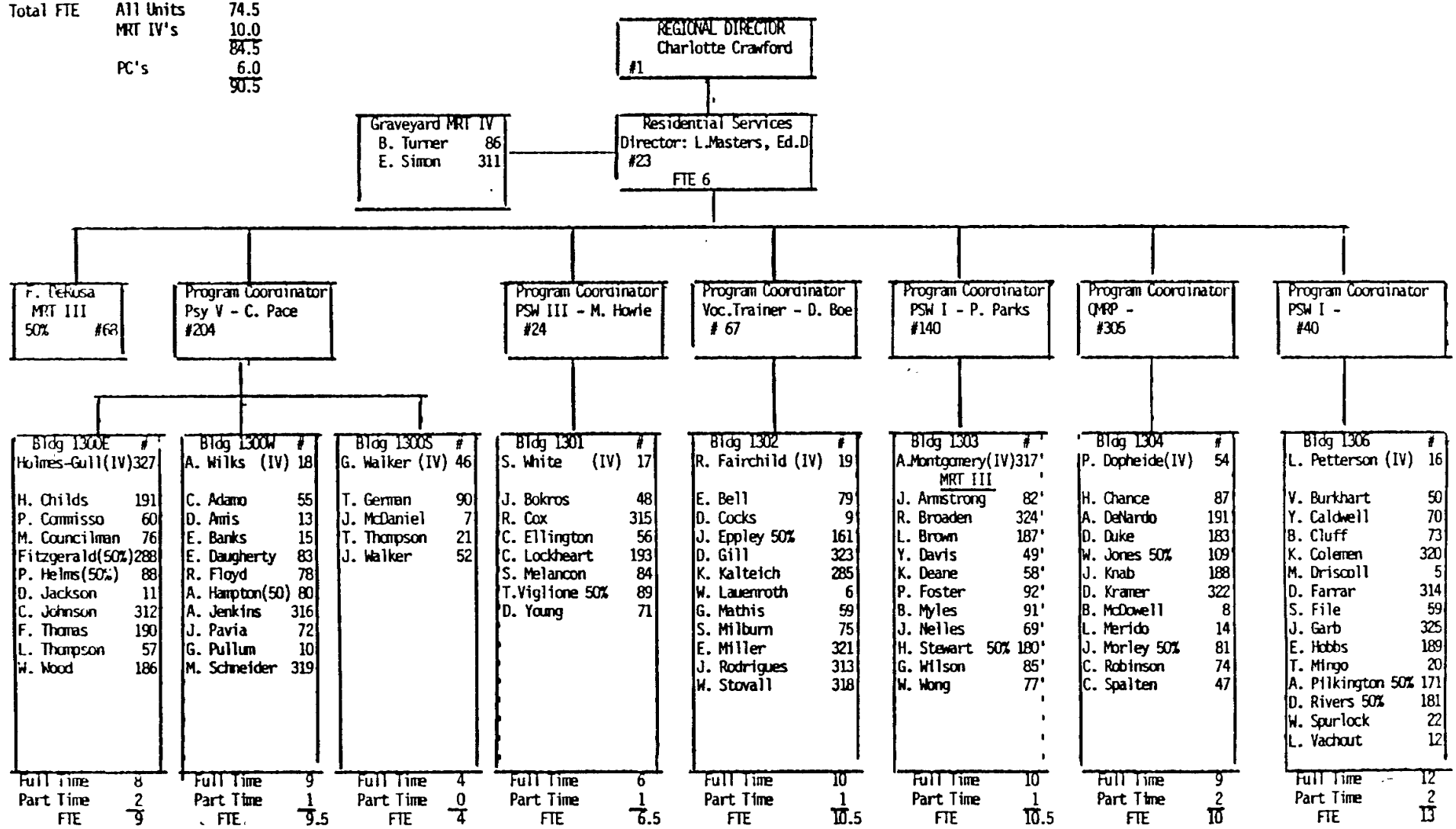
09/18/87

Total FTE Bus. Mgr. 16
Administration 4
20



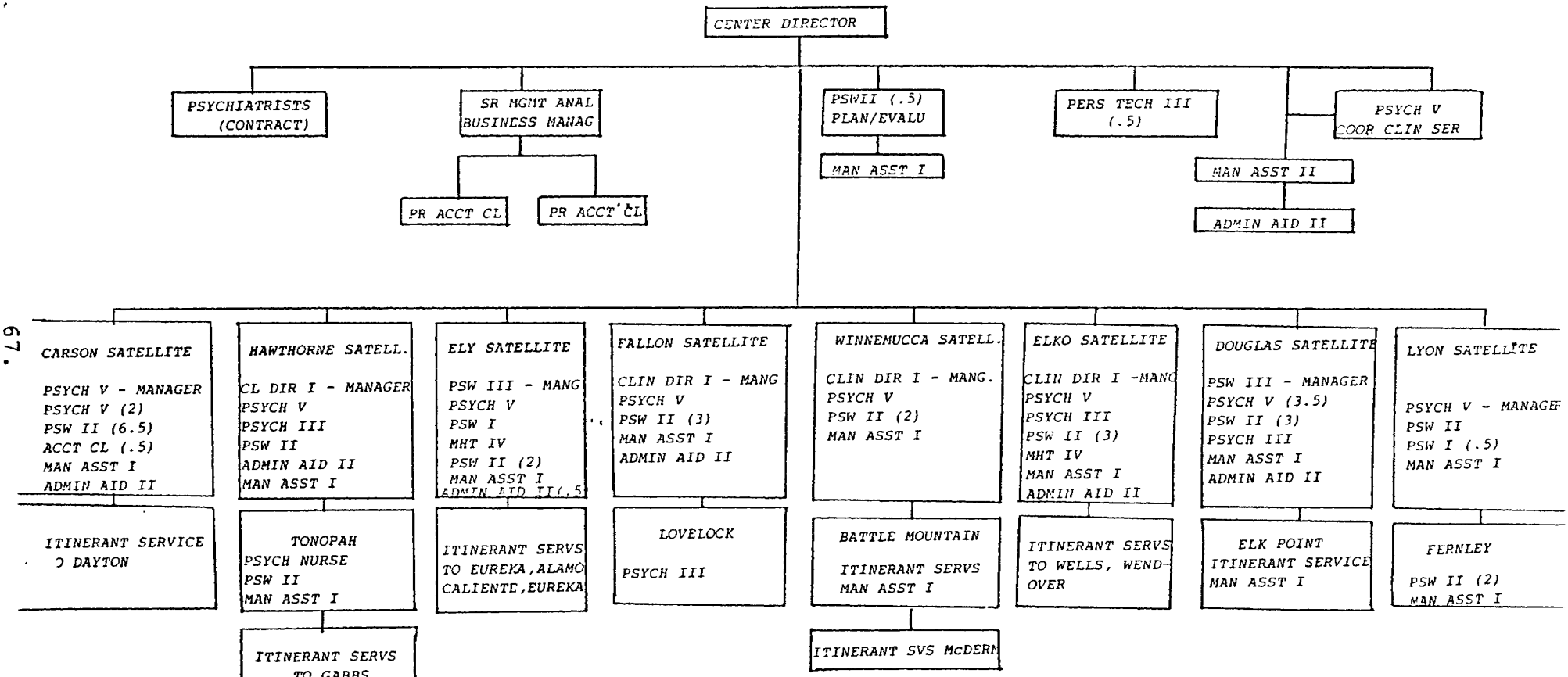
09/18/87

Total FTE	All Units	74.5
	MRT IV's	10.0
		84.5
	PC's	6.0
		90.5



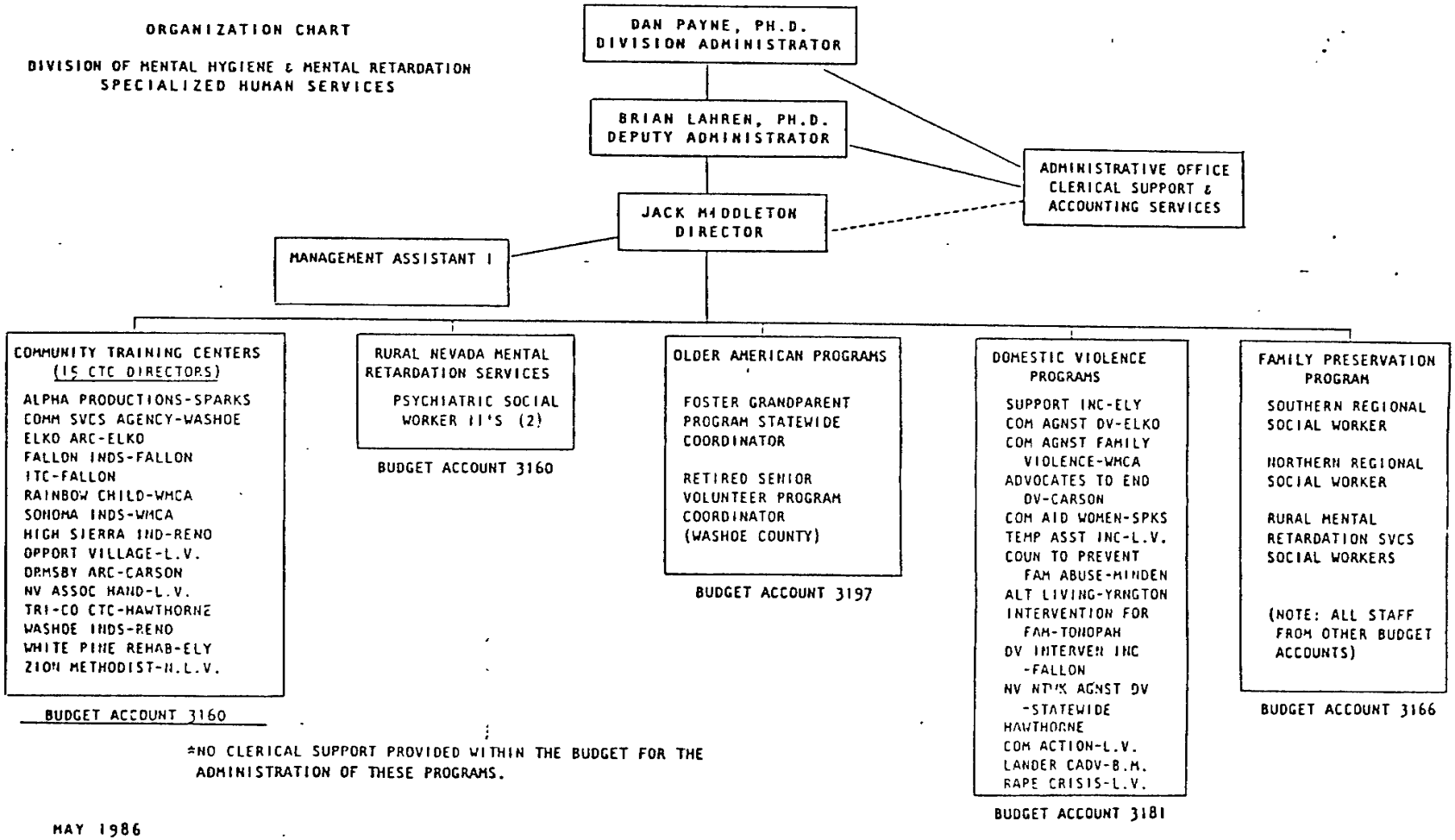
09/12/87

RURAL CLINICS FUNCTIONAL ORGANIZATIONAL CHART



COMMUNITY TRAINING CENTER PROGRAM - BUDGET ACCOUNT NUMBER 3160

II. ORGANIZATIONAL CHART



*NO CLERICAL SUPPORT PROVIDED WITHIN THE BUDGET FOR THE ADMINISTRATION OF THESE PROGRAMS.

MAY 1986

APPENDIX C

Community Training Centers - FY 1989 Allocations

COMMUNITY TRAINING CENTERS
FY 89 ALLOCATIONS

AGENCY	SERVICE	AVERAGE NUMBER (FTE)	DAYS	TOTAL DAYS	DAILY RATE	TOTAL	MINIMUM REG	MIN PRES	ADJUST ALLOCATION
ALPHA PRODUCTIONS	REGULAR	12	229	2,748	15.25	$41,907.00			$41,907.00
ALPHA PRODUCTIONS	PREWORK	6	218	1,308	24.75	$32,373.00			$32,373.00
						$74,280.00			$74,280.00
RUBY MOUNTAIN	REGULAR	19	229	4,351	15.25	$66,352.75			$66,352.75
RUBY MOUNTAIN	PRESCHOOL	19	173	3,287	16.85	$55,385.95			$55,385.95
						$121,738.70			$121,738.70
ZION METHODIST	PRESCHOOL	60	173	10,380	16.85	$174,903.00			$174,903.00
FALLON INDUSTRIES	REGULAR	13	229	2,977	15.25	$45,399.25			$45,399.25
SONOMA INDUSTRIES	REGULAR	6	229	1,374	15.25	$20,953.50	13,965.00		$34,922.50
ORMSBY ARC	REGULAR	22	229	5,038	15.25	$76,829.50			$76,829.50
ORMSBY ARC	PRESCHOOL	10	173	1,730	16.85	$29,150.50			$29,150.50
						$105,980.00			$105,980.00
WHITE PINE	REGULAR	8	229	1,832	15.25	$27,938.00	6,984.50		$34,922.50
WASHOE ARC	REGULAR	94	229	21,526	15.25	$328,271.50			$328,271.50
ITC FALLON	PRESCHOOL	6	173	1,038	16.85	$17,490.30		11,660.20	$29,150.50
TRI-COUNTY	REGULAR	9	229	2,061	15.25	$31,430.25			$31,430.25
TRI-COUNTY	PRESCHOOL	13	173	2,249	16.85	$37,895.65			$37,895.65
						$69,325.90			$69,325.90
HIGH SIERRA	REGULAR	32	229	7,328	15.25	$111,752.00			$111,752.00
OPPORTUNITY VILLAGE	REGULAR	215	229	49,235	15.25	$750,833.75			$750,833.75
OVI HENDERSON	REGULAR	28	229	2,412	15.25	$97,783.00			$97,783.00
NV ASSOC HANDICAP	REGULAR	42	229	9,618	15.25	$146,674.50			$146,674.50
NV ASSOC HANDICAP	PREWORK	14	218	3,052	24.75	$75,537.00			$75,537.00
						$222,211.50			$222,211.50
RAINBOW	PRESCHOOL	9	173	1,557	16.85	$26,235.45			$26,235.45
RAINBOW	EARLY INT	1	145	145	20.10	$2,914.50			$2,914.50
RAINBOW	REGULAR	1	229	229	15.25	$3,492.25			$3,492.~~35~~ .25
						$32,642.20			$32,642.20

TOTAL BUDGETED	$2,322,892.00
TOTAL ALLOCATED	$2,234,116.30
UNALLOCATED	$88,775.70

* Subject to the approval of the MH/MR Commission

RECEIVED
SEP

APPENDIX D

Domestic Violence Program - FY 1989 Allocations

Domestic Violence Program - Budget Account Number 3181
Allocations for Fiscal Year 1989

County	Base Allotment	Population Estimates 7/1/87	Per Capita	Tota Gran
Carson City	$7,000	36,650	$22,540	$ 29,5
Churchill	7,000	17,460	10,735	17,7
Clark	35,000	631,920	388,631	423,6
Domestic Violence ($360,086)				
Rape Crisis ($63,545)				
Douglas	7,000	25,200	15,498	22,4
Elko	7,000	25,000	15,375	22,3
Esmeralda	7,000	1,280	0	7,0
Eureka	7,000	1,950	0	7,0
Humboldt	7,000	12,180	0	7,0
Lander	7,000	4,580	0	7,0
Lincoln	7,000	4,250	0	7,0
Lyon	7,000	19,750	12,146	19,1
Mineral	7,000	6,470	0	7,0
Nye	7,000	15,520	9,545	16,5
Pershing	7,000	4,360	0	7,0
Storey	7,000	2,130	0	7,0
Washoe	35,000	236,480	145,435	180,4
White Pine	7,000	7,950	0	7,0
TOTAL	$175,000	1,053,130	$619,905	$794,9

*Population statistics utilized are from 1981 through 1987 Official Stat Estimates dated December 1987.

July 19, 1988
MHMR9/dv

Domestic Violence Program - Budget Account No. 3181
Fiscal Year 1989

Agency Organization	Marriage License Grant	Total Budgeted
Lyon County A.L.I.V.E.	$ 19,146.00	$ 33,146.00
Committee to Aid Abused Women (CAAW)	180,435.00	392,010.84
Domestic Violence Intervention, Inc.	24,735.00	39,495.00
The Family Council of Douglas County	22,498.00	48,113.00
Elko County Committee Against Domestic and Sexual Violence	22,375.00	45,440.00
Advocates to End Domestic Violence	43,540.00	108,302.00
Community Action Against Rape	63,545.00	114,123.00
Committee Against Family Violence	7,000.00	10,000.00
Support, Inc.	14,000.00	50,420.00
Temporary Assistance for Domestic Crisis, Inc.	367,086.00	592,810.00
Lander County Committee Against Domestic Violence	7,000.00	8,680.00
The Family Tree Resource Center	23,545.00	37,895.00

MHMR/dv

APPENDIX E

Department of Personnel

RICHARD H. BRYAN
Governor

STATE OF NEVADA

GLENN B ROC
Director

DEPARTMENT OF PERSONNEL

209 E. Musser Street
Carson City, Nevada 89710
(702) 885-4050

MEMORANDUM

TO: Bob Guernsey, Deputy Fiscal Analyst
Legislative Counsel Bureau

FROM: Glenn B. Rock, Director
Department of Personnel

DATE: June 9, 1988

SUBJECT: Survey of Selected Medical and Health Service Classes

As requested by the Sub-Committee studying the Division of Mental Health and Mental Retardation, we are forwarding the preliminary report on our survey of selected medical and health service classes.

I would stress the fact that the survey is on-going and will be updated throughout the summer as we continue to receive data from employers in the medical and health care field.

It is our intention to finalize the survey results this fall and formulate recommendations in preparation of the executive budget and the legislative process.

GBR/PMB:akb
cc.: Tim Hay, Director, Dept. of Administration
Jerry Griepentrog, Director, Dept. of Human Resources

M E D I C A L A N D H E A L T H S E R V I C E S

S U R V E Y

F O R

S E L E C T E D C L A S S E S

(Preliminary Report)

from the

DEPARTMENT OF PERSONNEL

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D. PSYCHIATRIC REGISTERED NURSE QUESTIONNAIRE

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INTRODUCTION

The Department of Personnel has conducted a national survey of State governments to obtain salary information for classes involved with medical and health services. This included survey questionnaires for Psychiatrist and Psychiatric Registered Nurses regarding pay practices, benefits and recruiting practices. The results of the survey compiled to date are included under sectional dividers for:

Salary Survey Data

Psychiatrist Questionnaire

Psychiatric Registered Nurse Questionnaire

It should be noted that we are still receiving information from State governments. As such, we will be updating the information and intend to provide a final summation with recommendations at a later date.

METHODOLOGY

The salary data on the following pages reflects comparisons with Nevada's monthly salaries. The comparisons are made against the average and weighted average salaries to reflect a plus or minus differential. Average and weighted average salaries are distinguished as follows:

Average Salaries reflect a straight average of the minimum, maximum and average monthly salary reported by each state for the respective class being surveyed.

Weighted Average Salaries reflect the number of employees reported by a state in that the total number of employees is multiplied by the salary reported, minimum, maximum and average salary. This is done for each employer, totaled and the result is divided by the total number of employees. Example as follows:

No. of Employees	Salary	
10 X	$1,986 =	$19,860
20 X	$2,321 =	$46,420
	TOTAL:	$66,280
	TOTAL NO. OF EMPLOYEES:	30

$66,280 ÷ 30 = $2,209 weighted average salary

It should also be noted that the lower employer-paid retirement salary is used for comparisons at the minimum and maximum salaries. Nevada's average salary, however, reflects a combination of salaries from both the higher employee/employer retirement pay schedule and the employer-paid retirement pay schedule. As a result, some average salaries may exceed the maximum of the salary range reported.

Class: Sr. Psychiatrist (Range A)

State	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Nat Lic
Colorado	10.111A	Psychiatrist I	4003	10	3636	4372	3760	X	
Connecticut	10.111A	Psychiatrist II	4014	7	4682	5524	5022	X	
Delaware	10.111A	Psychiatrist II	4015	13	3390	6644	5550	X	
District of Columbia	10.111A	Senior Psychiatrist	4016	17	4345	5347	4474	X	
Hawaii	10.111A	Psychiatrist I	4019	10	4412	4825	4563	X	
Idaho	10.111A	Physician, Psych. Specialty	4014	1	4311	6582	5470	X	
Illinois	10.111A	Physician	4020	33	4124	6930	5514	X	
Indiana	10.111A	Psychiatrist E II	4021	5	4524	7034	6556	X	
Kentucky	10.111A	Medical Specialist	4024	4	6458	7427	6534	X	
Louisiana	10.111A	Psychiatrist I	4025	1	3371	5592	4482	X	
Massachusetts	10.111A	Psychiatrist II	4029	80	3787	4671	4229	X	
Michigan	10.111A	Psychiatrist III	4029	84	6283	7951	7923	X	
Minnesota	10.111A	Sr. Staff Phys.(Range A)	4030	9	4305	5991	5242		
Missouri	10.111A	Psychiatrist I	4032	11	5523	6054	5576	X	
Montana	10.111A	Physician Specialized	4005	4	5049	8333	5734	X	
Nebraska	10.111A	Psychiatrist I	4033	1	3333	5823	4583	X	
New Hampshire	10.111A	Psychiatrist	4034	3	3643	4655	4655	X	
New Jersey	10.111A	Clinical Psychiatrist II	4035	3	4251	6395	5780	X	
New York	10.111A	Psychiatrist I	4037	334	5352	6389	6031	X	
North Carolina	10.111A	Physician II	4038	21	3915	6409	5614	X	
North Dakota	10.111A	Psychiatrist I	4039	3	5000	7317	7500	X	
Ohio	10.111A	Psychiatric Physician	4040	15	3906	5496	4574	X	
Pennsylvania	10.111A	Staff Psychiatrist	4042	133	4775	4997	4997		
Rhode Island	10.111A	Psychiatrist III	4043	1	3670	4136	4136	X	
Utah	10.111A	Psychiatrist	4008	8	5783	6868	6536	X	
Vermont	10.111A	Clinical Director	4047	1	5480	5486	5486	X	
Virginia	10.111A	Mental Health Phy. A	4048	3	4447	6393	6350	X	
Washington	10.111A	Psychiatrist I	4009	1	4339	5032	4686		
Wisconsin	10.111A	Physician	4050	1	4502	6302	5402	X	
Wyoming	10.111A	Med. Consultant Forensic Psych	4049	1	4493	7130	5844	X	
		Average			4551	6052	5447		
		% difference			15	-16	-4		
		Weighted Avg.			4936	6006	5675		
		% difference			6	-15	-8		
		Nevada			5234	5234	5234		

is: Sr. Psychiatrist (Range B)

e	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Nationa. License
rado	10.111B	Psychiatrist II	4003	9	3636	4872	4846	X	
ecticut	10.111B	Psychiatrist III	4014	43	4851	5717	5572	X	
gia	10.111B	Psychiatrist (Board Eligible)	4018	64	5108	6952	6030	X	
ii	10.111B	Psychiatrist II	4019	11	4520	4945	4655	X	
nois	10.111B	Physician Specialist-Option C	4020	50	5583	7250	601[illegible]	[illegible]	
	10.111B	Physician Specialist	4022	21	4855	6134	6096	X	
as	10.111B	Psychiatrist I	4023	1	6116	7166	6641	X	
ucky	10.111B	Medical Specialist Senior	4024	16	6667	7796	7209	X	
siana	10.111B	Psychiatrist II	4025	11	3610	5995	4993	X	
e	10.111B	Physician II	4026	6	3810	5320	5209	X	
land	10.111B	Physician C	4027	102	4036	5331	5207	X	
igan	10.111B	Psychiatrist IV	4029	4	6796	7951	7951	X	
esota	10.111B	Sr. Staff Phys. (Range B)	4030	20	5023	7183	6222		
issippi	10.111B	Psychiatrist	4031	5	5833	5833	5833	X	
ouri	10.111B	Psychiatrist II	4032	23	5501	6332	5772	X	
aska	10.111B	Psychiatrist II	4033	1	4167	6667	6289	X	
Hampshire	10.111B	Psychiatrist	4034	4	3726	4733	4733	X	
h Carolina	10.111B	Physician III	4038	115	4723	7797	6333	X	
h Dakota	10.111B	Psychiatrist II	4039	2	6250	7917	7917	X	
	10.111B	Psychiatrist	4040	96	4938	6949	5826	X	
homa	10.111B	Staff Psychiatrist	4041	3	4304	6733	6417	X	
on	10.111B	Physician Specialist	4007	28	4194	5354	5068		
e Island	10.111B	Psychiatrist IV	4043	6	3981	4446	4334	X	
h Carolina	10.111B	Psychiatrist II	4044	42	4282	607[illegible]	5523	X	
inia	10.111B	Mental Health Phy. B	4048	44	5033	7026	6034	X	
ington	10.111B	Psychiatrist II	4009	28	4790	5554	5554	X	

	Min. Sal.	Max. Sal.	Avg. Sal.
Average	4863	6310	5870
% difference	12	-16	-13
Weighted Avg.	4795	6530	5808
% difference	12	-20	-3
Nevada	5452	5452	5452

