ADMINISTRATION OF MENTAL HYGIENE AND MENTAL RETARDATION PROGRAMS IN NEVADA

Bulletin No. 79-6

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

October 1978

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LEGISLATIVE COMMISSION

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Assembly Concurrent Resolution No. 55—Committee on Ways and Means

FILE NUMBER 126

ASSEMBLY CONCURRENT RESOLUTION—Directing the legislative commission to study the administration of mental hygiene and mental retardation programs in Nevada.

WHEREAS, In 1973, the Rand Corporation of Santa Monica, California, was awarded a grant from the Max C. Fleischmann Foundation of Nevada to conduct a comprehensive study of the mental health and mental retardation system in Nevada; and

WHEREAS, The report of the 2-year study was published in 1976, and it identified major deficiencies in the state's mental health and mental retardation programs; now, therefore, be it

Resolved by the Assembly of the State of Nevada, the Senate Concurring, That the legislative commission study the administration of mental hygiene and mental retardation programs in this state to:

1. Determine whether or not the recommendations made in the Rand Corporation report should be carried into effect;
2. Determine whether or not the division of mental hygiene and mental retardation of the department of human resources is furnishing the types of programs which it is required to provide by law;
3. Determine whether or not the division should be reorganized in order to provide greater efficiency; and
4. Determine whether or not the programs developed by the division fully utilize the available resources,

and be it further

Resolved, That the results of such study and any recommended legislation be reported to the 60th session of the Nevada legislature.

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REPORT OF THE LEGISLATIVE COMMISSION

This report is submitted in compliance with Assembly Concurrent Resolution No. 55 of the 59th Session of the Legislature which directed the Legislative Commission to study the Administration of Mental Hygiene and Mental Retardation Programs in Nevada.

To conduct the study, the Commission appointed a subcommittee with the following members: Assemblyman James N. Kosinski, Chairman; Assemblyman Marion D. Bennett, Vice Chairman; and Senator Joe Neal, Assemblyman John M. Vergiels, and Assemblyman Peggy Westall, members. The subcommittee held 7 days of meetings and visited Division of Mental Hygiene and Mental Retardation facilities in northern and southern Nevada. At these meetings were mental health professionals, community providers, state personnel, and other individuals interested in Nevada's mental hygiene and mental retardation programs.

A task force of mental health professionals was organized by Aaron Smith, Ph. D., in response to the subcommittee's obvious need for professional input to the study. Dr. Smith expended great energy in enlisting the services of some of the state's top mental health professionals, coordinating their efforts, and putting together a very comprehensive and exhaustive report in a short period of time. The report of the task force is included as a section of this report.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada

SUMMARY OF RECOMMENDATIONS

1. The administration should assume the role of leadership and management of the Division of Mental Hygiene and Mental Retardation.

2. The administrative structure of the division should not be regionalized.

3. The division should develop a plan for a functional structure of the division.

4. A management information system and a program evaluation system should be established within the division.

5. The Henderson Mental Health Center should be merged into the operation of the Las Vegas Mental Health Center.

   The Reno Mental Health Center should be merged into the operation of the Nevada Mental Health Institute.

6. The division should not obtain a federal staffing grant for the Henderson Mental Health Center if that necessitates establishing two separate and independent mental health delivery systems in Clark County.

7. The Rural Clinics' program should be funded at the level of need, as determined by the legislature, and not necessarily at the level mandated by the federal government under the NIMH grant.

8. Rural Clinics' programs should merge, administratively, with the other programs operated by the division pursuant to the "functional" structure.

9. Legislative approval should be required prior to the acceptance of grants by the division which exceed $50,000.

10. Letters of intent should be incorporated within the general appropriation act and the authorization act at the conclusion of each legislative session.

11. The Advisory Board should take a more active role in representing the consumer viewpoint before the legislative and executive branches of government.

12. Additional state resources should be earmarked for prevention programs.

13. The legislature should require semiannual reports concerning the programs designed and implemented by the Human Service Educator within the division administration.

14. The subcommittee recommends that the division continue to operate the retardation programs and that these programs continue to function independently of the mental hygiene programs.

15. Psychiatric care should be provided for mentally retarded clients.

16. Substantially increase funding for the community training centers.

17. The Department of Administration and its Personnel Division should be exercising greater supervision over the executive agencies and the use of the variable workweek.

18. National search committees should be convened to fill top administrative positions.

19. The money committees should require that each state agency provide a delineation of the proposed and actual use of training funds and out-of-state travel.

20. The Department of Administration and its Personnel Division should adopt uniform and carefully delineated policies for the expenditure of tax dollars for educational benefits that are primarily of benefit to employees.

21. The division should be directed to periodically report to the Interim Finance Committee during the 1980-81 biennium concerning the utilization of training funds.

22. Legislation should be enacted requiring legislative approval prior to changing the authorized number and grade of state employees within a budget.

23. Authorized personnel of the legislature and its committees and subcommittees should be provided access to records of the division to enable the legislature to adequately evaluate the division's programs.

24. Repeal NRS 449.200 as an unnecessary and ineffective restriction on the public's access to information about the quality of health facilities.

25. A secure facility for severely disturbed adults should be established at the Nevada Mental Health Institute.

26. Increase funding for community residential facilities to serve adolescents and adults.

27. A secure adolescent residential facility and an outpatient services program should be established at the Nevada Mental Health Institute.

28. A secure adolescent facility should be established at the Las Vegas Mental Health Center if the northern facility does not satisfy the needs of the entire state.

29. Capital improvements requested by the division should be carefully reviewed by the legislature with a view toward program needs and staffing costs.

30. The use of satellite offices should be carefully reviewed by the division.

REPORT OF THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY THE ADMINISTRATION OF MENTAL HYGIENE AND MENTAL RETARDATION PROGRAMS IN NEVADA

I. INTRODUCTION

The 1977 Session of the Nevada Legislature adopted Assembly Concurrent Resolution 55 directing the Legislative Commission to study the administration of mental hygiene and mental retardation programs in the State of Nevada. This directive was adopted, in part, because the Rand Corporation had conducted a comprehensive review of the state's mental hygiene and mental retardation programs and had issued a report in early 1976 containing 71 recommendations concerning the quality and quantity of the service available to the residents of Nevada. The Rand Corporation reported that the major problems included "Insufficient service capacity in relation to need, inequitable distribution of services by geographic location, lack of coordination and direction of the service system, poor facilities, inadequately trained personnel in some programs and hence poor quality services, failure to provide a full range of service, lack of a continuum of levels of intensity of service, failure to have a variety of treatment modalities available to match the variety of people's needs, and a deficiency of information needed for program management and evaluation of program effectiveness."[1] Differing opinions were presented to the 1977 Legislature as to whether or not the recommendations of the Rand Report should be adopted, if adopted how they should be implemented, and whether or not some of the recommendations were related to legitimate problems.

The Division of Mental Hygiene and Mental Retardation experienced very rapid growth and change during the 5-1/2 years preceding the 1977 Legislature which also was requested to approve substantial increases. By way of illustration, a total of $5.9 million was approved by the 1971 Legislature for the fiscal year 1971-72. Six years later, more than $17 million was requested for fiscal year 1977-78, and the 1977 Legislature eventually approved $17.6 million representing an increase of 300 percent. A number of mental health professionals in the community and some members of the division's staff greeted the growth and change less than enthusiastically. Conflicting opinions were aired before the legislature and in the press as to whether or not services to Nevada residents were improving commensurate with the increased commitment of resources to the di-

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1 The Rand Corporation, Mental Health and Mental Retardation Services in Nevada, 1976, p. 14.

vision. On one hand, the Assembly Ways and Means Committee heard mental health professionals insist that the state had committed adequate resources to the division and that the ineptitude of the division administration was responsible for the poor quality of services. The division, on the other hand, pointed proudly to its record of improving programs and was quick to develop a shopping list of new programs, facilities and staff to meet any gaps in services, problems or criticisms--often without adequate concern for the cost of these programs.

Another factor leading to the commissioning of the study was that the division proposed a regional reorganization of its administrative structure. The reorganization of mental retardation programs along regional lines was recommended by the Governor and approved. The legislature, however, believed the proposal for reorganization within the mental hygiene section of the division required further study, especially in view of the division's cost estimates for the new administrative structure which exceeded $1 million per year. This would have amounted to more than a 300 percent increase in administrative costs over the previous fiscal year.

Against this background of controversy and conflicting opinions, it is appropriate to highlight the recent history of the division. Details on each of the programs are presented in Appendix B.

II. THE DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Until the beginning of the 1970's, the activities of the Division of Mental Hygiene and Mental Retardation were geared to the operation of the State Hospital in Sparks. In the Las Vegas area, there were only a few clinicians providing outpatient services and the same situation prevailed in Reno where 3 or 4 staff members counseled clients on an outpatient basis. During this period, there were only 2 or 3 clinicians in the Rural Clinics' program and they were traveling to rural Nevada counseling on an outpatient basis. The growth of the division in terms of money available and new facilities, beginning with fiscal year 1971-72, is detailed in Appendix C.

Of the $11.9 million support approved for the 1971-73 biennium, $8 million or 67 percent was earmarked for the State Hospital in Sparks which at that time was a 484-bed institution[2] serving both mentally ill and mentally retarded persons in the state. $1.6 million was approved for biennial support of mental retardation programs other than those at the State Hospital, $1.8

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2 Executive Budget, Fiscal Years 1971-72 and 1972-73, State of Nevada, 1971, p. 207.

million for the Las Vegas Mental Health Center, and $1/2 million for the support of the outpatient clinics' program which was newly created through realignment of existing budgets to include Reno and Rural Mental Health Clinics' programs. All programs of the Division of Mental Hygiene and Mental Retardation at the time were administered by the superintendent of the State Hospital.

During the period between the 1971 and 1973 legislative sessions, the hospital superintendent, who was a psychiatrist, left the employ of the state. Subsequently, a new budgeting unit, "Division of Mental Hygiene and Mental Retardation," was administratively carved out of the State Hospital allegedly as a mechanism to shift to a nonmedical administration. This budget was established with two positions--a Chief of Division of MH/MR and a clerical employee. A psychologist from the Rural Clinics' section of the Outpatient Clinics' program who had only recently completed his Ph. D. at the University of Nevada, Reno (while employed in the Rural Clinics' program), was appointed to head the division. This person apparently lacked the administrative expertise to direct a comprehensive, statewide mental hygiene and mental retardation program.[3] An employee of the Rural Clinics' program who also had recently received a Ph. D. in psychology from the University of Nevada, Reno; and who lacked administrative experience was appointed by the new division head as assistant administrator and program coordinator.[4] She served in this capacity but was paid out of the Rural Clinics' budget until the position of assistant administrator and program coordinator was approved as a new position in the division's administrative budget by the 1973 Legislature.

In his 1973 State of the State message, Governor O'Callaghan placed emphasis on upgrading and expanding services to mentally retarded and mentally ill persons, providing an impetus that carried throughout his administration. In answer to the Governor's request, the 1973 Legislature approved increased operating support of the division for the 1973-75 biennium of almost 40 percent over the 1971-73 period. The increases were primarily in areas other than the State Hospital (renamed Nevada Mental Health Institute) moving the state's mental hygiene and men-

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3 Curriculum Vita of Charles R. Dickson as furnished to the Ways and Means Committee of the 1977 Legislature.

4 Curriculum Vita of Gwen O'Bryan as furnished to the Ways and Means Committee of the 1977 Legislature.

tal retardation programs toward community based care. Additionally, $4.7 million was approved for capital improvements including money for construction of the Clark County Children's Behavioral Services facility and the Lake's Crossing forensic facility. Funding for programs to be housed in these facilities was also provided. Additionally, the 1973 Legislature approved several requested budgetary changes which had significant effect on how Nevada's services to the mentally handicapped would be organized and managed in the years to follow. These included a complement of new positions for the division's administration budget and the segregation of the mental health clinics' program into separately budgeted operating units titled "Rural Clinics" and "Reno Mental Health Center." Funding was requested and provided for each existing and each newly created operating unit to be staffed with a director and a full complement of program and support staff to allow operation as independent units.

During the same session, Senate Bill No. 511 was enacted to accommodate the new management structure by amending existing mental health statutes to shift duties of the superintendent of the State Hospital to either the administrator of the Division of Mental Hygiene and Mental Retardation or, where appropriate, to new positions of institute director and medical director at the Nevada Mental Health Institute. The institute director was designated as the executive and administrative head of the Nevada Mental Health Institute. The medical director was designated as the medical head of the Nevada Mental Health Institute. A medical director position was also created for the Las Vegas Mental Health Center.

In addition to the increases in support provided by the 1973 Legislature, people in Clark County were provided much needed increases in services when in October 1973 the Las Vegas Mental Health Center received a federal National Institute of Mental Health (NIMH) Community Mental Health Center staffing grant. The NIMH grant, effective for an 8-year period, nearly doubled the amount of funds available to the Las Vegas Mental Health Center during the first year it was in effect and provided for decreasing federal support during the remaining 7 years.

During 1974, a third person with a recent Ph. D. in psychology from the University of Nevada, Reno, was brought into division top management from the Rural Clinics' program. This individual was paid from the allocation for the position of director of the newly created, but yet to be constructed, Lake's Crossing facility; and was assigned to the division's administrative offices to serve as "Special Assistant Administrator - Division of Mental Hygiene and Mental Retardation."[5] This person had no

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[5] Curriculum Vita of Kenneth Sharigian as furnished to the Ways and Means Committee of the 1977 Legislature.

experience with mental offender programs, and did not qualify for the director's position.

Again in 1975, Governor O'Callaghan proposed upgrading and expanding services of the Division of Mental Hygiene and Mental Retardation. In response, the 1975 Legislature provided continued support for the Las Vegas Mental Health Center staffing grant and approved an increase in total funding for the division of some 50 percent. Capital improvement projects of $7.5 million were also approved. Most of the operating increases went for expansion of programs other than at the Nevada Mental Health Institute reflecting a further shift from the reliance on a hospital setting for treatment of mentally ill and mentally retarded persons.

Among the capital improvement projects approved by the 1975 Legislature was the construction of the Desert Developmental Center to serve the mentally retarded persons in Clark County, a Children's Behavioral Services facility for Washoe County, and 3 new 16-bed inpatient buildings at the Nevada Mental Health Institute. Also approved were funds to continue the ongoing renovation and improvements to the aged buildings at the Nevada Mental Health Institute.

After a great deal of debate in committees and in part due to the lobbying efforts of the Division of Mental Hygiene and Mental Retardation, the 1975 Legislature enacted Senate Bill 374, the Nevada Mental Health and Mental Retardation law. This bill made substantial organizational policy and procedure changes in division programs. Among these changes was the addition of section 6 which reads:

> "Administrative officer" means the person with overall executive and administrative responsibility for a state or nonstate mental health or mental retardation facility. In the case of mental health centers and mental retardation centers, the administrative officer is the clinic director. In the case of the institute, the administrative officer is the institute director.

Medical director was redefined as "chief medical officer of any division of mental health or mental retardation program." The net effect of these and other related changes was to establish one individual, the administrative officer, as head of each operating unit to be directly accountable to the division administrator. Further, the various operating units were listed in the statutes, in effect, legitimizing them as independent units of government.

The practical effect of these changes was to further remove mental hygiene and retardation programs from the "medical model." The advisability of this shift in program theory is still being debated by the providers of mental health services in our state.

In response to the Governor's budget recommendation for the fiscal years 1977-78 and 1978-79, another major funding increase amounting to over 45 percent and capital improvement projects in excess of $2.5 million were approved by the 1977 Legislature. Included in this expansion were new positions and increased funds for the Las Vegas Mental Health Center to comply with newly enacted federal regulations for facilities receiving NIMH staffing grants. Also approved was the reorganization of the mental retardation section into a regional organizational structure. Among the capital improvement projects was money to build a new Sierra Developmental facility for mentally retarded individuals adjacent to the Mental Health Institute.

In advance of the construction of the new Sierra Developmental Center, the legislature approved segregation of support for about 100 beds for mentally retarded individuals from the Mental Health Institute budget. After this division, effective July 1, 1977, the inpatient capacity at the Mental Health Institute was 138 beds according to the 1977 Executive Budget, a major change from the 484-bed statewide facility of 1971.

After adjournment of the 1977 Legislature and early in the course of this study, the division received another substantial NIMH 8-year staffing grant. This time seed money was provided to expand the Rural Clinics' program into a Community Mental Health Center. Prior to receipt of the grant, the program had an annual budget of $733,000 and a staff of 29. Under the grant, staff increased to 97 and the annual budget to $2.4 million. The federal share decreases each year during the 8-year life of the grant. At the end of the 8-year period, assuming moderate inflation, the annual program cost of some $4.5 million will have to be supported with state funds if the program is to be continued.

The NIMH staffing grant was received as a result of work funded by a 1976 federal planning grant. Neither the planning grant nor the Community Mental Health Center staffing grant were presented to the legislature for its approval or information.

During June of 1978, prior to completion of this study, the administrator of the division, Charles R. Dickson, resigned his position reportedly after being told he would be suspended during an investigation into his private business. Allegations were that he engaged in private practice in violation of NRS 232.270, which prohibits other employment. Questions were also raised about the propriety of contracts between the division and the administrator's alleged business associates--and possibly in violation of the State Ethics Law, NRS 281.401 through 281.551. The subcommittee took no action in the matter since an investigation was undertaken by the director of the Department of Human Resources and the Office of Attorney General. That investigation was not complete as of the subcommittee's final meeting--approximately 3 months later.

III. SUBCOMMITTEE METHODOLOGY

To conduct the study the Legislative Commission appointed Assemblyman Jim Kosinski (Washoe) as subcommittee chairman, Assemblyman Marion Bennett (Clark) as vice chairman, Senator Joe Neal (Clark), Assemblyman John Vergiels (Clark) and Assemblyman Peggy Westall (Washoe) as subcommittee members. The Legislative Commission allocated a budget of $3,100 to provide for the cost of the meetings and printing of the final report.

The subcommittee held its initial meeting on December 6, 1977, in Carson City. Subsequent hearings were held on February 22 and 23, 1978 in northern Nevada (Reno) and on March 22 and 23, 1978 in southern Nevada (Las Vegas). These 5 meetings were devoted to subcommittee organization, a review of the Division of Mental Hygiene and Mental Retardation, site visits and public hearings. All meetings were posted in compliance with the Open Meeting Law, press releases were circulated to the news media throughout the state on the nature and scope of the meetings, and letters were sent to more than 100 individuals and organizations throughout the state inviting input to the subcommittee. Individual subcommittee members also visited Mental Hygiene and Mental Retardation Division facilities on their own during the course of the study.

At the meetings, testimony was provided by community mental health professionals and other community providers, local elected officials and their representatives, and representatives of other public and private organizations concerned about mental hygiene and retardation services, the director of the Department of Human Resources, the director of the Division of Mental Hygiene and Mental Retardation, various employees of the Division of Mental Hygiene and Mental Retardation, and other individuals interested in Nevada's mental hygiene and mental retardation programs. The subcommittee also reviewed other studies concerning Nevada's mental hygiene and mental retardation programs, materials provided by the Division of Mental Hygiene and Mental Retardation and other materials relating to the delivery of mental hygiene and mental retardation services in general. The 71 recommendations of the Rand Corporation report were reviewed and the subcommittee findings and conclusions on each are listed in Appendix A.

Additionally, the subcommittee held a meeting on June 8, 1978, in Carson City to hear the report of its task force on State Provided Mental Health Services in Nevada, the text of which is contained in section V of this report. The task force of mental health professionals was organized by Aaron Smith, Ph. D., Research Coordinator of the Veterans Hospital in Reno, and a member of the University of Nevada, Reno, Medical School faculty, in response to the subcommittee's obvious need for professional input to the study. Dr. Smith expended great

energy in enlisting the services of some of the state's top mental health professionals, coordinating their efforts and putting together a very comprehensive and exhaustive report in a short period of time. Others serving on the task force were: Michele Baldwin, MSW, Ph. D.; Martha Irwin, R.N.; Edward Lynn, M.D.; R. Edward Quass, M.D.; Diane Turnbough, Ph. D., who resigned midway through the study; and Diane Spitzer, M.S., who served as staff investigator. The only remuneration available to these individuals was a small grant by the Department of Human Resources to reimburse the members for travel expense.

The subcommittee met in a work session on September 25, 1978, in Las Vegas. The final recommendations, as called for by A.C.R. 55, were formulated at this meeting. Also, the subcommittee considered the division's request to the Max E. Fleischmann Foundation for funding the construction of new facilities. The subcommittee's findings on the Foundation funding request are the subject of a separate report.

IV. SUBCOMMITTEE FINDINGS AND CONCLUSIONS

A. Organization of the Division of Mental Hygiene and Mental Retardation:

1. Organization of Division Administration

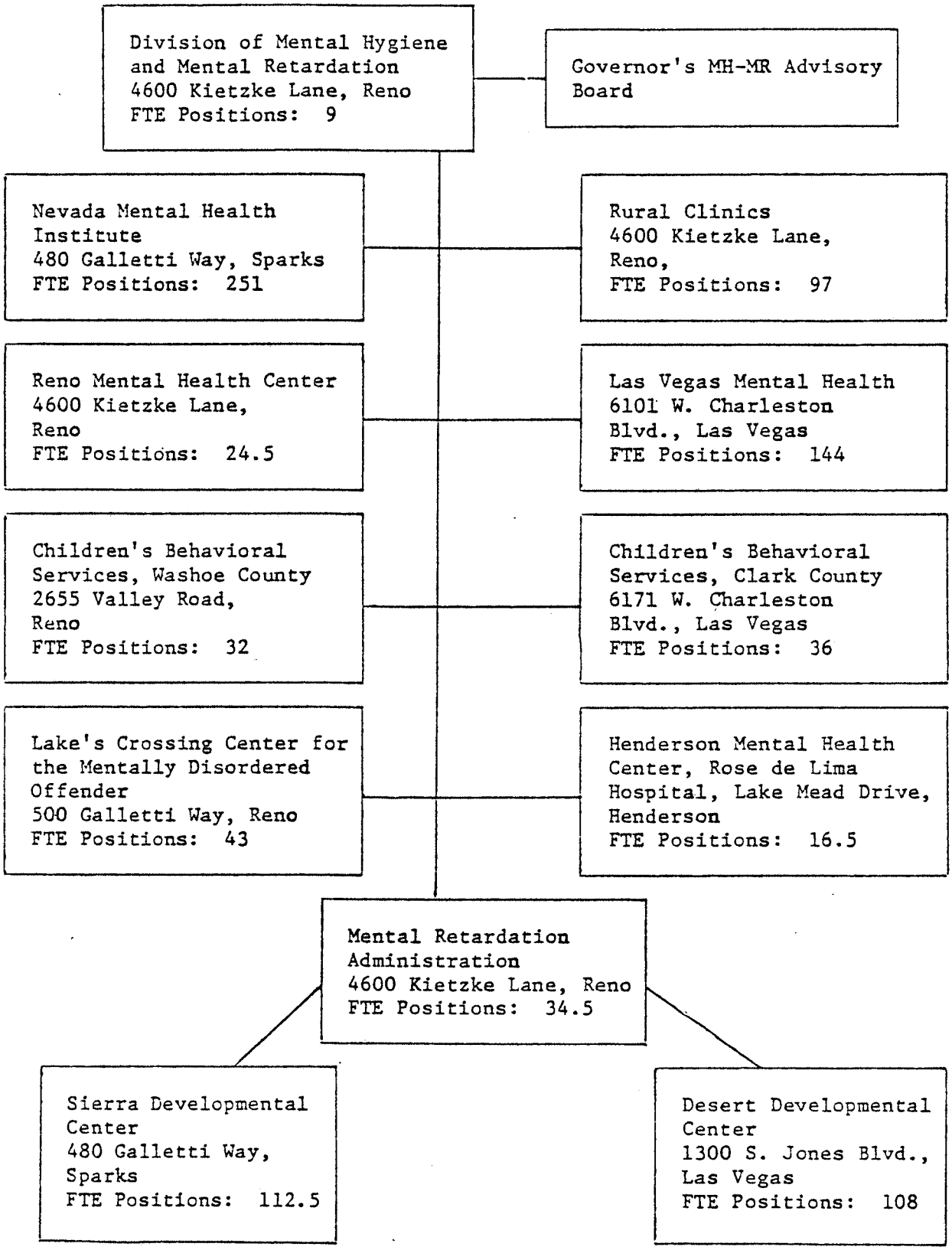
Nevada's Division of Mental Hygiene and Mental Retardation is organized under the Department of Human Resources which is the umbrella agency over divisions involved in a wide range of social services and other assistance, custodial care and youth correction programs. Other divisions include aging services, health, welfare, rehabilitation and youth services. Various operating units of the division and corresponding number of full-time equivalent positions are depicted on the organization chart (Exhibit 1, page 14).

The Rand Corporation Report of 1976 found the state's mental health services to be fragmented and lacking in coordination and direction. The subcommittee's mental health task force recommended that "....Mental health facilities of the division should be recognized as parts of a single unified system rather than autonomous agencies with overlapping functions and underserviced populations." This need for improved management direction and coordination was reiterated often in testimony before the subcommittee.

In response to a request by the subcommittee for an explanation of the role of the division's administration in coordinating transfer of patients between facilities, the division stated, "Each Division of Mental Hygiene and Mental Retardation agency operates in an equal organizational level of autonomy and authority. Consequently,

EXHIBIT 1

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION



referrals and transfers of clients between agencies must proceed as if the agencies were independent. At times it is necessary for the division's central office to arbitrate disputes which may occur, but this activity is discouraged because of limitations to central office manpower."[6]

During the course of the subcommittee's study, a number of requests for general information about the division's activities were made to the division's administration. In most cases, the division's administration did not have information at hand to answer the requests and had to relay the subcommittee's request to the various operating agencies for input. The division had to answer requests for information on waiting list policy and training in this manner. The later section of this report brings out the problem the division had in attempting to answer questions on utilization of training funds with uniform and consistent data.

The Division of Mental Hygiene and Mental Retardation currently exists as a group of independent and autonomous agencies coordinated by an isolated administration. This structure evolved during the past 7 years as programs were rapidly expanded. The problems with this structure have been recounted by many sources and there seems to be general agreement that the current structure is not a good one.

2. Regional Organization of Administration of Mental Health Services

A proposal to reorganize the mental health services of the division was also presented to the 1977 Legislature. The Executive Budget describes the proposal for the Northern Nevada Mental Health Services as below. The same description is provided for the proposed southern Nevada unit with the exception that the agencies to be combined are the Las Vegas Mental Health Center, the Henderson Mental Health Center and Children's Behavioral Services, Las Vegas.

> "The Division of Mental Hygiene and Mental Retardation proposes to reorganize its mental health services to maximize the efficiency of program delivery and management functions. To accomplish this goal,

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[6] Response of the Division of Mental Hygiene and Mental Retardation to an inquiry of the subcommittee by Gwen O'Bryan, Ph. D., Assistant Administrator and Program Coordinator, September 30, 1977.

the division proposes the formation of two regional units, one for Washoe County and one for Clark County. The various mental health programs in these areas would operate within these new administrative structures. This would reduce the present span of control for top level management, and allow for a more integrated approach to program management, evaluation and development.

The regional administrative units are designed to operate in a strongly decentralized manner in relationship to the division central administrative offices. The regional administration would provide:

1. Program evaluation and quality of service monitoring.

2. Program planning and development.

3. Oversight of all management functions.

4. Coordination of services to ensure continuity of care.

5. Provision of inservice education for professional staff of the mental health programs in the region.

6. Provision of community education and consultation services.

It is proposed that the Northern Nevada Mental Health Services be part of one appropriation to include the Nevada Mental Health Institute; Reno Mental Health Center; and Children's Behavioral Services, Washoe County.

The reorganization of the mental health services will be accomplished without additional state funds. Personnel will be reassigned to administer the region from existing programs. By combining the budgets under one administrator, personnel, facilities and resources will be more effectively utilized."

The Executive Budget indicates that the division's initial request for the regionalized administrative structures included 18 new positions and appropriations in excess of $1 million. This was more than a 300 percent increase over the fiscal 1977 administrative budget.

The proposed reorganization was rejected by the money committees of the 1977 Legislature with comments that it appeared to be the layering of another level of administration which might serve to further remove the division administration from the programs. The subcommittee and mental health task force received similar testimony indicating that the administration was already too aloof and remote; and that regionalization would only aggravate this problem. The 1977 Legislature also heard objections concerning the loss of visibility and control that could result from lumping the separate budgets of agencies in the south into one appropriation area and lumping the agencies in the north into one appropriation area. Also, the money committees noted that the Governor's budget had, on one hand, recommended elimination of the central administration of the community college system and, on the other hand, recommended two additional central administrative units within the Division of Mental Hygiene and Mental Retardation.

The division administration in testimony before the subcommittee restated their desire to reorganize mental health services on a regional basis. The revised regional reorganization proposal that they presented to the subcommittee contained all the basic elements of the 1977 legislative proposal. This proposal and accompanying material was provided to the subcommittee's task force for review and professional input. The task force advised against regionalization. The task force recommendations and comments (beginning on page 70 of the Task Force Report) point out that while the expectations of the regional structure were worthy goals, the regional organizational structure itself does not necessarily afford assurances that these goals will be achieved. Other possible methods of regional coordination are suggested.

3. Reorganization of the Division

Little guidance can be found in looking to other states for specific organization structures that might be copied by Nevada. There is an almost endless list of possible organization structures for delivery of people-to-people services. No two states have organizations that could be termed more than generally similar. Some include mental retardation with developmental disabilities programs in operating units separate from the mental health programs. In some cases, mental health services are delivered by the agency charged with social services delivery in general. Some states still adhere to an older concept of a department of institutions for their psychiatric facilities.

The 1972 report of Governor O'Callaghan's Committee on Economy and Efficiency provides a guide for organization of state government.[7] That group, known as the Swackhamer Committee after its chairman, William Swackhamer, reported that it adopted the implementation of the following management corollaries as its objective in conducting the study:

> "1.....
>
> 2. Organize departments along functional lines, with minimum overlap between agencies. Agencies that are administering highly interrelated programs should be structurally related or integrated to insure that coordination is achieved and duplication of effort reduced.
>
> 3. Budgeting, planning, personnel administration, and financial administration are tools of both policy formulation and management and should be structurally related to the chief executive.
>
> 4....."

The task force identified major deficiences in the administration of the division. These included: (1) A lack of a central determination of priorities with a clear and integrated assignment of mission and responsibilities to programs throughout the division. (2) Inadequate coordination in the delivery of mental health services by the division's various programs and facilities. (3) Absence of needed management information to assist the division's administration in carrying out its responsibilities.

The subcommittee believes that some of these deficiences could be alleviated by a functional organization of the division. The present structure with its autonomous agencies has resulted in duplication of services, service gaps and inefficient expenditures of tax dollars.

The implementation of a management information system and a program evaluation system is deemed critical by the subcommittee. The division is presently expending in excess of $20 million per year without knowledge of the effectiveness, if any, of its various programs. With a division-wide information system, the division can efficiently employ a program evaluator to develop a vehicle to establish program accountability throughout the entire division and its various programs.

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7 The Governor's Committee on Efficiency and Economy, To Conduct the Public Business, July 1972, pp. 8-9.

Recommendation No. 1:

The administration should assume the role of leadership and management of the Division of Mental Hygiene and Mental Retardation.

The division currently functions as little more than a second umbrella agency within the Department of Human Resources over the various agencies or centers providing mental hygiene and mental retardation service programs. The emphasis must be changed from coordinator, grant writer and information gatherer to leadership, implementation and evaluation.

Recommendation No. 2:

The administrative structure of the division should not be regionalized.

While the regional reorganization of the administrative structure of mental health services programs may on the surface sound appealing, the subcommittee does not feel it stands up to scrutiny nor fits the service needs or political climate of Nevada. This is not to say that geographic considerations are not important in the location of intake and information services. This function, however, should not be confused with administrative structure requirements. One administrative unit for the north and one administrative unit for the south would, in effect, even further decentralize the responsibility for operating quality programs and hence complicate the task of administering the state's human service programs in general. It would also require a substantial expenditure of resources which could be better utilized to provide needed client services. There is no doubt that the subcommittee (as well as the 1977 money committees) is troubled by the $1 million cost estimated for regionalization by the division.

Even though the money committees of the 1977 Legislature did approve what was described as a regional reorganization of the mental retardation services programs, the size and nature of the programs and the characteristics of the clients served does not make that realignment comparable with the proposed reorganization of the mental health services program. In northern Nevada, the staff of the Northern Retardation Center was combined with the former mental retardation ward at a mental health institute to form a single northern organizational unit titled the Sierra Developmental Center. In the Las Vegas area, the staff of the Southern Nevada Mental Retardation Center was combined with the soon to be opened operation of the Desert Developmental Center to form a central southern organization unit. The effect was to combine like programs functioning at the

same geographic location which serve a small and comparatively stable case load. These parameters are substantially different from those which characterize our mental health programs.

Recommendation No. 3:

The division should develop a plan for a functional structure of the division.

The subcommittee finds that the Division of Mental Hygiene and Mental Retardation should be reorganized in order to more effectively and efficiently provide mental health and retardation services to the residents of Nevada. Reorganization should be guided by the management corollaries set out in the Swackhamer Committee Report, both as they apply to state government as a whole and as applicable to smaller segments of state organization. Reorganization should be undertaken as a cooperative effort of the executive and legislative branches. The main focus of the reorganization should be a centralization of the division's administrative structure and functions. The autonomy provided various agencies under the broad span of control presently existing should be corrected by consolidating existing independent organizational units within the division and by centralizing various functions. The subcommittee recommends that the division implement the reorganization during the 1979-81 fiscal years within the framework suggested in this report.