Class: Sr. Psychiatrist (Range C)

State	Class Code	Job Title	Empl. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Na Li
Alaska	10.111C	Staff Psychiatrist	4012	7	7449	8116	7778	X	
Arizona	10.111C	Physician III	4001	25	4564	8032	6622	X	
Arkansas	10.111C	Psychiatrist	4013	10	6550	6550	6550	X	
Colorado	10.111C	Psychiatrist III	4003	2	3636	4872	4872	X	
Connecticut	10.111C	Psychiatrist IV	4014	16	5211	6119	6095	X	
Delaware	10.111C	Psychiatrist III	4015	5	4776	7795	6462	X	
Georgia	10.111C	Physician (Board Certified)	4016	22	6663	7946	7305	X	
Idaho	10.111C	Physician, Clin. Dir. Inst.	4004	1	5686	7613	5970	X	
Illinois	10.111C	Physician Specialist-option D	4020	36	6250	7917	6546	X	
Indiana	10.111C	Psychiatrist E I	4021	26	4964	7754	7216	X	
Iowa	10.111C	Board Certified Physician	4022	15	5136	6491	6434	X	
Kansas	10.111C	Psychiatrist II	4023	1	6529	8286	7408	X	
Kentucky	10.111C	Medical Specialist Principal	4024	10	6875	8189	7559	X	
Louisiana	10.111C	Psychiatrist Clin. Program Dir	4025	17	3863	6403	5215		
Maine	10.111C	Physician III	4026	7	4382	6127	6134	X	
Maryland	10.111C	Physician D	4027	125	4424	6755	5689	X	
Michigan	10.111C	Psychiatrist V	4029	3	7205	7951	7951	X	
Minnesota	10.111C	Sr. Staff Phys. (Range C)	4030	13	5391	8625	7097		
Mississippi	10.111C	Psychiatrist	4031	2	6250	6250	6250	X	
Missouri	10.111C	Senior Psychiatrist	4032	10	5778	6611	6215	X	
Alaska	10.111C	Psychiatrist III	4033	3	5000	7500	6002	X	
New Hampshire	10.111C	Psychiatrist	4034	6	3976	4988	4983	X	
New Jersey	10.111C	Clinical Psychiatrist I	4035	83	4720	8603	6372	X	
New York	10.111C	Psychiatrist II	4037	423	5921	7026	6716	X	
North Dakota	10.111C	Psychiatrist III	4039	2	6667	9583	9167	X	
Oklahoma	10.111C	Senior Psychiatrist	4041	20	5192	6808	6650	X	
Oregon	10.111C	Physician Specalist	4007	12	4194	5354	5068		
Pennsylvania	10.111C	Psychiatric Phys. I Supv.	4042	45	4993	5223	5110	X	
South Carolina	10.111C	Psychiatrist III	4044	49	4454	6313	5998	X	
South Dakota	10.111C	Psychiatrist	4045	5	6653	9981	8232	X	
Virginia	10.111C	Mental Health Phy. C	4043	83	5556	7814	7241	X	
Wisconsin	10.111C	Physician Specialist	4050	3	4502	6302	6142	X	
		Average			5413	7093	6555		
		% difference			16	-13	-4		
		Weighted Avg.			5414	6883	6503		
		% difference			16	-9	-3		
		Nevada			6300	6300	6300		

ss: Psychiatric Social Worker II

te	Class Code	Job Title	Empir. Nc.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	National License
ska	10.144	Mental Health Clinician II	4012	11	3036	3954	3568		
oona	10.144	Hosp Soc Serv Rep II	4001	10	1790	2671	2099		
ansas	10.144	Social Worker III	4013	24	1486	2495	2068		
orado	10.144	Social Worker II	4002	9	2126	2849	2335		
necticut	10.144	Psychiatric Social Worker	4014	39	2239	2666	2450		
aware	10.144	Psy. Soc. Wkr. II	4015	6	1514	2523	22.3		
trict of Columbia	10.144	Social Worker	4016	135	2346	3046	2603		
rgia	10.144	Human Services Provider	4015	285	1611	2543	1847		
aii	10.144	Social Worker III (generic)	4019	1	1610	2491	2072		
inois	10.144	Social Worker II	4020	145	1904	2495	2207	X	
iana	10.144	Psysc. Soc. Worker III	4021	47	1520	2248	1770		
a	10.144	Social Worker II	4022	503	1581	1955	1732		X
sas	10.144	Social Worker II	4023	207	1762	2354	2040	X	
tucky	10.144	Social Worker MH/MR Specialist	4024	6	1527	2250	1765		
isiana	10.144	M. H. Clinical Social Worker	4025	34	1501	2657	2051		
ne	10.144	Psychiatric Social Wkr. I	4026	10	1484	2006	1656		
yland	10.144	Health Services Soc. Worker II	4027	1	1734	2348	2064	X	
sachusetts	10.144	Clinical Social Worker II	4028	268	2346	3082	2714		
higan	10.144	Clinical Social Worker VIB	4029	347	2102	2745	2695	X	
nesota	10.144	Social Worker Senior	4030	93	1916	2521	2230		
sissippi	10.144	Social Wkr., Institutional	4031	34	1244	1662	1323		
souri	10.144	Clinical Social Worker II	4032	135	1776	2271	1962		
tana	10.144	Psych. Social Worker II	4005	2	1817	1956	1876		
aska	10.144	Psychiatric Social Worker II	4033	22	1663	1752	1752		
Hampshire	10.144	Psychiatric Social Worker	4034	17	1760	2030	1879		
Jersey	10.144	Social Worker I (Psychiatric)	4035	18	1866	2615	224.		
Mexico	10.144	Social Worker II, Opt. A	4036	23	1382	2343	1473		
York	10.144	Social Worker II	4037	830	2436	3021	2827		
th Carolina	10.144	Social Worker III	4038	45	1736	2767	2211		
th Dakota	10.144	Social Worker III	4039	105	1707	2582	1970	X	
e	10.144	Soc Services Worker III	4040	300	1517	1819	1793		
ahoma	10.144	Social Worker II	4041	30	1742	2324	2038		
gon	10.144	Psychiatric Social Worker	4007	1	1818	2300	2059		
nsylvania	10.144	Social Worker I	4042	141	1519	2060	1969	X	
de Island	10.144	Clinical Social Worker	4043	22	2059	2397	2291		
th Carolina	10.144	Social Worker III	4044	242	1606	2277	1754		
mont	10.144	Psychiatric Social Worker	4047	6	1519	2565	1717		
ginia	10.144	Clinical Soc. Worker C	4048	67	1907	2605	2447		
hington	10.144	Psychiatric Social Worker II	4009	15	1839	2417	2279		
t Virginia	10.144	Social worker V	4049	1	1401	2522	1977	X	X
consin	10.144	Social Worker III	4050	49	2102	2935	2405		
ming	10.144	Benavioral Dev. Spec/Counselor	4049	11	1673	2674	2 05		

Average	1807	2472	2116
% difference	12	12	2
Weighted Avg.	1907	2514	2213
% difference	7	10	17
Nevada	2021	2753	2606

Class: Psychologist II

State	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Ma L
Alabama	10.1260	Psychologist II	4011	14	1961	2873	2401		
Alaska	10.1260	Mental Health Clinician II	4012	11	3336	3954	3563		
Arkansas	10.1260	Psychologist	4013	14	1911	3015	2749	X	
Colorado	10.1260	Psychologist IA	4014	10	2584	3402	3000		
Connecticut	10.1260	Psychology Associate	4015	9	3301	2807	2552		
District of Columbia	10.1260	Counseling Psychologist	4016	46	2811	3654	3261		
Idaho	10.1260	Psychologist, Specialist	4004	26	2248	3014	2605		
Illinois	10.1260	Psychologist II	4020	95	2225	2967	2726		
Iowa	10.1260	Psychologist II	4022	21	2036	3863	2529		
Kansas	10.1260	Psychologist I	4023	40	1762	2.83	1915	X	
Kentucky	10.1260	Psychologist Licensed Chief	4024	4	2383	3634	3209	X	
Louisiana	10.1260	Psychological Associate III	4025	29	1715	2343	2272		
Maine	10.1260	Psychologist II	4026	12	2123	2919	2359	X	
Maryland	10.1260	Psychologist Associate III	4027	28	1764	2443	2319		
Massachusetts	10.1260	Psychologist III	4028	232	2501	3034	2803		
Michigan	10.1260	Psychologist VIB	4029	183	2496	3223	2227	X	
Minnesota	10.1260	Psychologist 2	4030	49	2401	32.5	2809		
Missouri	10.1260	Psychologist I	4032	78	2177	2915	2447		
Montana	10.1260	Psychologist	4035	5	2156	2600	2554		
Nebraska	10.1260	Psychologist I	4033	11	1884	2113	2040		
New Hampshire	10.1260	Psychologist II	4034	14	1936	2681	2331		
New Jersey	10.1260	Staff Clinical Psychologist I	4035	94	2270	3178	2582		
New Mexico	10.1260	Psychologist II	4036	33	1844	3141	2164		
New York	10.1260	Psychologist II	4037	526	2355	3513	3414		
North Carolina	10.1260	Staff Psychologist II	4038	123	1977	3177	2372		
North Dakota	10.1260	Psychologist II	4039	17	1792	2690	2081	X	
Ohio	10.1260	Staff Psychologist I	4040	1	2078	2185	2185	X	
Oklahoma	10.1260	Psychologist I	4041	10	2010	2702	2316		
Oregon	10.1260	Psychological Associate	4007	22	1640	2047	1872		
Pennsylvania	10.1260	Psychologist III	4042	16	2823	3867	3736		
Rhode Island	10.1260	Clinical Psychologist	4043	22	2066	2328	2230		
South Carolina	10.1260	Psychologist II	4044	57	1807	2561	1974		
South Dakota	10.1260	Masters Psychologist	4045	1	1802	2747	2057		
Utah	10.1260	Psychologist	4006	7	2620	3572	3225	X	
Vermont	10.1260	Ver. State Hosp. Psychologist	4047	2	2951	3255	3045	X	
Virginia	10.1260	Psychologist C	4048	31	2036	2849	2827		
Washington	10.1260	Psychologist IV	4019	16	2148	2737	2626	X	
West Virginia	10.1260	Psychologist II	4049	1	1563	2765	2164		
Wisconsin	10.1260	Psychologist III	4050	47	2436	3447	2804		
Wyoming	10.1260	Psychologial Specialist/Counse	4043	6	2141	3428	2621		
				Average	2135	3012	2626		
				% difference	-9	-9	-1.		
				Weighted Avg.	2403	.16.	2564		
				% difference	-19	-15	-20		
				Nevada	2.01	2753	2382		

chologist V

e	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	National License
bama	10.126E	Psychologist IV	4011	1	2673	4076	3380	X	
ska	10.126E	Mental Health Clinician IV	4012	2	4382	5206	5572		
zona	10.126E	Psychologist III	4001	7	2843	4250	4018	X	
orado	10.126E	Psychologist II	4003	23	2991	4009	3800	X	
necticut	10.126E	Psychologist III	4014	14	3771	4572	4505	X	
aware	10.126E	Psychologist III	4015	2	2431	4050	3276	X	
rict of Columbia	10.126E	Psychologist	4016	3	3948	5139	4564		
ida	10.126E	Clinical Psychologist VIII	4019	4	2709	4349	4153	X	
rgia	10.126E	Psychologist, Chief	4004	8	2360	3164	2892	X	
inois	10.126E	Psychologist III	4020	88	2494	3336	3002		
iana	10.126E	Psychologist E VII	4021	14	2364	3536	3221	X	
a	10.126E	Psychologist IV	4022	4	2863	3622	3469		
sas	10.126E	Psychologist IV	4023	13	2473	3322	3006	X	X
tucky	10.126E	Psychologist Licensed Program	4024	4	3247	4456	3991	X	
siana	10.126E	Psychologist III	4025	24	2754	4565	3159	X	
ne	10.126E	Psychologist IV	4026	8	2482	3412	3096	X	
yland	10.126E	Psychologist II	4027	66	2603	3417	3362	X	
sachusetts	10.126E	Psychologist V	4028	19	2951	3615	3282	X	
igan	10.126E	Psychologist VII	4029	22	2697	3612	3612	X	
nesota	10.126E	Psychologist 3	4030	11	2803	3741	3002		
sissippi	10.126E	Psychologist II	4031	12	2414	3616	2492		
souri	10.126E	Psychologist II	4032	22	2972	3969	2792		
raska	10.126E	Psychologist III	4033	7	2575	3605	2962		
Hampshire	10.126E	Sr. Psychologist II	4034	7	2487	2965	2965	X	
Jersey	10.126E	Principal Clinical Psychologis	4035	61	3943	4260	661		
Mexico	10.126E	Psychologist III, Opt. B	4036	7	2347	4002	3222		
York	10.126E	Assoc. Psychologist	4037	265	2355	3515	3515		
th Carolina	10.126E	Sr. Psychologist I	4038	17	2248	3652	2702		
th Dakota	10.126E	Clinical Psychologist III	4039	12	2773	4135	3372	X	X
o	10.126E	Staff Psychologist II	4040	58	2230	3145	3145	X	
ahoma	10.126E	Psychologist III	4041	22	2514	3354	2823		
gon	10.126E	Psychologist II	4007	10	2441	3037	2915		
nsylvania	10.126E	Psychologist IV	4042	1	2345	3373	3373		X
de Island	10.126E	Clinical Psychologist (PhD Qua	4043	6	2502	2802	2607		
th Carolina	10.126E	Psychologist IV	4044	39	2473	3505	2745	X	
th Dakota	10.126E	Ph.D Psychologist	4045	7	2304	3455	2696	X	
nont	10.126E	Ver State Hosp Psychology Serv	4047	1	2321	3639	3639	X	
ginia	10.126E	Psychologist D	4048	10	2492	3571	3013		
nington	10.126E	Psychologist V	4009	50	2432	3171	3135	X	
t Virginia	10.126E	Psychologist IV	4049	1	1870	3329	2600		
consin	10.126E	Psychologist IV	4050	17	2622	2701	3293	X	
ming	10.126E	Psychological Consultant/Couns	4049	2	2482	3376	2619		
					Average	2584	3717	3250	
					% difference	0	-1	9	
					Weighted Avg.	2583	3655	3243	
					% difference	0	2	10	
					Nevada	2528	3916	3668	(1)

ada's average salary is a combination of employees on employer paid and employee /employer paid compensation.

Class: Sr. Physician (Range B)

e	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Ma Li
Alaska	10.219B	Medical Officer	4012	1	5380	6425	6879	X	
Arizona	10.219B	Physician II	4001	7	4163	7382	5749	X	
Arkansas	10.219B	Physician Specialist	4013	15	5741	5741	5741	X	
Colorado	10.219B	Physician III	4003	11	3636	4872	4630	X	
Connecticut	10.219B	Physician III	4014	45	4851	5717	5509	X	
Delaware	10.219B	Physician III	4015	5	4176	6960	5728	X	
District of Columbia	10.219B	Physician	4016	17	4345	5347	4474	X	
Idaho	10.219B	Physician	4004	1	3847	5157	4454	X	
Illinois	10.219B	Physician Specialist-Option A	4020	13	4583	6000	5378	X	
Kansas	10.219B	Physician I	4023	1	5062	6095	5579	X	
Kentucky	10.219B	Physician Sr.	4024	7	4300	6199	5675	X	
Louisiana	10.219B	Physician I	4025	1	2347	4885	3916	X	
Maine	10.219B	Physician II	4026	6	3810	5320	5229	X	
Maryland	10.219B	Physician C	4027	102	4096	5281	5307	X	
Michigan	10.219B	Physician III	4029	81	5627	7459	7257	X	
Minnesota	10.219B	Sr. Staff Phys. (Range B)	4030	20	5029	7163	6222		
Mississippi	10.219B	Physician, Senior	4031	75	2654	6443	4525	X	
Missouri	10.219B	Medical Specialist I	4032	1	5223	6054	5361	X	
Montana	10.219B	Physcian Full Credential	4005	4	4494	5587	4899	X	
New Hampshire	10.219B	Sr. Physician	4034	4	3643	4655	4655	X	
New York	10.219B	Medical Specialist II	4037	213	5921	7026	6690	X	
North Carolina	10.219B	Physician IV	4038	23	4949	8154	7453	X	
North Dakota	10.219B	Physician I	4039	2	5417	6250	5834	X	
	10.219B	Physcian	4040	29	3906	5498	4503	X	
Oklahoma	10.219B	Physician (LIP)	4041	1	3273	4369	3821	X	
Pennsylvania	10.219B	Phys. Spec. in Family Practice	4042	3	4370	4573	4573	X	
Rhode Island	10.219B	Senior Physician	4043	21	2174	3543	3378	X	
South Carolina	10.219B	Physician I	4044	8	3661	5188	4162	X	
Utah	10.219B	Physician	4008	3	4878	5938	5252	X	
Virginia	10.219B	Corrections Physician	4048	16	4253	5809	5656	X	
Washington	10.219B	Physician II	4009	34	4339	5082	4937	X	
West Virginia	10.219B	Physician III	4049	1	4507	7799	6159	X	
Wyoming	10.219B	Medical Staff Physician	4049	7	4177	6677	4673	X	
				Average	4440	5953	5417		
				% difference	18	-14	-4		
				Weighted Avg.	4745	6810	5806		
				% difference	10	-21	-11		
				Nevada	5234	5234	5234		

ss: Sr. Physician (Range C)

te	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	National License
ansas	10.219C	Physician Specialist	4013	15	5303	5308	5308	X	
crado	10.219C	Physician IV	4003	1	3636	4872	4640	X	
rgia	10.219C	Physilan (Board Certified)	4018	32	6663	7946	7305	X	
inois	10.219C	Physician Specialist-Option B	4020	31	5000	6500	6255	X	X
iana	10.219C	Physician E II	4021	12	3340	5970	5355	X	
a	10.219C	Board Certified Phusician	4022	16	5136	6491	6434	X	
sas	10.219C	Physician II	4023	1	5475	6818	6147	X	X
tucky	10.219C	Physician Chief	4024	4	5500	7210	6953	X	
ne	10.219C	Physician III	4026	7	4382	6127	6134	X	X
yland	10.219C	Physician D	4027	128	4424	5755	5689	X	
sachusetts	10.219C	Physician III	4028	34	4258	5142	4700	X	
higan	10.219C	Physician IV	4029	8	6283	7951	7951	X	
nesota	10.219C	Sr. Staff Phys. (Range C)	4030	13	5391	8625	7097		
souri	10.219C	Medical Specialist II	4032	15	5501	6332	5921	X	
raska	10.219C	Physician III	4033	5	4167	6667	5819	X	
Hampshire	10.219C	Sr. Physician	4034	6	3976	4988	4988	X	X
Jersey	10.219C	Physician Specialist I	4035	86	4720	6603	5664	X	X
York	10.219C	Medical Specialist II	4037	213	5921	7026	6690	X	
th Dakota	10.219C	Physician II	4039	2	5833	7083	6458	X	
o	10.219C	Physician Specialist	4040	23	4375	6156	5011	X	
anoma	10.219C	Physician	4041	1	3781	5050	3803	X	
'e Islanc	10.219C	Supervising Physician	4043	13	3563	4010	3948	X	X
.h Carolina	10.219C	Physician II	4044	77	4121	5836	5271	X	
th Dakota	10.219C	Staff Physician	4045	1	5895	8842	6899	X	
hington	10.219C	Physician, Child Psychiatrist	4009	2	4790	5554	5554	X	
t Virginia	10.219C	Physician Specialist I	4049	1	4507	7799	6153	X	
consin	10.219C	Physician Supv.	4050	24	4502	6302	6590	X	

	Min. Sal.	Max. Sal.	Avg. Sal.
Average	4872	6428	5905
% difference	14	-16	-6
Weighted Avg.	5040	6431	6026
% difference	10	-16	-9
Nevada	5551	5551	5551

Class: Psychiatric Nurse I

S	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Nat. Lic.
Alaska	10.309	Nurse II	4012	100	2353	2804	2516	X	
Arizona	10.309	Psychiatric Nurse II	4001	83	1940	2894	2543	X	
Arkansas	10.309	Nurse II	4013	69	1393	2253	2025	X	
Colorado	10.309	Nurse IB	4003	305	2025	2344	2202	X	
Connecticut	10.309	Staff Nurse	4014	197	2031	2436	2178	X	
Delaware	10.309	Psych. Nurse III	4015	50	2268	2473	2473	X	
District of Columbia	10.309	Psychiatric Nurse	4016	70	2345	3827	3412	X	
Georgia	10.309	Staff Nurse (Inpatient Srvs)	4018	73	1611	2543	1923	X	
Hawaii	10.309	RPN III (generic concept)	4019	1	2409	2498	2454	X	
Idaho	10.309	Nurse, Psychiatric	4004	7	2038	2733	2142	X	
Illinois	10.309	Nurse I	4020	918	1767	2382	2141	X	
Indiana	10.309	Nurse IV	4021	191	1588	2368	1777	X	
Iowa	10.309	Nurse	4022	185	1945	2610	2226	X	
Kansas	10.309	Registered Nurse II	4023	16	1850	2479	1966	X	
Kentucky	10.309	Registered Nurse	4024	90	1508	2012	1814	X	
Louisiana	10.309	Registered Nurse II	4025	940	1498	2483	1878	X	
Maine	10.309	Nurse II	4026	45	1611	2179	1934	X	
Maryland	10.309	Nurse II, Institutional	4027	299	1784	2343	2292	X	
Massachusetts	10.309	Registered Nurse III	4028	918	2134	2566	2359	X	
Michigan	10.309	Clinical Nurse Spl. II	4029	8	2216	2897	2397	X	
Minnesota	10.309	Registered Nurse Senior	4030	190	2138	2901	2656		
Mississippi	10.309	Nurse II	4031	213	1595	2390	1922	X	
M[illegible]uri	10.309	Gaduate Nurse II	4032	137	1633	2039	1931		
Mo[illegible]na	10.309	Psych Nurse	4005	22	1507	2286	1811		
Nebraska	10.309	Nurse II	4033	136	1659	1752	1752	X	
New Hampshire	10.309	Registerred Nurse II	4034	80	1618	1912	1912	X	
New Jersey	10.309	N.C.T. Use Head Nurse Primaril	4035	318	1779	2490	2433	X	
New Mexico	10.309	Nurse II, Opt. C	4036	1	1449	2465	1957	X	
New York	10.309	Nurse II (Psych.)	4037	1999	1963	2487	2278	X	
North Carolina	10.309	Staff Nurse	4038	122	1662	2641	1856	X	
North Dakota	10.309	Registered Nurse II	4039	88	1627	2448	1901	X	
Ohio	10.309	Psychiatric Nurse II	4040	472	1903	2401	2219	X	
Oklahoma	10.309	Psychiatric Nurse I	4041	6	1619	2170	1730	X	
Oregon	10.309	Registered Nurse II	4007	116	1729	2163	2041	X	
Pennsylvania	10.309	Psychiatric Nurse I	4042	625	1644	2180	1973	X	
Rhode Island	10.309	Clin. Nurse Spec. Psychiatric	4043	6	2182	2465	2414	X	
South Carolina	10.309	Staff Nurse	4044	683	1544	2139	1893	X	
South Dakota	10.309	Staff Nurse	4045	38	1461	2193	1639	X	
Utah	10.309	Registered Nurse	4008	31	1986	2703	2216	X	
Vermont	10.309	Ver State Hosp Direct Care RN	4047	20	1714	2720	1886	X	
Virginia	10.309	Registered Nurse	4048	784	1596	2181	1761	X	
Washington	10.309	Registered Nurse II	4009	334	1701	2148	2094	X	
West Virginia	10.309	Nurse III	4049	1	1710	3033	2372	X	
Wisconsin	10.309	Registered Nurse II	4050	127	1932	2702	2104	X	
Wyoming	10.309	Institution Patient Care Spec.	4049	8	1673	2674	2178	X	
		Average			1822	2465	2142		
		% difference			-5	-7	0		
		Weighted Avg.			1802	2401	2128		
		% difference			-5	-4	0		
		Nevada			1715	2311	2232		

ss: Correctional Nurse II

te	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	National License
ska	10.318	Nurse III	4012	23	2518	3004	2830	X	
zona	10.318	Cor. Reg. Nurse	4001	60	1790	2671	2525	X	
ansas	10.318	Nurse II	4013	63	1393	2358	2035	X	
orado	10.318	Nurse IB	4002	305	2025	2044	2202		
necticut	10.318	Correctional Nurse	4014	33	2031	2436	2250	X	
trict of Columbia	10.318	Nurse (Correctional)	4016	70	2945	3827	3412	X	
rgia	10.318	Staff Nurse (Community/Clinic	4013	167	1611	2542	1708	X	
aii	10.318	RPN III (generic concept)	4019	1	2200	2438	2379	X	
ho	10.318	Nurse Registered, Charge	4004	26	1849	2478	1941	X	
nois	10.318	Nurse I	4020	918	1787	2532	2141	X	
iana	10.318	Nurse IV	4021	191	1588	2358	1777	X	
a	10.318	Nurse	4022	185	1945	2610	2232	X	
sas	10.318	Registered Nurse III	4023	272	2141	2353	2261	X	
tucky	10.318	Registered Nurse	4024	90	1508	2012	1814	X	
isiana	10.318	Corrections R.N. II	4025	2	1490	2021	1871	X	
sachusetts	10.318	Registered Nurse III	4028	918	2134	2566	2350	X	
higan	10.318	Registered Nurse III	4029	105	2068	2706	2771	X	
nesota	10.318	Registered Nurse Senior	4030	190	2138	2201	2066		
souri	10.318	Graduate Nurse III	4032	360	1845	2572	2160		
tana	10.318	Professional Nurse	4006	1	2048	2048	2048		
raska	10.318	Nurse II	4033	136	1663	1752	1752	X	
Jersey	10.318	N.C.T. Use Head Nurse primari	4035	130	1779	2437	2404	X	
York	10.318	Nurse II (Psych.)	4037	1487	1963	2437	2225	X	
th Carolina	10.318	Lead Nurse	4038	450	1736	2767	2020	X	
th Dakota	10.318	Registered Nurse II	4039	88	1627	1448	1901	X	
o	10.318	Nurse II	4040	61	1746	2154	1953	X	
ahoma	10.318	Registered Nurse II	4041	5	1742	2324	1742		
gon	10.318	Registered Nurse III	4007	110	2007	254.	2259	X	
nsylvania	10.318	Nurse I	4042	425	1849	2180	1703	X	
th Carolina	10.318	Staff Nurse	4044	663	1544	2189	1882	X	
th Dakota	10.318	Staff Nurse	4045	28	1461	2133	1633	X	
h	10.318	Registered Nurse	4026	31	1986	2706	2216	X	
mont	10.318	Correctional Health Care Spec.	4047	9	1619	2565	1711	X	
ginia	10.318	Registered Nurse	4043	784	1596	2181	1761		
hington	10.318	Registered Nurse II	4009	58	1701	2143	2034	X	
st Virginia	10.318	Nurse II	4048	1	1495	2041	2068	X	
sconsin	10.318	Registerd Nurse II	4050	61	1952	2703	2032	X	
					Average	1851	2482	2140	
					% difference	1	2	14	
					Weighted Avg.	1851	244	211	
					% difference	1	3	15	
					Nevada	1865	2524	2412	

Class: Occupational Therapist

State	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Nati Lice
A[illegible]	10.618	Ocupational Therapist I	4012	4	2353	2804	2373		
Arizona	10.618	Occup. Therapist II	4001	3	1655	2469	2062		
Arkansas	10.618	Occupaional Therapist II	4013	10	1333	2258	2085	X	
Colorado	10.618	Clinical Therapist	4003	42	2232	2584	2463		
Connecticut	10.618	Occupational Therapist II	4014	22	2239	2666	2324	X	
Delaware	10.618	O. T. I.	4015	3	1733	2889	1885	X	X
District of Columbia	10.618	Occupational Therapist	4016	2	2811	3653	3606		
Georgia	10.618	Occupational Therapist	4018	11	1611	2543	1949	X	
Hawaii	10.618	Occupational Therapist III	4019	53	1613	2491	2097		X
Idaho	10.618	Occupational Therapist	4004	5	1849	2478	2066	X	
Illinois	10.618	Physical/Occupational Therapis	4020	6	1728	2246	2173	X	
Indiana	10.618	Occupational Ther. IV	4021	7	1504	2246	1642		X
Iowa	10.618	Occupational Therapist I	4022	4	1945	2610	2499	X	
Kansas	10.618	Occupational Therapist	4023	23	1942	2602	1988	X	
Kentucky	10.618	Occupational Therapist	4024	5	1987	1987	1987	X	
Louisiana	10.618	Occupational Therapist I	4025	5	1498	2483	1760	X	
Maine	10.618	Occupational Therapist I	4026	5	1614	2200	1901	X	
Maryland	10.618	Occupational Therapist II	4027	48	1921	2524	2394	X	
Massachusetts	10.618	Occupational Therapist I	4028	153	2050	2450	2250	X	
Michigan	10.618	Occupational Therapist VI	4029	86	1967	2517	2486		
Minnesota	10.618	Occupational Therapist	4030	9	1916	2615	2181		
Mississippi	10.618	Therapist, Occupational	4031	2	1619	2426	1746		
Missouri	10.618	Occupational Therapist I	4032	36	1701	2177	1931		
Montana	10.618	Occupational Therapist	4005	3	1952	2224	1976		
Nebraska	10.618	DPI Occupational Therapist	4033	5	1669	2346	1805		
N[illegible]ampshire	10.618	Occupational Therapist I	4034	5	1618	1918	1912	X	
N[illegible]ersey	10.618	Senior Occupational Therapist	4035	19	2162	3027	2595		
New Mexico	10.618	Occupational Ther. II	4036	6	1596	2716	2389	X	
New York	10.618	Occupational Therapist	4037	38	1963	2487	2093	X	
North Carolina	10.618	Occupational Therapist I	4038	37	1811	2898	2026		
North Dakota	10.618	Occupational Therapist II	4039	25	1627	2448	1792	X	
Ohio	10.618	Occupational Therapist	4040	20	1903	3145	3145	X	
Oklahoma	10.618	Occupational Therapist	4041	12	1700	2278	1761	X	
Oregon	10.618	Occupational Therapist	4007	13	1870	2342	2285		
Pennsylvania	10.618	Occupational Therapist	4042	4	1590	2145	1663	X	
Rhode Island	10.618	Registered Occupational Therap	4043	4	1792	2059	2012		
South Carolina	10.618	Occupational Therapist II	4044	6	1954	2770	2023	X	
South Dakota	10.618	Occupational Therapist	4045	3	2099	3149	2326		
Utah	10.618	Occupational Therapist II	4008	3	2055	2523	2285	X	
Vermont	10.618	Occupational Therapist	4047	1	1714	2720	1832	X	
Virginia	10.618	Occupational Therapist	4048	48	1907	2605	2234		
Washington	10.618	Occupational Therapist 2	4009	24	1972	2520	2437	X	
West Virginia	10.618	Occupational Therapist I	4049	1	2142	3830	2986		
Wisconsin	10.618	Therapist II	4050	12	1952	2708	2149	X	
Wyoming	10.618	Occupational Therapist	4049	4	1846	2955	1917		
				Average	1862	2572	2166		
				% difference	-4	-7	14		
				Weighted Avg.	1911	2524	2280		
				% difference	-7	-5	11		
				Nevada	1788	2413	2474 (1)		

Nevada's average salary is a combination of employees on employer paid and employee/employer paid compensation.

: Physical Therapist

	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	National License
ka	10.634	Physical Therapist I	4011	1	1450	2201	1826	X	
a	10.634	Physical Therapist I	4012	3	2353	2804	2711	X	
na	10.634	Physical Therapist II	4001	1	1940	2894	2142	X	
sas	10.634	Physical Therapist II	4013	1	1393	2258	2085	X	
ado	10.634	Clinical Therapist	4003	42	2232	2584	2463		
cticut	10.634	Physical Therapist II	4014	19	2239	2666	2311	X	
are	10.634	P. T. I.	4015	1	1733	2389	1834	X	
ict of Columbia	10.634	Physical Therapist	4016	3	2346	3048	2684		
ia	10.634	Physical Therapist	4018	6	1611	2543	2151	X	
i	10.634	Physical Terapist III	4019	19	1613	2491	2132	X	
	10.634	Physical Therapist	4004	1	1849	2473	2164	X	
ois	10.634	Physical/Occupational Therapis	4020	6	1728	2546	2173	X	
na	10.634	Physical Ther. IV	4021	2	1674	2502	1855		X
	10.634	Physical Therapist I	4022	0	1945	2610	2278	X	
s	10.634	Phuysical Therapist	4023	5	2039	2733	2039	X	
cky	10.634	Physical Therapist	4024	1	2191	2698	2445	X	
iana	10.634	Physical Therapist I	4025	2	1603	2657	1783	X	
	10.634	Physical Therapist I	4026	2	1614	2200	2150	X	
and	10.634	Physical Therapist II	4027	13	1921	2524	2515	X	
chusetts	10.634	Physical Therapist II	4028	82	2050	2450	2250	X	
gan	10.634	Physical Therapist VI	4029	1	2141	2822	2672	X	
sota	10.634	Physical Therapist I	4030	1	1916	2521	2521		
ssippi	10.634	Therapist, Physical	4031	1	1755	2623	1835	X	
uri	10.634	Physical Therapist I	4032	4	1701	2177	2155		
na	10.634	Physical Therapist	4005	1	1647	2286	1967		
ska	10.634	DPI Physical Therapist II	4033	2	2073	2302	2235	X	
Hampshire	10.634	Physical Therapist I	4034	2	1618	1912	1912	X	
Jersey	10.634	Senior Physical Therapist	4035	5	2162	3027	2703	X	
Mexico	10.634	Physical Therapist II	4036	7	1536	2716	2501	X	
York	10.634	Physical Therapist	4037	12	1963	2467	2093	X	
h Carolina	10.634	Physical Therapist I	4038	18	1830	3035	1934		
h Dakota	10.634	Physical Therapist II	4039	7	1792	2690	2509	X	
	10.634	Licensed Physical Therapist	4040	1	2078	2769	2424	X	
homa	10.634	Physicial Therapist I	4041	1	1700	2278	1989	X	
on	10.634	Physical Therapist	4007	1	1870	2342	2342	X	
sylvania	10.634	Psysical Therapist	4042	1	1667	2259	2258	X	
e Island	10.634	Physical Therapist	4043	1	1518	1679	1599	X	
h Carolina	10.634	Physical Therapist I	4044	7	1879	2881	2030	X	
h Dakota	10.634	Physical Therapist	4045	1	1877	2817	2385	X	
ont	10.634	Physcat Therapist	4047	1	1714	2720	2217	X	
inia	10.634	Physical Therapist	4048	49	1907	2505	2279		
ington	10.634	Physical Therapist II	4009	7	1972	2520	2460		
Virginia	10.634	Physical Therapist I	4049	1	2142	3630	2986	X	
onsin	10.634	Therapist II	4050	70	1952	2709	2148	X	
ing	10.634	Physical Therapist	4049	1	1846	2955	2603		
					Average	1864	2601	2242	
					% difference	-4	-9	9	
					Weighted Avg.	1960	2600	2258	
					% difference	-10	-8	8	
					Nevada	1738	2415	2403 (1)	

Nevada's average salary is a combination of employees on employer paid and employee/employer paid compensation.

Class: Social Worker II

State	Class Code	Job Title	Empir. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	N L
Alaska	12.361	Social Worker III	4012	107	2702	3226	2955		
Arkansas	12.361	Social Worker II	4013	37	1292	2258	1806		
Colorado	12.361	Social Worker IB	4003	9	2126	2849	2285		
Hawaii	12.361	Social Worker III (generic)	4019	1	1613	2491	2052		
Illinois	12.361	Social Worker II	4020	145	1904	2495	2307	X	
Indiana	12.361	Social Worker IV	4021	77	1336	1996	1542		
Iowa	12.361	Social Worker II	4022	509	1581	1955	1782		
Louisiana	12.361	Soc. Svcs. Counselor II	4025	210	1222	2027	1586		
Minnesota	12.361	Social Worker Senior	4030	93	1916	2521	2280		
Nebraska	12.361	Social Serices Worker II	4033	55	1444	2021	1516		
New York	12.361	Social Work Asst. III	4037	422	2076	2624	2428		
North Carolina	12.361	Social Worker II	4038	252	1592	2522	1964		
South Carolina	12.361	Social Worker II	4044	92	1220	1871	1496		
Vermont	12.361	Social Worker A	4047	31	1581	2420	1745		
West Virginia	12.361	Social Serice Worker III	4049	1	1611	2302	1807	X	
					Average	1671	2372	1969	
					% difference	7	2	20	
					Weighted Avg.	1718	2318	2012	
					% difference	4	4	17	
					Nevada	1788	2415	2383	

ss: Social Worker II(1

e	Class Code	Job Title	Emplr. No.	Employees	Min. Sal.	Max. Sal.	Avg. Sal.	State Lic.	Nationa. License
bama	12.361A	Social Worker II	4011	466	1346	2046	1846		
zona	12.361A	Human Serv Spec II	4001	265	1533	2287	1775		
necticut	12.361A	Social Worker	4014	458	2309	2816	2496		
trict of Columtia	12.361A	Social Worker Assoc.	4016	4	1755	2282	2106		
aii	12.361A	Social Worker III (generic)	4019	1	1733	2491	2142		
ho	12.361A	Social Worker, Senior	4004	180	1761	2360	1952	X	
sas	12.361A	Social Worker II	4022	297	1762	2360	2040	X	
tucky	12.361A	Social Woker Principal	4024	3	1385	1882	1574		
ne	12.361A	Human Services Case Worker	4026	280	1523	2036	1840		
ylani	12.361A	Social Work Associate III	4027	35	1539	2070	1818	X	
sachusetts	12.361A	Social Worker III	4023	1027	1927	2523	2225		
higan	12.361A	Soc. Services SPL. VIB	4029	1531	1833	2441	2434	X	
sissippi	12.361A	Social Worker	4031	76	1244	1863	1504		
souri	12.361A	Social Service Worker II	4032	1129	1510	1922	1620		
tana	12.361A	Social Worker II	4005	122	1396	2251	1679		
Hampshire	12.361A	Social Worker II	4034	93	1554	1835	1795		
Jersey	12.361A	Social Worker II	4035	125	1694	2371	1948		
Mexico	12.361A	Social Worker II. Opt A	4036	33	1382	2348	1473		
th Dakota	12.361A	Social Worker II	4033	118	1549	2334	1742	X	
o	12.361A	Soc. Services Worker III	4040	309	1517	1819	1732		
ahoma	12.361A	Social Worker II	4041	1749	1742	2334	1758		
gon	12.361A	Social Service Worker II	4007	41	1589	2018	1788		
sylvania	12.361A	Social Worker I Caseworker	4042	113	1513	2060	1973	X	
ce Island	12.361A	Social Caseworker II	4043	176	1792	2306	1952		
th Dakota	12.361A	Human Services Social Worker	4045	14	1335	2004	1471		
n	12.361A	Social Worker	4008	22	1739	3116	2129	X	
ginia	12.361A	Social Worker B	4048	135	1451	1994	1739		
hington	12.361A	Caseworker II	4009	16	1626	2048	1855		
consin	12.361A	Social Worker II	4050	94	1952	2703	2095		
ming	12.361A	Family/Comm. Srrvices Spec	4049	60	1515	2421	1934		
				Average	1623	2239	1883		
				% difference	15	13	31		
				Weighted Avg.	1725	2285	1979		
				% difference	8	10	24		
				Nevada	1865	2524	2459		

Includes employees in protective services for children.

SUMMARY OF RESPONSES TO PSYCHIATRIST SURVEY QUESTIONNAIRE

A. SPECIAL PAY PRACTICES/BENEFITS

1. Do you pay malpractice insurance?

The majority of the states' comments indicate that Psychiatrists ar covered by their state's self insurance program.

Comments on page C-4.

2a. Do you allow your Psychiatrist to have a private practice on the side?

The majority of states indicate that they allow Psychiatrist to have private practice as long as it does not present a conflict of interest wit their State employment.

Affirmative answers with comments on page C-5.

2b. Do you provide public office space for private practice?

Only one state indicated that they provide public office space for privat practice.

See page C-5.

3. Do you reimburse costs for continuing education?

The majority of the states indicate that they do have some provision fo reimbursement of costs for continuing education. State policies vary, man require management approval and job relatedness with limitations on specific number of credit hours or dollar value per semester. One state Massachusetts, reports that education for State employees at State funde facilities is free (tuition reimbursement).

Affirmative answers with comments on page C-6.

4. Do you pay licensing fees?

Two states, Connecticut and Montana, report payments for licensing fees.

See page C-7.

5. a. Do you offer sabbaticals to Psychiatrists?

b. How is service provided during such absences?

Eleven states report a policy of providing sabbaticals for Psychiatrists Service is most typically provided by other staff, contractual arrangement or temporary appointments.

Affirmative answers with comments on page C-7.

6. a. Do you offer time-off to attend professional conferences, etc.?

   b. Do you pay out-of-state travel allowance to attend professional conferences, etc.?

   The majority of states provide time-off to attend professional conferences and pay for out-of-state travel. A number of states commented that the conferences must be job related and/or receive approval.

   Affirmative answers with comments on page C-8 and C-9.

7. Do you offer educational loans that are liquidated by work in public service?

   Only five states responded that they provided such a policy.

   Affirmative answers with comments on page C-10.

8. Do you offer cash bonuses to current employees who recruit a Psychiatrist?

   There were no affirmative answers to this question.

9. Do you offer new recruits a cash bonus for completion of a given period of service?

   Only two states responded, both indicating that this was negotiable.

10. Do you offer a special longevity pay plan for Psychiatrists?

    Six states indicated that they offer a special longevity pay plan for Psychiatrists. Specifics of their plans were, however, not reported.

11. Do you pay a geographical pay differential?

    Eight states report a geographical pay differential for Psychiatrist. Only one state, North Carolina, indicates a set amount, 10% for the Eastern or Western part of the state. Most of the other states indicate some discretion by departments.

12. Do they receive any special paid time off or special on-call pay arrangements?

    Nineteen states report a provision to provide compensatory time off or payment for on-call hours.

13. Do you offer any other special pay provisions or benefits not listed above?

    See comments from states on page C-12.

B. RECRUITING PRACTICES FOR PSYCHIATRISTS

1. Summarize advertising efforts listing particular professional journals newspapers, or other periodicals that have produced results.

   The major sources of advertising were professional journals and newspapers. Major newspapers such as the New York Times, Los Angeles Times Wall Street Journal and Boston Globe were named as producing good results.

See comments on page C-13.

2. Have you used a professional recruiting service? If so, please name company, total cost for a position, and summarize results.

   Seven states responded that they have used a professional recruiting service. Comp Health was named by three of the states with cost ranging from $5,900 to $20,000 per placement. Results of services were not very encouraging with only two states reporting placements.

See comments on page C-14.

3. Do you make recruiting visits to schools to recruit directly? Do these visits involve out-of-state travel for employees? If yes, have these efforts been successful?

   Fifteen states responded that they make recruiting visits to schools to recruit. Seven of them involved out-of-state travel. Results are inconclusive due to lack of response to this question by participants. The states which did respond indicate only limited success.

See comments on page C-15.

4. Do you direct mail information to potential Psychiatrists? If yes, where do you get the direct mail lists? Have these efforts been cost effective?

   Ten states indicate that they direct mail information to Psychiatrists Direct mail lists come from a variety of sources including recent graduates, referrals, AMA, boards and professional associations. Four of the states report that efforts have been cost effective.

See comments on page C-16.

PSYCHIATRIST SURVEY RESULTS

A. SPECIAL PAY PRACTICES/BENEFITS

1. Do you pay malpractice insurance?

STATE	YES/NO	COMMENTS
Alaska	No	The state is self insured; all employees covered.
Arizona	Yes	
Arkansas	Yes	
Delaware	Yes	Up to $1,300.00
Georgia	Yes	
Idaho	Yes	
Iowa	No	The State is self-insured.
Kansas	Yes	Varies - between agencies: $0 to $5,000
Kentucky	Yes	
Louisiana	Yes	
Maine	No	Tort Law.
Maryland	No	Tort Law - $100,000 liability limit.
Mississippi	Yes	Negotiable.
Missouri	No	State self insured fund.
Montana	Yes	Self insured through state.
New Hampshire	Yes	
New Jersey	No	State is self insured, so not necessary while employed by us.
New Mexico	Yes	
New York	No	Blanket coverage by State.
North Dakota	Yes	$500,000 for all employees, physicians/ psychiatrists may purchase more.
Oregon	No	State paid Tort liability.
Pennsylvania	Yes	
Rhode Island	No	Only when there is no outside practice.
Utah	No	State takes obligation.
Virginia	Yes	Malpractice insurance in the amount of $1,000,000 is provided for all psychiatrists.
Washington	No	Self insured.
Wyoming	Yes	

2a. Do you allow your Psychiatrist to have a private practice on the side?

Yes responses with comments as follows:

STATE	COMMENTS
Arkansas	
Colorado	
Connecticut	So long as no conflict of interest.
Delaware	
District of Columbia	Providing that it does not cause a conflict.
Georgia	
Hawaii	
Illinois	
Indiana	
Iowa	As long as no conflict of interest.
Kansas	Varies among agencies.
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	Not during working hours.
Mississippi	
Missouri	Not on State time.
Nebraska	The private practice or consulting work must be their own time and cannot conflict with Interest work with State.
New Hampshire	
New Jersey	With prior approval.
New Mexico	
New York	
North Carolina	
North Dakota	If it doesn't interfere.
Ohio	As long as it does not conflict with assigned wo hours.
Oregon	
Pennsylvania	
Rhode Island	
South Dakota	Outside standard work hours.
Utah	Need own insurance then.
Vermont	If it does not conflict with State role.
Virginia	Approval of department head and commissione contingent on no conflict with assigned duties interests.
Washington	Usually not the case.
West Virginia	
Wisconsin	

2b. Do you provide public office space for private practice?

Yes responses with comments as follows:

STATE	COMMENTS
South Dakota	But not during working hours.

3. Do you reimburse costs for continuing education?

Yes responses with comments as follows:

STATE	COMMENTS
Alaska	
Arkansas	
Connecticut	Up to 9 credits per semester.
Hawaii	
Idaho	Totally job-related.
Illinois	
Iowa	If approved by management.
Kentucky	
Louisiana	Partial reimbursement.
Maryland	Do not pay for regular schooling; however, do pay for conferences where workshops are available for academic credit.
Massachusetts	Education at State facilities is free.
Mississippi	Negotiable.
Missouri	
Montana	
Nebraska	Tuition assistance - 75% of up to a maximum of six credit hours per semester, provided course work job related.
New Hampshire	
New Jersey	Sometimes if funds are available.
New Mexico	
New York	
North Carolina	
North Dakota	
Ohio	At discretion of appointing authority and based on availability of funding.
Oregon	Allow up to $500.00 per person per biennium.
Pennsylvania	
Rhode Island	Partially, 15 days educational leave for conferences.
South Dakota	Partial
Utah	
Vermont	Consider on individual case basis.
Virginia	
West Virginia	Possibly. Stipend available.
Wisconsin	Varies.
Wyoming	Within budgetary limitations.

4. Do you pay licensing fees?

Yes responses:

STATE	COMMENTS
Connecticut	
Montana	

5a. Do you offer sabbaticals to Psychiatrists?
b. How is service provided during such absences?

Yes responses with comments regarding how service is provided:

STATE	COMMENTS
Connecticut	Participation very limited.
Hawaii	Temporary replacement when necessary.
Indiana	Up to the appointing authority at each hospital Temporary staff.
Louisiana	We could make arrangements for unpaid LOA Restricted or temporary appointments or contract.
Mississippi	Another staff member.
Montana	Increased workload.
Nebraska	Services are assumed by other doctors.
New Mexico	
North Dakota	Short duration retreats; long term-no. Othe physicians will cover for them.
Rhode Island	Up to 6 months for professional enrichment throug the use of part-time hires.
Vermont	Will consider if requested. Contractual servic arrangement.

6a. Do you offer time off to attend professional conferences, etc.?

Yes responses with comments as follows:

STATE	COMMENTS
Alaska	
Arizona	
Arkansas	
Colorado	
Connecticut	Time off deducted from employee's leave.
Delaware	5 days per year.
District of Columbia	Administrative leave.
Georgia	
Hawaii	
Idaho	
Illinois	
Indiana	Depending on workload.
Iowa	If approved by management.
Kansas	
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	
Michigan	
Mississippi	
Missouri	On individual basis.
Montana	
Nebraska	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	Administrative leave is granted.
North Dakota	
Ohio	
Oklahoma	
Oregon	As needed.
Pennsylvania	
Rhode Island	Only conference tuition.
Utah	
Vermont	
Virginia	
Washington	
West Virginia	
Wyoming	

6b. Do you pay out-of-state travel allowance to attend professional conferences, etc.?

Yes responses with comments as follows:

STATE	COMMENTS
Alaska	
Arizona	Only if directly related to duties.
Arkansas	
Connecticut	$400 per year for conference and travel costs.
Delaware	Only to the extent that funds are available.
District of Columbia	Depending upon the budget.
Georgia	
Idaho	
Illinois	
Iowa	If approved by management and executive council.
Kansas	
Kentucky	
Louisiana	Only if we require them to attend.
Maine	By approved request.
Maryland	
Michigan	
Mississippi	
Missouri	On individual basis.
Nebraska	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	
North Dakota	
Ohio	If authorized by employer.
Oklahoma	
Oregon	Meals-$22; lodging - commercial travel - minim available.
Pennsylvania	
Utah	
Vermont	
Virginia	
Washington	
West Virginia	Contingent upon benefits to be derived by Heal Department.
Wyoming	Out-of-state travel has been cut from 89-budgets.

7. Do you offer educational loans that are liquidated by work in public service?

Yes responses with comments as follows:

STATE	COMMENTS
Louisiana	
Mississippi	
North Carolina	
Ohio	At discretion of appointing authority.
West Virginia	Provide educational leave with pay. Incumbent must agree to work for state for a certain length of time. 1 semester = 8 months work.

8. Do you offer cash bonuses to current employees who recruit a Psychiatrist?

STATE	COMMENTS

(No affirmative answers.)

9. Do you offer new recruits a cash bonus for completion of a given period of service?

Yes responses with comments as follows:

STATE	COMMENTS
Mississippi	Negotiable.
South Dakota	Negotiable.