The subcommittee further recommends that the executive branch be given flexibility in implementing its reorganization during these two fiscal years, and that approval for changes of duties of personnel and shifts in appropriations first be sought of the Interim Finance Committee, as overseer of the reorganization.

The subcommittee believes that NRS 433.094 should be amended to eliminate or at least alleviate the present impact that facilities have on the division's programming. However, the subcommittee believes that the present budget categories should be retained to assist the legislative and executive branches in evaluating the operation of the division during this transition.

The subcommittee believes that the division's administration has expended excessive resources on buildings. Special facilities are not needed for the majority of the division's programs, particularly outpatient services. It is believed that adequate facilities could be leased on an as-needed basis to adjust to population movement and the evolution of program theories.

The subcommittee recognizes the benefits that might be enjoyed from eliminating the admittedly artificial budget barriers between the division's programs. However, the subcommittee lacks confidence in the present division administration. It is anticipated that at some future date mental hygiene and retardation programs in Nevada could be provided through a single budget identified more by types of services than by facilities.

Recommendation No. 4:

A management information system and a program evaluation system should be established within the division.

The most critical need of the division's administration is adequate management information. With the development of such a system, the division could also establish a program evaluation system. The administration of the division is presently unable to determine the effectiveness of their various programs; and, in some cases, whether programs actually exist or are needed.

Systems of this nature would enable the division to more effectively utilize existing resources and, it is believed, provide long-term savings to the taxpayers.

Adequate management information and program evaluation systems necessitate access to computer technology and professional personnel. The subcommittee believes that adequate funds should be appropriated to the division to permit it to obtain services from central data processing, department of general services.

The task force suggested that the division be allocated a program evaluator, 2 professional personnel and 2 clerical positions. The subcommittee believes that an experienced program evaluator, a data manager and a clerical position should be sufficient to develop these programs. Additional personnel, if necessary, could be added to the budget during the 1981 session.

With the creation of a program evaluator in the division administration, the subcommittee believes that the positions of program evaluator in the Nevada Mental Health Institute and the Las Vegas Mental Health Center should be eliminated. We see no justification for establishing separate systems within the division. Data managers or management analysts could be added to these staff after the information and evaluation systems are developed.

Recommendation No. 5:

The Henderson Mental Health Center should be merged into the operation of the Las Vegas Mental Health Center.

The Reno Mental Health Center should be merged into the operation of the Nevada Mental Health Institute.

The subcommittee is aware that the Task Force Report, page 13, recommends that "Three comprehensive community mental health centers should be developed, two in Las Vegas and one in Reno. The Las Vegas Mental Health Center and the Henderson Mental Health Center should be expanded to fill these roles in the south and the Reno Mental Health Center should undergo major expansion in the north." The subcommittee does not feel that its recommendation is at odds with the recommendations of its Task Force. Consolidation of these programs is being recommended within a larger framework or reorganization of the division in order to assure coordination of services and eliminate duplication. Currently, the Mental Health Institute provides both inpatient and outpatient services in the Reno area with an annual budget of nearly $5 million and a staff of approximately 250. The Reno Mental Health Center provides outpatient services within Reno with a staff of 22 and an annual budget of about $1/2 million. The subcommittee sees no reason for this kind of duplication in a community the size of Reno. A similar situation exists in the Las Vegas area where the Las Vegas Mental Health Center provides a large portion of its services to persons who reside within the catchment area of the Henderson Mental Health Center. Henderson Mental Health Center, in effect, seems to operate as a separate organizational unit providing satellite services for the Las Vegas Mental Health Center. The subcommittee cannot endorse such an awkward geographic division of administrative and program responsibilities within Clark County. Testimony offered by the division concerning the federal staffing grant to the Las Vegas Mental Health Center, though vague and often conflicting, did not convince the subcommittee that a consolidated structure would jeopardize the grant so long as the required basic services were provided to clients living in the western catchment area of Clark County.

Recommendation No.6:

The division should not obtain a federal staffing grant for the Henderson Mental Health Center if that necessitates establishing two separate and independent mental health delivery systems in Clark County.

The Henderson Mental Health Center is in the process of making application to the National Institute of Mental Health for a Community Mental Health Center staffing grant to substantially increase the size and scope of their existing programs. Consistent with its recommendations in No. 5, the subcommittee does not believe that a second comprehensive community mental health center should be

established in Clark County at this time. The subcommittee believes that the first priority of the division should be to consolidate and strengthen existing programs and to develop a basis for program management.

B. Division Resources

A tremendous amount of material was available to the subcommittee describing what programs are or should be available within the State of Nevada. The theme of much of the 500 pages of the Rand Corporation Report deals with this subject and much of the testimony presented to the subcommittee centered on programs and facilities. In toto, the materials are too massive, too subjective and too subject to change, thus making comprehensive program descriptions and recommendations beyond the capabilities of a legislative subcommittee. The report of the subcommittee's task force of mental health professionals does an excellent job of covering selected areas.

The subcommittee does feel confident in presenting findings and recommendations on certain aspects of programs and facilities of the Division of Mental Hygiene and Mental Retardation.

1. Rural Clinics Program

The Rural Clinics program within the division was expanded to the concept of a community mental health center with a staffing grant which was not presented to the legislature. After adjournment of the 1977 Legislature and early in the course of this study, the division received another substantial NIMH 8-year staffing grant. This time seed money was provided to expand the Rural Clinics' program into a community mental health center. Prior to receipt of the grant, the program had an annual budget of $733,000 and a staff of 29. Under the grant, staff increased to 97 and the annual budget to $2.4 million. The federal share decreases each year during the 8-year life of the grant. At the end of the 8-year period, assuming moderate inflation, the annual program cost of some $4.5 million will have to be supported with state funds if the program is to be continued. See Table I on page 24.

The NIMH staffing grant was received as a result of work funded by a 1976 federal planning grant. Neither the planning grant nor the community mental health center staffing grant were presented to the legislature for its approval or information. This program will serve all "rural" areas in Nevada which, in effect, means the entire state except Washoe and Clark Counties. By 1985, these areas combined are projected to have a population totaling approximately

TABLE I

RURAL CLINICS
COMMUNITY MENTAL HEALTH CENTER OPERATIONS GRANT

	Allotments Per Federal Grant		Adjusted[1] Budget Allotments	
	Total Budget	State Share	Total Budget	State Share
1977-78	$2,455,881	$ 600,839	$2,455,881	$ 600,839
1978-79	$2,385,881	$ 749,877	$2,385,881	$ 749,877
1979-80	$2,385,881	$1,102,759	$2,624,469	$1,341,347
1980-81	$2,385,881	$1,455,541	$2,886,916	$1,956,576
1981-82	$2,385,881	$1,564,935	$3,175,608	$2,354,662
1982-83	$2,385,881	$1,559,935	$3,493,168	$2,667,222
1983-84	$2,385,881	$1,674,229	$3,842,485	$3,125,833
1984-85	$2,385,881	$1,669,229	$4,226,734	$3,510,082
1985-86	- End of grant -		$4,649,407	$4,524,226[2]

1 Adjusted for merit increases, cost-of-living increases and inflation.

2 Program income and other funding estimated to be $125,181 per year ($4,524,226 + $125,181 = $4,649,407).

157,000.[8] Approximately 50 percent of this population will be within Carson City and other communities surrounding the Reno area and the balance will be in communities scattered thoughout the state. This population of 157,000 will be serviced as a community mental health center with its main office in Carson City, in spite of the fact that areas other than Carson City and vicinity will be more accessible by common carrier or by motor vehicle from Las Vegas or Reno. It is not clear why Carson City is a "rural area." If this segment of our population was removed from the "rural" classification, there might be considerably less difficulty and expense in providing services to "rural Nevada."

In addition to the demographics of providing rural services, a number of concerns about the services to be provided were brought to the attention of the subcommittee. For example, the White Pine District Attorney testified before the subcommittee that the Rural Clinics' program was expanding the number of employees in its Ely office and would have the same number of employees as the Ely Police Department. He questioned the need for stationing this number of persons in a small rural community. Also, the Rand Report suggested that in view of unmet mental health services needs in Nevada, scarce money should not be allocated into secondary prevention, such as identifying developmental and situational conflicts, and the expansion of alcohol and drug abuse programs is not recommended for the same reason. Yet, secondary prevention and alcohol and drug abuse services appear to be a major focus of the expanded Rural Clinics' program. There are also reports of Rural Clinics' personnel lacking tasks to occupy their available staff time.

Recommendation No. 7:

The Rural Clinics' program should be funded at the level of need, as determined by the legislature, and not necessarily at the level mandated by the federal government under the NIMH grant.

The subcommittee questions whether the new Rural Clinics' organizational structure would have been approved by the 1977 Legislature. The subcommittee recognizes that mental health services must be made available to residents who live in the geographic area served by Rural Clinics, but

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8 Estimated Population for the Years 1970-1980 by County and Ethnic Group (Unpublished data of the State of Nevada Health Division), 1978.

questions the method of delivering these services. It is important to recognize that residents of rural areas are accustomed to traveling to metropolitan areas for specialized services and in some cases there is no other reasonable way to make quality services available. The plight of rural hospitals, in part, reflects the problems in attempting to provide specialized care in a rural setting.

Recommendation No. 8:

Rural Clinics' programs should merge, administratively, with the other programs operated by the division pursuant to the "functional" structure included under A, (3), above.

In viewing the division's mental health services as a single unit of state government, rather than numerous independent agencies, the subcommittee believes a functional structure is a more efficient and economical way to deliver services. See A, (3). The size and scope of Rural Clinics' programs does not justify its treatment as a separate entity.

Recommendation No. 9:

Legislative approval should be required prior to the acceptance of grants by the division which exceed $50,000.

The subcommittee further recommends that legislation be enacted to require approval of the legislature while in session, or the Interim Finance Committee when not in session, before new funding exceeding authorized levels by more than $50,000 can be accepted by the division. Such a requirement for approval will complement the oversight function during the reorganization. Suggested legislation is included with this report (section 5, BDR 39-210). The subcommittee recommends that the 1979 Legislature consider extending this requirement to all agencies of the Executive Branch. The subcommittee believes that the Executive Branch of government should not be obligating the legislature to future spending programs.

Recommendation No. 10:

Letters of intent should be incorporated within the general appropriation act and the authorization act at the conclusion of each legislative session.

During the 1977 session, the division was instructed, via a letter of intent, to station the clinical director of the Rural Clinics' program in the rural area rather than in Reno. The Ways and Means Committee had determined this to be a more efficient use of division resources. The Ways

and Means Committee concluded that Rural Clinics had excessive administrative personnel in relation to direct service providers. The division did not follow this directive.

A letter of intent does not have the force of law. If the money committees make an appropriation based upon a course of action to be followed by the effected agency, there should be some assurance that this directive will be followed.

2. Mental Hygiene and Mental Retardation Advisory Board

Recommendation No. 11:

The Advisory Board should take a more active role in representing the consumer viewpoint before the legislative and executive branches of government.

The subcommittee does not believe that the Mental Hygiene and Mental Retardation Advisory Board is having a significant effect on the quality and quantity of mental health and mental retardation programs in Nevada. The present members of the board seem adequately qualified for their task. However, the board seems to be limited by its statutory powers, its access to information and its influence with decision makers.

Testimony indicated that board members did not have sufficient access to needed information and that often information was "spoon fed" to the board by the division administration.

The subcommittee is not making a recommendation for statutory changes concerning this board. The problems which exist, if any, could better be resolved through recognition by the legislature and, more importantly, the chief executive, that the board should represent the consumers of mental health and mental retardation services on an equal basis with the influence and prestige of the administration of the division.

3. Prevention of Mental Illness and Mental Retardation

Recommendation No. 12:

Additional state resources should be earmarked for prevention programs.

The subcommittee believes that prevention programs should be further explored by the legislative and executive branches of our government. The subcommittee was particu-

larly impressed by the possibility of our school systems acting as a vehicle for prevention programs. Funding for elementary school counselors is an example of where additional resources could be used to facilitate the identification and alleviation of mental illness and development of disabilities among our residents.

Recommendation No. 13:

The legislature should require semiannual reports concerning the programs designed and implemented by the Human Service Educator within the division administration.

The subcommittee has already indicated its concern for effective prevention programs in mental health. The job description for this position mandated the design and implementation of education, including prevention programs. The subcommittee could find no evidence that this position is being appropriately utilized by the division.

The legislature should direct the division to submit semiannual reports to the Legislative Commission concerning programs developed by this position. If necessary, prevention programs should be assigned to an agency which will properly discharge its assigned duties.

4. Mental Retardation Programs

Recommendation No. 14:

The subcommittee recommends that the division continue to operate the retardation programs and that these programs continue to function independently of the mental hygiene programs.

The subcommittee believes that the retardation programs are suffering from a similar lack of strong leadership that is evident within the mental hygiene programs. Personnel from some of the community training centers commented on difficulties they experienced in communicating with numerous administrative personnel in order to obtain decisions or assistance. A possible explanation for these administrative difficulties may be the recent reorganization of the mental retardation programs--though that was more than a year ago.

The subcommittee was informed that the Department of Human Resources was exploring alternative delivery systems for developmental disability programs. However, the department has not prepared recommendations in this area.

The subcommittee believes that any problem in this area

might be resolved or alleviated by new division administration. It, therefore, makes no recommendations concerning the structure of these programs.

Recommendation No. 15:

Psychiatric care should be provided for mentally retarded clients.

The subcommittee heard testimony that psychiatric services are not adequately available to retarded clients in the division's residential facilities. Apparently, at least in the north, a medical doctor who is not a practicing psychiatrist is administering psychiatric drugs to the mentally retarded clients.

The associate administrator for the retardation programs testified that mentally retarded clients do not have a higher incidence of psychiatric disorders than the rest of the population--an assertion that defies both common sense and the incomplete documentation provided by the associate administrator.

The division was provided funds to obtain psychiatric care for mentally retarded clients, and the subcommittee recommends that they utilize these funds when appropriate.

Recommendation No. 16:

Substantially increase funding for the community training centers.

The subcommittee believes that increased emphasis should be placed on the community training centers for providing services to the mentally retarded. These centers offer both unique and effective programs. The dedication and hard work provided by those who operate these nonprofit programs is not easily duplicated.

The division in cooperation with the community training centers has been reexamining the funding formulas for the CTC's. The subcommittee believes that the legislature should carefully review these new proposals when they are completed and presented to the 1979 legislative session.

5. Administrative Personnel

Much of the public testimony heard by the subcommittee was critical of the manner in which the Division of Mental Hygiene and Mental Retardation was administered. While this is not unexpected in public hearings on a state human services provider, both the depth of feeling and the creden-

tials of individuals who testified was striking. Psychiatrists, psychologists, and local government officials expressed a lack of confidence in the administration of the division. The administration was characterized as uncooperative, authoritarian, and generally unable or unwilling to deal with many of the major problems. Some members of the subcommittee had heard much of the same criticism during the 1977 Session of the Legislature. Similar criticism was expressed to individual subcommittee members privately by local elected officials, members of the judicial system, and by division employees.

The myriad of problems found by the subcommittee's mental health task force tends to substantiate criticisms of the quality and style of the division leadership. Chapter VII of the Task Force Report is particularly pointed in citing administrative shortcomings. The division's response to the subcommittee's Task Force Report also reflects an attitude uncharacteristic of good leadership of such critically important programs.

In addition to the aforementioned, certain other occurrences came to the attention of the subcommittee. First, as has been pointed out earlier in this report the individual who until recently served as administrator of the division allegedly had a part-time private practice in apparent violation of NRS 232.270, which requires that each division head devote his entire time and attention to the business of his office and not pursue any other business or occupation. The extent of the part-time practice, if any, is not known. Also, this administrator reportedly scheduled himself for a variable workweek; working four, 10-hour days, in spite of there being no statutory authority for an unclassified employee of the state to opt for a variable workweek.

The individual serving as assistant administrator and program coordinator (who is now division administrator) and her secretary have been attending classes at the University of Nevada, Reno to work toward master degrees in business administration. The secretary was reimbursed her tuition by the state taxpayers. The assistant administrator was also allegedly on a variable workweek schedule.

Under these circumstances and those specified under staff training (B, 6) it is understandable why the division administration has not had sufficient resources to properly administer the division's programs.

Recommendation No. 17:

The Department of Administration and its Personnel Division should be exercising greater supervision over the executive agencies and the use of the variable workweek.

The subcommittee believes that it is highly inappropriate for one of the highest paid administrators in government to limit himself to a 40-hour workweek. This is particularly true in the case of this particular division administrator because of the lack of statutory authority for his use of the variable schedule, and because of the substantial administrative problems existing within the Division of Mental Hygiene and Mental Retardation. Legislation may be needed if the department administration is not able to exercise greater control over the use of taxpayers' money.

Recommendation No. 18:

National search committees should be convened to fill top administrative positions.