10. Do you offer a special longevity pay plan for Psychiatrists?

Yes responses with comments as follows:

STATE	COMMENTS
Hawaii	
Kansas	Built into schedule.
Maine	Per union contract.
Mississippi	
Ohio	
Utah	

11. Do you pay a geographical pay differential?

Yes responses with comments as follows:

STATE	COMMENTS
Indiana	Indirectly. Higher salaries can be commanded a certain locations.
Kansas	
Louisiana	This can be done.
Massachusetts	
Missouri	Recruitment rates set by facilities.
North Carolina	10% more paid to go to Eastern & Western part c state.
Ohio	If requested and authorized by director of Depart ment of Administrative Services.
West Virginia	Possibly, depends on Health Department's needs.

12. Do they receive any special paid time off or special on-call pa arrangements?

Yes responses with comments as follows:

STATE	COMMENTS
Alaska	Officer of the Day pay.
Colorado	On-call time back.
Connecticut	$310 for each night of standby duty.
Delaware	Comp time.
District of Columbia	
Georgia	
Idaho	On-call administrative leave.
Illinois	
Maine	As arranged with agency clinical directors.
Massachusetts	On-call or standby pay/Board certificati incentive.
Missouri	On-call policy usually set by facilities.
Montana	Accrue compensatory time.
North Carolina	Compensatory time is provided for hours on-call the rate of 1 hour for every 8 hours on-call.
North Dakota	
Ohio	On-call pay for Mental Health & Mental Retard tion/Developmental Disabilities.
Pennsylvania	On-call - quarterly payment.
Rhode Island	Compensatory time; contractual basis for nig admissions: $20 an hr. weekdays; $22 an hr. wee ends.
Utah	16 hours comp per weekend worked.
Wisconsin	

13. Do you offer any other special pay provisions or benefits not listed above?

Yes responses with comments as follows:

STATE	COMMENTS
Iowa	Officer of the Day-1 hr. of comp. time for 3 hrs. service. Clinical Director Pay-10% in addition to salary.
Louisiana	Some facilities may offer housing.
Missouri	Housing at some facilities.
North Carolina	Extended duty policy for direct care and treatment of patients, provides straight time payment at a rate of pay to be determined by the nature of the duties performed. May be higher, lower or the same as the established rate of pay.

B. RECRUITING PRACTICES FOR PSYCHIATRISTS

1. Summarize advertising efforts listing particular professional journals newspapers, or other periodicals that have produced results.

STATE	COMMENTS
Alaska	Psychiatric News and Clinical and Hospita Psychiatry. Don't run ads in any newspaper. Othe journals considered were too expensive.
Arizona	Local newspapers and State Association newsletter.
Arkansas	Use Psychiatric publications.
Colorado	Local newspaper, Statewide Recruitment and Nation Psychiatric News.
Connecticut	Modest results from a variety of professional jou nals and newspapers.
District of Columbia	For hard to fill positions we use major newspaper such as Washington Post, New York and Los Angel Times, professional journals and magazines.
Georgia	Depends on the area of the state but advertising done through professional journals.
Illinois	AMA Journal - local newspapers.
Iowa	Journal of American Medical Association, Psychi tric News, Hospital & Community Psychiatry, Io Medical Journal.
Kansas	Varies among individual agencies.
Kentucky	Contact with two state medical schools - word mouth.
Maine	Journals (APA primarily).
Maryland	Professional journals such as Psychiatric News, t American Psychiatric Journal, and the Psychiatr Times and local newspapers.
Michigan	Due to the specialized nature of the position individual departments such as Mental Health a Corrections have advertised in local newspapers a journals.
Missouri	Continuous advertising in Psychiatric News a Clinical Psychiatry News have produced be results.
Montana	Journals, Psychiatric Times and Psychiatric News.
Nebraska	Advertised in Psychiatric Times, Hospital Communi Psychiatry and Psychiatric News.
New Jersey	We use the Newark Star Ledger, the New York Tim and the Philadelphia Inquirer. The New York Tim has produced the best results.
New Mexico	We use all mediums listed above with good results
North Carolina	Advertised in Psychiatric Times and Psychiatr News Journals; American Psychiatric Associati Convention; Opportunities for Psychiatrists (pu lished by Division of Mental Health).
North Dakota	Four major sources: Hospital & Community Psychi trist, Psychiatric Times, Clinical Psychiatr News, Psychiatric News.

1. (cont.)

STATE	COMMENTS
Oregon	Recruitment by word of mouth and advertising in newspaper.
Pennsylvania	APA News, Psychiatrist News, Hospital & Community Psychiatric News Letter.
Rhode Island	Advertisements in Rhode Island Medical Society Journal resulted in 9 hires; Boston Globe and New York Times have been successful as well.
South Dakota	APA News, Hospital & Community Psychiatry.
Utah	Journal of Psychiatry used.
Virginia	Richmond Times Dispatch, Roanoke Times and World News; Norfolk Virginian Pilot; Hampton Daily Press; Wall Street Journal.
Washington	Recruited locally (where hospitals are) - local newspapers, professional journals, word-of-mouth, keep announcement bulletin open continuously.
West Virginia	May advertise in professional journals.
Wyoming	Psychiatric Times, Psychiatric News, Hospital and Community Psychiatry, Denver and Salt Lake City papers.

2. Have you used a professional recruiting service? If so, please name company, total cost for a position, and summarize results.

Yes responses with comments as follows:

STATE	COMPANY USED	TOTAL COST PER POSITION	SUMMARIZATION OF RESULTS
Alaska	Comp Health	$20,000	None placed as of yet.
Colorado	Comp Health	$5,900	Obtained Psychiatrist
Georgia			
Idaho	AMA		Results not good.
North Dakota	Psychiatric Placement Service		
South Dakota	Hospital & Community Psychiatry		
Wyoming	Comp Health	Temporary $10,600 mo.	Permanent hire would require paying Comp Health $20,000 for each psychiatrist hired. Obtain only temporaries no permanent placements. Currently negotiating with NOVA Med. Group.

3. Do you make recruiting visits to schools to recruit directly? Do the visits involve out-of-state travel for employees? If yes, have the efforts been successful?

STATE	RECRUITING VISITS	OUT-OF-STATE TRAVEL	HAVE EFFORTS BEEN SUCCESSFUL?
Connecticut	Yes	Yes	Minimally
Kansas	Yes	No	Limited success.
Kentucky	Yes (1)	Yes (1)	Moderately successful.
Maryland	Yes	Yes	Ongoing contact and exchange of informatio between schools in the geographic region and headquarters personnel
Michigan	Yes	No	Success of recruitment is difficult to determine since it mainly involves career fairs.
Mississippi	Yes	Yes	Minimally successful.
Missouri	Yes (2)		Success not yet determinable; only done onc
Nebraska		Yes	No results.
New York	Yes	No	
North Carolina	Yes	No	
Oregon	Yes (3)	No	
South Dakota	Yes	Yes	Yes
Virginia	Yes		
West Virginia	Yes		
Wyoming	Yes	Yes (4)	No

(1) American Psychiatric Association conventions.
(2) University of Missouri-Columbia, University of Missouri-Kansas City Psychiatric Residency Programs, small luncheon for each school.
(3) University of Oregon only.
(4) Usually connected with other related business, trips are not solely for recruitment purposes.

4. Do you direct mail information to potential Psychiatrists? If yes, where do you get the direct mail lists? Have these efforts been cost effective?

STATE	YES	WHERE DO YOU OBTAIN LISTS?	COST EFFECTIVE?
Arkansas	Yes	Recent graduates.	Yes
Colorado	Yes	Referrals	Yes
Idaho	Yes	AMA	No
Kansas	Yes	Personal contacts.	
Kentucky	Yes	Kentucky Psychiatric Association	No
Missouri	Yes	Internal sources and AMA.	Have good cost-per-hire ration. Was successful in past.
North Carolina	Yes		
North Dakota	Yes	Bd. of Medical Exmrs.	Cost effectiveness questionable.
South Dakota	Yes	Training sites.	Unknown.
Virginia	Yes	Licensing Boards, professional organizations.	Yes

SUMMARY OF RESPONSES TO PSYCHIATRIC NURSING SURVEY QUESTIONNAIRE

A. SPECIAL PAY PRACTICES/BENEFITS

1. Do you reimburse costs for continuing education?

   Thirty-four states report a policy of reimbursement for continuing educa tion. Of those commenting, the majority indicate payment is based on mar agement approval and job relatedness and is limited to a specific number c credit hours or a dollar value per semester. One state, Massachusetts reports that education for State employees at State funded facilities i free (tuition reimbursement).

   Affirmative answers with comments on page D-4.

2. Do you pay licensing fees?

   Only Connecticut reports a policy of paying licensing fees.

3. Do you employ students on a part-time basis as "interns"?

   Nineteen states report such a policy.

   Affirmative answers with comments on page D-5.

4. Do you offer educational loans that are liquidated by subsequent service your organization or repayable at special interest rates over a period years?

   Ten states report such a policy.

   Affirmative answers with comments on page D-5.

5. Do you differentiate in salary between nurses who have completed a progr of less than 4 years versus those who have completed a 4 year program a received a BS degree?

   Eleven states report such a policy, generally implemented at the time hire.

   Affirmative answers with comments on page D-6.

6. Do you offer cash bonuses to current employees who recruit another Nurse?

   No affirmative answers to this question.

7. Do you offer new recruits a cash bonus for completion of a given period of service?

Only four states report a cash bonus or cash payment.

Affirmative answers with comments on page D-6.

8. Do you offer special longevity pay for Nurses?

Only two states report a special longevity recognition program for Nurses.

9. Do Nurses receive premium pay for working overtime? (If yes, at what rate?)

Twenty-seven states report a premium payment for Nurses. Most respondents indicate the premium payment is at time and one-half.

Affirmative answers with comments on page D-7.

10. Do you provide any special paid time off or special on-call pay arrangements?

Only seven states report such a policy. Compensatory time is provided or cash payment based on the number of hours in on-call status.

11. Do you hire at accelerated pay rates contingent on experience and/or education?

Thirty-one states have such a policy, primarily based on experience and education.

Affirmative answers with comments on page D-9.

12. Do you use fixed shifts for the Nurses in your facilities? How many days and hours are the Nurses on shift? (Indicate any flexible shift arrangements.)

Thirty-seven states reported fixed shift (5 days - 8 hours/day) arrangements for Nurses. Most states report 40 hour weeks with employees working five-eight hour shifts. Six states report that they provide for flexible shift arrangements.

13. Do you pay a shift premium for Nurses that is different than other employees?

Twenty-two states indicate that they provide a shift premium which is different than other employees. Of those reporting a fixed amount, an average of $.75/hour is paid for the second shift and $.83/hour for the third shift.

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14. Do you offer any other special pay provisions or benefits not listed above

Six states responded. (See comments on page D-11.)

B. RECRUITING PRACTICES

1. Summarize advertising efforts listing professional journals, newspapers, c other periodicals that have produced results.

Twenty-eight states responded. Most indicate that they have obtained the best results from newspaper advertising.

Affirmative answers with comments on page D-12.

2. Have you used any professional recruiting service? If so, please name coı pany, total cost for a position, and summarize results.

Only five states responded that they have used a professional recruiting service. Comments do not provide sufficient information relevant to cost or results.

Affirmative answers with comments on page D-13.

3. Do you make recruiting visits to schools to recruit directly? Do these visits involve out-of-state travel for employees. If yes, have these efforts been successful?

Twenty-seven states make recruiting visits. Only seven of these report that recruiting involves out-of-state travel. While comments regarding success are inconclusive due to limited response some do indicate good success from recruiting efforts, mostly in-state.

4. Do you direct mail information to potential Nurses? If yes, where do you get the direct mail lists? Have these efforts been cost effective?

Ten states indicated that they direct mail information to nurses. Direct mail listings come from State licensing agencies, state nursing boards, a school and nursing associations.

Affirmative answers with comments on page D-15.

PSYCHIATRIC REGISTERED NURSE SURVEY RESULTS

A. SPECIAL PAY PRACTICES/BENEFITS

1. Do you reimburse costs for continuing education?

Yes responses with comments as follows:

STATE	COMMENTS
Arizona	Only 6 semester hours per semester.
Alaska	
Connecticut	Up to 9 credits per semester.
Delaware	Up to $750.00 per year for job related courses.
Hawaii	
Idaho	Job related.
Illinois	
Iowa	If approved by management.
Kentucky	
Louisiana	If we require them to attend.
Maine	Partial, upon approved request for education loan.
Maryland	
Massachusetts	Education at state facilities is free.
Montana	
Mississippi	
Missouri	At some facilities on individual application.
Nebraska	Tuition assistance - 75% of up to a maximum of six credit hours per semester provided course work is job-related.
New Hampshire	
New Jersey	Occasionally, if funds available.
New Mexico	
New York	
North Carolina	
North Dakota	
Ohio	Subject to discretion of appointing authority and based on availability of funding.
Oregon	As resource permits.
Pennsylvania	Up to a maximum of $625.00.
Rhode Island	
South Dakota	Minimal amount - no budget - provide in-service.
Utah	
Vermont	Paid leave of absence can be considered.
Virginia	Subject to approval and available funding.
West Virginia	Stipend fund available.
Wisconsin	Varies.
Wyoming	Within budget limitations.

2. Do you pay licensing fees?

Yes responses with comments as follows:

STATE	COMMENTS
Connecticut	

3. Do you employ students on a part-time basis as "interns"?

Yes responses with comments as follows:

STATE	COMMENTS
Alaska	As of 7/1/88.
Colorado	
Georgia	
Illinois	
Indiana	
Kentucky	Very limited.
Louisiana	
Maine	At Bangor Mental Health Institute.
Mississippi	Varies.
Missouri	At some facilities.
Nebraska	
New Jersey	Have a 3 month internship program with local nursin schools.
New Mexico	
North Dakota	
Ohio	
Oklahoma	
South Dakota	Just started this year.
Utah	
Vermont	

4. Do you offer educational loans that are liquidated by subsequent service i your organization or repayable at special interest rates over a period o years?

Yes responses with comments as follows:

STATE	COMMENTS
Delaware	Year for year.
Indiana	
Kentucky	Educational leave contracts for employees - repai through services.
Louisiana	
Mississippi	Negotiable.
New Hampshire	
North Carolina	
Ohio	Subject to discretion of appointing authority.
Virginia	
West Virginia	Liquidated by subsequent service.

5. Do you differentiate in salary between nurses who have completed a program of less than 4 years versus those who have completed a 4 year program and received a BS degree?

Yes responses with comments as follows:

STATE	COMMENTS
Arkansas	
Delaware	Hired at a higher entry level.
Georgia	Only the hiring level (step). One step for BS; two steps for MS.
Maine	Entry level only; upon approved request by appointing agency.
Maryland	
Missouri	
New Jersey	We currently pay a one time bonus of $500 for BS and $1,000 for MS in nursing.
New Mexico	
New York	Pay additional salary for BS and/or experience.
Oregon	Baccalaureate in nursing - 4.75% of salary. Master's degree in nursing - 9.5% of salary.
Rhode Island	

6. Do you offer cash bonuses to current employees who recruit another Nurse?

STATE	COMMENTS

No affirmative answers.

7. Do you offer new recruits a cash bonus for completion of a given period of service?

Yes responses with comments as follows:

STATE	COMMENTS
Connecticut	$500 after 12 months on 2nd or 3rd shift. Planned increase to $1,500 in three increments beginning November 1988.
Ohio	Not a cash bonus. Professional Achievement Incentive Levels for all under 1199 contract. Level 1 - 10% of step one of pay range. Level 2 - 15% of step one of pay range. Level 3 - 20% of step one of pay range.
New Jersey	$3,000 annually in quarterly lump sum payments.
Pennsylvania	Nurse Retention Incentive Bonus - $3,000 annually in Philadelphia area only.

8. Do you offer special longevity pay for Nurses?

Yes responses with comments as follows:

STATE	COMMENTS
Maine	.15/hr. over 15 years. .25/hr. over 20 years.
Rhode Island	

9. Do Nurses receive premium pay for working overtime? (If yes, at wh rate?)

STATE	COMMENTS
Alaska	Time and one-half.
Colorado	Time and one-half after 40 hour week.
Connecticut	Time and one-half after 40 hours.
Delaware	1-1/2 hourly rate of pay.
District of Columbia	Overtime is paid at the rate of 1-1/2 OT.
Hawaii	Over 8 hrs. day; 40 hrs. week; work on holiday.
Illinois	
Indiana	Overtime is at time and one-half.
Kansas	1.5 times rate of pay.
Louisiana	Rate varies by shift and facility.
Maine	Nurse I & II @ 1-1/2; Nurse III @ 1-1/2 for fu shift only.
Massachusetts	Time and one-half after 40 hours/week or 8 hrs./da
Michigan	Time and one-half employee's regular rate.
Missouri	
Nebraska	Time and one-half.
New Hampshire	All nursing positions by law are entitled to ti and one-half pay after 40 hours.
New Jersey	Time and one-half.
New York	Time and one-half for over 40 hours.
North Carolina	Time and one-half.
North Dakota	Time and one-half.
Ohio	Time and one-half.
Oregon	Time and one-half.
Pennsylvania	1-1/2 and double time for 7th consecutive day.
Rhode Island	Time and one-half only.
Virginia	1.5 or straight time at facility option.
Washington	1.5 times base rate.
Wyoming	Time and one-half over 40 hours.

10. Do you provide any special paid time off or special on-call pay arrangements?

Yes responses with comments as follows:

STATE	COMMENTS
Colorado	Compensatory time.
District of Columbia	Nurses shall be compensated at one-half their basic hourly rate for hours in an on-call status.
Idaho	On-call administrative leave.
Massachusetts	Stand-by pay.
Michigan	One hour straight time pay for five (5) hours on-call.
North Carolina	$.94 per hour for being on-call.
Washington	Standby pay @ $.63 to $.84 per hour.

11. Do you hire at accelerated pay rates contingent on experience and/or education?

Yes responses with comments as follows:

STATE	COMMENTS
Arizona	
Alaska	Four categories of Nurses I-IV dependent on experience.
Arkansas	
Colorado	Nurse I-A and I-B.
Connecticut	Hiring above minimum not uncommon.
Delaware	Negotiable depending on education and experience.
District of Columbia	Based on superior qualification standards.
Georgia	One step for BS; two steps for MS.
Idaho	
Indiana	Two percent per year of education/experience.
Iowa	
Kentucky	
Maine	
Maryland	Blanket authorization to recruit at above base salary due to recruitment problems.
Massachusetts	
Missouri	
Nebraska	
New Hampshire	
New Jersey	Hire graduate nurses at step 8.
New Mexico	
New York	
North Carolina	
Oregon	At a rate within the approved salary range.
Rhode Island	
South Dakota	In some instances.
Utah	
Vermont	May do on case-by-case basis.
Virginia	Negotiable based on experience.
Washington	We are having recruiting problems for Register Nurses.
West Virginia	
Wyoming	2-1/2% (1 step) for every year of experience above the minimum to a maximum of 6 steps.

12. Do you use fixed shifts for the Nurses in your facilities? How many days and hours are the Nurses on shift? (Indicate any flexible shift arrangements.)

STATE	COMMENTS
Arizona	40 hours.
Alaska	7-3 3-11 11-7 7:30-3:30 3:30-11:30 11:30-7:30 Total=37.5/hr/wk
Colorado	40 hour week.
Connecticut	Permanent assignment to 1st, 2nd or 3rd shift.
Delaware	7-1/2 hr. days/37-1/2 hrs. per week. Flex time must equal 37-1/2 hours per week.
Georgia	
Hawaii	Five 8 hour shifts per week.
Idaho	Mostly 8 hour shifts, 5 days/week.
Illinois	
Indiana	5 days - 40 hours per week.
Iowa	7am-3pm 5 days; 3pm-11pm 5 days; 11pm-7am 5 days. Have some flexibility from institution to institution.
Kentucky	
Louisiana	Most shifts are 8 hrs/5 days. Some are 10 hrs/4 days. Weekend shifts are 12 hrs/2 days.
Maine	8 hour shifts; others by approved request.
Maryland	Most rotate shifts for 40 hour week. Some facilities allow employees to request permanent evening or night shift.
Massachusetts	8 hour shift/flex time.
Michigan	
Mississippi	40 hour work week, normal.
Missouri	Yes and no - this can vary between facilities.
Montana	Five days, 40 hours.
Nebraska	5 days/8 hour shift or 8/80.
New Hampshire	Shifts are fixed at 40 hours on a five day shift.
New Jersey	8 hours per day. Five days per week.
New Mexico	
New York	8 hour shifts. Flexibility determined by facility.
North Carolina	Varies considerably.
Ohio	5 days - 8 hour shift.
Oregon	40 hours - 5 days.
Rhode Island	8 hour shifts.
South Dakota	8 hours part-time or full-time then comp time.
Utah	Alternating shifts 40 hours per week.
Vermont	Shifts generally fixed and for 40 hours but position sharing and part-time services also used.
Virginia	Shifts vary among facilities. Staggered work hours or alternate work schedules at agency head's discretion.
Washington	40 hours per week (flex time possible).
West Virginia	5 days, 40 hours.
Wisconsin	Varies.
Wyoming	

13. Do you pay a shift premium for nurses that is different than othe employees?

STATE	COMMENTS
Arkansas	
Connecticut	60¢/hr. for supervising nurses; 55¢/hr. for nurses.
Delaware	
Georgia	
Illinois	
Kansas	Varies, generally $.90 per hour.
Kentucky	
Louisiana	
Maryland	62¢ per hour evening and night differential. Prc posals for FY89 including raising differential t $1.25 per hour and paying weekend differentials.
Massachusetts	
Nebraska	Shift differential of 80¢/hr. second shift $1.00/hr. third shift.
New Mexico	
New York	Amounts vary by geographic area.
Ohio	If requested by employer.
Oklahoma	
Oregon	75¢ per hour - evening shift, 85¢ per hour - nigl shift.
Pennsylvania	Weekend differential of $8.00 per hour (only i Philadelphia area).
South Dakota	P.M. and night shift.
Utah	30¢, 60¢, 90¢ differentials per hour.
Virginia	Up to 9% of step 1 of assigned salary grade f rotating nurses. 13.5% of step 1 for permaner shift assignment.
Washington	$1.00 per hour ($.50 for all others).
Wisconsin	

14. Do you offer any other special pay provisions or benefits not listed above

Yes responses with comments as follows:

STATE	COMMENTS
Hawaii	.30/hr. for working in corrections facility; .40/h various other specified areas such as closed inte sive supervision unit.
Maine	Stipends authorized by legislature to enhan recruitment and retention.
Massachusetts	Two professional days off/year.
New Jersey	We spend 1/4 to 1/2 million per year on scholarshi for paraprofessional employees to become Nurses wi a 71% retention rate, which is unusually high f us. Also have recruitment and retention paymen (see attached SAM $11-88).
North Carolina	Holiday premium pay.
Rhode Island	College tuition for advanced degrees.

B. RECRUITING PRACTICES

1. Summarize advertising efforts listing professional journals, newspapers, or other periodicals that have produced results.

Yes responses with comments as follows:

STATE	COMMENTS
Arizona	Local newspaper ads have produced good results. Other media has been sporadic.
Alaska	No advertising for Sr. Psychiatric Nurses. For Registered Nurses, trade newspapers have been successful. Presently revising procedures.
Arkansas	Use classified section in local papers only.
Colorado	Local newspaper, periodically for Statewide Nursing Conventions.
Connecticut	Minimal results from American Nurses Assn., magazine, better results from local newspapers.
Delaware	Local newspaper and local colleges with nursing courses. Results have been limited.
District of Columbia	For hard to fill positions, we use major newspapers, such as Washington Post, New York Times, Los Angeles Times, professional journals and magazines.
Georgia	Professional journals - other advertising efforts depend on area of the state.
Illinois	Local newspapers - Nursing Spectrum.
Kansas	Local newspapers.
Kentucky	Newspapers.
Maine	Newspapers in labor market area of appointing agency. Journals and N.E. distribution for senior nursing staff only.
Maryland	Mainly local area newspapers.
Michigan	Individual departments such as Mental Health and Corrections have advertised in local newspapers and journals, due to the specialized nature of the positions.
Missouri	Job fairs, presentation at nurse schools and ads in local papers give best results.
Montana	Professional journals and newspapers.
New Jersey	We advertise for nurses in newspapers throughout the state both large and small. In addition, we use the New York Times for North Jersey and the Philadelphia Inquirer for South Jersey needs.
New Mexico	We use all mediums listed with good results.
North Dakota	State newspapers and publications - generally in-state.
Oregon	Newspaper advertising, local market recruitment.
Pennsylvania	American Nurse - Current Health Care Jobs (Va.) - Health Care Career (Fl.)
Rhode Island	A contractual advertising agency places recruitment ads in the largest state newspaper.
South Dakota	Br. of nursing Newsletter and Nurses Assn. Journals.
Utah	Local newspapers.

1. (cont.)

STATE	COMMENTS
Virginia	Richmond Times Dispatch, Roanoke Times and World News; Norfolk Virginian Pilot; Hampton Daily Press Wall Street Journal.
Washington	Our nurses are recruited locally (where hospitals are) - local newspaper ads, state recruiting bulletins, some statewide journals.
West Virginia	Professional nursing journals, newspapers.
Wyoming	American Journal of Nursing (AJN), Salt Lake City and Ogden, Utah papers.