The task force, recommendation V in chapter 5, suggests a comprehensive and ideal approach for filling top administrative positions. The subcommittee recommends that the Department of Human Resources immediately initiate such a procedure to obtain a highly qualified administrator for the Division of Mental Hygiene and Mental Retardation. The subcommittee further recommends that the legislature provide an adequate salary to make this position competitive on a national basis.

6. Staff Training

A serious lack of staff training, particularly with respect to mental health technicians, was reported in the Rand Corporation Study. The following is an excerpt from that report:

> "....many mental health technicians, in both residential and nonresidential mental health programs, currently carry a heavy responsibility for direct treatment of people with mental health disorders, but many of them are seriously underqualified or unqualified to fulfill that responsibility. The job requirements include only a high school education, plus experience and training for higher levels in the 'mental health technician' job series. Unfortunately, the training of many technicians is clearly substandard. The officially required training levels are low to begin with. However, the Division of Mental Hygiene and Mental Retardation did not appear to have provided

> even those minimum amounts of training in most cases, and had certainly not adhered to the spirit of the training requirements. Each program is supposed to provide training for its own technicians. At the time of our interviews in 1974, we were told about the existence of some very brief training, but saw no high quality, formal training program...."

The subcommittee's task force reviewed staff training within the division (beginning on page 38 of the Task Force Report) and found it generally inadequate and in many cases nonexistent. Mental health technicians were found to be in "dire need" of formal training. The task force questioned whether training was taking place or even available in some cases.

To correct the training deficiency reported by the Rand Corporation, the 1977 Legislature appropriated $70,000 for training during fiscal year 1977-78, and an additional $50,000 for fiscal year 1978-79. Of the $70,000 appropriation, $37,000 was placed in the division's administration budget for the mental health programs, excluding Lake's Crossing facility. Lake's Crossing and the mental retardation program budgets all received their own training appropriations which are a part of the total $70,000.

Schedule 1 depicts the line-item expenditures of the $37,000 appropriation per the 3.0 report of the state's central accounting system (FMIRS), August 18, 1978. It was necessary to use FMIRS for a line-item breakdown since the materials submitted by the division were inadequate for such a task. Although a center-by-center breakdown is not available, it is apparent that the single largest expenditure was for out-of-state travel. The second largest expense was for contract services and the third was dues and registrations at seminars, conferences and conventions. The division's analysis suggests that 42 percent of total division training resources were spent on mental health technicians. From the information provided, this cannot be verified. Additionally, it is noted that these same centers spent over $14,000 in fiscal year 1977-78 for out-of-state travel in category 02. It is not known what these out-of-state trips were for.

Schedule 2 is a summary of the detail provided by the division in their year-end training report. From this, it is apparent that substantial sums were spent on training for administrative and professional employees. Also listed are expenses for conferences and conventions.

SCHEDULE 1

LINE-ITEM BREAKDOWN OF ACTUAL EXPENDITURES
TRAINING DIVISION BUDGET[1]
Fiscal Year 1977-78

Item	Expenditure
Out-of-State Travel	$11,943.85
In-State Travel	5,663.53
Operating Supplies	76.70
Printing, Copying, etc.	122.55
Contract Services	10,690.00
Dues and Registrations	6,276.94
Instructional Supplies	736.09
Special Reports	(51.05)
Equipment	431.55
Specialized Equipment	1,383.43
	$37,273.59

Source: FMIRS 3.0 dated 8/18/78

1 The Division's Report on Training was too inconsistent and lacking to extract this information by center. Therefore, the only analysis available currently is the controller's FMIR's report.

SCHEDULE 2

TRAINING EXPENDITURES - FISCAL YEAR 1977-78
PROFESSIONAL AND ADMINISTRATIVE STAFF

	Total Training Expenses	Expended on Admin. & Professional	Expended on Conferences & Conventions
Division Administration	$ 8,300.00	$ 4,736.90	$2,210.94
Children's Behavioral Services - Clark	3,618.28	3,263.28	1,813.68
Children's Behavioral Services - Washoe	3,478.80	1,455.52[1]	179.50[1]
Henderson Mental Health Center	2,990.23	622.12	166.00
Las Vegas Mental Health Center	7,000.00	3,205.00	[2]
Reno Mental Health Center	2,612.64	2,461.16	1,579.64
Mental Health Institute	9,412.76	1,651.76	550.00
	$37,412.71	$17,395.74	$6,499.76
		46.5%	17.4%

Source: Division Report "Training Funds Expended in Fiscal 1977-78"

1 Information incomplete. Details provided in report are only for 6 months of the year.

2 Information provided in report was not compatible with this breakout. Las Vegas Mental Health Center information was inconsistent with other centers.

Among the uses of training funds by the division's administration was the reimbursement of tuition of a clerical employee for classwork toward a master's degree in business administration. Since expenditures of this nature require advanced authorization of the State Personnel Division, Jim Wittenberg, State Personnel Administrator, was asked to comment. His comments indicated that the Personnel Division routinely approves training requests within very broad policy guidelines since state policy says that the basic responsibility for training programs lies with the respective operating departments. The explanation with the voucher authorizing the last payment was "receipt of a master's degree in business administration will greatly enrich job advancement opportunities." Mr. Wittenberg said that this case does not constitute a common practice. Also, he said that at least six other clerical employees within the Division of Mental Hygiene and Mental Retardation had requested employer payment for college credit. Of these six, four received approval. Further, he stated that the criteria for an employee's tuition to be paid by the state is developed by individual administrators and he was unable to get that information from the Division of Mental Hygiene and Mental Retardation. Also, the division would not tell the personnel administrator how much it had spent during the past academic year for tuition payments.[9]

This situation is particularly objectionable because this training money was critically needed to train mental health technicians in the basic principles of their job responsibilities.

The subcommittee does not believe that the Department of Administration and its Personnel Division adequately supervised the budget allocations providing for employee education.

Of the $10,000 for training allocated by the central office to the Nevada Mental Health Institute, $5,600 was allocated to contracts with two Reno area psychologists to develop materials to train mental health technicians. During the period March 1, 1978 to June 30, 1978, they each were to spend up to a maximum of 20 hours per month at $35/hour providing services to the state for a maximum of $2,800 each. The purpose of each contract was described as follows:

> Contractor 1: Consultant will develop and prepare training materials concerning psychotherapy techniques for incoming mental health technicians. Consultant will work with the existing mental health technicians and all incoming mental health technicians during the

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9 A copy of Mr. James Wittenberg's letter is contained in this report as Appendix D.

next 4 months to refine the teaching and training package.

Contractor 2: Contractor will initially develop a manual to be used by supervisors of mental health technicians. The manual will contain information on case management and basic psychotherapy techniques. Contractor will work with supervisors, assisting them in their teaching, management and evaluation of mental health technicians at the Nevada Mental Health Institute.

One of the parties approving these contracts on behalf of the state was division administrator Charles R. Dickson. Dr. Dickson currently is associated with the two contractors in private practice, and was either associated with or planned the association while the contract was in force.

Each contractor billed the state for the full 20 hours per month or $2,800. On June 15, 1978, the claims were processed and the checks were forwarded to the division offices for distribution. In checking with the Mental Health Institute, we are told that as of September 5, 1978, no materials were received from the contractor. The checks are reportedly being held at the division office.

Additionally, division administration staff consisting of 5 professional and 4 clerical employees and a deputy attorney general found time to spend some $4,000 in training funds for in and out-of-state conferences and registration fees during fiscal year 1977-78. At the same time, an additional $1,500 in regular out-of-state travel was also spent.

Recommendation No. 19:

The money committees should require that each state agency provide a delineation of the proposed and actual use of training funds and out-of-state travel.

Under the present budget line item identification, the legislature is not being presented with a clear picture concerning the use of taxpayers' money for out-of-state travel. The excessive use of out-of-state travel by the division clearly illustrates that greater supervision is necessary.

Recommendation No. 20:

The Department of Administration and its Personnel Division should adopt uniform and carefully delineated policies for the expenditure of tax dollars for educational benefits that are primarily of benefit to employees.

The subcommittee believes that the Personnel Division should adopt policies relating to the use of educational funds as soon as possible. If this is not accomplished by the 1979 session, the subcommittee recommends that the legislature adopt statutory guidelines for the expenditure of tax dollars in this area.

Recommendation No. 21:

The division should be directed to periodically report to the Interim Finance Committee during the 1980-81 biennium concerning the utilization of training funds.

The subcommittee finds that the critical problem of training mental health technicians is not being adequately addressed by the division. The subcommittee recommends periodic reporting concerning the use of training funds contained in the next biennial budget. This problem, apparently, can only be addressed by increased legislative supervision over the expenditures of funds by the division.

7. Utilization of Personnel

Historically, the state has spent about 80 percent of the money allocated for mental health and mental retardation programs for paying salaries. Any judgment, therefore, on how well resources are being utilized must necessarily center around the utilization of personnel. Both the Rand Corporation Report and the report of the subcommittee's mental health task force cite problems in the operation of current programs which are easily related to the utilization of personnel and gaps in existing services which require additional employees. Given a finite level of resources, the need is to identify personnel resources that can be freed up in order to expand services and to assure that existing and new resources allocated to division programs are being used judicially.

Schedule 3 below summarizes personnel information on the division administration and the budgets of the major centers within the division excluding Rural Clinics. It can be seen that the legislature approved a total of 606.5 full-time equivalent positions for these sub-units of the division, effective July 1, 1977. Approximately 1 year later, 15 new positions had been added to these and 89 positions or 15 percent of all positions authorized by the 1977 Legislature had been reclassified. Fifty-four of these positions were reclassified to something other than what is in their series; such as a mental health technician being reclassified to a psychologist, a food service worker being reclassified to a management assistant, a storekeeper reclassified to a management assistant and a

SCHEDULE 3

Agency	Full-Time Equivalent Positions		
	Authorized As of 7/1/77	Existing As of 8/2/78	Net Change
Division Administration	9.0	9.0	0
Mental Health Institute	243.0	248.0	5.0
L. V. Mental Health Center	138.0	144.0	6.0
Sierra Developmental Center	112.0	112.5	.5
Desert Developmental Center	104.5	108.0	3.5
	606.5	621.5	15.0

	Positions Reclassified 7/1/77 to 8/2/78		
	Total Reclassified	Reclassified Within Series	Reclassified To Other Series
Division Administration	2	0	2
Mental Health Institute	50	19	31
L. V. Mental Health Center	23	12	11
Sierra Developmental Center	8	2	6
Desert Developmental Center	6	2	4
	89	35	54

Source: Nevada State Personnel Division Letter of September 6, 1978.

mental health technician reclassified to a senior research analyst. Approximately 30 percent of these cross series reclassifications were mental health technician positions being reclassified to some other duties. In addition to positions listed in schedule 3, 68 new positions amounting to a 300 percent increase in staff were created administratively for the Rural Clinics program during the past year as a direct result of receipt of the National Institute of Mental Health 8-year staffing grant. Other smaller centers within the division also experienced changes in position duties during the past year.

In addition to noting a substantial number of reclassifications during the course of this study, it became apparent that a number of individual employees within the operating units of the division are assigned duties which do not fit the title of the position which they fill. An example of this was mentioned earlier in the report wherein an individual serving as special assistant administrator--Division of Mental Hygiene and Mental Retardation was filling a position as the head of the Lake's Crossing facility. Since this individual did not qualify to head the facility once it was opened, he was placed in the position in the administrative budget titled human services educator where he continued to serve as special assistant administrator until recently when he was appointed to the unclassified position of director of the Nevada Mental Health Institute. Further, it is difficult to verify that persons occupying this position have actually developed significant educational and prevention programs during their tenure as required by the job description. There is no way to know how many positions there are within the division filled with individuals whose duties do not match the position description. It is believed that the number is substantial and that too often direct care positions are used as administrative positions.

Recommendation No. 22:

Legislation should be enacted requiring legislative approval prior to changing the authorized number and grade of state employees within a budget.

The subcommittee finds that the Department of Administration has not judicially exercised its authority to create new positions and reclassify positions, and recommends that this "blank check" policy be discontinued. Therefore, the legislature should exercise more control over this important aspect of state government (section 5, BDR 31-211). In retrospect, it appears that when the legislature refuses to fund a position the agency merely reshuffles its budget. In the division this has resulted in direct care service positions being lost to administrative positions.

8. Legislative Review

Access to original treatment records was a prerequisite for the subcommittee's task force to make an evaluation of the treatment provided by the Mental Hygiene and Mental Retardation Division. This access, with some restrictions, was gained only through a process of negotiation with the administrator of the division since neither the legislature nor the director of the Department of Human Resources have clear authority to commission an independent evaluation of original treatment records. Other agencies, however, have routinely been given access to the records including the Joint Commission of Accreditation of Hospitals, the Federal Department of Health, Education and Welfare and the State of Nevada's Bureau of Health Facilities.

Another area where the subcommittee found a barrier to the legislature's right to know about the operation of state agency programs was NRS 449.200. This requires the Bureau of Health Facilities of the State Health Division to keep information and records concerning hospital licensure confidential. There appears to be no particular reason for this requirement since virtually the same information, in the form of the Bureau's Medicaid, Medicare Certification Report, is a public record.

The subcommittee recommends that legislation be enacted to broaden access to clinical records of mental patients to insure better legislative oversight of the Division of Mental Hygiene and Mental Retardation. The subcommittee also recommends the repeal of NRS 449.200 which restricts access to hospital licensure information. A bill to do these things accompanies this study (section 5, BDR 39-54).

Recommendation No. 23:

Authorized personnel of the legislature and its committees and subcommittees should be provided access to records of the division to enable the legislature to adequately evaluate the division's programs.

NRS 433a.360 should be amended to provide access by qualified staff for consultants of the legislature and the staff of the Department of Human Resources to client's records within the division. The present statutory provisions seemingly prohibits an evaluation of the performance of the division and its staff.

Recommendation No. 24:

Repeal NRS 449.200 as an unnecessary and ineffective restriction on the public's access to information about the quality of health facilities.

According to information obtained from the Bureau of Health Facilities, there is no reason for the existence of this statute.

9. Other Program Needs

The subcommittee finds that there are a number of obvious needs for programs which are apparently not currently being met.

Recommendation No. 25:

A secure facility for severely disturbed adults should be established at the Nevada Mental Health Institute.

The state presently lacks a secure facility for severely disturbed adult clients not involved in the Criminal Justice System. The Lake's Crossing facility has occasionally been used for this purpose, but the subcommittee believes this to be an inappropriate use of the Lake's Crossing facility and program. Only one such facility in the state is recommended because the number of beds needed is not substantial and the cost of operating such a facility is high.

Recommendation No. 26:

Increase funding for community residential facilities to serve adolescents and adults.

Additional community facilities are needed both in northern and southern Nevada. These facilities should include half-way houses to transition people from institutional care back into the community, and foster care and group care facilities for those who do not need 24-hour residential care. The subcommittee recommends that the money committees of the legislature provide funding for these types of facilities. The division has been reducing the number of residential beds without providing alternative facilities and programs for these patients.

Recommendation No. 27:

A secure adolescent residential facility and an outpatient services program should be established at the Nevada Mental Health Institute.

The subcommittee finds that a secure adolescent facility and corresponding outpatient adolescent services should be provided in the northern Nevada area. The need for a secure residential facility for adolescents has been made clear by members of the Judicial System, the numerous out-of-state placements for these clients, and the Mental Health Task Force.

The subcommittee is cognizant of recommendations that such a facility be located away from the grounds of existing programs. This may indeed be desirable. However, the subcommittee feels that a physical facility capable of housing a secure adolescent program and outpatient adolescent services currently exists on the grounds of the Nevada Mental Health Institute. The secure residential portion of this facility should serve both southern and northern Nevada until the need for an additional facility of this type is clearly established.

Recommendation No. 28:

A secure adolescent facility should be established at the Las Vegas Mental Health Center if the northern facility does not satisfy the needs of the entire state.

Southern Nevada presently has residential and outpatient services for adolescents. However, there are no secure residential facilities for severely disturbed adolescents. A secure facility in southern Nevada should only be constructed when and if a northern facility proves inadequate to serve the entire state.

Recommendation No. 29:

Capital improvements requested by the division should be carefully reviewed by the legislature with a view toward program needs and staffing costs.

The subcommittee offers certain caveats concerning the approval of new programs and facilities for the Division of Mental Hygiene and Mental Retardation. First, facilities built in the recent past are staff intensive and not conducive to flexibility in program operation. The legislature should insist that staffing estimates be part of future requests for capital improvements for the division.

An illustration of the problem is the neuropsychiatric cottages at the Nevada Mental Health Institute. These buildings were constructed at a cost of approximately $500,000 each and are very attractive with kitchens, fireplaces, and barbecue pits. However, without heavy staffing ratios severely disturbed patients cannot be adequately supervised in these facilities. The division has already begun limiting these facilities to less intensive levels of care.

The division should also more fully explore the use of lease space for its programs. Specially designed buildings are expensive, limited in program applicability, and too quickly obsolete.

Recommendation No. 30:

The use of satellite offices should be carefully reviewed by the division.