2. Have you used any professional recruiting service? If so, please name company, total cost for a position, and summarize results.

Yes responses with comments as follows:

STATE	COMMENT
Delaware	Hamm & Assoc. Just recently contracted this company-too early to measure results.
Georgia	
New Jersey	Until three years ago used Rank International, N.Y. city and paid $800/position but they no longer service us since we are not a large enough customer compared to N.Y. city organizations.
Oklahoma	
Vermont	

3. Do you make recruiting visits to schools to recruit directly? Do these visits involve out-of-state travel for employees? If yes, have these efforts been successful?

STATE	YES/NO	OUT-OF-STATE TRAVEL	HAVE EFFORTS BEEN SUCCESSFUL?
Arizona	Yes	Yes	No
Colorado	Yes	No	Yes Recruitment/Schools
Connecticut	Yes	Seldom	
Delaware	Yes	Yes	Limited
Georgia	Yes		
Hawaii	Yes	No	
Kansas	Yes		In-state recruitment at schools.
Kentucky	Yes	Some	Not very
Maine	Yes	No	Some interaction with UM and Husson programs.
Maryland	Yes		Headquarters personnel have ongoing contact with schools in the geographical area.
Massachusetts	Yes	No	
Michigan	Yes	No	Difficult to determine since it mainly involves career fairs.
Mississippi	Yes	No	Minimal.
Missouri	Yes	Some-contiguous states	Very successful.
New Jersey	Yes	Yes	Fairly good.
New York	Yes	No	
North Carolina	Yes		
North Dakota	Yes		
Oklahoma			
Oregon	Yes	No	Univ. of Oregon only.
Pennsylvania	Yes		
South Dakota	Yes	No	
Utah	Yes		
Vermont			
Virginia	Yes		
West Virginia	Yes	No	Occasionally, if situation necessitates.
Wyoming	Yes	Yes	Somewhat

4. Do you direct mail information to potential Nurses? If yes, where do you get the direct mail lists? Have these efforts been cost effective?

Yes responses with comments as follows:

STATE	YES/NO	WHERE DO YOU OBTAIN LISTS?	COST EFFECTIVE?
Connecticut	Yes	State Health Dept.	Just begin.
Delaware	Yes	State Nursing Bd.	Very successful.
Missouri	Yes	State License Ofc.	Not effect.
New Jersey	Yes	Licensing Agency	Moderate
North Carolina	Yes	Weekly vacancy reports from institutions.	
North Dakota	Yes	Schools and Nursing Assn.	
Oklahoma			
Pennsylvania	Yes	Bd. of Nurse Examiners	If done on a routine basis, no.
South Dakota	Yes	School of Nursing Board of Nursing	Very little difference.
Virginia	Yes	Licensing Bds., Prof. organizations	Yes

PH:akb
6/3/88

APPENDIX F

Dr. Norton Roitman, 5-Minute Summary Report

Five-minute Summary of Report to Interim Study Committee

PURPOSE AND GOALS

On December 18, 1987, a presentation was made to the Interim Study Committee on Mental Health/Mental Retardation by the Coordinator of Medical Programs. In response to that presentation, Mr. Spinello, Mr. Humke and Ms. Evans requested a written report delineating the problems impacting the Institute (both internal and external) and proposals that would improve the present and future operations. The goals of this proposal were presumed to be the following:

1. To expedite the mission of the State's psychiatric hospital(s).
2. To secure the licensure/accreditation and certification of the facility.
3. To provide a learning environment conducive to a residency program in psychiatry.
4. To assure a system of governance both internal and external to the Institute that would perpetuate goals 1, 2 and 3.

CONCEPT OF PROBLEM

Although this report is often critical, it should be made clear at the outset that no blame rests on any individual or organ of government either within or outside of the Institute; rather, the inadequate health care product and conditions are the result of a flow of authority that is disproportionally weighed in favor of fiscal responsibility. A final resolution of a major conflict between spending and quality would ultimately result in a plan for "How to spend money" based on objective, clinically determined priorities. This will enhance the achievement of mission, regulatory compliance, and reimbursement.

Currently, the Institute administration is desperately seeking doctors, but this is not due to clinical need. What motivates this is the loss of funds from HCFA not to solve the problems of the patients. The intention of the clinical site review by HCFA was entirely missed. Their conclusions meant that the hospital is not a professional atmosphere and there is little therapy, treatment or health promoted in the Institute. The reason for this is not only that there are not enough doctors but because the decision makers have not been setting their priorities properly, nor is there sufficient incentive or accountability for them to do so.

The line of authority lacks a clear accountability system to the hospital's mission. The preponderance, the overwhelming dominance of the "saving of money" mission amongst executive management personnel is promoted and enforced by budget accountability systems without clinical checks and balances. The repeated failure of the current system in achieving accreditation appears to be putting pressure on this system. Eventually it will be seen that the goal of reimbursement and clinical competence are the same and the fiscal people will learn to depend and trust their experts in care.

MORE SPECIFICALLY

The proposal to develop a logical clinical accountability system is the first necessary step in the effective abetment of many of the long-standing problems and future problems such as the lack of approved and established successful treatment methods. Nevada can then apply the lessons learned elsewhere as their methods would be comparable to other public and private operations. It can be very, very expensive to indulge in the wish to do it our own way.

The proposal is a "systems" approach to the problems. The major change is the introduction of a person invested with the responsibility to measure, define and propose solutions to the problems that block the mission of the hospital. In this way, the state's government could be assurred that the money it is currently spending is not going to waste. The citizens should know that the millions of dollars going into public psychiatry annually are doing what they think they are doing.

In an attempt to do just that, AB400 was adopted three years ago to monitor the quality of service. This was an excellent step in the right direction but as you can see from our experience in the last two years it was not enough. The following proposals are an extension of the intent of that legislation. It is a plan to make the review of agency policy and procedures a reality. The events of the last two years, the attrocity of transporting acutely insane people on public airlines, on the same planes with businessmen, out-of-town visitors, and the Governor himself, is the product of a decision made exclusively on the basis of cost, without the proper influence of common sense, let alone clinical judgement. A change should result from this mistake.

RECOMMENDATIONS

A Medical Director, a full-time employee of the University of Nevada-Reno, School of Medicine, Department of Psychiatry, directly accountable to and supervised by the "Clinical Regulatory" Commission on MH/MR.

His/Her position would be analogous to a Chief Executive Officer of a Board of Directors, responsible and accountable to the mission as defined by NRS and interpreted by the Commission MH/MR.

The Medical Director should have an Office of Epidemology under his/her direction.

The Medical Director should have a budget realistic enough to support epidemological research.

There should be written policies or statutes by which budget proposals are reviewed by both executive and legislative bodies for the Institute. These policies and procedures should include testimony by the Medical Director representing the Commission.

The Medical Director's proposals both to increase and/or decrease services in particular areas should be based on epidemological surveys of the population of Nevada, quality assurance and outcome studies and program effectiveness. He/She should be free from direct accountability in regards to cost (except for his/her own department, of course). This testimony should be taken into consideration in the final decisions and choices made ultimately by the legislature. The Medical Director would not be encountered by inhibitory lines of fiscal authority and supervision in his report.

The Medical Director and the Division Administrator should be encouraged to work together and establish a dialogue; but, as peers under different lines of supervision, neither has authority over the other.

The Administrator MH/MR should not be expected to give testimony in clinical fields about which he has no education, such as medicine or psychiatry.

The position of this Medical Director should be on par with the Administrator MH/MR. The Commission should be on par with the Department of Human Resources.

The position of Coordinator of Medical Programs at the Institute and at the State Hospital in Las Vegas should be supervised by the Medical Director.

The Child and Adolescent facilities should be accredited by Joint Commission on Accreditation of Hospitals (JCAH). The atmosphere and procedures of the Child and Adolescent agencies should be changed so as to provide a position for a physician to have the authority to directly supervise the medical and psychiatric activities of these agencies. He/She should oversee all psychiatric treatment as well as assuring that the role of organic causes of emotional and behavioral disorders are not ignored and the supervision of medical and medicine therapies is not neglected. This physician should be a psychiatrist and be supervised by the Medical Director.

The same is true for the Developmentally Disabled facilities which are identifying more and more psychiatric needs and is making greater and greater use of the Institute inpatient facility (inappropriately) for the developmentally disabled patient.

The relationship between the Department of Human Resources and the Commission of MH/MR should be clearly defined in statute, the Department responsible for the fiscal management through its functionary the Division of MH/MR, the "Clinical Regulatory" Commission for the clinical management through its functionary the Medical Director. The Department of Human Resources should be limited by statute in the inception or institution of any fiscal policy that impacts on the clinical program unless it can be adequately justified to and approved by the Commission.

The Governor's offices should mediate unresolvable conflict between Commission and Department.

The Commission should be granted a realistic budget to include an office and clerical support with equipment (xeroxing and word processing), separate from the Division. In addition, the Commission would have to have a staff including personnel trained and experienced in quality assurance and policy and procedure review and generation in order to assist the Commission in fulfilling its legislated purposes.

The Commission members should be budgeted for orientation and continuing education in health care management, governing board competence, and self evaluation.

The Commission should have its own risk management and legal counselor as by statute it is responsible for the policies and procedures of all mental health/mental retardation agencies. The Department of HR should be monitored to assure that it does not encroach upon the Commission's legal mandate.

Under certain conditions, the Institute could be a premiere site for training psychiatrists. The way it is now, unfortunately, the trainee would learn poor psychiatry and disrespect for their patients.

INTERNAL FACTORS

The following is a compilation of the most serious problems at the Institute and proposed solutions. Many of these have been chronic and intractable. Many of these have been addressed in prior initial budget proposals but have not survived due to the priorities established by reviewers within the Department and the Division. These areas could be converted into more structured proposals and "costed" out. Prior to that, however, the administration at the Institute would benefit from knowing that there would be support and that it would be worthwhile expending resources on its further development. This issue is closely linked to the development of a powerful, credible, clinically relevant governance.

The chronicity of these problems indicate that the current method of decision making is not effective at advocacy or achieving successful outcome to date. This is because these problems rest in a realm of clinical and treatment needs rather than cost saving strategies. As stated previously, both are required. In my opinion, the highest priority would be the institution of a empowered clinical liaison to the decision making apparatus. I think that in short order, this list of problems would be addressed and solved as well as others that arise in the future.

FOOD SERVICES: Too few personnel.
Proposal: Division to write policies and procedures pertaining to staffing and minimum standards in accordance to community standards and census fluctuations.

SANITATION AND INFECTION CONTROL: Conditions unsafe and unhealthy.
Proposal: Infection control officer position defined and allocated. Physical plant modification. Training and awareness program. Develop contract for laboratory and x-ray services.

DISASTER AND FIRE SAFETY: There is only a bare minimum of orientation and training available for fire safety. The buildings are old, the patients are dangerous, lack judgement, many with arson histories, and are inadequately supervised. There is no viable disaster plan.
Proposal: Training officer with budget to run training program and monitoring.

PHARMACEUTICAL: Tremendous increase in service demand, resulting in more and more errors in filling and administration.
Proposal: Training officer. Division to write policy and procedure to determine number of pharmacists in accordance with the community standard. Pharmacy department head to participate in staff and patient education. Increase the number of nurses to technical staff ratio.

SAFETY: The Institute attracts violent, disorganized individuals that lack judgement and social conscience; yet there is no security system either on grounds or within the treatment sites.
Proposal: Specified personnel to cover campus security needs. (See Transportation Services below.) Install panic alarm systems.

TRANSPORTATION SERVICES: No transfer mechanisms at all for dangerous patients. We somehow have to be able to securely transport patients in crisis to Washoe Medical Center for certification and medical screening.
Proposal: Two staff on duty 24 hours, plus a secure vehicle, safe for the transportation of violent and suicidal patients. NRS should be revised to offer protection for the Institute to participate in this activity subsequent to the filing of an application for emergency certification, prior to admission and certification.

PROGRAM DIFFERENTIATION: We treat all the patients with the same generic treatment, in total blindness of scientific research and fact. The result is mixing frightened, depressed people in rooms with violent, berserk, brain damaged psychotics. In acute phases they should have different treatment sites and different plans.
Proposal: Program Differentiation component parts include:
1. Program Coordinator positions,.
2. Budget for therapeutic activities by different programs.
3. Program staff.
4. Physical Plant expansion and/or modification.
5. Acceptance of fixed costs based on programmatic requirements.
6. Plan should be developed by Institute staff and administration, not Division or Department. This should be assured by Commission MH/MR.

FACTORS RELATED TO MISSION

PROFESSIONAL SERVICES: As the admission rate and census increase, the work load of professional staff is shifted away from care and treatment as admission and discharge become priority activities. Added to that is the fact that over 80% of the persons hired to be responsible for these victims of mental illness (patients) are untrained, uneducated and are subject to their own emotional problems and reactions, without adequate guidance or supervision.
Proposal: Develop professional identity, standards, environment and supervision. Establish W.P.S. for psychiatrists including timed expectations for patient contact. Establish Department of Human Resource policy or statute dictating procedures to accommodate service demand in excess to predicted rate. Delete purely clerical activities from work performance expectations of all professional staff and provide ward clerks for each program. Support library with realistic budget. Create environment which promotes ethical and professional attitudes.

ADMINISTRATIVE SERVICES:
1. Limit the range and scope of the duties and responsibilities of the Medical Director and provide assistance.
2. The administrative functionaries are not proficient in the management of a health care agency and instead tend to adhere to a mission of not spending resources, generic to any state agency. The line of authority and working relationship between the Business Manager and the Medical Director is unclear and inherientlv conflicting. The "business" side is totally freed from responsibility for the mission of the hospital and accreditation. This design does not produce a plan on <u>how</u> to spend money. Fiscal responsibility and accountability is not shared by clinical departments and programs. The budget process is disjointed and irrevelant to the true needs of the agency.

3. Program evaluation is non-existant. Budget preparation is inadequate and disjointed from true need. The request and allocation of resources is therefore overly vulnerable to political pressures, thereby encouraging all aspects of hospital functions to engage in distortion, exaggeration, hyperbole and manipulation. Competence and control is discouraged; crisis becomes powerful.

Proposal:

Reorganize and add administrative personnel, specifically educated and experienced with the requirements and management of a health care facility.

COMMUNITY RELATIONS: The Institute is generally misunderstood by the groups with which it must do business. The poor reputation affects public confidence and diminishes the public's sense of security and faith in a vital function of the State. It severely interferes with the realistic funding of the hospital in accordance with its true need.

Proposal:

1. Institute staff to conduct seminars and training for community.
2. Informational brochures.
3. Administrative resources allocated to coordinate and lead a local mental health association with other psychiatric facilities, to develop community awareness programs, suicide prevention, referral and triage systems, procedure integration.

Although honestly stated, my opinions are subject to my lack of experience and the intense pressure and frustration of the last two years. For this reason I offer you the following suggestion.

FURTHER ASSESSMENT

The American Psychiatric Association has a systems consultation service administrated by Bert Pepper, M.D., well respected by the social psychologists in the Division and the medical professionals as well. The state could receive a report and specific plan from an outside objective review team that has good working knowledge of JCAH and HCFA requirements. I would recommend they see this report, JCAH and HCFA site visit transcripts and reports and be asked to review the governance, the clinical accountability and the role of clinical findings in decision making on the hospital, division, department and budget development level.

If the goal is to improve and keep pace with HCFA, JCAH and other measures of national standards, it must be recognized that HCFA and JCAH are composed of nurses and doctors hired by the Federal government or in the case of JCAH a private corporation of professional associations to review for the viability of the clinical resource. Neither the Department or the Division, from this point of view, are currently prepared to fully understand these site visits or to plan in accordance with the regulations. Their mandate has been and remains to be fiscal responsibility and accountability. This is as it should be, but it must be balanced. A doctor is not an accountant and an accountant is not a doctor. We need both.

The full report contains more information and more specific proposals, as well as an administrative autopsy of the conditions and decisions affecting the Las Vegas patients transferred to the Institute.

There are numerous support documents available for review in the office of the Medical Director, NMHI, generated from December 1985 to January 1988, if desired.

Submitted by:

Norton A. Roitman, M.D.
Coordinator of Medical Programs
(Medical Director)
Nevada Mental Health Institute
January 22, 1988

FULL REPORT TO THE INTERIM STUDY COMMITTEE - MH/MR

Norton A. Roitman, M.D.
Coordinator of Medical Programs
Nevada Mental Health Institute

January 22, 1988

INTRODUCTION

On December 18, 1987, a presentation was made to the Interim Study Committee on Mental Health/Mental Retardation by the Coordinator of Medical Programs, Nevada Mental Health Institute, concerning liaison between the Institute and the Department of Psychiatry, School of Medicine, University of Nevada, Reno. The problems associated with the recruitment and the retention of physicians at the Institute along with the difficulty of achieving and maintaining licensure, accreditation and certification from the relevant regulatory bodies was also presented. In response to that presentation, Mr. Spinello, Mr. Hunke and Ms. Evans requested a written report delineating the problems impacting the Institute (both internal and external) and proposals that would improve the present and future operations. The goals of this proposal were presumed to be the following:

1. To expedite the mission of the State's psychiatric hospital(s).
2. To secure the licensure/accreditation and certification of the facility.
3. To provide a learning environment conducive to a residency program in psychiatry.
4. To assure a system of governance both internal and external to the Institute that would perpetuate goals 1, 2 and 3.

For the sake of brevity and comprehensiveness, this report is written in three sections: the first, a brief summary; the second, a complete explication of the problems, their recent history, and the reasons why they remain fixed; the third, reference documents to substantiate the problems identified and their intractability. It is intended that the summary be totally supported by text or documentation provided in the subsequent sections.

It should be made clear at the outset that no blame rests on any individual or organ of government either within or outside of the Institute; rather, the inadequate health care product and conditions are the result of a flow of authority that is disproportionally weighed in favor of fiscal responsibility. The proper balance of clinical and professional accountability is absent. Within any health care institution, tension between efficient utilization of resources and appropriate spending for human services is always present. It is a sign of the viability of the system when the interplay between the two are a give and take and the outcome results from a fair negotiation between competing demands. From the perspective of this report, this is an achievement which is yet to come in regards to the Institute. On the other hand, many of the elements of this mature dialogue are at hand requiring only definition and leadership.

Although not explicitly mentioned in the above tension between fiscal responsibility and professional accountability, the people of Nevada are naturally concerned about both money and quality. On one hand, it is their tax dollars that must be carefully measured. On the other hand, their needs both as direct consumers of health care and as the public that requires adequate and appropriate provisions for their mentally ill citizens are entrusted to the Governor and the legislature. The people are not on one side or the other of the debate, they are on both. Responsible government is required to design the method by which both mandates are respected.

The resolution of the conflict between minimum spending and maximum quality will ultimately result in a plan for "How to spend money" based on objective, clinically determined priorities. This in itself will greatly enhance the goals of achievement of mission, regulatory compliance, and reimbursement.

Another point is it is with some degree of detachment that this writer prepares this report, as I am resigning from my position of Coordinator of Medical Programs as of January 22, 1988, and therefore I have little to gain or lose directly from revisions in a plan for mental health services. However, I remain invested in the care of the quality of psychiatric services in the State as this has become my State and as an informed citizen I feel responsibility; and as a physician I still retain the idealism and hope necessary to sustain therapeutic activity in the face of severe illness. Lastly, as a human being there is a moral sense of rightness for which I must advocate.

I very much appreciate this opportunity to contribute to the information base from which you draw for your important and difficult decisions.

EXTERNAL GOVERNANCE

Imbedded in this report is the answer to the question "What is wrong with the Institute and why don't the problems get corrected?". The next part, "Internal Factors" attempts to answer the "what is wrong" part. This portion on governance addresses the "why".

THE DECISION POINT

At some point in the future I envision the citizens and their elected representatives making a decision. The decision will be whether they wish to run and fund a psychiatric hospital which is comparable to others, both public and private, or whether they are content with a temporary holding facility that has psychiatric consultation, a bit of social service, and nursing. Once this decision is made, the uncomfortable contradiction at the Instition will go away. This contradiction is about the Institute administration and staff struggling to be a hospital while operating with only the resources of a holding facility.

A list of characteristics of each is found in Table 1 on the following page.

This decision as to which type of facility is desired addresses difficult political questions such as:

1. How much money does the state want to spend on this function?

2. Does a hospital system for mental illness have more benefit for the direct recipients of care?

3. Is it more beneficial for business, law enforcement and citizenry and other indirect recipients?

4. Would a holding facility be an embarrassment to the state?

5. Is a holding facility less expensive in the long run? Is it effective?

6. Does a hospital treatment system cause a substantial improvement in the patients such that their future utilization of resources decreases?

7. Is a hospital system truly inhumane, archaic and unnecessary?

8. Is there certainty and confidence in the value and outcome of an "alternative" delivery system?

Table 1. A COMPARISON OF GOALS - The elements of the decision.

Holding Facility	Hospital
-Houses" voluntary and involuntary clients".	-Treats patients who are ill.
-Consulting professsional staff.	-Professional staff.
-Direct services by non-professional staff.	-Direct services by professional staff and non-professional staff are assistants.
-Requires strong training program.	-Requires continuing education program.
-Responsibility for mission on administration.	-Responsibility for mission on staff (professional conduct and ethics) and administration.
-Requires powerful supervisory presence and authority.	-Requires peer review and peer regulation as well as supervision.
-Depends on clearly defined legislation, policies and procedures. Therefore, somewhat inflexible accountability mostly through legal system.	-Depends on tried and true methods of treatment, staff accountable to professional standards as well as statutes and policies.
-Client load is a liability.	-Patients using facility are ill and potentially violent/suicidal. The more the hospital is used, the more successful it is. Patient cure is the mission.
-Errors by staff may cause loss of job, grevious errors may cause legal action.	-Errors by professional staff may cause loss of profession, loss of investment in career, legal action, as well as loss of job.
-Views use of medication as a restrictive control.	-Views medicine as a treatment for an illness based on research.
-Can depend entirely upon state regulated personnel system and and lines of supervisory authority.	-Requires a clinical administrative system to uphold standards that cannot be recorded in statute to their full extent.
-A client is assumed to be controllable.	-A patient contains a disease. The disease must be treated to set the patient free. The disease is not the patient's fault.
-Does not encourage innovation or creativity. Encourages standardization.	-Maximizes creative problem solving. Professional staff is a resource and draws from large bodies of information, research and experience.

Table 1. A COMPARISON OF GOALS - The elements of the decision. (continued)

Holding Facility	Hospital
-Training and education of students not able to be generalized to other facilities. Unique and exclusive to one place.	-Provides a good base for training of professionals that can serve the state in a variety of ways, on par with any other state's professional citizen.
-May have difficulty recruiting professional consultants.	-Will draw high quality, scientifically interested professional personnel.
-Not generally reimbursable and not qualified for grants.	-Standard criteria for reimbursement and grants.
-Can blend well with state administration systems such as motor pool; does not easily support or promote the subjective values of job performance.	-Requires unique structure with administrators, supervisors, and legislative liaison trained and experienced in health care management. Unique training of administration and focus of responsibility within employees. This is very supportive for sick patients.
-Poorly distinguishable from welfare.	-Clearly distinct from welfare.
-Wide management pool available.	-Fewer clinical administration specialists.
-Poorly compatible with JCAH and HCFA medicare standards.	-Compatible with JCAH and HCFA regulations.
-Admission seen as client's failure.	-Admission seen as patient's misfortune. It is an opportunity to administer more effective, intensive treatment.
-Staffing less expensive, no standards.	-Staffing more expensive, standards can be calculated.
-No staffing principles available.	-Standard staffing patterns available.
-Outcome uncertain, not tested.	-Outcome predictable, testable through quality assurance.
-Unorthodox methods, no standards, legal and public image vulnerability ("snake pit").	-Standard acceptable practices measured against a national community.
-Minimized public perception of the client problems. Clients seen as problem of the society that must controlled.	-Emphasizes the seriousness and suffering of the individuals afflicted, a promotes empathy. (This is what be alcoholism tried to do to improve public understanding that alcoholism is an affliction of a human being.)

A CASE FOR THE HOSPITALIZATION OF MENTAL HEALTH CARE OR THE MENTALLY ILL

EXAMPLES FROM RECENT HISTORY

The State's decision makers can draw from it's own recent history to answer some of these questions. For example, it was the Institute, with it's medical program system, that solved the problem of the Las Vegas overflow of emotionally disabled patients. It was the non-hospital, holding facility model in Las Vegas which did not plan for the crisis and which could not help itself, bound to a social engineering model which does not see mental illness as a persistent progressive disease entity that can be treated, not just contained.

The NASAC facility has had two deaths recently. It is possible that a medical professional on site could have averted those fatalities.

One way of looking at the SDC sexual permissiveness allegations is in terms of hospital versus alternative management design. Perhaps the problem could have been averted by standard hospital systems because sexual permissiveness is not a treatment modality taught in professional schools. An untrained person may allow certain acts since he/she is not guided by ideas, thoughts or theories engendered by professional education. It is not hard to understand that untrained people would not provide therapy. It would be harder to understand if the staff were educated professionals proficient in the treatment of the population targeted by the facility, familiar with and accountable to national standards of professional health care.

Although there have been two recent deaths at the Southern Nevada Mental Health "Service" in Las Vegas, it has been years since this has occurred at the hospital in the north. Las Vegas appears to be experimenting with health care systems. The more they learn, the closer they get to hospital systems. JCAH will require full compliance.