The use of satellite offices to bring services to various neighborhoods has undoubtedly been implemented with good intentions. The subcommittee, however, recommends that the use of satellite offices be carefully weighed. A heavy reliance on such facilities could prove cost inefficient and, in effect, establish a network of costly offices serving a narrow range of inadequate services which dilute resources at the larger mental health centers.

Conclusion:

Governor O'Callaghan began his first term in office with a commitment to upgrade services for mentally ill and mentally retarded residents of Nevada. The legislature has followed the Governor's leadership and provided substantial funding to the Division of Mental Hygiene and Mental Retardation and its programs. The growth has been phenomenal, but necessary to fulfill the Governor's commitment of compassionate care for the mentally handicapped.

It is time to reexamine the rapid growth of the division and to provide a period of consolidation and management development. An administrator with highly developed management skills is now needed to fully realize the Governor's commitment.

V. SUBCOMMITTEE'S MENTAL HEALTH TASK FORCE

A. Report of Subcommittee's Task Force

B. Division's Press Release on Task Force Report

C. Division's Response to Task Force Report

V. SUBCOMMITTEE'S MENTAL HEALTH TASK FORCE

The report of the subcommittee's task force is the product of some 1,000 hours of combined hard work of the professionals who served on the task force. Between January 13 and April 28, 1978, the task force held six all-day meetings; plus members also attended the subcommittee's June 8, 1978 meeting. The group as a whole made site visits to division facilities in northern Nevada on January 26, 1978, and site visits to facilities in southern Nevada on March 16, 1978. Additionally, some 6 feet of reports and other material were reviewed and analyzed. The task force randomly selected 20 patient charts from each of the agencies it reviewed and analyzed them in-depth.

The task force staff investigator visited each of the agency sites except the Henderson Mental Health Center on at least two occasions. Individual interviews of some 75 people which were of 1 to 3 hours in duration were conducted. In addition, the chairman of the task force held a number of meetings with the director of the division, the director of the Department of Human Resources and the subcommittee chairman, and attended all of the subcommittee meetings.

All of the hours that went into the study, which included many late nights and weekends, were donated to the subcommittee. If the subcommittee were to have hired these services privately, they would have cost at least $50,000-$75,000. The subcommittee was truly impressed with the dedication of the members of its task force.

Initial reaction by the Division of Mental Hygiene and Mental Retardation to the task force report was a press release which is included in this section. This press release was distributed by the division prior to the June 8, 1978 meeting that the subcommittee scheduled to receive the report. During August 1978, the division provided the subcommittee with a response to each of the recommendations of its task force. That reponse is also included in this section.

A. Report of Subcommittee's Task Force:

STATE PROVIDED MENTAL HEALTH SERVICES

IN NEVADA

A Report of the

Mental Health Task Force

Aaron Smith, Ph.D., Chairman
Michele Baldwin, M.S.W., Ph.D.
Martha Irwin, R.N.
Edward Lynn, M.D.
R. Edward Quass, M.D.

June 1, 1978

PREFACE

In the Fall of 1977, Assemblyman Jim Kosinski, the chairman of the Legislative Subcommittee on Mental Health and Mental Retardation, approached Aaron Smith, Ph.D., Associate Professor of Psychology at the School of Medical Sciences, University of Nevada/Reno, and Research Coordinator, Veterans Administration Hospital, Reno, about providing consultation to the Subcommittee on the evaluation of mental health programs. Mr. Kosinski explained that the April 1976 report of the Rand Corporation on Mental Health and Mental Retardation Services in Nevada (the "Rand Report") had identified a number of problems and limitations in the provision of mental health services by the State. In addition, the last session of the Legislature had heard conflicting testimony about the programs provided by the Division of Mental Hygiene and Mental Retardation. The Division had questioned many of the Rand Report conclusions and recommendations claiming that they were based on outdated information (1974 and 1975) or described deficiencies that had been corrected by the time the Rand Report was published.

The Legislature was faced with discrepant testimony in a number of important areas and decided, quite wisely, to direct the Legislative Commission to study, during the interim between sessions, the administration of mental hygiene and mental retardation programs in Nevada and to report its results and recommendations to the next (60th) session of the Nevada Legislature.

The Legislative Commission assigned responsibility for the study to the Subcommittee on Mental Health and Mental Retardation. The Legislative Commission did not have among its own staff the mental health professionals whose assistance would be needed by the Subcommittee for such a study. Thus Mr. Kosinski, the Subcommittee's Chairman, needed to develop such professional resources for his Subcommittee.

In the earliest discussions between Mr. Kosinski and Dr. Smith, agreement was reached that the evaluation task was beyond the capacity of any one person and that a Task Force appeared to be the most practical vehicle for professional input. If mental health professionals of diverse backgrounds, training, and theoretical orientation could be found who would be willing to volunteer their services for an admittedly arduous task, then their study would profit through the sharing of different perspectives and from the enhanced credibility that would come from loyalty to no single institution, discipline, theory, or employer.

Strict criteria were established for the selection of Mental Health Task Force members. Each must:

Have an established reputation as highly competent in his or her own mental health profession.

Not be employed by the Division of Mental Hygiene and Mental Retardation.

Be a resident of Nevada.

Have a reputation for objectivity and fairness.

Be willing to contribute the time necessary for the study without compensation.

In addition it was believed essential to have a geographic balance between North and South and to have representation of the major mental health professions.

Nominations and suggestions were sought from identified leaders in each of the professions. Literally scores of persons were consulted before arriving at a list of mental health professionals who would be asked to serve because they appeared to have all the necessary qualifications. Each of the following individuals was asked to serve on the Mental Health Task Force and each, despite extremely busy schedules, agreed to serve.

Mental Health Task Force

Aaron Smith, Ph.D. (Chairman)
Associate Professor of Psychology
School of Medical Sciences
University of Nevada, Reno
and
Research Coordinator
Veterans Administration Hospital
Reno, Nevada

Michele Baldwin, M.S.W., Ph.D.
Assistant Professor
Department of Psychiatry and Behavioral Sciences
School of Medical Sciences
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Martha Irwin, R.N.
Chief, Nursing Service
Veterans Administration Hospital
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Edward Lynn, M.D.
Professor of Psychiatry
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University of Nevada, Reno
and
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R. Edward Quass, M.D.
Chief, Department of Psychiatry
Valley Hospital
Las Vegas, Nevada
and
President
Nevada Psychiatric Association

P. Diane Turnbough, Ph.D.
Assistant Professor of Psychology
University of Nevada, Las Vegas
Las Vegas, Nevada
and
President
Nevada Psychological Association

ACKNOWLEDGMENTS

Midway through the study Dr. Turnbough found it necessary, because of personal circumstances, to withdraw from the Task Force. The loss of her wise counsel and extensive knowledge was missed by her fellow members. They wish to publicly acknowledge her contributions to the design and approach of the studies contained in this report.

It was apparent from earliest planning efforts that the Task Force would require the services of a competent, perceptive staff investigator. Diane Spitzer, M.S., Research Associate, Veterans Administration Hospital, Reno ably served in that role. She collected most of the data that was subsequently analyzed by the Task Force and conducted a great many of the interviews that were so central to many of the studies.

Ed Schorr, Deputy Fiscal Analyst for the Legislative Counsel Bureau, made available voluminous materials on every aspect of State supported mental health programs and proved to be a rich source of information on state government procedures in Nevada.

Harry Potter, Director, VA Hospital, Reno was not only personally supportive of the efforts of the Mental Health Task Force but authorized an Assignment Agreement under the Intergovernmental Personnel Act of 1970 which permitted the temporary transfer of Mrs. Spitzer from Federal Service to the State Department of Human Resources for her work as staff investigator for the Task Force.

Both Thomas J. Scully, M.D., Dean of the School of Medical Sciences, University of Nevada, and Mr. Potter of the Veterans Administration Hospital viewed the activities of the Task Force to be of sufficient importance to Nevada to authorize attendance at Task Force meetings and site visits to mental health facilities by Task Force members who are employees of the two institutions. Their support was essential for many of the study activities to have occured at all. The Medical School generously provided use of a conference room for the meetings of the Task Force.

Michael Melner, Director, Department of Human Resources, the umbrella organization of which the Division of Mental Hygiene and Mental Retardation is a component, early recognized the potential value of the Task Force's data and recommendations to his own needs for independent evaluation for planning purposes. Mr. Melner arranged for entry to Division facilities and authorized interviews of staff members and access to records and reports. His active cooperation made this legislatively initiated study a practical undertaking.

The Task Force members wish to acknowledge the unfailing courtesy of the Directors and staffs of each mental health facility that was visited and called upon to supply data.

Most welcome was the generous input from citizens and various public officials representing the consumers perspective. Numerous interviews were held and enthusiastically responded to by police officials, district attorneys, judges, public defenders, court officials, probation officers, community physicians, hospital administrators, social welfare agency directors and staffs, attorneys, mental health advocacy groups, and a miscellany of interested citizens.

CONTENTS

Chapter I

DESCRIPTION OF THE STUDY

It is as important to understand what this report does not contain as it is to recognize what it covers. When the Mental Health Task Force began its work in January 1978, it was immediately apparent that difficult decisions would need to be made about the scope of the study. The Rand Corporation study took two years, a large full time staff, and several hundred thousand dollars. Its scope was exceedingly broad. The Mental Health Task Force had about three months to conduct its study, one part-time staff member, and essentially no money. (The Department of Human Resources defrayed most of the travel expenses.)

Initial decisions were made to exclude from consideration the State's mental retardation programs, its drug and alcohol programs, and finally the Rural Clinics programs. The latter exclusion was based on the fact that Rural Clinics had very recently been given a large staffing grant by the Federal government. This grant was making possible a very rapid tripling of the staff of the rural mental health clinics program.

The Rand Report had been pointed in its criticism of the Rural Clinics program. Most observers acknowledged the validity of those criticisms and the Division of Mental Hygiene and Mental Retardation had sought very substantial Federal funding to attempt to correct the identified deficiencies. The Task Force felt it would be patently unfair to include in its study a program undergoing the degree of change that the Rural Clinics development effort was bringing about. While the effectiveness of this program will need to be evaluated, the Task Force estimates it will be another year before such a study can be conducted.

Essentially then the Task Force study concerned itself with aspects of mental health services provided by the following State facilities: Nevada Mental Health Institute; Lakes Crossing; Reno Mental Health Center; Children's Behavioral Services, Washoe County; Las Vegas Mental Health Center; Henderson Mental Health Center; and Children's Behavioral Services, Clark County.

All aspects of the provision and quality of mental health services were not considered. The focus of the Mental Health Task Force was on the current status of major areas that had been previously identified as problems or in need of improvement. The Task Force conducted detailed reviews of the Rand Report and other documents in order to develop a list of leading problem topics about which there had been strong critical views expressed and about which there was currently confusion.

The goal of the Task Force was to identify a set of critical issues and conduct an in depth study of those topics so that the Legislature and the Department of Human Resources could be provided objective information about the current status of each problem area and an accompanying set of recommendations.

Since developments in the provision of mental health service tend to be in constant flux, in Nevada as well as in the rest of the country, programs do not stand still while they are being assessed. Consequently the Task Force adopted a reporting convention of describing programs and activities as they existed on or about March 15, 1978, the time by which most data had been received and most interviews conducted.

The Task Force is aware that all facilities and the Division central office are regularly involved in planning new programs and modifying old ones. Nonetheless, experience has indicated that a substantial number of plans in all organizations are never implemented. Accordingly we have reported on what we found to actually exist not what we found was planned to exist.

The Task Force identified the following six topics which appeared as major concerns in the Rand Report and of major interest to the Legislative Subcommittee.

1. Entry into the Mental Health System, Coordination of Services and Long Term Care.

2. Treatment of the Patient Who is a Management Problem or Security Risk.

3. Availability of All Major Mental Health Treatment Approaches.

4. Staffing: Requirements, Qualifications and Training.

5. Mental Health Program Evaluation.

6. Mental Health Administration.

The body of this report is made up of a series of studies on the topics listed. Each study starts with a brief introduction to the topic followed by a description of the methods employed in studying the topic. The results of the study are then presented and the conclusions drawn by the Task Force are indicated. While the results are objective statements of what was found, the conclusions represent the Task Force's viewpoint on the meaning or implications of the results.

Each study ends with a set of specific recommendations designed to improve or further develop the area under study. The recommendations included in each section of this report present the considered views of the Task Force on how best to solve the described problems. Some

of these recommendations will be found to be similar to those contained in the Rand Report, others emphasize aspects not considered in the Rand Report, and a few are at variance with the positions taken in the Rand Report.

No effort was made to determine the costs of implementing each of the recommendations nor was there consideration given to the practical feasibility of winning the political support necessary to translate recommendations into programs. What is provided are proposed solutions to important human problems which we believe are scientifically sound, humanely oriented, modest in scope, and achievable in Nevada.

Chapter 2

ENTRY INTO THE MENTAL HEALTH SYSTEM

COORDINATION OF SERVICES AND

LONG TERM CARE

I. Introduction

A well coordinated mental health system provides for a highly publicized entry point, immediate assessment by qualified and highly skilled mental health professionals, referral to the most appropriate mental health program, follow-up to ascertain if treatment has been provided, and services to aid reintegration of the client back into the community including support systems to help maintain the client whenever possible.

Since clients' mental health problems, like their medical problems, will vary at different times in their lives, the mental health treatments they require will also vary. Thus any one client might require services from a variety of mental health agencies over a period of time. Such multi-agency services require excellent interagency communication and record keeping, along with clear cut delineation of agency services, and smooth interagency coordination.

The Mental Health Task Force selected this topic to study because the Rand Report identified major problems with the coordination and provision of mental health services and because of continuing public criticism.

II. How the Study was Conducted

Interviews were conducted with a substantial number of individuals including police officials, judges, district attorneys, psychiatrists, psychologists, nurses, social workers, directors of State Mental Health Facilities, community and private hospital administrators, staff members and emergency room personnel, and administrators of nursing homes and nursing care facilities. (See appendix for list.)

Numerous reports, audits, program descriptions, interagency agreements, and Nevada statutes were reviewed.

The information gained from all these sources was collated and analyzed. Consistently emerging points are highlighted in this report.

III. Results

A. Entry into a Mental Health Facility

Referrals for mental health treatment come from a wide array of sources ranging from the client himself (self-referral), the more complex police referral, thru the hospital emergency room referral of the unsuccessful suicide attempter.

Currently, every State Mental Health Facility in Nevada directly accepts new clients, but the one to which a client is referred may not be appropriate to his needs thereby frustrating the referral source in its search for a helpful program. Unnecessary and possibly fatal delays in initiating treatment and increased cost to the State, caused by manhours wasted on repetitious evaluations can result.

This study revealed that although most service providing agencies, mental health professionals, and legal services were able to identify available mental health resources, they were not always able to select the appropriate agency for the client requiring mental health treatment. For the most part, the average citizen, either "shopped around", kept returning to the agency which had provided service in the past, even if no longer appropriate, or just gave up. Sometimes the outcome was a more serious problem for the client and the community.

One frequently cited point in the interviews was the cumbersome system involved in referral of clients to mental health facilities by other agencies. This system is so difficult to penetrate, it, in effect, often denies mental health treatment to those most in need. Only the most persistent or most obviously disturbed are able to hurdle the obstacles to needed treatment and then only after needless delays.

In the case of a suspected mentally disturbed person picked up by the police as a result of a complaint, the individual is held in jail until an assessment is made by the psychiatric consultant to the police. If the conclusion reached is that the person does not belong in jail but requires psychiatric hospitalization because of the likelihood of harming oneself or others or being unable to care for oneself, an emergency commitment is made to a mental health facility. In Las Vegas this will be to Southern Nevada Memorial Hospital and in Northern Nevada the emergency commitment is made to Nevada Mental Health Institute (NMHI).

The police report that even though they are supplied with a properly executed Emergency Commitment, the Nevada Mental Health

Institute can, and frequently does, refuse to admit the person. If admission is refused, the person remains a police problem and will usually be returned to jail where there are no facilities or personnel for mental health treatment. If the person presents a clear danger to himself, there is often no alternative but a padded cell - at least until the jail physician can prescribe medication.

If the person that the police and their consulting psychiatrist believe is mentally disturbed is also intoxicated, the chances for rejection by the mental health system is reported by the police to approach 100 percent. The NMHI is highly selective in its admission policy. Police angrily report that little or no attention is given to their observations despite the fact that they may have had very substantial contact with the person. Instead they claim that hasty and superficial evaluations at the NMHI predictably lead to rejection for admission of individuals acutely in need of mental health treatment. Reasons for rejection most frequently cited were that the person was not in need of emergency commitment, or that the secure facilities needed to treat such a person were not available at NMHI, or that the person did not fit into the programs provided by NMHI.

Emergency Room personnel report that in Northern Nevada there are no twenty-four hour resources for crisis intervention to which they can refer individuals clearly in need of immediate mental health care. While Emergency Room personnel may give a patient in need of such help the phone number of a facility that he can contact the next day, there is little, if anything, they can offer or suggest for the person in desperation at night or on weekends. Thus individuals who have attempted suicide are often released as soon as their physical condition permits.