THE POSITIVE VALUES OF THE MEDICAL SYSTEM

The very purpose for which hospitals were developed in the first place was for the care of the mentally ill. The nonprofessional service centers will have to experiment, trying to develop their own systems and expertise to approach the proficiency already established by health care agencies. During this experimentation period there is significant risk.

The most fearsome possibility may be associated with the AIDS epidemic, swiftly approaching Nevada's mentally ill population. Psychiatric symptoms may be the first to appear in 20 to 50% of the AIDS infected patients. Hospitals have procedures for infection control. Nurses learn about it in school. Doctors know the orders to write. There are <u>standard</u> professional operating procedures proven by time, trial and past errors.

Facilities with non-medical leadership (as are most in the Division of MH/MR) may suffer a period of confusion. Because the Division facilities are not clearly identified as health care facilities, the AIDS task force did not study them or consider their unique position in the identification and management of the irresponsible, aggressive, emotionally disturbed patient. Expensive in-house courses will have to be set up, taught out of manuals by poorly accountable medical consultants, or some such variation.

If one needs tooth care, one goes to a dentist, not a dental assistant who gets to talk with a dentist for one hour per week about all the cases. If one is ill, one needs medical care. Changing the name of patient to client, or hospital to mental health institute doesn't change that fact. A serious debilitating condition, frequently terminal, treated with medicine is best attended to DIRECTLY by a doctor with a multidisciplinary team of professionals, each with several years training and experience in their specialties. The specialists are required to be continuously reviewed, licensed and recertified on the basis of demonstrated competence and education.

A CONFUSION OF THE MEANING OF DECERTIFICATION

As of now, at the Institute, the administration is desperately seeking doctors. What motivates this is the attempt to solve the problem of loss of funds from the federal government (HCFA). This is not motivated by an attempt to solve the problem of the hospital or the patients. The intention of the clinical site review by HCFA was entirely missed. Their conclusions meant that the hospital is not a professional atmosphere and there is little therapy, treatment or health promoted in the Institute. The reason for this is not only that there are not enough doctors. The fact is that there is not enough doctoring, medical leadership and medical decision making. The decision makers have not been setting their priorities properly, nor is there sufficient incentive or accountability for them to do so.

NO BLAME - A NATURAL CONSEQUENCE OF A DEVELOPMENTAL STAGE

In my perspective, this is not anyone's fault. Any individual who would find themselves in a position in the current authority structure would find themselves performing in the same exact manner as those good individuals in the Department of HR and the Division of MH/MR. This is because the line of authority, the state government's lack of a clear accountability system for the mission, and the preponderance, the dominance of the "saving of money" mission amongst these upper and middle management executive personnel is promoted and enforced by budget accountability systems without checks and balances. The repeated failure of the current system in achieving accreditation appears to be putting pressure in the direction of growth and development.

The following breakdown of the problems in governance is to support the notion that the Institute's problems are perpetuated by the lack of a credible accountability system for the clinical mission of the hospital. The clinical problems are never solved because it is believed that they will require an initial investment unacceptable to the state. I don't think the investment will be that large and I believe it is exactly what the state wants to see as soon as possible.

The proposal to develop a logical clinical accountability system is the first necessary step in the effective abetment of many of the long-standing problems and future problems such as the lack of approved and established successful treatment methods. Nevada can then apply the lessons learned elsewhere as their methods would be comparable to other public and private operations. It can be very, very expensive to indulge in the wish to do it our own way.

The proposal is a "systems" approach to the problems. The major change is the introduction of a person invested with the responsibility to measure, define and propose solutions to the problems that block the mission of the hospital.

The state's government should be assurred that the money it is currentl spending is not going to waste. The citizens should know that the millions o dollars going into public psychiatry annually are doing what they think the are doing.

A STEP IN THE RIGHT DIRECTION

In an attempt to do just that, AB400 was adopted three years ago to increase the quality of service. This was an excellent step in the right direction but as you can see from our experience in the last two years it was not enough. The following proposals are an extension of the intent of that legislation. It is a plan to make the review of agency policy and procedures a reality. As it is now, the Commission serves the state merely as a "fall guy" if anything goes wrong after the fact. The events of the last two years, the attrocity of transporting acutely insane people on public airlines, on the same planes with businessmen, out-of-town visitors, and the Governor himself, is the product of a decision made exclusively on the basis of cost, without the proper influence of common sense, let alone clinical judgement. A change should result from this mistake.

A MORE DETAILED PLAN FOR CORRECTION OF GOVERNANCE OVER THE HEALTH CARE AGENCIES

1. A Medical Director, a full-time employee of the University of Nevada-Reno, School of Medicine, Department of Psychiatry, directly accountable to and supervised by the "Clinical Regulatory" Commission on MH/MR, should be funded with a salary in current dollars of $100,000/year. This position should be separate and apart from the Coordinator of Medical Programs, NMHI.

2. His/Her position would be analogous to a Chief Executive Officer of a Board of Directors, responsible and accountable to the mission as defined by NRS and interpreted by the Commission MH/MR. (There is an option as to whether the Medical Director would oversee all MH/MR Division agencies, or only the Institute and hospital type facilities of the Division. More staff than proposed in #3 should be optional in the latter case).

3. The Medical Director should have an Office of Epidemology under his/her direction, including at least one professionally trained epidemologist, one statistician, one data processing operator and two clerical positions, one in Las Vegas and one in Reno. This department may be under the School of Medicine. (Further advise on the personnel should be sought from states who currently conduct such an office, e.g., Arizona.)

   The value in epidemiological study is that the size and specific needs of the mentally ill population of Nevada can be known. There are established methods of doing this, standard knowledge to any public health professional. Planning can be based on statistics. The legislature can be involved in setting priorities based on a truthful measurement and costs based on the experience of other states. For instance, the legislature and Governor can review how much it would cost for a program aimed at reducing the rate of suicide of specific sub-populations (children, abused women, residents, non-residents) and choose how much and what kind of program to support based on facts. Most importantly, the outcome of the investment can be measured after the program is instituted. Currently, how do we know our tax dollars are doing anything effective?

4. The Medical Director should have a budget realistic enough to support epidemological research.

5. There should be written policies or statutes by which budget proposals are reviewed by both executive and legislative bodies for the Institute. Policy and procedures should require direct contact with Institute administration and not just business management administration. These policies and procedures should include testimony by the Medical Director representing the Commission.

   The Medical Director's proposals both to increase and/or decrease services in particular areas should be based on epidemological surveys of the population of Nevada, quality assurance and outcome studies and program effectiveness. He/She should be free from direct accountability in regards to cost (except for his/her own department, of course). This testimony should be taken into consideration in the final decisions and choices made ultimately by the legislature. In addition, he/she should not be expected to cost out his/her own proposals, but to submit these in time frames specified by the policy and procedure to the Division of MH/MR for this purpose.

6. The Medical Director and the Division Administrator should be encouraged to work together and establish a dialogue; but, as peers under different lines of supervision, neither has authority over the other. The clinical needs and the financial needs require thoughtful weighing to establish priority, and not intrusively dominate one over the other. Current practices can allow for such imbalance and therefore legislative directive is needed.

7. The Administrator MH/MR should not be expected to give testimony in clinical fields about which he has no education, such as medicine or psychiatry. The Administrator should be expected to establish a good working relationship with the Medical Director and continue to advocate for cost saving and possibly alternative treatment methods.

8. The position of this Medical Director should be on par with the Administrator MH/MR. The Commission should be on par with the Department of Human Resources. Grant applications for clinical programs should be written exclusively by the office of the Medical Director, in consultation with the Administrator.

9. The position of Coordinator of Medical Programs at the Institute and at the State Hospital in Las Vegas should be supervised by the Medical Director.

10. The Child and Adolescent facilities should be accredited by Joint Commission on Accreditation of Hospitals (JCAH). The atmosphere and procedures of the Child and Adolescent agencies should be changed so as to provide a position for a physician to have the authority to directly supervise the medical and psychiatric activities of these agencies, including the personnel supervision of nursing, pharmacy, infection control, and safety and sanitation functions analagous to the Institute.

He/She should oversee all psychiatric treatment as well as assuring that the role of organic causes of emotional and behavioral disorders are not ignored and the supervision of medical and medicine therapies is not neglected. This physician should be a psychiatrist and be supervised by the Medical Director.

11. The same is true for the Developmentally Disabled facilities which are identifying more and more psychiatric needs and is making greater and greater use of the Institute inpatient facility (inappropriately) for the developmentally disabled patient.

12. The relationship between the Department of Human Resources and the Commission of MH/MR should be clearly defined in statute, the Department responsible for the fiscal management through its functionary the Division of MH/MR, the "Clinical Regulatory" Commission for the clinical management through its functionary the Medical Director. The Department of Human Resources should be limited by statute in the inception or institution of any fiscal policy that impacts on the clinical program unless it can be adequately justified to and approved by the Commission.

13. The Governor's offices should mediate unresolvable conflict between Commission and Department. The Department and the Commission should be strongly encouraged to work out their conflicts and budgetary differences without the help of the Governor's office.

14. The Commission should be granted a realistic budget to include an office and clerical support with equipment (xeroxing and word processing), separate from the Division. In addition, the Commission would have to have a staff including personnel trained and experienced in quality assurance and policy and procedure review and generation in order to assist the Commission in fulfilling its legislated purposes. This would probably be four to six persons, one being a quality assurance director.

15. The Commission members should be budgeted for orientation and continuing education in health care management, governing board competence, and self evaluation.

16. The Commission should have its own risk management and legal counselor as by statute it is responsible for the policies and procedures of all mental health/mental retardation agencies. The Department of HR should be monitored to assure that it does not encroach upon the Commission's legal mandate.

If the psychiatric residency, under certain conditions, the Institute could be a premiere site for training psychiatrists. The way it is now, unfortunately, the trainee would learn poor psychiatry and disrespect for their patients. The Department of Psychiatry will present arguments in favor of a residency and there is no need to reiterate them here. However, it is necessary to say that unless major corrections in the commitment to a mental health environment are made, the quality of psychiatrists in Nevada will severely deteriorate. With a realistic change in decision making procedures, the benefits of residents in the state facility would be dramatic. In general, whatever is "good" for residents will be good for our patients as their problems would be studied, the

treatments would be based on scientific principles and research, and the results of their treatments would be assessed. Also, residents would infuse the therapeutic environment with hope, ideas and enthusiasm. This is the stuff of which mental health is composed.

A VIABLE ALTERNATIVE: REALISTIC EXPECTATIONS

1. Disband the Commission.

2. Drop the requirement for JCAH accreditation and HCFA certification and reduce expectations for revenue reimbursement from third parties and federal government.

3. Minimize medical records accounting.

4. Model system along the lines of the prison and reduce professional staff to absolute minimum. Follow ratios established by prisons for persons symptomatic to psychiatrist (consulting).

5. Develop community relations director to deal with community elements unhappy with the change toward maintenance.

6. Fund smaller community based control centers with supervisory capabilities so that clients can be limited and rights denied as needed.

7. Change legislation to allow greater latitude in the declaration of incompetence and liberalization in regard to denial of rights and abuse.

INTERNAL FACTORS

The following is a compilation of the most serious problems at the Institute and proposed solutions. Many of these have been chronic and intractable. Many of these have been addressed in prior initial budget proposals but have not survived due to the priorities established by reviewers within the Department and the Division. These areas could be converted into more structured proposals and "costed" out. Prior to that, however, the administration at the Institute would benefit from knowing that there would be support and that it would be worthwhile expending resources on its further development. This issue is closely linked to the development of a powerful, credible, clinically relevant governance.

The chronicity of these problems indicate that the current method of decision making is not effective at advocacy or achieving successful outcome to date. This is because these problems rest in a realm of clinical and treatment needs rather than cost saving strategies. As stated previously, both are required. In my opinion, the highest priority would be the institution of a empowered clinical liaison to the decision making apparatus. I think that in short order, this list of problems would be addressed and solved as well as others that arise in the future.

FOOD SERVICES

Too few personnel. Employees working outside of job description, very poor coverage when sick leave is used. Patients and staff reportedly complain about cold food, sometimes raw food, inadequate portions.
PROPOSAL: Food service personnel should be calculated in accordance with a community standard. Staffing and operational budget should be calculated in accordance with census. Division to write policies and procedures pertaining to staffing and minimum standards in accordance to community standards and census. Policy to be basis for budget or subject to legislative debate.

SANITATION AND INFECTION CONTROL

Conditions unsafe and unhealthy. Not enough sinks for hand washing, soap dispensers archiac, not enough attention to this important hospital function. In addition, AIDS may present at first with psychiatric symptoms (20 to 50% of the time) so the Institute may be the place where AIDS infected people appear first. Agency does not sense itself as being a hospital as much as it should. Because of the low degree of awareness and resources, it may be impossible to design protocols adequate enough to protect the uninfected staff and patients. No separate bathroom or residences are available.
PROPOSAL: Infection control officer position defined and allocated. Allocation for physical plant modification along with training and awareness program. Develop contract for laboratory and x-ray services so that infection control officer is not diverted from the monitoring and educational function and these functions are covered when absent.

DISASTER AND FIRE SAFETY

There is only a bare minimum of orientation and training available for fire safety. The buildings are old, the patients are dangerous, lack judgement, many with arson histories, and are inadequately supervised. There is no viable disaster plan although the community might expect this, as a hospital, to be a potential resource should a crisis occur.
PROPOSAL: Training officer with budget to run training program and monitoring.

PHARMACEUTICAL

Tremendous increase in service demand, resulting in more and more errors in filling and administration. Medicines can be poisons if improperly monitored. Monitoring system has been put in place but there is no effector mechanism available to correct problems identified. Agency does not have identification as a hospital. Also, patient education concerning their medications is absent. (Medicine compliance is the major factor in maintenance of mental health.)

PROPOSAL: Training officer. Division to write policy and procedure to determine number of pharmacists in accordance with the community standard, taking into account the inpatient and outpatient demand and the number of admissions and the need for pharmacy to be represented on treatment teams and in training and educational tasks. Pharmacy department head to participate in staff and patient education and awareness promotion. Pharmacy to participate on treatment teams. In addition, increase the number of nurses to technical staff ratio so more people trained with the use and nature of medication are present and in contact with patients.

SAFETY

The Institute attracts violent, disorganized individuals that lack judgement and social conscience; yet there is no security system either on grounds or within the treatment sites. There is tremendous potential for attack against persons and property from people who aren't even patients. Even public libraries have security. In addition to grounds which are regularly violated, vandalized and robbed, the inpatient employees have no way to notify each other if they get trapped or attacked. Lake's Crossing has such security. Our population is not that dissimilar.

PROPOSAL:

1. Transportation personnel to cover campus security needs (see below).
2. Install panic alarm systems.

TRANSPORTATION SERVICES

No transfer mechanisms at all for dangerous patients. We somehow have to be able to securely transport patients in crisis to Washoe Medical Center (WMC) for certification and medical screening. Patients directly seeking admission to NMHI are often suicidal. There is currently no way to deal with them unless we call costly ambulance services. Most often we send them out on their own to take the bus. The police will no longer help unless we pay them. They are an inappropriate service for this population anyway. We have no cars, no staff and face some liability participating in their transportation without their being admitted first. However, we cannot admit them until they are medically cleared and certified. In addition, patients must be returned from WMC or St. Mary's Hospital and be taken to and from doctor appointments, community placement, bus, plane and train.

PROPOSAL:

1. Twenty-four hour emergency room services, or
2. Sufficient psychiatric staff for 24 hours per day on campus coverage, plus and/or
3. Two staff on duty 24 hours, plus a secure vehicle, safe for the transportation of violent and suicidal patients. Staff to be trained in behavioral control techniques and be accountable to a clinical director.
4. NRS should be revised to offer protection for the Institute to participate in this activity subsequent to the filing of an application for emergency certification, prior to admission and certification.

These staff and this vehicle can double to serve security; another Institute need discussed above.

PROGRAM DIFFERENTIATION

The Institute serves a tremendous variety of people, all different with distinct needs, diagnoses, and illnesses. This population is much different than the mentally retarded because their mental capacity is not constricted by their condition. In fact, the "volume" of their mental productions are turned way up, their emotions more powerful and disturbing and their creativity is enhanced. They destroy organized systems and do not respond well to behavior modification. They do fall into some naturally occuring categories. We have to ignore these categories, however, and we treat all the patients with the same generic treatment, in total blindness of scientific research and fact. The result is mixing frightened, depressed people in rooms with violent, berserk, brain damaged psychotics. The admissions procedure is devoid of systemic sensitivity to the individual needs. The first 15 minutes of clinical contact can be crucial to fostering the hope and belief that would support the cure and re-establishment of self reliance. Neglected populations include:

1. Substance abuse with psychopathology
2. Mentally ill with psychopathology
3. Alzheimers patients with psychopathology
4. Depressed, acutely suicidal people
5. Persons with chronically assaultive behavior, perhaps due to brain damage
6. The chronically disturbed, non-progressing patient

Please note that currently all sites are designed on the principle of severity of symptoms, not type of symptoms. As symptoms abait and persons are normalized, the chances of them mingling are greater, but in acute phases they should have different treatment sites and different plans. In psychiatry, the community is the treatment to a very large extent. Using the same setting regardless of the disorder is like treating everyone who gets physically ill enough to go to the hospital with insulin, regardless of whether they have diabetes, heart disease, a broken leg, cancer, constipation or an inflamed gall bladder.

PROPOSAL: Program Differentiation component parts include:

1. Program Coordinator positions, defined, acknowledged by State Personnel, and funded to conduct program activities, in accordance with community standards.
2. Budget for therapeutic activities by different programs. There is currently no money for therapy except recreation.
3. Program staff - assistants, clerical and operational - may be drawn from professional departments, and the professional departments must then be increased in size.
4. Physical Plant expansion and/or modification:
   a) Must be designed in accordance with the function of the program.
   b) Separate sites for separate programs.
   c) Allowance for more complex food, pharmacy, medical records, and other personnel and operational costs.
   d) Expandable capacities.
5. Acceptance of fixed costs based on programmatic requirements.

FACTORS RELATED TO MISSION

PROFESSIONAL SERVICES

As the admission rate and census increase, the work load of professional staff is shifted away from care and treatment as admission and discharge become priority activities. Clinicians look for "windows of opportunities" to discharge a patient, whether or not they are adequately treated in any permanent fashion. Certain therapies, especially medication based, can be conducted quicker than others. For instance, a patient can be sedated with tranquilizers rapidly and discharged although the appropriate therapy may be Lithium carbonate, which requires a minimum of 10 days, let alone psychotherapy or humanistic approaches. There is little incentive to conduct the appropriate assessment and therapy when your colleagues are suffering under loads they perceive are created by your careful thoughtful individual approach to a person and their suffering. The atmosphere is not conducive to supporting humanistic values and promoting the motivations and incentives available to professionals to guide their conduct. It is more conducive to a "crass, belligerent resistance to getting involved with any of these indigents who are just draining the state of its limited resource." Added to that is the fact that over 80% of the persons hired to be responsible for these victims of mental illness are untrained, uneducated and are subject to their own emotional problems and reactions, without adequate guidance or supervision. The technical staff have no requirement to know anything about psychiatric illness, treatment, or things that promote mental health. They are attacked daily, are abused physically and verbally by people with poor hygiene and bad manners. The technical staff has little or nothing to lose. In addition, the very high frequency with which patients come in and out of the hospital is so great that it works totally against the formation of attachments that modulate staff reaction and is the stuff of which mental health is made.

PROPOSAL:

1. Develop professional identity, standards, environment and supervision:
   a) To as great an extent as possible, State Personnel lines of authority should be congruent with established lines of education and training, within each profession.
   b) Training to assist clinicians in the development of administrative and supervisory skills-training taught by clinicians specifically for clinicians. Could be accomplished by making this ability a prerequisite of the medical director, that he/she be a physicians executive with time allocated for staff development.
   c) Cease consideration of any unorthodox method of staffing (e.g., "generalist" or "specialist" series) that would make Nevada's mental health system incompatible with national standards.
   d) The salary of medical director to be significantly increased in relation to the other psychiatrists.
   e) The Department Chief of Psychiatry be designated Chief-of-Staff by State Personnel. A significant salary differential in relation to the other psychiatrists. At least .5 FTE for supervision of other psychiatrists and clinical departments and multiple other administrative tasks required by JCAH and HCFA, in line with community standards.
   f) Establish W.P.S. for psychiatrists including timed expectations for patient contact, from admission through treatment to discharge, taking into account contact with family members, consultation for other physicians, care and attention to patient's medical, medicinal and psycho

social needs, planning conferences and team leadership and clinica supervision. Establish standards of care for professionals sufficien enough for the lay personnel to regularly witness professional activitie with patients and to allow for review and accountability systems so tha the professional staff is monitored to assure their presence and qualit of performance.

g) Establish Department of Human Resource policy or statute dictatin procedures to accommodate service demand in excess to predicted rate including criteria for over-utilization, allowance for contracte treatment by private facilities, emergency hiring and recruitmen procedures, both temporary and permanent positions, establish procedure for automatic increases for operating funds and support staff.

h) Support <u>all</u> professional departments with budget allocation for:

1-equipment and materials
2-educational activities
3-clerical support

i) Delete purely clerical activities from work performance expectations o all professional staff and provide ward clerks for each program.

j) Support library with realistic budget (community standard).

k) Create environment which promotes ethical and professional attitudes:

1-Promote broad base of responsibility through peer review and peer pressure. Allow for these activities in W.P.S. and in staf allocation for each professional department.

2-Administrative assistance and clerical support for planning, revie and educational functions.

3-Problem identification mechanisms through: (a) Quality Assurance t maintain focus on mission, and (b) analysis, not investigation.

4-Problem solution through: (a) case review and seminars, (b) education, not punishment, and (c) outside consultants, community experts.

ADMINISTRATIVE SERVICES

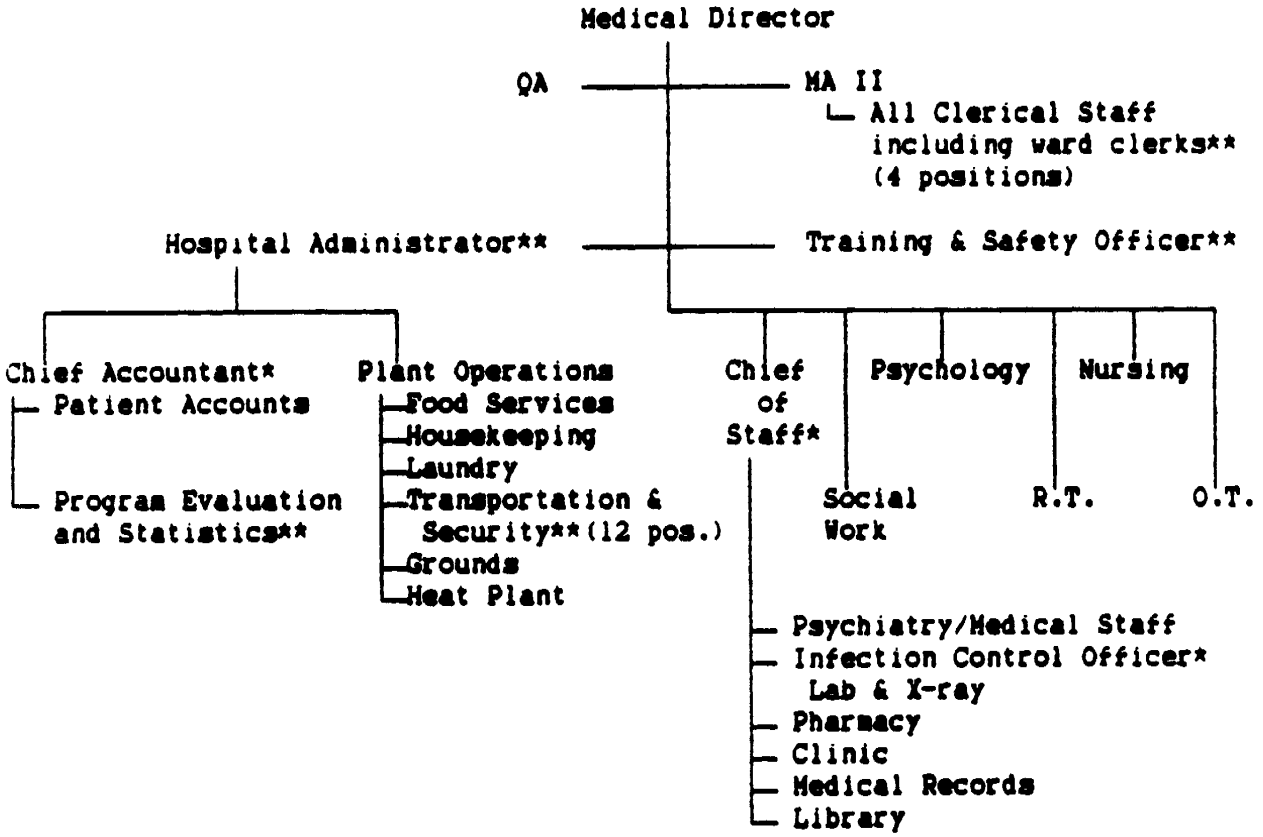
1. The range and scope of the duties and responsibilities of the Medical Director is much too great without additional assistance and personnel.
2. The current administrative functionaries lack proficiency in the management of a health care agency and instead tend to adhere to a mission of not spending resources allocated to the Institute. The line of authority and working relationship between the Business Manager and the Medical Director is unclear and inheriently conflicting. Neither is accountable to the other. The "business" side is totally freed from responsibility for the mission of the hospital and accreditation. It is a generic position, available to any accountant of financial manager. This design does not produce a plan on <u>how</u> to spend money. Fiscal responsibility and accountability is not shared by clinical departments and programs who are in the position to make judgements and set priorities. The budget process is disjointed and irrevelant to the true needs of the agency. There is no hospital administrator, no forum for internal planning and no appreciation of the requirements of a 24 hour facility that must operate to prevent mistakes from occuring in the first place as health and safety are of primary importance. Instead, half the hospital remains content to allow problems to manifest. This is a complex problem and is the outcome of a supervisory and regulatory system, not the failing of any one person. The design of the hospital administration is off, resulting in blocking, an inability to address problems and a pessimistic resistance to change.

3. Program evaluation is non-existant. Substantiation on a statistical basis in impossible to come by. There is no personnel or equipment dedicated to this function. Therefore, budget preparation is inadequate and disjointed from true need. The request and allocation of resources is therefore overly vulnerable to political pressures, thereby encouraging all aspects of hospital functions to engage in distortion, exaggeration, hyperbole and manipulation. Needs assessment tasks fall upon amateurs. An atmosphere of crises becomes powerful. Competence and control is discouraged.

PROPOSAL:

1 & 2. Reorganize and add administrative personnel, specifically educated and experienced with the requirements and management of a health care facility. Revise State Personnel regulations so as to require health care administration experience in Medical Director and Hospital Administrator. There is the option of having the Medical Director accountable to the Hospital Administrator. This is viable, but does not enhance the mission or purpose of the hospital and a non-professional always has a difficult time supervising professionals. The Medical Director, however, must be a manager. The Chief of Staff may always back up the Medical Director.

3. A program evaluator, possible two, should be added along with whatever data processing backup required, in accordance with a state agency standard. Program evaluation and statistics definately should have health care agency familiarity as this product is unique and outcome measures often require definition of quality, not quantity.



Program Coordinators would fall within clinical department.

*Modification of existing positions.
**New positions.

COMMUNITY RELATIONS

The Institute is generally misunderstood by the groups with which it must do business. It is unwanted and unappreciated until it is needed. It is not thought of as a professional resource maintained by the state; it is seen as a mentally ill person is seen, with the same prejudice and disregard. The poor reputation affects public confidence and diminishes the public's sense of security and faith in a vital function of the State. The staff is reluctant to tell acquaintances they work. This affects morale and therefore service. It severely interferes with the realistic funding of the hospital in accordance with its true need. Its current condition can be seen as an indulgence of the public's wish to neglect and dismiss mental illness, the mentally ill, and the mental health institute. This tendency should be persistenly countered. The truth of the matter is that the Institute is very dependable, the expert in dealing with the most difficult population in the state, operating well despite tremendous constraints in resources, in stature from the medicine and from Advocacy and Protection.

It is the premiere resource in the state for training mental health professionals. It is the support system for police, casinos, hospitals, families in crises, the courts, and all other mental health facilities and practitioners in Nevada. It solved the problem Las Vegas had over the last year in the unanticipated demand for service. It has had no suicides or deaths in years, a record unmatched by Las Vegas or almost any other teritory psychiatric care facility statewide. It's cost per patient day has decreased by $15 to $25. The hospital is the foundation of a wide ranging, integrated community based mental health system.

PROPOSAL:

1. Institute staff to conduct seminars and training for community practitioners consultation to public and private, jails and police, casinos, security personnel, homeless centers, salvation army and mission, Washoe Medical Center, Truckee Meadows Hospital, St. Mary's Hospital, and facilities that have increasing frequency of contact with the mentally ill. Staffing, work performance standards and a training officer with clerical support to make these arrangements.
2. Informational brochures with programs, personnel notices, etc., to promote Institute to be regularly distributed.
3. Administrative resources allocated to coordinate and lead a local mental health association with other psychiatric facilities, to develop community awareness programs, suicide prevention, referral and triage systems, procedure integration.
4. Support UNR School of Medicine, Department of Psychiatry
   a) research
   b) training and education
   Support Department of Nursing, Social Work, Education, O.T., R.T., etc., with space, some administrative liaison. Training officer would probably need an assistant for these community activities.
5. Promote and support family therapy groups and organization through additional clinical personnel trained in collateral therapies. Night hours funded for this.
6. Expand outreach services at WMHC, provide community services position for the important work being done over there within the community.

IN CONCLUSION

For those of you who invested your time in reading this entire report, I thank you on behalf of the seriously mentally ill, the hopeless and the suffering. I acknowledge that I have less than six years of experience working in and around state and county facilities. However, I have 16 years in health care, 12 of those in direct medical care of patients and several courses in administration. I have eight years of direct experience in administration. I am board certified in both general and child psychiatry and board eligible in administrative psychiatry. My views are definitely influenced by the conviction that patients have the same needs, regardless of what health care system they find themselves in, public or private. We can either meet their needs or neglect them. We cannot make them diminish through not providing for them.

Although honestly stated, my opinions are subject to the intense pressure and frustration of the last two years. For this reason I offer you the following suggestion.

FURTHER ASSESSMENT

The American Psychiatric Association has a systems consultation service administrated by Bert Pepper, M.D., well respected by the social psychologists in the Division and the medical professionals as well. For a cost of $2000 to $5000, depending on the stated scope and objectives, the state could receive a report and specific plan from an outside objective review team that has good working knowledge of JCAH and HCFA requirements. I would recommend they see this report, JCAH and HCFA site visit transcripts and reports and be asked to review the governance, the clinical accountability and the role of clinical findings in decision making on the hospital, division, department and budget development level.

If the goal is to improve and keep pace with HCFA, JCAH and other measures of national standards, it must be recognized that HCFA and JCAH are composed of nurses and doctors hired by the Federal government or in the case of JCAH a private corporation of professional associations to review for the viability of the clinical resource. Neither the Department or the Division, from this point of view, are currently prepared to fully understand these site visits or to plan in accordance with the regulations. Their mandate has been and remains to be fiscal responsibility and accountability. This is as it should be, but it must be balanced. A doctor is not an accountant and an accountant is not a doctor. We need both.

A case study: ADMINISTRATIVE AUTOPSY OF THE LAS VEGAS PATIENT TRANSFERS

The transporation of committed patients to NMHI. An analysis of decisions, their components, foundations and complications.

I. Pre-Transfer Components

A. No epidemologic study of the population in Las Vegas.
   1. No basis for determining growth.
   2. No information concerning what type of facilities are needed.
   3. Planning scanty, based on limited study, unbalanced in approach tc mental illness, heavily weighted on belief in social psychology/ engineering.

B. Investment in community service.

C. No accurate investment in hospital services, delays in building, lack of administrators experienced in hospitals and inpatient services. Planning based on surveys of administrators' opinions, not research in true value and effectiveness.

D. Hospital service demand overwhelmed, facility-emergency fund set up. Delay of adequate investigation of renting and staffing empty hospital wing.

E. Norton Roitman, M.D., hired at NMHI.

II. Transfer Decision

A. Absence of policy or written proposal by Department HR or Division of MH/MR for overcensus.

B. Costs were compared between:
   1. Continued supplemental funding for contract beds in Las Vegas.
   2. Cost of converting a building and staffing it on NMHI grounds and plane tickets for patients determined (greater than 1 million dollars).
   3. Cost of converting office spaces on existing inpatient unit at NMHI, plus plane tickets, plus staff component increase (2 RN's, 9 technicians and 1 occupational therapist)
      a) no realistic basis for figuring staff increase
      b) no written procedures
      c) no consideration of operational budget increase
      d) assumption that was communicated that a maximum census increase of 12 patients transferred

C. Decision based exclusively on lowest cost: Lack of planning in regard to impact on clinical environment.
   1. No plan in regard to further escalating demands.
   2. No plan in regard to increased load on professional staff.
   3. No emphasis placed on recruitment. No thought given to increased difficulty in recruitment due to deterioriated working conditions.
   4. No consideration given to continued accreditation or certification (JCAH and HCFA).

5. No consultation with clinical experts on clinical matters, inside or outside of state government.
6. Absence of health and safety considerations, infection control, medical records, physical examination, family connection, public perceptions, or even hygiene (patients would ride the airplane without shoes and socks). Problems allowed to manifest. No preventative planning, an essential characteristic of health care management.
7. Staffing addition very meager without consideration of the increase on professional demand or that this 24 hour/7 day per week facility absorbed those 12 personnel into three major treatment areas without making any significant impact. (That is one person per area per shift.)
8. No responses to repeated written communications by Coordinator of Medical Programs informing administration of problems.
9. Coordinator of Medical Program required to neglect some administrative responsibilities to take on Geriatrics ward (18 patients).

III. Post Transfer Period

A. Role of Commission
1. Not consulted, no policy or procedure proposal written or submitted. Decisions not framed as policies although a radical change in practice through decisions made on Department level. No communication between Department and Commission.
2. Members of Commission brand new, unfamiliar with responsibilities, no lines of authority, no defined relationship with department/division, no adequate procedural counseling, no orientation, no defined linkage with Department of HR, their companion in management.

B. Constant progressive increase in flow of Las Vegas transfers, up to 12 per week, up to a census of 55 patients from Las Vegas alone.
1. Number of Washoe County residents decreased.
   a) untreated, under or over medicated, very dangerous situation
   b) very high incentive to discharge local Washoe County patients because of problems returning patients to Las Vegas
      1) Las Vegas social workers with low incentive to cooperate
      2) no policies/procedures worked out
      3) length of stay for Las Vegas patients double that of Washoe County. Much sicker patients.
      4) local M.D.'s and referral sources diverting Washoe County patients away from Institute as they didn't want to be responsible for sending people to that overcrowded environment.
      5) Institute policy to defelct patients from Washoe Medical Center, Veteran's Administration Hospital, jails, community and to make services hard to get
2. Morale plummets, staff quit, difficult conditions to successfully recruit M.D.'s, sick leave usage increase, incidents of violence and self destructive behaviors increase.
3. Fall very far behind on charting in medical records.
4. All hospital functions suffer, internal accountability systems fail.

5. Quality of treatment settings deteriorate, 12 extra beds on each ward, problems getting enough food (angry, violent patients are now hungry also). Living space is crowded.
6. Reports filed to Division and Commission. No written policies. No increase staff components sought. No written responses. No plans other than waiting for legislated solution. Crisis in credibility.

C. HCFA site visit and conditions found to be deplorable. Placed on probation. Funding component threatened.

D. In response to decertification and decreased funding, request for proposal of additional nursing staff component made by Division.
1. Staffing design in accordance to three potential designs:
   a) minimum health and safety monitoring
   b) minimum health and safety with minimum professional supervision
   c) minimum professional treatment
2. Option selected - minimum professional staff supervision. The psychiatrists, psychologists and social workers were doing only intakes and discharges. No therapy was being conducted so patients were not really getting better. The discharge apparatus was regularly flooded. Problem was not fixed.

IV. Legislative Session and Budget Process

A. Institute assured that transfers would stop.
1. No epidemiological study of service demand in Washoe County.
2. No attention paid to warning that Washoe County's recent service demand was artificially reduced. Planning was based on hope.
3. New staff allocation temporary for HCFA re-site visit. Staff transferred in mathematical order down to Las Vegas.

B. Recertified on probationary site visit, due to:
1. Good faith in state commitment to and assurance of increased staff.
2. "Belief" in Dr. Roitman on the part of site visitors.

C. Budget proposal for Institute devoid of serious attention to inpatient facility. A minimum of needs met. Vast majority of funding (relatively speaking) awarded to outpatient services.
1. Not based on epidemiologic study.
2. Based on belief in social psychology theory.
3. No measurements of our population, just as in past before problem arose in Las Vegas. Same problem repeated. No learning or changes from this disasterous experience.

D. Washoe County admissions and rural clinic admissions climbed, reaching peaks similar to conditions when Las Vegas patients were being transferred. This situation continues.
1. Division unprepared.
2. Still no policies to deal with overwhelming census.
3. Supplemental staff already reallocated to Las Vegas, legislature out of session, no relief in sight.
4. Although assured by Division that Interim Finance would fund more supplemental staff if needed, no criteria for overcensus, no plan to go to Interim Finance, no response to request for more space and treatment sites, no improvement in undifferentiated therapeutic environments. Proposals by Medical Director ignored. No commitment on recruitment of psychiatrists, although now discussed with State Personnel Department.

5. Basis for planning fixed on average daily census, but this basis inadequate and unrealistic for managing census peaks and admission rates.

V. Re-visit by HCFA

A. Institute told that it would lose certification again.
   1. Same condition as last survey, same staff ratio, same census although now they are all from Washoe County and rural clinics.
   2. No basis for further confidence in state planning.

B. Again, in response to threatened loss of Federal dollars (not horrible clinical conditions):
   1. Increased commitment to serious recruitment procedure for psychiatrists.
   2. Serious recalculation of honest nursing staff to patient ratios.
   3. Increased hourly rate proposal for inpatient contract M.D.'s.
   4. No comprehensive analysis of the problems represented by HCFA criticisms.
      a) decision making process
      b) decreased clinical accountability
      c) leadership not knowledgeable about the hospital's tasks
      d) the need for more differentiated treatment sites, treatment teams, professional working conditions
      e) there is no scientifically based planning. Had the dollars granted to community services been put into the hospital instead, we would not have been decertified and we could have still, although slowly, developed a community service. Priorities were not clearly set.
      f) Administrators in direct contact with hospital's problems not in direct contact with decision makers. Division personnel assumed to be able to adequately define problems and propose relevant solutions. Leadership too distant from problems.
   5. These temporary measures are costly and in the long run much of this immediate planning will be ineffective.

VI. Currently - Discussion about increased benefits for psychiatrists.

A. Decision makers in Department are not talking directly to psychiatric staff. Unfamiliar with the needs/motivations of professional staff.

B. Decisions are not based on an analysis of working conditions. Assumption is being made that "all that the doctors want is money".

C. Still no planning based on study or scientific prediction. For all we know, census and admissions could jump by another 15 to 25% over the next year. No planning, no information.

D. No attention to different treatment sites, programs, space, operational budget.

APPENDIX G

Nevada Association of Psychiatric Physicians,
Report on Site Visits to NMHI and LVMHI

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE

Department of Psychiatry
and Behavioral Sciences
Reno, Nevada 89557-0046
(702) 784-4017

May 28, 1987

Richard H. Bryan
Governor
State of Nevada
Executive Chambers
Carson City, NV 89710

Dear Governor Bryan:

As promised in my previous letters, please find enclosed the site visit report of the Nevada Mental Health Institute in Reno and the Las Vegas Mental Health Center conducted by Drs. David Johnson, Donald Molde, and William O'Gorman at the direction of the Nevada Association of Psychiatric Physicians. I hope this report is useful to you in your consideration and continued support for the mental health care of Nevadans. If you have questions regarding this matter, please feel free to contact me.

Sincerely,

Grant Miller

Grant D. Miller, M.D.
Past President
Nevada Association of Psychiatric Physicians

GDM/cb

enclosure

cc: Robert Daugherty, Jr., M.D., Ph.D.
Ira B. Pauly, M.D.
Dan Payne, Ph.D.
✓Norton Roitman, M.D.
Doug Sudduth, M.S.W.
Frank Weinrauch
Nevada Association of Psychiatric Physicians Executive Committee

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE

Department of Psychiatry
and Behavioral Sciences
Reno Nevada 89557-0046
(702) 784-4917

May 8, 1987

Grant D. Miller, M.D., President
Nevada Association of Psychiatric Physicians
Department of Psychiatry and Behavioral Sciences
University of Nevada School of Medicine
Reno, Nevada 89557

Dear Grant:

As you know, the Nevada Association of Psychiatric Physicians at its February 1987 annual meeting directed a three-person committee to conduct site visits of both the Nevada Mental Health Institute in Reno and the Las Vegas Mental Health Center. Elected to this committee were David Johnson, M.D. (chairman), Professor of Psychiatry at the University of Nevada, Reno; together with Donald Molde, M.D. and William O'Gorman, M.D., two of Nevada's senior private psychiatrists. To put these site visits in context, you of course are aware of the failure of the afore-mentioned facilities to satisfy the accreditation requirements of the surveyors from the Health Care Financing Administration (HCFA) in October 1986. This failure was based primarily on both inadequate staffing requirements and inadequate medical records. As you also know, a number of Nevada's psychiatrists had been concerned about the standards of care at the state's mental health facilities for some years. Recent events only heightened these concerns, which thus led to the Association appointing this committee.

The site visits were duly conducted at Reno on April 1st and at Las Vegas on April 22nd, 1987.

The committee now submits to you our report for your study and for distribution as you, as President of the Association, consider appropriate.

Yours sincerely,

David Johnson (Chairman)

David Johnson, M.D.

Donald Molde MD

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Enclosure

Nevada Association of Psychiatric Physicians

Site Visits to Nevada Mental Health Institute
and Las Vegas Mental Health Center

April 1987

A. Synopsis of Report

1. Findings

a. Inadequate staffing has been a serious problem at both sites. Shortage of psychiatrists was particularly striking in face of the frequency of above-license patient census.

b. The weekly practice of transporting psychiatric patients from Las Vegas to Reno by air is regarded by all staff and by this committee as an outrage.

c. Indiscriminate mixing of patients based on inadequate staffing leads to poor patient care.

d. The physical plant at both sites has been simply inappropriate for the numbers of patients.

e. Staff morale was characterized by profound and pervasive disillusion at all levels. This was more marked in Reno than in Las Vegas. At the latter site there is now guarded optimism among some staff resulting from very recent changes, i.e., reduction of patient census and employment of new staff.

f. Education and supervision of staff at both sites has been sorely neglected.

g. The commitment process by which so many patients enter the Las Vegas state mental health facilities (and then are transferred to Reno) was challenged by many staff as being seriously flawed.

h. Those dedicated staff who despite the problems continue to strive for high standards and who long for improvements earned the admiration and respect of this committee.

2. Main Conclusions and Recommendations

a. Patient care has been severely compromised, reached a totally unacceptable level in late 1986/early 1987, and must be improved.

b. Funding for mental health has been inadequate. Fortunately, recent legislative action has increased funding but given Nevada's population increase, ongoing monitoring of mental health care needs is essential.

c. Planning for Nevada's mental health needs in the past decade has been deficient and the consensus opinion is that for too long policy has been based on attention to regular crises. Proactive planning by a planning group is recommended. Psychiatric input should be an integral part of this.

d. Ongoing education, supervision, and training of all staff requires much greater attention.

B. Full Report

We visited the Nevada Mental Health Institute on Wednesday, April 1, 1987. Information was obtained in four ways:

1. Copies of the HCFA findings were made available to us.

2. We conducted a series of interviews with various groups of staff members.

3. We inspected the two admission wards.

4. Questionnaires were completed by 15 staff members.

Our findings are as follows:

1. The HCFA conclusion that there is inadequate staffing is beyond dispute. The admission wards have been struggling to cope with numbers above licensed census. This has led in everyone's view to an unworkable ratio between numbers of psychiatrists and numbers of patients. A relentlessly excessive demand on staff has resulted in a treatment strategy based entirely on a crisis mode of operating. There is an emphasis on control. Medication is of course prescribed to afford symptom relief. Other than that, staff energies are largely devoted to trying to accommodate patient basic needs while at the same time trying to prevent violence. On occasions there are as many as 15 patients in a ward of 50 who are on suicide precautions. Senior nurses have described this as "a chaotic environment". In addition to insufficient psychiatric staff, we heard reports that the pharmacy frequently feels itself to be facing inordinate demands. In addition, there appeared to be insufficient support staff. There are no ward clerks. The medical staff have no secretary. There is no transcribing capability.

2. The weekly practice of transporting psychiatric patients from Las Vegas to Reno by air is regarded by all staff as an outrage on many scores.

   a. While as yet there has been no calamity resulting from the practice, it is surely only a matter of time before some severely disturbed patient creates severe disturbance en route.

   b. In terms of patients' rights, it is surely indefensible. Many patients object to the transfer. One psychotic patient in a moment of clarity said sadly, "They ship us up here like so many cattle." Further, the length of stay of the Clark County patients so transported is said to be about twice as long as that of local patients from Reno. The fact is, once hospitalized in Reno, it is on occasions extremely difficult indeed to arrange for the patients' return to Las Vegas. All staff can recall instances where patients were clearly ready to return to outpatient care but several weeks lapsed before the necessary "go-ahead" to transfer was received from Las Vegas.

c. A family assessment is an important part of a thorough psychiatric assessment with most patients, and on occasions family interventions are required to correct a situation which may have contributed to the need for admission. For obvious reasons this family work becomes quite impossible when the patient is so far removed from the family context.

d. The impossible patient loads, believed to be characteristic of both Reno and Las Vegas settings, lead to poor coordination of work between the two (and, indeed, even to feelings of enmity). Thus the good communication and exchange of information so essential to optimal patient care is substantially obstructed.

3. Many staff regard the indiscriminate mixing of patients with primary substance abuse problems with patients suffering from primarily psychotic illnesses as further eroding their ability to provide good care. A frequent comment was that substance abuse problems are medically addressed where necessary, but in terms of ongoing treatment are ignored.

4. The physical plant is simply not appropriate for the numbers of patients. To see the admission wards with 6 extra occupied beds lined up outside the nursing station and 44 other patients looking on is a demoralizing sight, to say the least. Some staff recalled sadly the time when the Institute actually had more buildings, but over the years they have watched these be rented out to other agencies.

5. Staff morale. We cannot state too emphatically our concern in face of a profound and pervasive level of disillusion among Institute staff at all levels. The reasons for this are numerous and include:

a. A struggle (which has gone on too long) to do good work in what has become an almost impossible work context.

b. A sense of betrayal among long-standing employees, who recall other times of crisis when improvements were promised but in their view not delivered. "Three times in the past eight years," we were told, there has been juggling of staff from north to south, or reallocation of funds. This was referred to by many as "the shell game". The belief that the situation is steadily worsening despite these maneuvers is strong.

c. A lack of hope that there will be improvement seems common. Many staff feel sadly that neither divisional leadership nor the political process will be able to effect lasting improvement. This disillusion is not directed toward any one individual, but seems to rest on the accumulated experience of a decade.

d. Everyone considers that the transfer of patients from Las Vegas to Reno is wrong. The cessation of this transfer to coincide with the second HCFA survey in March (so that these surveyors saw a somewhat less chaotic environment with a reduced census) was exactly what staff had expected and predicted. They await what they regard as the inevitable resumption of this practice once the certification crisis is passed (at least until the next time).

6. Education and supervision. Not surprisingly, where energies are almost totally devoted to managing the unmanageable, ongoing education and supervision are regarded as luxuries. In fact, they are necessities which sustain and rejuvenate staff, thereby enabling them to continue work with the severely mentally ill, which will never be easy but which can be made more rewarding. Too many staff responded that they derive little or no reward from their work under present circumstances. The absence of regular teaching/supervisory sessions adds to the burdensome nature of the work.

Our site visit committee next visited the Las Vegas Mental Health Center on Wednesday, April 22, 1987. We pursued a similar methodology to that which we adopted in Reno. Our findings are as follows:

1. Inadequate staffing. Again, we concur with the HCFA finding that too few staff have been attempting to deal with too many patients. Again, the shortage of psychiatrists is particularly striking. A facility designed for some 36 patients was in the early part of the year containing some 47 patients. As is now well recognized, many staff reached a point of desperation faced with the impossible staff:patient ratio. In addition to the unanimous viewpoint that there have been too few psychiatrists at the Las Vegas facility, it was also emphasized to us, particularly by nursing staff, that there is a related and serious lack of adequate medical coverage. Apparently at one point there was a general physician contracted to attend to the physical illnesses of the psychiatric patients. This position is not currently filled and the nurses find the process of getting attention to physical illness slow and problematic.

2. The commitment process. Many staff offered the opinion that there are very serious questions to be appropriately raised about the process by which patients are committed to mental health facilities. Those staff members who have worked in other states were particularly likely to emphasize that they had never known such large numbers of patients to be committed as apparently occurs in Las Vegas. To these quantitative concerns others added qualitative questions, suggesting that the large numbers ruled out the possibility of the kind of time-demanding but nonetheless appropriately lengthy assessment really needed to reach the appropriate conclusions.

3. As in Reno, many Las Vegas staff were troubled by what they regarded as the indiscriminate mixing of patients. It was put to this committee that where 47 patients are housed in a facility designed for 36 with inadequate psychiatric coverage, thorough individual assessment leading to specialized approaches for clearly demarcated diagnostic groups (an emphasis of modern psychiatry everywhere at this point) becomes impossible.

4. The physical plant again was simply not designed for the numbers of patients for which it has been used. We were told that at one point 45 patients were sharing two showers. In addition, there were several complaints about the inadequacy of the equipment in other parts of the center. We were told that there was no budget for occupational and recreational therapy. We found it particularly hard to imagine a medical records office without a typewriter or copying machine.

5. Staff morale. Whereas in Reno staff morale seemed to be universally poor, we are pleased to note that while some Las Vegas staff echoed the disillusion and hopelessness of their Reno counterparts, others were more optimistic. The pessimists told us that they expected no significant improvements. The optimists informed us that already there had been significant improvements in recent weeks. For example, the census had fallen to 36 patients and there was every hope that this would not now be exceeded. Already some staff were finding that they were much more able to provide the standards of care in keeping with their professional aspirations. In addition, it was clear that there have been welcome additions to the staff in recent weeks of colleagues who are apparently emanating competence. This committee was assured that tremendous efforts had gone into preparation for the second HCFA survey and it was felt that these efforts had borne fruit. Given these improvements, a source of serious concern to nursing staff (the largest professional group) is that they are not represented on the managerial council of the center.