Concern over the slim likelihood of treatment following a referral was expressed in the Emergency Rooms, by the police, by the Director of Crisis Call, and by private therapists who report that persons who are admitted to the NMHI will usually be discharged within a short time.

These are merely a sample of the multiple problems caused by the present entry system. While this is a topic which should be addressed in more detail, within the scope of this report, due to time limitations, we can only broadly sketch this particular obstacle to treatment.

B. Assessment of the Client

Prompt and skillful evaluation of a person requiring mental health treatment and rapid referral to an appropriate treatment program is perhaps the most critical event in the treatment of mental health problems and can be the factor which prevents the development of more complex and costly problems.

Since mental health problems erupt at unscheduled times, the availability of highly skilled, qualified mental health professionals is required 24 hours a day, 7 days a week. Because of the continuous need for this service, a single entry point for each region may be an economic necessity.

Assessment services provided by the Division's facilities are severely limited in two areas; the qualifications of the staff assigned to this task, specifically at night and on weekends, and the relative unavailability of such services after hours. With the exception of some evaluative efforts in connection with the 24 hour consultation program at the Las Vegas Mental Health Center, and some limited evaluations in connection with admissions at Southern Nevada Memorial Hospital, and some highly selective evaluation services after hours at NMHI, evaluation services are essentially nonexistent during times other than the scheduled 40 hour week.

Comprehensive but scheduled evaluation services are provided by some facilities. Particularly worthy of note are the evaluation efforts of Children's Behavioral Services both in Reno and Las Vegas.

C. Referral

Appropriate referrals are dependent upon the accurate assessment of the problem, a thorough knowledge of the mental health agencies and the services they provide, and the availability of a variety of treatment programs to meet the mental health needs of the community.

A review of the programs offered by the Division's facilities revealed agencies in the same area providing similar programs, both Reno Mental Health Center and the NMHI offer outpatient programs, while other vitally needed programs either do not exist or are provided in such a limited or superficial way as to be virtually nonexistant.

The following programs and services either do not exist or are pointedly inadequate:

1. Crisis Intervention

Relatively speaking, individuals in crisis in Southern Nevada fare a little better than their counterparts in the North. The Las Vegas Mental Health Center will admit on a twenty-four hour basis to its inpatient unit or attempt to secure immediate mental health consultation. (The Reno Mental Health Center does not have an Inpatient Unit or a twenty-four hour crisis intervention program.) While far from comprehensive, crisis intervention appears somewhat more accessible in the South than the North.

2. Inpatient Adolescent Services

The only inpatient treatment program for adolescents in the State is a small overfilled, 16 bed program at the Las Vegas Mental Health Center. If the adolescent requires admission to a secure psychiatric facility, the situation can be described as woefully inadequate at best. There are no secure mental health facilities for adolescents in either Northern or Southern Nevada. Adolescents who require the services that can be provided only in a secure intensive inpatient treatment program specifically designed for their needs must be sent out of state to receive them. Costs of such programs run high. A realistic estimate is that Nevada spends about $1,500 per month to maintain an adolescent in such an out-of-state facility. The Division requested approximately $400,000 for fiscal year 1978 to fund care and treatment of Nevada children and adolescents in programs run by others. (Most but not all of these were out-of-state programs.)

3. Secure Facility for Adults

Adult clients who because of their mental health problems present a danger to themselves or a danger to others (suicidal, self destructive, homocidal, assaultive, severely psychotic, etc.) are clearly in need of the protection that can be provided by a physically secure facility until appropriate treatment resolves the problems requiring such a secure physical environment. The need for and lack of secure psychiatric facilities for adults in Nevada are discussed in detail in another section of the Task Force Report.

4. Intermediate Care

Intermediate care programs such as day treatment centers and half-way houses are increasingly valued alternatives to inpatient hospitalization for those whose treatment needs are greater than can be supplied through traditional outpatient services and yet may not require full inpatient care. Such programs can be effectively utilized for patients released from inpatient care; for those who can use it as an alternative to hospitalization; and for those who can live in a group care home or with their families if provided the regular structure of this therapeutic programming.

Presently there is only a small day care center at Las Vegas Mental Health Center and an equally small unit in the North, the Transitional Unit at NMHI.

Half-way houses, in essence, do not exist in Nevada. The Division utilizes whatever community resource it can find to house its clients, while mental health treatment in such settings is so sporadic and superficial it appears to be without impact.

Serious concern exists regarding the disposition of patients who no longer require the services provided in a long-term facility but still need to live in a supportive setting. There is no such setting available either in Reno or in Las Vegas. As a result, some patients are being kept in a setting that is at times more restricted than needed and which does little to alleviate serious mental health problems.

5. Long Term Care

There are persons, of all ages, in every community who require long term mental health care for relatively permanent conditions or for conditions that have led to symptoms or disabilities that are relatively long standing. While many individuals can be treated quickly and intensively, there are some who do not show improvement despite heroic treatment efforts and others who have never received adequate care and now have relatively chronic and disabling or limiting conditions. The Rand Report indicated a paucity of treatment facilities and programs for such people. The situation has not materially improved.

Long term inpatient care at the present time is relatively unknown in Nevada. The most appropriate location for inpatient long term care, which should include a locked

unit for severely disturbed, senile clients, is the NMHI. Unfortunately, the NMHI, in their attempt to move clients out of the hospital, frequently made highly questionable placements. Currently the number of beds assigned to long term patients is totally inadequate.

The Institute's plan was to concentrate on utilizing intermediate care programs, such as half-way houses and day treatment programs, but very few exist. Other patients were to be placed with their families or in other community facilities such as skilled and intermediate nursing homes and boarding homes. Institute personnel were to provide long term follow-up treatment. Although patients were released, for the most part, they did not receive the care they required.

Those patients who were placed with their families upon release typically did not have the benefit of the follow-up care that was meant to help sustain them. Occasional visits, for the lucky ones, from a liaison nurse from NMHI is a meager substitute for the community mental health services that were assured in the publicity that accompanied the release programs.

Many patients were placed in group care homes. These are boarding homes typically providing meals, laundry, and maid service but no organized activities and no mental health services. Most boarders finance their stay through welfare or social security. Many patients so placed were geriatric patients and others were relatively young but suffering from chronic schizophrenia.

Liaison nurses from NMHI were supposed to follow group care home patients who had been discharged from NMHI. They do occasionally visit these group homes, but such visits do not appear to offer much help. Several sources gave specific case histories of young patients with chronic schizophrenia vegetating in those facilities for lack of needed rehabilitative and psychological assistance.

Skilled nursing and intermediate care facilities received placements of discharged chronic mental patients from NMHI and Las Vegas Mental Health Center. It is important to note that patients admitted to those facilities must have a physical impairment as the primary diagnosis. For patients with such a diagnosis, this kind of placement is appropriate. Some patients, however, are kept in skilled care facilities through manipulation of their diagnoses or for lack of community placements with accompanying intermediate care.

Common to all such facilities is a significant lack of personnel trained to deal with mental health problems. There is no uniform manner of handling acute psychiatric episodes within such facilities. Some nursing homes have a transfer agreement with the NMHI which provides that a patient with an acute episode will be returned to NMHI for the duration of the acute phase. Some handle the acute episode on the premises by judicious use of medication. In rural areas, an assessment of needs is conducted by a staff person of a Rural Mental Health Clinic before transfer to an acute facility.

6. Follow-Up

Follow-up services are needed to assist a client to reintegrate into the community and to provide a support system to help keep him there.

As with most other services what little is provided is not only inadequate but is frequently incomplete. For example, the NMHI usually establishes a follow-up plan at discharge but there is no mechanism to ascertain that the patient is actually coming back for follow-up visits. Since no accurate reports were maintained, it was up to the individual therapist to follow through if a patient did not show up for an appointment. As a consequence, follow-up has been a sporadic affair.

At the Southern Nevada Memorial Hospital in Las Vegas, discharged patients are referred to the LVMHC outpatient clinic and an initial appointment is usually made. Unfortunately, a follow-up to determine if the appointment was kept is not done.

Follow-up and continuity of care, while far from perfect, is a viable concept at the Las Vegas Mental Health Center, where discharged patients are assigned to after-care staff for ongoing outpatient services.

The above examples demonstrate the confusing and inefficient overlapping of inadequate mental health services. Many basic services are not provided at all.

D. Coordination of Services

Since a client may require the services provided by a variety of mental health agencies, within and without the Division, effective working relationships among them is essential.

Coordination requires that each agency provide specified services which aggregated over the whole system assure availability of all needed services. Each agency must be aware of the available resources within the Division and services provided by other than Division facilities. Effective working agreements must exist between the Division and other providers of mental health treatment within the State. Clear and frequent communication must take place between all of the agencies.

Unfortunately, competition between Division agencies occurs. Services are duplicated. There is uncertainty about what resources exist. Effective working agreements between the Division and other mental health providers do not appear to have developed. Conflicts with non-Division mental health professionals have become part of the Nevada Mental health scene.

There was virtual unanimity among those interviewed that the coordination of mental health services in Nevada was very poor.

IV. Recommendations

Mental Health Facilities of the Division should be recognized as parts of a single unified system rather than autonomous agencies with overlapping functions and underserviced populations.

Based on its study of existing services, their limited coordination, and the all too evident gaps in service, the Mental Health Task Force has prepared a series of recommendations.

A. Regional Mental Health Evaluation Offices

A single point of entry should be developed (one in the North and one in the South) with the capacity of providing highly skilled professional mental health evaluations and referrals to the appropriate treatment program 24 hours a day, 7 days a week. Admission to all facilities would be arranged here. It is suggested that the Evaluation Office be located within or closely adjacent to a community general hospital. This location is recommended for several reasons. People perceive a community general hospital emergency room as the place to go in times of crisis. The availability of 24 hour access to medical care is a definite advantage for a Mental Health Admission Service. Availability of immediate mental health evaluation for patients being treated in the Emergency Room as a result of attempted suicide, child abuse, rape, etc. is clearly desirable.

The Mental Health Evaluation office should provide 24 hour crisis intervention service and follow-up of referrals to determine if treatment has been furnished. Such an office would be the place of choice to maintain a central registry of persons entering the system and services provided.

B. Community Mental Health Centers

The Mental Health Task Force has no doubt of the need for three comprehensive Community Mental Health Centers, two in Las Vegas and one in Reno. At the present time the Las Vegas Mental Health Center is on the way to developing a comprehensive program, although it is not there yet. The Henderson Mental Health Center provides only a limited number of services but appears to have the potential for development into a fully comprehensive center. Both Centers should begin the long term planning necessary to the development of comprehensive programs.

Reno, despite its evident need, is far from having a comprehensive Community Mental Health Center. The Task Force believes that the Reno Mental Health Center should be designated for such expansion.

These Centers should provide short term inpatient care (up to 60 days), outpatient care, day care, treatment and consultation to intermediate care facilities, and other support services to maintain clients in the community.

C. Residential Treatment Programs for Adolescents

The Mental Health Task Force believes adolescents who require inpatient care have their best chance when they are treated at a separate facility. Just as the State recognized the importance of separate facilities for children and built the Children's Behavioral Services in Clark and Washoe Counties, we believe it should now recognize the importance of separating adolescent mental health facilities from adult mental health facilities.

We recommend that the overcrowded adolescent unit at LVMHC be converted to adult inpatient use and that adolescents not be housed in that facility.

We recommend that an adolescent inpatient unit be constructed or developed in the North and another in the South. Just as the southern facility should not be on the grounds of LVMHC, the northern one should be far removed from NMHI. Such co-existence

in the North would impose additional problems of stigmatizing adolescents who were sent there. It is important to recognize the reality of the stigma that accompanies admission to NMHI.

There has been much misunderstanding of the nature of an appropriate inpatient facility for adolescents. Such a group of patients is quite heterogeneous. Some are likely to be severely disturbed and in need of control via the physical structure of the facility. For most adolescents, however, a secure facility would be destructive. Thus, contemporary design of adolescent units suggests utmost flexibility. There is a need for a section or component of an adolescent unit which is capable of being locked and the adolescent patients in it being physically prevented from leaving. But the essential character of such a structure is that it be capable of providing gradations of physical control from complete security to complete freedom, with the open sections being the preponderant style.

D. Utilization of the NMHI As a State-Wide Facility

Specialized services which would not be economically feasible to duplicate in the North and the South but which are essential components of a mental health system should be developed at the Institute. These include:

1. A secure facility for severely disturbed, extremely assaultive or suicidal clients who have not been charged with or convicted of a crime and who cannot be adequately protected in the Community Mental Health Center inpatient units.

2. A facility for the long term care of persons whose treatment needs will require the structure of a hospital setting for prolonged periods.

3. An expanded geriatric facility providing active treatment, realistic programming, and a variety of security levels.

4. The Institute might also be the logical location for an expanded alcoholism treatment program and possibly a drug abuse program, but since these conditions were not studied, specific recommendations cannot be made in this report.

E. Intermediate Care Facilities

Presently there are few, if any, alternatives between inpatient hospitalization and outpatient treatment yet there are clearly

large needs for intermediate care progrems such as day hospitals or day treatment centers and half-way houses.

The recommendation has already been made that the Community Mental Health Centers establish day treatment programs and provide treatment and consultation to intermediate care facilities. Unfortunately, adequate intermediate care facilities are in short supply. Consideration should be given to the development of intermediate care facilities either by the Division or by the community with the assistance of the Division. It would be reasonable for the Division to establish a half-way house near each of the Community Mental Health Centers so that patients could have easy access to day care and other treatment facilities. Other types of intermediate facilities to be developed are boarding homes, to provide housing and meals, with the Community Mental Health Centers to provide for treatment needs, consultation, and other support services for patients requiring even less assistance than offered by a half-way house.

F. Agreements Between Division Facilities and Other Providers of Mental Health Treatment Within Nevada

Formal agreements should be arranged to facilitate every person in Nevada requiring mental health treatment to receive the needed services. Nevada, because of its large transient population and large geographical area, is presented with many unique and complex problems; thus it is essential that all available resources be utilized as fully as possible.

There are times when the inpatient units of Community Mental Health Centers are filled thus leading to rejection of new patients who require inpatient treatment or premature discharge of patients in order to make room for new admissions. We recommend that the Legislature appropraite contract money for the purchase of care from the private sector when conditions of overflow occur in State facilities.

Such agreements should be made at the Division level and should be public. In particular, all Division personnel should be fully informed of any agreements which involve the sharing of treatment resources.

G. Mental Health Councils

Mental Health Councils consisting of the directors of all public and private mental health facilities or programs should be established in Reno and Las Vegas. These Mental Health Councils,

meeting on a regular basis, could be a valuable tool in the coordination and development of mental health services. The resolution of interagency problems would be facilitated by the regular opportunities for communication provided by these meetings.

Chapter 3

TREATMENT OF THE PATIENT WHO IS A MANAGEMENT PROBLEM OR SECURITY RISK

I. Introduction

This study deals with the need for secure facilities in the State of Nevada to deal with patients who are violent and dangerous or whose behavior is such that existing facilities are unable to manage or control them. This topic was chosen for study by the Task Force, not only because of the reported lack of such facilities in the state, but because the Rand Report addressed itself to this issue:

> We recommend the mental health section of the Nevada Mental Health Institute concentrate on inpatient mental health treatment for rural Nevadans, for those who need a secure* facility, for those who need more than short term residential treatment at the mental health centers, and for those unable to enter the inpatient unit at the mental health centers because they are temporarily filled to capacity.
>
> We recommend that the Nevada Mental Health Institute accept responsibility for providing a secure* Neuro-psychiatric unit for those patients who need it and have not been charged with or convicted of crimes.
>
> We recommend that the Mentally Disordered Offender Facility be used primarily for treatment of prisoners with mental health disorders and not* for persons who have neither been charged with or convicted of crimes, but who need treatment in a secure facility.
>
> We recommend that provision be made for mental health services within the Nevada State Prison for mentally disordered persons who do not need the intensive level of treatment provided by the Mentally Disordered Offender Facility, or who need follow-up services after intensive treatment at the facility. (page 306)

* emphasis added

An attempt will be made in this study to identify the needs of patients who are a security risk, review how these needs are currently met, and make recommendations, where appropriate, as to how the current system could be improved in order to meet these needs.

II. How the Study was Conducted

Information for this study was gathered through extensive interviewing of individuals with knowledge of and direct experience with mental health security needs. The names of individuals interviewed are included in the appendix of the report.

Site visits were conducted to provide opportunities for direct observation and evaluation of facilities.

Numerous reports were reviewed including the Rand Report, reports on Lakes Crossing, and audit reports on several mental health facilities. In addition reviews were conducted of the program descriptions prepared by each mental health facility.

Analysis of this data focused on congruities and consistencies among the sources. The section on results reports those observations and comments made by at least 75% of the individuals interviewed. In many cases there was near unanimity in the comments despite the differences in backgrounds and training of those interviewed.