6. Education and supervision. Again as in Reno, it was noteworthy to this committee what little emphasis appears to be placed on education and supervision, both at the point of entry of new staff and in any systematic ongoing way.

Conclusions and Recommendations

In preparing our conclusions and recommendations this committee is aware that legislative action has already overtaken us and that the increased funding appropriated for mental health should alleviate some of the problems described above. Nonetheless, we do wish to add our voices (on behalf of the Nevada Association of Psychiatric Physicians) to those who have already pointed out that the mental health system has experienced serious problems and that these problems are by no means yet over. We wish to draw attention to the following issues:

1. Patient care. For many reasons, the care of the psychiatrically ill in the two facilities surveyed has been severely compromised. There is not one person we met who is not troubled by the realization that patient care fell to a very low level. Many feel that this deterioration has been progressive over a decade and that late 1986 and early 1987 saw a particularly low point reached. Our recommendation here is a global one and an obvious one and is that the standards of patient care must at all costs be improved. There are staff in Las Vegas who particularly feel that the worst is past and that recent improvements have been real and substantive.

2. Funding. It goes without saying that we feel that funding has simply been quite inadequate to do the job and that, of course, we are delighted that recent legislative action has increased that funding. We would, however, add a word of caution here. It would seem to this committee that, as with the prison situation, there has been a serious miscalculation of mental health needs in the last several years. We would urge an ongoing careful and scientifically acceptable monitoring of the ratios between psychiatric beds and staffing and the increase in Nevada's population. There are those who feel that by the time new buildings are in use, as apparently proposed at recent legislative

hearings, that the population, particularly in the south, will have increased even further and that the process of eternally trying to catch up with mental health needs will continue.

3. Planning. Whatever the reasons for it, it would seem that planning for Nevada's mental health needs has been seriously flawed, contributing to the very real seriousness of the recent situation. Here it is all too easy to choose one's favorite target and lay blame at the door of politicians, mental health administrative leaders, or professional staff. Our recommendation here is for acknowledgement at all levels that there has been insufficient planning and to strongly make the case for proactive planning for the future. One staff member told us, "In the 16 years I've been around it's always been a matter of putting out flash fires and reacting in a knee jerk way to crises." This committee has been persuaded that there is much truth to that viewpoint. We, like everyone else, would like to see that change. While we do not believe that psychiatrists merely by being part of that professional discipline are necessarily successful administrators, we do feel there should be psychiatric voices at the core of divisional planning for the future.

4. Education, supervision, and training. We feel that the education and training of employees of all disciplines is sadly underemphasized and we strongly recommend increased attention to this in the future. We are in no doubts but that not only will this lead to improved staff morale, but that there will be subsequent substantive improvements in patient care.

Finally, in concluding this report, this committee cannot hide its dismay that the standards of care in the Nevada state mental health facilities were allowed to reach such a low level. This is an inescapable and troubling conclusion. In saying this, we are humbly aware of the relative luxury of making such judgments from the perimeter of a system. We cannot help but feel sympathy for the patients who have received less than optimal care and the staff who have ended up being truly burned out and who acknowledge their bitterness and sense of hopelessness. Equally, however, we are full of admiration for those staff at all levels who have stood fast, who will stand fast, and who have retained the hope and the energy to do their utmost to bring about much-needed improvements.

We respectfully submit this report to you for your serious attention.

Yours sincerely,

David Johnson, M.D. (Chairman)

Donald Molde, M.D.

William O'Gorman, M.D.

(on behalf of the Nevada Association of Psychiatric Physicians)

DJ/DM/WO:aa

APPENDIX H

Memorandum from Robert M. Daugherty, M.D., Ph.D.,
Re: Potential Residency Training Program in Psychiatry

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE

Office of the Dean
Savitt Medical Sciences Building
Reno, Nevada 89557-0046
(702) 784-6001

Date: June 6, 1988

To: Interim Legislative Study Committee
for Mental Health and Mental Retardation

From: Robert M. Daugherty, Jr., M.D., Ph.D.
Dean

Subject: Requested Information Related to a Potential Residency Training Program in Psychiatry for the State of Nevada

This memorandum briefly addresses five factors relevant to the development of a residency training program in psychiatry.

I. Critical Need for Psychiatrists in Nevada

The severe problem of emotional illness in Nevada is reflected in the high rates of suicide, divorce, alcoholism, crime, and unwanted pregnancies. Although prevention is the preferred method for reducing these rates, treatment by mental health workers, including psychiatrists, is always needed for an effective and comprehensive program. Presently in Nevada there is approximately one psychiatrist for every 20,000 citizens, as compared to approximately two psychiatrists for the same number nationally. Thus, although Nevada has the highest rate of emotional disturbance in the country, the number of psychiatrists is only half the national average.

II. A Residency Training Program Will Aid Psychiatrists Recruitment

It is anticipated that much of the training will occur in our state system, including the Nevada Mental Health Institute in Reno and the Las Vegas Mental Health Clinic in Las Vegas. We hope to attract these graduates to work in the state system. This has been true in Maryland and several other states having cooperative university-state connections.

Our department has engaged in joint recruitment of psychiatrists for our state mental health system during recent years. In the last few months, we have recruited Drs. Maultsby, Thrasher, and Murphy. All acknowledged that their decision to come was strongly influenced by the university appointment and the hope for a psychiatry residency program in the state system. The latter reason is important because a training program enhances quality of patient care. Training programs also enhance morale and limit stagnation and burnout, which characterize many state hospital systems, including our own.

III. Service Benefits of a Residency Training Program

Although residents carry a small caselaod they will add manpower to the existing pool of psychiatrists in the state system.

One of the great needs in our system currently is inservice training for the allied professional staff. The same team training psychiatric residents would help in the training of psychiatric aides, nurses, social workers, and psychologists. Thus, the training needs of other mental health professionals could be met while simultaneously training psychiatric residents.

IV. Impact on Patient Care

Because a resident will be present in the hospitals 24 hours every day, the quality of patient care will be improved.

However, in order to establish a residency program, the clinical setting will need to be improved to be suitable for training. The staff will need to be brought up to community and JCAH standards. The recruitment of Drs. Maultsby, Thrasher, and Murphy is a great stride toward this aim. The presence of residents requires good role models in the form of faculty psychiatrists. Most physicians enjoy teaching and also are aware that teaching and research provide an important balance to the demands of patient care.

Having new physicians in training is healthy, prevents stagnation, and enhances morale. Residents are usually very enthusiastic and innovative in their approaches to patient care and research.

Finally, as noted above, other mental health workers will benefit from active teaching within the system and their improved skills will certainly improve patient care.

V. Cost

The residency would require three additional faculty at an approximate cost of $100,000 each per year. One position will be added each year beginning in 1989-90 and reaching the full complement of three in 1991-92.

Residency stipends would be borne by all clinical sites where residents rotate, i.e. Reno VA Medical Center, Truckee Meadows Hospital, Washoe Medical Center, Montevista Centre, University Medical Center of Southern Nevada and the state mental health system. The cost of resident stipends to the state would be approximately $200,000 by 1993-94 when the program is in full operation.

Finally, a one-time-only expense for remodeling Building #6 on the grounds of the Nevada Mental Health Institute is required to house the program. This will cost approximately $300,000 and will provide office space and furniture and equipment for faculty and residents, and a much-needed outpatient department which will augment services provided for newly-discharged patients from the Nevada Mental Health Institute.

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APPENDIX I

Suggested Legislation

SUMMARY--Creates legislative subcommittee and advisory committee relating to mental health and mental retardation. (BDR 39-399)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; creating a legislative subcommittee on mental health and mental retardation and defining its duties; creating a medical and professional advisory committee within the mental hygiene and mental retardation division of the department of human resources and defining its duties; requiring the mental hygiene and mental retardation division to report to the legislative subcommittee on certain matters; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 433 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 10, inclusive, of this act.

Sec. 2. *1. There is hereby created within the interim finance committee a legislative subcommittee on mental health and mental retardation*

consisting of three members of the senate and two members of the assembly. The majority leader of the senate shall appoint two members and the minority leader of the senate shall appoint one member. The speaker and the minority leader of the assembly shall each appoint one member. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to mental health and mental retardation. The persons appointed to the subcommittee need not be members of the interim finance committee.

2. The majority leader of the senate shall select the chairman of the subcommittee and the speaker of the assembly shall select the vice chairman of the subcommittee. The term of office for the chairman and vice chairman is 2 years commencing on July 1 of each odd-numbered year. If a vacancy occurs in the chairmanship or the vice chairmanship, the majority leader of the senate or the speaker of the assembly, as appropriate, shall appoint a replacement for the remainder of the unexpired term.

3. Any member of the subcommittee who does not seek reelection or is not reelected to the legislature continues to serve until the next session of the legislature convenes.

4. Vacancies on the subcommittee must be filled in the same manner as original appointments.

Sec. 3. *1. The legislative subcommittee on mental health and mental retardation shall meet at least once each quarter and throughout the year at the times and places specified by a call of the chairman or a majority of the subcommittee. The director of the legislative counsel bureau or his designee shall act as the nonvoting recording secretary. The subcommittee shall prescribe*

regulations for its own management and government. Three members of the subcommittee constitute a quorum, and a quorum may exercise all the powers conferred on the subcommittee.

2. Except during a regular or special session of the legislature, a member of the subcommittee is entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the subcommittee or is otherwise engaged in the business of the subcommittee plus the per diem allowance and travel expenses provided for state employees generally.

3. The salaries and expenses of the subcommittee must be paid from the legislative fund.

Sec. 4. *The legislative subcommittee on mental health and mental retardation may:*

1. Review and evaluate the quality and effectiveness of programs provided for mentally ill and mentally retarded persons in this state.

2. Analyze the overall system of providing care to mentally ill and mentally retarded persons to determine methods of coordinating and providing services to those persons, avoid the duplication of services and achieve the most efficient use of all available resources.

3. Examine actions of the division including:

(a) Actions taken to evaluate the future needs of this state concerning the treatment of mental illness and mental retardation and the development of ways to improve treatment already provided.

(b) All budgets submitted by the division.

(c) The needs of persons employed by the division to provide services for mentally ill and mentally retarded persons and whether those needs are being met.

(d) The training and standards for certification of persons employed by the division to provide services for mentally ill and mentally retarded persons.

(e) Any proposal for capital improvements required to improve services for mentally ill and mentally retarded persons.

5. Conduct investigations and hold hearings in connection with its review and analysis.

6. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties.

7. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

8. Recommend to the legislature any appropriate legislation.

Sec. 5. *1. In conducting investigations and hearings of the legislative subcommittee on mental health and mental retardation:*

(a) The secretary of the subcommittee, or in his absence any member of the subcommittee may administer oaths.

(b) The secretary or chairman of the subcommittee may cause the deposition of witnesses, residing either inside or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in district courts.

(c) The chairman of the subcommittee may issue subpenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpena, the chairman of the subcommittee may report that fact to the district court by a petition which sets forth that:

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpenaed by the subcommittee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpena before the subcommittee which is named in the subpena, or has refused to answer questions propounded to him,
and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the subcommittee.

3. Upon receiving such a petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days after the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the subcommittee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpena was regularly issued by the subcommittee, the court shall enter an order that the witness appear before the subcommittee at the time and place fixed in the order and testify or produce the

required books or papers. Failure to obey the order constitutes contempt of court.

Sec. 6. *1. There is hereby created within the division a medical and professional advisory committee consisting of nine members.*

2. The committee consists of:

(a) The medical director of the division.

(b) The medical directors of the Las Vegas mental health center and the Nevada mental health institute.

(c) The directors of nursing of the Las Vegas mental health center and the Nevada mental health institute.

(d) A psychiatrist employed by the Las Vegas mental health center and a psychiatrist employed by the Nevada mental health institute.

(e) A psychologist employed by the Las Vegas mental health center and a psychologist employed by the Nevada mental health institute.

3. The term of office for each member of the committee is 4 years.

4. Biennially the committee shall select from among its members a chairman and vice chairman.

Sec. 7. *1. The medical and professional advisory committee shall meet at least once each quarter and throughout the year at the times and places specified by a call of the chairman. Five members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.*

2. A member of the committee is entitled to receive a salary of $60 for each day he is engaged in the business of the committee.

Sec. 8. *The medical and professional advisory committee shall:*

1. Advise the division on matters relating to issues affecting those employees of the division who provide services for mentally ill and mentally retarded persons.

2. Make recommendations to the division concerning the administration of the division.

3. Make recommendations to the division concerning training and standards for certification of persons employed by the division to provide services for mentally ill and mentally retarded persons.

4. Submit quarterly reports to the legislative subcommittee on mental health and mental retardation which include:

(a) An analysis of the quality of the care and treatment provided for mentally ill and mentally retarded persons in this state;

(b) The needs of persons employed by the division to provide services for mentally ill and mentally retarded persons;

(c) Recommendations on improving the quality of care provided to mentally ill and mentally retarded persons;

(d) Ratios of members of the staff of the division to persons receiving services from the division;

(e) A review of the division's budget;

(f) A review of standards of treatment within the division; and

(g) Any other information requested by the legislative subcommittee.

Sec. 9. *The administrator shall report at least twice each year to the medical and professional advisory committee on the activities of the division.*

Sec. 10. *1. The division shall submit to the legislative subcommittee on mental health and retardation:*

(a) A plan to provide training for nurses employed by the division to allow them to satisfy requirements for their continuing education; and

(b) Annual reports of the proposed ratios of members of the staff of the division to inpatients, outpatients and other persons for whom services are provided or paid for by the division.

2. The division shall:

(a) Prepare a 5-year plan to provide services to mentally ill and mentally retarded persons of the state;

(b) Revise that plan annually; and

(c) Report on the original plan and all revisions to the legislative subcommittee.

SUMMARY--Requires mental hygiene and mental retardation division of department of human resources to carry out program for certification of certain employees of division. (BDR 39-400)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health care; requiring the mental hygiene and mental retardation division of the department of human resources to carry out a program for the certification of certain employees of the division; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 433 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The division shall carry out a vocational and educational program for the certification of persons employed by the division for the care of clients. The program must be carried out in cooperation with the University of Nevada System. The division shall specify the classifications of employees to be required to be certified.

2. The division shall adopt regulations to carry out the provisions of this section.

Sec. 2. The mental hygiene and mental retardation division of the department of human resources shall submit to the 66th session of the Nevada legislature a plan specifying a vocational and educational program for the certification of persons employed by the division for the care of clients.

Sec. 3. Section 1 of this act becomes effective on July 1, 1991.

SUMMARY--Makes appropriation for establishment and support of residency training program for psychiatrists. (BDR S-401)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT making an appropriation to the University of Nevada System for the establishment of a residency training program for psychiatrists; making an appropriation to the state public works board for the renovation of a building to be used in that program; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. There is hereby appropriated from the state general fund to:

1. The University of Nevada System the sum of $388,119 for the establishment of a residency training program for psychiatrists.

2. The state public works board the sum of $561,881 for the renovation of Building No. 6 at the Nevada mental health institute for use in the residency training program for psychiatrists established pursuant to subsection 1.

Sec. 2. Any remaining balance of the appropriations made by section 1 of this act must not be committed for expenditure after June 30, 1991, and revert to the state general fund as soon as all payments of money committed have been made.

Sec. 3. This act becomes effective upon passage and approval.

SUMMARY--Amends requirements for certification of psychiatrists employed by mental hygiene and mental retardation division of department of human resources. (BDR 39-402)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; requiring the certification of psychiatrists employed by the mental hygiene and mental retardation division of the department of human resources within 5 years of the first day of their employment; authorizing the employment of psychiatrists eligible to be certified by the American Board of Psychiatry and Neurology under certain circumstances; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 433.267 is hereby amended to read as follows:

433.267 [Any] *1. Except as otherwise provided in subsection 2, any* psychiatrist who is employed by the division must be certified by the American Board of Psychiatry and Neurology within [3] *5* years after his first date of

employment with the division. The administrator shall terminate the employment of any psychiatrist who fails to receive such certification.

2. The division may employ a psychiatrist who is eligible to be examined for certification by the American Board of Psychiatry and Neurology if he has been approved by the interim finance committee.

SUMMARY--Requires certain facilities operated by mental hygiene and mental retardation division of department of human resources to be accredited by nationally recognized organization. (BDR 39-403)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; requiring the accreditation of certain mental health facilities operated by the mental hygiene and mental retardation division of the department of human resources; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 433 of NRS is hereby amended by adding thereto a new section to read as follows:

Division facilities which treat inpatients must be accredited by the Joint Commission on Accreditation of Hospitals or another nationally recognized organization approved by the division.

Sec. 2. Mental health facilities which treat inpatients and are being operated by the mental hygiene and mental retardation division of the

department of human resources on July 1, 1989, shall comply with the requirements of section 1 of this act by July 1, 1992.

SUMMARY--Amends definitions of abuse and neglect of mentally ill and mentally retarded persons. (BDR 39-404)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental health; requiring the division of mental hygiene and mental retardation of the department of human resources to adopt regulations relating to the abuse and neglect of a client of the division; amending the definitions of abuse and neglect; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 433 of NRS is hereby amended by adding thereto a new section to read as follows:

The division shall adopt regulations to:

1. Provide for a more detailed definition of abuse of a client of the division, consistent with the general definition given in NRS 433.554;

2. Provide for a more detailed definition of neglect of a client of the division, consistent with the general definition given in NRS 433.554; and

3. Establish policies and procedures for reporting the abuse or neglect of a client of the division.

Sec. 2. NRS 433.554 is hereby amended to read as follows:

433.554 1. Any employee of the division or other person who:

(a) Has reason to believe that a client of the division or of a private institution or facility offering mental health services has been or is being abused or neglected and fails to report it;

(b) Brings intoxicating beverages or a controlled substance into any building occupied by clients unless specifically authorized to do so by the administrative officer or a staff physician of the facility;

(c) Is under the influence of liquor or a controlled substance while employed in contact with clients, unless in accordance with a prescription issued by a physician, podiatrist or dentist;

(d) Enters into any transaction with a client involving the transfer of money or property for personal use or gain at the expense of the client; or

(e) Contrives the escape, elopement or absence of a client,

is guilty of a misdemeanor.

2. Any employee of the division or other person who willfully abuses or neglects any client:

(a) If no substantial bodily harm to the client results, is guilty of a gross misdemeanor.

(b) If substantial bodily harm to the client results, shall be punished by imprisonment in the state prison for not less than 1 year nor more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment.

3. Any person who is convicted pursuant to this section is ineligible for 5 years for appointment to or employment in a position in the state service and, if he is an officer or employee of the state, he forfeits his office or position.

4. For the purposes of this section:

(a) "Abuse" means any willful or reckless act or omission to act which causes physical or mental injury to a client, including, but not limited to:

(1) The rape, sexual assault or sexual exploitation of the client;

(2) Striking the client;

(3) The use of excessive force when placing the client in physical restraints; and

(4) The use of physical or chemical restraints in violation of state or federal law.

Any act or omission to act which meets the standard practice for care and treatment does not constitute abuse.

(b) "Client" includes any person who seeks, on his own or others' initiative, and can benefit from care, treatment and training in a private institution or facility offering mental health services.

(c) "Neglect" means any act or omission to act which causes injury to a client or which places the client at risk of injury, including, but not limited to, the failure to:

(1) Establish or carry out an appropriate plan of treatment for the client;

(2) Provide the client with adequate nutrition, clothing or health care; and

(3) Provide a safe environment for the client.

Any act or omission to act which meets the standard practice for care and treatment does not constitute neglect.

(d) "Standard practice" is the skill and care ordinarily exercised by prudent medical personnel.

SUMMARY--Prohibits retaliatory action against state officer or employee who discloses improper governmental action. (BDR 23-405)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to state government; prohibiting any retaliatory disciplinary action against a state officer or employee who discloses an improper governmental action; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 281 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 8, inclusive, of this act.

Sec. 2. *As used in sections 2 to 8, inclusive, of this act, unless the context otherwise requires:*

1. "Commission" means the commission on ethics.

2. "Improper governmental action" means any action taken by a state officer or employee in the performance of his official duties, whether or not the action is within the scope of his employment, which is:

(a) In violation of any state law or regulation;

(b) An abuse of authority;

(c) Of substantial and specific danger to the public health or safety; or

(d) A gross waste of public money.

3. "State employee" means any person who performs public duties under the direction and control of a state officer for compensation paid by or through the state.

4. "State officer" means a person elected or appointed to a position with the state which involves the exercise of a state power, trust or duty, including:

(a) Actions taken in an official capacity which involve a substantial and material exercise of administrative discretion in the formulation of state policy;

(b) The expenditure of state money; and

(c) The enforcement of laws and regulations of the state.

Sec. 3. *It is hereby declared to be the public policy of this state that a state officer or employee is encouraged to disclose to the commission, to the extent not expressly prohibited by law, improper governmental actions, and it is the intent of the legislature to protect the rights of a state officer or employee who makes these disclosures.*

Sec. 4. *1. A state officer or employee may disclose information concerning improper governmental action by filing a statement with the commission on a form and in the manner prescribed by the commission.*

2. The commission shall, with the assistance of the attorney general, investigate each statement of improper governmental action filed by a state officer or employee pursuant to subsection 1 and render an opinion.

3. The opinion must be:

(a) Rendered expeditiously.

(b) Kept confidential, except when:

(1) The person about whom the opinion was requested discloses the content of the opinion; or

(2) Any reprisal or retaliatory action is taken against a state officer or employee as set forth in section 6 of this act.

4. Nothing in this section authorizes a person to disclose information otherwise prohibited by law.

Sec. 5. *1. A state officer or employee shall not directly or indirectly use or attempt to use his official authority or influence to intimidate, threaten, coerce, command, influence or attempt to intimidate, threaten, coerce, command or influence another state officer or employee in an effort to interfere with or prevent the disclosure of information to the commission concerning improper governmental action.*

2. For the purposes of this section, "use of official authority or influence" includes taking, directing others to take, recommending, processing or approving any personnel action such as an appointment, promotion, transfer, assignment, reassignment, reinstatement, restoration, reemployment, evaluation or other disciplinary action.

Sec. 6. *1. If any reprisal or retaliatory action is taken against a state officer or employee who provides the commission with specific information on any matter which:*

(a) Warrants further investigation or other action; or

(b) Is given, in good faith, as determined by the commission, although further investigation or other action is warranted,

within 2 years after the commission renders its opinion on the matter, the state officer or employee may seek judicial review of the reprisal or retaliatory action in district court, whether or not there has been an administrative review. In such an action, the reviewing court may apply any legal or equitable relief or operation of law and award reasonable attorney's fees.

2. For the purposes of this section, "reprisal or retaliatory action" includes:

(a) Denial of adequate staff to perform duties.

(b) Frequent replacement of staff members.

(c) Frequent and undesirable office changes.

(d) Refusal to assign meaningful work.

(e) Unwarranted and unsubstantiated letters of reprimand or evaluations of work performance.

(f) Demotion.

(g) Reduction in pay.

(h) Denial of promotion.

(i) Suspension.

(j) Dismissal.

Sec. 7. *Each year a written summary of sections 2 to 8, inclusive, of this act and the procedures for reporting improper governmental actions established by the commission must be made available by the director of the department of personnel to each state officer and employee.*

Sec. 8. *Sections 2 to 7, inclusive, are intended to be directory and preventive rather than punitive. These sections do not abrogate or decrease the effect of any of the provisions of the Nevada Revised Statutes which define crimes or prescribe punishments with respect to the conduct of state officers or employees.*

SUMMARY--Increases rate at which nurse employed by state earns credit for overtime. (BDR 23-406)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to nurses; increasing the rate at which a nurse employed by the state earns credit for overtime; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 284.180 is hereby amended to read as follows:

284.180 1. The legislature declares that since uniform salary and wage rates and classifications are necessary for an effective and efficient personnel system, the pay plan must set the official rates applicable to all positions in the classified service, but the establishment of the pay plan in no way limits the authority of the legislature relative to budgeted appropriations for salary and wage expenditures.

2. Credit for overtime work directed or approved by an agency head or his representative must be earned at the rate of time and one-half, except for

those employees determined by the department to be executive, administrative, professional or supervisory. Executive, administrative, professional and supervisory employees earn credit for overtime at their regular straight time rate [.] , *except for nurses. Nurses earn credit for overtime at the rate of time and one-half.* Overtime is considered time worked in excess of an 8-hour day or a 40-hour week, except for:

(a) Those employees who choose and are approved for a variable workday, in which case overtime will be considered only after working 40 hours in 1 week; and

(b) Those employees who choose and are approved for a variable 80-hour work schedule within a biweekly pay period, in which case overtime will be considered only after working 80 hours biweekly.

3. An agency may experiment with innovative work weeks upon the approval of the head of the agency and after majority consent of the affected employees.

4. This section does not supersede or conflict with existing contracts of employment for employees hired to work 24 hours a day [in a home setting.] *where the place of employment is managed as if it were a home.* Any future classification in which an employee will be required to work 24 hours a day in [a home setting] *such a place of employment* must be approved in advance by the commission.

Sec. 2. The amendatory provisions of this act expire by limitation on July 1, 1993.