III. Results

The results of this study were impressively uniform. Almost every source of information expressed dismay over the lack of secure facilities for the treatment of the severely disturbed or violent patient. With only one exception the employees of the Division also acknowledged the need for secure facilities. All but Lakes Crossing preferred that such a facility be located somewhere other than at their facility.

There was reported to be only a very small need for more secure facilities for children than are currently available at the two Children's Behavioral Services. The Division acknowledged that the children whom they could not manage had to be sent out of state but felt this was a rather rare occasion. Judges interviewed seemed to feel that this was a problem of somewhat greater importance but certainly not to the extent of the problem with adolescents.

The most frequently expressed need was for the development of secure facilities for adolescent patients. Las Vegas Mental Health

Center, which has an unlocked adolescent unit, acknowledged the need for a small locked facility, although they expressed a preference that it not be located on their grounds. Reno Mental Health Center expressed the following needs:

> A residential treatment center for adolescents who are fairly emotionally disturbed and for whom placement in an existing program in Washoe County is clearly inappropriate. This facility should provide a secure* section for those youths who present a danger to themselves or others. The establishment of such a program would meet a need which has brought about a great deal of conflict among several local agencies as well as between Department agencies and the center. Such a facility could significantly diminish or altogether eliminate the current need to place such youngsters in out-of-state facilities.

The interviewed judges uniformly saw this deficiency as their greatest area of difficulty. The innovative techniques and manipulations which they must go through in order to convince other state agencies to place these disturbed adolescents out of state is truly amazing. The judges expressed the opinion that, even with adolescents, the Division's philosophy was that if the patients did not want treatment, then they did not want to treat them. The judges expressed the opinion that this philosophy originated at the top administrative levels and that, did it not exist, they would have little or no problems dealing with the local facility directors. Judges also expressed their concern with the difficulty in getting reports about court ordered admissions. In one recent case, the judge had to threaten a psychiatrist and psychologist, both employees of the Division, with contempt of court in order to receive a treatment plan and progress report. The reason given for the initial refusal of this information was "patient confidentiality". The Director of the Nevada Mental Health Institute expressed considerable displeasure over the fact that one of the cottages had to be locked on an order from the court in order to keep a court ordered adolescent admission from eloping. The Nevada Mental Health Institute has no adolescent program per se but mixes its adult patients and its few adolescent patients. The facilities currently being used by Nevada Mental Health Institute consists of three unlocked cottages, an unlocked transitional unit, and a locked geriatric unit. None of the cottages lend themselves to the provisions of any real security.

The adult inpatient facilities at the Las Vegas Mental Health Center, though locked, are far from secure. The Director felt that their

* emphasis added

security was quite adequate; however, one of the staff psychiatrists stated that "it only takes one good kick at the door" in order for someone to leave the facility and that this did happen occasionally. For the year 1976-77, on the adult inpatient ward at the Las Vegas Mental Health Center there were:

11	elopements who were subsequently discharged or placed on leave.
5	transfers to either Lakes Crossing or Southern Nevada Memorial Hospital for security reasons.
140	court commitments, most of whom were sent from Southern Nevada Memorial Hospital.

Information was not available on how many of these were repeat commitments, one of the concerns expressed by almost all of the non-Division persons interviewed. The concern about repeat commitments is centered around the time wasted and the considerable monetary consequences to the county involved. Other concerns expressed about court commitments follow:

1. The Division often fails to notify law enforement agencies or the courts when an involuntary patient elopes.

2. The Division apparently has a policy of discharging patients who are court committed. if they do elope. At the Nevada Mental Health Institute, the court is usually notified that if the patient is not returned within ten days, he will be discharged.

Almost all non-Division sources interviewed felt that:

1. There would be fewer elopements if secure facilities were provided.

2. That when an involuntary patient does elope, he should be placed on leave for a longer period of time so that a recommitment hearing would not have to be held, once the patient was apprehended.

Although we have no way of verifying the figures, the Task Force was told that each commitment costs Clark County approximately $1,100 and Washoe County approximately $600. We cannot explain the difference in these costs. The hospital emergency rooms, law enforcement agencies and the judiciary all have the impression that the Division policy leads to a revolving door situation which is not only frustrating to them but also is economically taxing for the counties involved. The Reno Police Department expressed

concern that even when the Nevada Mental Health Institute accepts an emergency commitment for a person in need of security, this person will usually be released within 48 hours. The Clark County District Attorney and the Metropolitan Police Department in Las Vegas expressed the same concerns, but the time factor is somewhat different. Emergency commitments are not handled at the Las Vegas Mental Health Center but are taken to Southern Nevada Memorial Hospital, the county funded facility, where they are then given acute treatment. Once a week court hearings are held at which time patients in need of commitment are sent either to the Las Vegas Mental Health Center or directly to the Nevada Mental Health Institute.

One Las Vegas private practitioner related his experience of caring for a violent patient who had struck not only himself, but several other hospital staff, but who was willing to go to the Nevada Mental Health Institute voluntarily. The Institute refused to admit this patient and advised the private practitioner that what he should do was to press legal charges against the patient which would put him into the law enforcement system so that he would eventually end up in Lakes Crossing. This advice was unacceptable to the private practitioner. The patient was subsequently taken to a commitment hearing and was committed to the Nevada Mental Health Institute. Subsequent information reveals that the patient did not go to the Institute but was taken to Lakes Crossing where he remains at this time. He is not a criminal offender. Many of the people interviewed were concerned about nonoffenders being sent to Lakes Crossing as well as with the mix of offender patients at the facility. Concern was expressed regarding the rehabilitation efforts of Lakes Crossing being "wasted" on offenders who had little or no potential for rehabilitation. Concern was expressed about the lack of mental health treatment at the state prison for this type of offender. This concern was also expressed at both the Reno jail and the Clark County jail as regards to their access to mental health treatment. Reno police have a psychiatric consultant on contract who will make an assessment of the mental health status of a person in jail. In Clark County, the jail has a psychiatric consultant who gives treatment in the form of medications, or can arrange for transfer to Southern Nevada Memorial Hospital for treatment. For an approximate 12-month period, ending in January 1978, the Clark County jail consultant had seen 210 individual cases with the following characteristics:

1. Approximately 105 had to be seen 2 or more times.

2. 135 had had prior contact with other mental health resources, i.e., VA hospitals, Community Mental Health Centers,

private psychiatrists, state hospitals in other states, etc.

3. 59 required hospitalization.

4. 125 required medication.

5. Diagnostically the patients were found to be in the following categories:

   a. 60 had a diagnosis of functional psychosis (Schizophrenia, manic depressive, etc.)

   b. 34 had a diagnosis of toxic psychosis (including 5 cases of alcoholic D.T.'s).

   c. 37 had a primary diagnosis of character and behavior disorders.

   d. 46 had no psychiatric illness or were considered to be adjustment reaction diagnosis.

   e. 13 were mentally retarded.

   f. 16 had a diagnosis of neurosis (severe anxiety, reactive depression).

   g. 4 cases were not clearly labeled.

This jail currently has a capacity of 500 persons. The jail Commander stated that they were in the process of planning a new jail to hold 2,000 persons and that because of their experience with the State Mental Health System, he was requesting 50 psychiatric beds to be included within the jail itself. He felt that this was rightfully the responsibility of the State Mental Health System and an unnecessary expense for the county.

A current update of a Mental Health Report that had been prepared by a Las Vegas Ad Hoc Committee approximately two years ago identified only one improvement. Because of the psychiatric consultant, it is now easier to have prisoners transferred to Southern Nevada Memorial Hospital for acute care.

Lakes Crossing has had a number of recent reviews. Many of the non-Division sources expressed the same opinion regarding the whole Division as was expressed regarding Lakes Crossing in the November 8, 1977 report by Del Frost and Captain Peter Larson,

> ...we find them to be a dedicated, young, enthusiastic group of employees. They have received a thorough orientation to the

treatment program and philosophy. They are dedicated to carrying out the treatment program philosophy. This philosophy eminates from the Division Administrator and flows down through the Facility Director.

...based on our observations and the evidence which we have received, it is our opinion that the most serious problem that exists at the Lakes Crossing facility is one of attitude and training. The overriding philosophy of the facility is therapeutic community oriented. While the Director has done a good job of selecting and training personnel for implementation of the therapeutic program, he has done so in total ignorance of a minimally adequate security system. The philosophy of treatment runs through the minds of the facility personnel so strongly that they not only do not understand the need for good security practices, but resist suggestions for same, defending their program against the possible encroachment of security practices. The administrative staff appear naive in the area of the need of public safety and the need for good cooperative working relationships with outside agencies.

It was also repeatedly expressed in the personal interviews that the Division had apparently interpreted "treatment in the least restrictive environment" as meaning no restrictions.

IV. Discussion of Results and Recommendations

The conclusions to be drawn from this study are very direct. The Division of Mental Hygiene and Mental Retardation is currently not meeting the State's need for secure facilities. This results in a disservice to both the patient and the community and produces a "revolving door" situation.

It is clear that the state is obligated to provide secure facilities for the severely mentally disturbed and it should be obvious that they should be under the aegis of the Division of Mental Hygiene and Mental Retardation. The real question is how many and what types of facilities are needed and where they should be located. A more extensive study would have to be done to supply exact figures. Estimates from personal interviews indicate that in Clark County alone, if the Mental Health Center handled all the public acute and police care needs, they would require at least 40 security beds. If the acute and police patients continued to utilize Southern Nevada Memorial Hospital, rather than the Mental Health Center, it appears that the Mental Health Center would require 15 to 20 security adult beds and approximately 12 secure adolescent beds. Further study needs to be done on the extent of the needs for more secure childrens' facilities.

The adolescent services should be located in separate facilities, adapted for variable security levels, in both the North and the South.

The role of the Nevada Mental Health Institute depends somewhat on the reorganization of the Department of Mental Hygiene and Mental Retardation. Ideally a patient should be treated in his own community; however, from an economic standpoint, even if regional centers are developed, the Rand Report recommendations may prove to be the most feasible, i.e., one of the functions of the Institute would be to provide a secure facility for patients from all parts of the state.

It is recommended that the Division work with the large local jails as well as with the Nevada State Prison in making mental health services available within those facilities. This would allow the Lakes Crossing facility to be more selective in their acceptance of prisoners which would result in better utilization of their rehabilitative function.

The Division's philosophy appears to be in need of modification. The emphasis on patients' rights is certainly commendable and should not be disregarded. It is also important that the safety of the patients, public, and indeed the treatment staff itself, receive increased emphasis. The Division must take on the responsibility of providing adequate humane treatment in secure facilities when this need is indicated. They cannot restrict their admissions to only those who "want" treatment. The statutes do provide for treatment of a committed person against his will when it is documented that such a patient is a danger. It seems ill-advised to interpret the statute in such a way that a person can be committed, which in itself implies the patient's deficit in judgment, and then be given the prerogative of refusing treatment. The Supreme Court ruling regarding the patient's right <u>to</u> treatment led to local interpretations that this also meant that a patient had the right to refuse treatment. Many mental health professionals and informed citizens question the logic of committing a person to a hospital and then refusing to recognize that committment is for the purpose of treatment not imprisonment. We question the wisdom of committing a violent or dangerous psychotic patient and then giving him the prerogative to refuse treatment.

Chapter 4

AVAILABILITY OF ALL MAJOR MENTAL HEALTH TREATMENT APPROACHES

I. Introduction

A major and recurring concern of those with an interest in Nevada mental health programs has been the nature of the treatment and services provided by the Division of Mental Hygiene and Mental Retardation. Perhaps no other single issue has generated more accusations, explanations, and justifications than the question of what exactly does the Division provide in the way of services.

The Rand Report faulted the Division for serious deficiencies in the amount and quality of treatment provided and concluded that many of the Division's facilities overemphasized behavior modification as a treatment modality. They urged a better balance in the types of treatment available and an encouragement of treatment contributions from other mental health disciplines in addition to psychology.

Although there has been general acceptance on the part of most mental health professionals of the important role that can be played by behavior modification, there is also a strong mandate to provide the wide variety of treatment approaches that our present level of knowledge insists is necessary for any minimally acceptable state-wide system to offer.

While there has been an imposing amount of rhetoric both attacking and defending the treatment provided by the Division, the Task Force was distressed to learn how little actual data there was to support any of the opinions. Although claims and counterclaims abound, relevant data did not appear to exist. Even the very comprehensive Rand Report provided no data to support its conclusion that there was an overemphasis on behavior modification. The Division countered critical opinion with self-serving opinion, rather than with data. As a result the Mental Health Task Force began its study of this topic with not much more available to it than conflicting opinions.

The Task Force decided that it should take a totally empirical approach to this emotionally charged topic. Below is described the method employed by the Task Force to determine what types of treatment are actually provided in each of the State's Mental Health Facilities.

II. How the Study was Conducted

Rather than asking facility staffs to list the mental health services they had furnished, the information base that was used for this study was the only official record of what was actually provided, the client chart.

It is a long standing professional requirement to record in official patient or client charts the exact services provided, by whom they were rendered, and when they were furnished. Thus if one were to review all the client charts for a given facility over a fixed period of time, it would be possible to tell quite accurately what services were furnished by that facility. Unfortunately, the sheer magnitude of such a task renders it impractical. However, sampling techniques have been sufficiently refined so that it is possible to estimate from a relatively small random sample of charts what information would most likely be found if all the charts were reviewed.

Accordingly a sampling procedure was developed to select a random sample of 20 charts from each of the seven facilities studied, or 140 charts in all. All charts were selected on the basis of treatment termination or discharge dates. That is, charts were selected for clients terminating treatment on randomly selected dates during the period April 1, 1977 to March 31, 1978. For each facility five client charts were randomly selected for each quarter of the year. Thus, over the seven facilities, there were 35 charts for clients terminating treatment in April, May, and June 1977, another 35 for July, August, and September 1977, and so on. Stratifying the sample in this way permits an analysis of changes in treatments that might have occurred over time.

Each facility provided xerox copies of the charts of the 20 clients who terminated treatment on, or as close as possible to, the random set of dates provided to that facility. The facility deleted all names, addresses, and identifying information from the xerox copy of the chart prior to turning it over to the Mental Health Task Force. This lengthy and expensive procedure, designed by the Division, was meant to provide extra assurance against identification of any client.

A chart Audit Form was developed by the Task Force and used to abstract and record from the client's chart information about the nature of treatment provided as well as information on several other key issues including the presence or absence of each of a number of items that should be included in an acceptable treatment plan. In all, some 35 items of information were determined for

each of 140 client charts. All chart audits were performed by members of the Task Force and the Staff Investigator.

III. Results and Discussion

A. Ages of Clients

Services were provided to clients whose ages ranged from 2 to 74. However, there was a concentration of services for clients in a rather narrow age band. Leaving aside the two Children's Behavioral Services which treated youngsters age 2 to 12, the other five facilities treated a disproportionately high percentage of young and middle aged adults. Of our sample of 103 individuals who were treated at the five adult facilities, 75 of them were between 19 and 45 years of age. Only 12 clients were between 13 and 18 years of age, a figure much below the number one would expect to find in the adolescent age range. The lack of adolescent programs is the likely cause.

The inbalance among older adults was even more remarkable. Only 16 of the 103 clients were over age 45 and of that group only 6 were 55 or older. Comparison of these figures with the population distribution by age in Nevada suggests a very serious limitation in the provision of mental health services for the middle aged and older, with virtually no services being provided senior citizens. Only two clients were older than 65.

If, of course, older people were not as subject to mental health problems as younger people, there would be no cause for concern. Unfortunately individuals over age 65 have been found to have psychological problems sufficiently serious to require help about three times more often than younger people. The high incidence of depressive disorders and organic brain syndromes in the older age group is the major reason for the greater need for services. It is difficult to avoid the conclusion that the mental health needs of older adults in Nevada are seriously neglected.

B. Previous Treatment Histories of Clients

The seven mental health facilities differed considerably in regard to the kinds of clients they served and the treatments they provided. Some of those differences reflect major and expected variation in assigned mission, i.e. some facilities deal only with children, some provide, almost exclusively,

inpatient services while other focus on outpatient treatment.

For the most part clients who were treated at the two Children's Behavioral Services, Henderson Mental Health Center, Las Vegas Mental Health Center, and Reno Mental Health Center were being treated for the first time. Approximately 85 percent of those clients had not received treatment previously. In marked contrast only 15 percent of the patients at the Nevada Mental Health Institute and at Lakes Crossing had not been treated or hospitalized previously. Those at Lakes Crossing had a greater number of previous hospitalizations or treatment episodes than did the patients at NMHI.

C. Treatment Plans

If a client stayed in treatment beyond an initial evaluation, he was likely to have at least the rudiments of a treatment plan prepared for him in all facilities. Most such plans included a statement of the problems that were to be treated although at NMHI 7 of 20 plans did not even include this very basic information.

While a large proportion of all treatment plans (about 75 percent) specified the goals that treatment was intended to achieve, 16 out of 20 treatment plans at NMHI did not include any description of the goals for treatment.

Regularly all facilities included in their treatment plans the techniques or methods of treatment that were to be employed. Once more NMHI had the poorest record with 5 plans out of 20 including no specification of treatment methods.

All facilities, with the exception of NMHI, recognized the requirement of indicating who had developed the treatment plan and which people were responsible for carrying it out. NMHI in 5 cases did not indicate the persons responsible for developing the plan and in 18 out of 20 cases neglected to mention who would provide the planned treatment.

An overall judgment was made by Task Force members about each treatment plan in accordance with predetermined professional criteria. Thirty-eight percent of the plans were rated as fully acceptable, 48 percent were rated minimally acceptable, and 15 percent were rated as unacceptable. The inclusion of the treatment plans from NMHI pulled down the overall ratings appreciably. If NMHI is excluded from the analysis, the ratings for the other six facilities aggregate to 45 percent fully acceptable, 45 percent minimally acceptable, and 10 percent

unacceptable. The ratings for NMHI alone were: 0 percent were fully acceptable, 60 percent were minimally acceptable, and 40 percent were unacceptable. One parenthetical note of concern, NMHI was the only facility which provided treatment that was inconsistent with the services required by the treatment plan. One possibility is that the treatment plans were so vague the staff couldn't follow them. Lakes Crossing, Reno Mental Health Center, and Children's Behavioral Services, Washoe County had the best overall ratings for the quality of their treatment plans with Lakes Crossing clearly in the lead in this important professional activity.

D. Length of Treatment

Inpatient treatment was provided to patients at NMHI, Lakes Crossing, and Las Vegas Mental Health Center. The median length of stay at NMHI was 10 days, at Las Vegas Mental Health Center 13 days, and at Lakes Crossing 105 days. The brief length of stay at NMHI is more in keeping with that experienced on the inpatient units of community mental health centers than that which is found in psychiatric hospitals that treat patients with chronic mental illnesses. We do not view the short stays at NMHI as a sign of either efficiency or effectivenes.

Outpatient treatment was surprisingly brief at the five facilities whose clients received this form of service. The median number of appointments ranged from a low of 2.5 appointments per client at Henderson Mental Health Center to a high of 4.5 appointments per client at both Children's Behavioral Services, Washoe County and Las Vegas Mental Health Center. The median number of outpatient appointments for all five facilities combined was 3 appointments, a figure considerably lower than the number of appointments called for in most of the treatment plans. Only five clients out of 88 terminated cases had as many as 20 or more appointments. Very brief treatment is what the client generally experiences in state mental health facilities. We believe effective treatment generally requires lengthier service.

E. Treatment Drop Out Rate

The data reported on treatment is based on an analysis of the charts for the 117 clients who were provided some form of treatment out of the 140 client charts that were reviewed. Twenty-nine clients in the 140 closed cases were either seen for evaluation purposes only or declined the opportunity for treatment. It is not unusual in the treatment of mental health problems to find individuals not returning after an initial appointment. Every facility experienced some such

constriction in the size of the client group. Of the sample of 20 charts from each facility, an average of 17 clients received some form of treatment, no matter how brief. Some 16 percent of the clients who had sought or been referred for treatment and had had initial contact with the facility (either admission to an inpatient unit or a first appointment in an outpatient program) did not enter into treatment. The initial drop out rate was quite uniform from facility to facility with one exception. At Henderson Mental Health Center, 35 percent of the clients did not return for mental health treatment. It should be recalled that Henderson had the lowest median number of appointments, 2.5 appointments per client, a finding that was influenced by the relatively high drop out rate.

F. Type of Treatment Provided

State Mental Health Facilities differed markedly in the types of treatment they provided. The sharpest distinctions were between the children's facilities and the adult facilities. Both Children's Behavioral Services, Clark County and Children's Behavioral Services, Washoe County provided highly similar treatment services which contrast in a major way with services provided to most adults. In the two facilities for children, the treatment program revolves around counseling parents on effective child rearing practices. Major emphasis is on the teaching of behavior modification techniques to parents so that they can employ them to bring about desired changes in the child's behavior. While the child may participate in groups designed to teach and enhance social skills through the reinforcement of socially desirable behavior, the treatment focus is on the parents as potential change agents.

There are, of course, other services and activities provided such as school consultations, but the major emphasis on behavior modification is unmistakable. Of 32 children who received some form of treatment at the two facilities, 31, or 97 percent, were treated by means of some variant of behavior modification. In 27 cases, or about 85 percent, parents were given individual or group instruction on the application of behavior modification techniques to bring about desired changes in their children.

A very substantial body of scientific literature and professional experience supports the utility and appropriateness of behavior modification techniques for dealing with many mental health problems of children. However, there is no such support for exclusive reliance on these techniques to treat all mental health problems of all children.

Client charts from the two facilities clearly indicated that some parents were either unwilling or unable to accept and utilize this approach. No alternatives were offered such parents and they simply dropped out with their childrens' problems unresolved.

Despite the frequently expressed view that behavior modification is the principle treatment modality for all mental health clients in Nevada, only 21 percent of the adult patients were treated with some form or variation of behavior modification. Even that figure is quite misleading since most of the clients in the sample who received behavior modification treatment were patients at Lakes Crossing. If the latter facility is excluded from the analysis, only 3 percent of the adults treated at the remaining four facilities had any documented treatment with behavior modification methods.

How then are adults treated? Sixty-seven percent of adult patients were treated with one of the many variations of individual psychotherapy. The only commonality among those approaches was that verbal interaction between a single client and a designated therapist was always involved. What was discussed and how it was discussed covered a very wide range of therapeutic approaches.

Psychotropic medications were given to 53 percent of all adult patients but again that figure is misleading. Among inpatients treated at NMHI, Lakes Crossing, and LVMH, 88 percent received medications; however, only 20 percent of adult outpatients treated at all facilities were given medication. Parenthetically it should be noted that none of the children treated at the two Children's Behavioral Services received psychotropic medications.

Some treatment approaches were more notable for their absence. Only 8 percent of adult patients were provided group therapy and a relatively insignificant 13 percent were involved in family therapy. Some services such as occupational therapy and therapeutic recreation programs are rarely encountered except in inpatient settings. The chances of being provided these services are about 50 percent at Lakes Crossing and only about 25 percent at NMHI.

Each facility seems to have some one treatment wrinkle that isn't likely to be found very often at the other facilities. For example at Henderson Mental Health Center 54 percent of the patients were given relaxation exercises and taught relaxation techniques. Essentially no other facilities

provided this. On the other hand 33 percent of the clients at Reno Mental Health Center received Family Therapy which accounted for as many clients in this treatment form as all the other facilities combined. Sixty-five percent of the clients at Lakes Crossing participated in a social skills group designed to provide opportunities to develop important skills in daily living. Lakes Crossing, because it provided a much longer duration of treatment than any other facility, was able to furnish the widest variety of services and treatment, bar none, to its clients. A whole array of individual and group activities was available to clients.

In sad contrast to some of its fellow mental health facilities, NMHI had a very lean list of services actually provided. All 18 of the patients who were provided treatment at that facility received medication. Only 8 of the 18 patients received any treatment besides medication. No other facility in the state has a record of comparable neglect. Though we have no data on the comparative effectiveness of the treatments provided, all other facilities at least provide treatment to their clients. Eighty percent of the adults receiving treatment in the other mental health facilities were provided individual psychotherapy. Only 22 percent of the patients at NMHI were given such services. This bleak picture was not offset by any other redeeming features.

IV. Recommendations

A. Definitive plans should be made at the Division level to develop mental health services for middle aged and older adults.

B. The lack of critically needed mental health services for adolescents demands immediate correction. However, construction or development of adolescent treatment facilities, particularly inpatient, requires careful planning of the services and treatments to be offered. Planning around a single treatment modality, as was done with Children's Services, must be avoided.

C. Required standards for required treatment plans should be enforced at all facilities.

D. Careful consideration should be given to methods of reducing the attrition rate in treatment. Special emphasis should be placed on attempting to have clients receive the full duration of treatment called for in the treatment plan. This might be a useful topic for program evaluators to investigate in each facility.

E. The services and treatments available to children should be broadened. Special efforts should be made to explore the potential contributions that might be made by child psychiatrists and child psychologists who do not have a behavior modification orientation. Recruitment of new professional personnel should emphasize selection of individuals with a variety of viewpoints.

F. The recommended and anticipated remodeling or construction of a secure adult unit at LMHC and NMHI calls for early consideration of the type of treatment program that would be most effective in such a facility. A locked door is not therapeutic but it is sometimes required in order for therapy to proceed.

G. Proliferation of paper programs without substance, particularly at NMHI, should be stopped. Emphasis should be on developing sufficient quality and depth in existing programs so that they meet minimum professional standards.

Chapter 5

STAFFING: REQUIREMENTS, QUALIFICATIONS AND TRAINING

I. Introduction

In the Health Care Delivery field, one of the most important responsibilities is to determine what kind of persons are needed to perform the assigned tasks, what type of background they should bring with them, and what additional training is needed to supplement previously obtained knowledge and abilities. In the Mental Health Field, each client has the right to the best available care by qualified individuals. In a class action suit filed October 23, 1970 with the United States District Court for the Middle District of Alabama, the formal opinion and decree dated March 12, 1971 legally defined for the first time "Qualified Mental Health Professionals", as follows:

1. a psychiatrist with three years of residency training in psychiatry;

2. a psychologist with a doctoral degree from an accredited program;

3. a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;

4. a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.

It is imperative that adequate identification, utilization, and distribution of the available health manpower personnel take place. The Rand Report repeatedly emphasizes that there should be a sufficient number of appropriately qualified personnel to carry out the assigned missions.

II. How the Study was Conducted

Interviews were conducted with key individuals by the Staff Investigator as well as individual Task Force members. Agencies were asked to submit pertinent data relative to staffing, number,

qualifications, training programs and records of specific training. Interviews were conducted with lower level staff regarding actual training received. These individuals, many of them fearful, would not respond to questions unless they were assured that their identities would not be divulged. This assurance was given.

Position descriptions were furnished by the Deputy Fiscal Analyst. Published documents used included the Rand Report and the Court Record of Civil Action No. 3195-N of the United States District Court for the Middle District of Alabama, Northern District.

III. How the Data were Analyzed

Materials submitted from each facility, published documents, as well as information obtained from interviews were reviewed, sorted, and categorized according to the three main areas covered in this study: staffing requirements, qualifications, and training. Because available time and resources were limited, this study cannot be considered as providing comprehensive coverage of the topic.

IV. Results

Staffing requirements, qualifications, and training were reviewed individually and for the system as a whole. Qualifications of personnel, such as those at the Division level and Facility Directors, were also examined using State position descriptions as the standard and qualifications as listed in curriculum vitae.

A. Staffing Requirements

The total number of employees within the Division appeared adequate to provide planned services. No effort was made to determine whether disposition of personnel throughout the system was consistent with program needs and adequate to carry out specific treatment programs. Certain recurring problems in recruitment and retention of staff appeared.

It has been consistently difficult to attract highly qualified Mental Health Professionals to work for the State. Little has been done about this problem.

The decision to hire can be made at the local level, however, salaries are set by the State Personnel Board. Local facility directors erroneously believe that all recruits must start at Step One regardless of "superior qualifications".

A high turnover rate exists in the ranks of the Mental Health Technicians. Reasons include poor salary, too much responsibility, unrealistically high expectations of untrained persons, lack of job satisfaction, and a stepping stone to better positions.

In reviewing current staffing and assignments at those facilities which provide inpatient care, the following observations were made.

There exists a heavy concentration of Mental Health Professionals during administrative hours, (8 to 5, Monday thru Friday), and an inordinate number of nonprofessionals who have had little formal training and must function with minimal supervision during the remaining 123 hours of each week. Inpatient expertise and professional care providers therefore are absent much more than present.

B. Staff Qualifications

Division Level Positions

It appears that the persons occupying the top administrative positions had minimal experience in the areas of overall planning, coordinating and administering broad mental health programs at the time of appointment. General experience was in the area of rural health and clinic assignments. Previous experience in the area of hospital administration and its associated needs was totally lacking. Past experiences of the Administrator and Assistant Administrator appear to be "mirror images" rather than compl mentary. Possibly such experience deficits may have made programs involving hospital care of the difficult patient, the adolescent patient and the geriatric patient less attractive planning options.

Director Positions

All facility directors meet or met minimal qualifications as stated in current position descriptions at the time of appointment. State position descriptions vary little as far as minimum qualifications and, in fact, are identical for Director II and III. It would seem appropriate that the highest grade, Clinic Director III, should require evidence of progressively more responsible positions and definite

experience in the area of administration. Yet the only time the word administration is used is in an isolated sentence which states "Preferably one of the required years of experience (should be) in administration."

Psychiatrists

Persons occupying these positions met minimal qualifications as stated in current position descriptions at the time of appointment. However, Range A of the minimal qualifications is so loose that practically any experience qualifies a physician as a "Senior Psychiatrist". Information obtained from the November 1977 State personnel position roster indicated three Board Certified Psychiatrists and seven full-time and three part-time Board Eligible Psychiatrists employed by the Division in various facilities.

Psychologists

Individuals employed as psychologists met the minimum stated requirements for those positions but the term "Psychologist" as defined by position descriptions is deceiving. Historically, the public believes a "psychologist" possesses a doctorate degree in Psychology. However, this is required only for the Psychologists IV and V levels. "Psychologists" at the I, II, and III level might more appropriately be called Psychology Assistants or Associates. Minimal qualifications again can be so loosely applied that knowledge, skills and abilities are questionable.

Psychiatric Social Workers

Although those employed met the minimum requirements, a "Social Worker", nationally, is viewed as a person with MSW preparation and those with lesser qualifications are referred to as Social Work Assistants or Associates. Recruitment problems have been identified in that all MSW recruitment is focused out of state since such educational preparation is not available in the State of Nevada.

Nursing Employees

Minimum qualifications as stated in current position descriptions for employment of R.N.'s are adequate. R.N.'s with formal education and training in the psychiatric area who meet the minimum qualifications as stated in the position description entitled "Psychiatric Nursing Staff Specialist" are difficult to recruit since post-graduate education in the field of psychiatry for R.N.'s is not

available in Nevada.

Minimum qualifications for employment of L.P.N.'s as stated in current position descriptions are adequate. However, many L.P.N.'s are being assigned "in charge" duties with remote or nonexistent supervision. It should be noted that basic preparation of the L.P.N. does not include leadership techniques or primary therapist expertise.

Minimum qualifications for employment of Mental Health Technicians are adequate as stated in current position descriptions. Mental Health Technicians actually would be more appropriately called "Health Care Assistants". They are currently being called upon to perform duties which they are not prepared to perform due to serious lack of formal training, particularly for "in charge" and "primary therapist" duties. Remote or nonexistent supervision is not conducive to providing "quality" or even "good" care even in familiar areas. Lack of available Mental Health Professional consultation and appropriate training precludes even mediocrity in performance.

C. Staff Training

The Rand Report states, "The facility should have an active and appropriate staff training program that includes induction training for each new employee and continued inservice training for all employees." All facilities were contacted and asked to provide the Task Force with training programs and training records. The Las Vegas Mental Health Center complied fully with this request, partial compliance was provided by the Reno Mental Health Center, Lakes Crossing, Children's Behavioral Services, Washoe County, Children's Behavioral Services, Clark County, and the Henderson Mental Health Center. The Nevada Mental Health Institute provided only Nursing Service Educational Programs.

Reno Mental Health Center

This facility provided the training plans and budget for FY 1977-78. Orientation training was not included, nor was any evidence provided that training actually takes place at the facility level.

Children's Behavioral Services, Washoe County

A partial training schedule was submitted, however no inservice plans have been formulated.

Children's Behavioral Services, Clark County

This agency furnished a list of In-Service and Out-of-State conferences attended since June 1, 1976 as well as a list of in-service training programs offered by CBS - Clark County since June 1, 1976. The target audience was listed regarding the in-service programs; however, no evidence was submitted as to how many employees were involved and whether this information was documented in individual staff members' folders.

Henderson Mental Health Center

A well developed manual for use with new employees in orientation and continued training was submitted to the Task Force by the Training Officer. Also, a list of workshops and employees involved in orientation was submitted. Total training hours was identified as 526 to date during this Fiscal Year. Again no evidence was submitted as to documentation of training received by specific individuals.

Lakes Crossing

This facility made a token effort to meet the request of the Task Force. Educational Programs described are shallow and supposedly are presented on an "as needed" basis. Samples included Fire Drill Procedure, Fire Extinguisher Use, Control Room Operation, Self-Defense, and use of the telephone.

Las Vegas Mental Health Center

This agency submitted the following documents:

Staff Development Plan for 1977-78.

Copy of Quarterly Training Calendar.

Training Report (7-1-76 to 7-1-77).

Training Report (7-1-77 to 12-31-77).

Copy of Evaluation Form.

Copies of Staff Training Records.

This facility appears to have a well developed training program and makes a genuine effort to provide a means of meeting educational needs.

Nevada Mental Health Institute

This facility did not submit any hospital-wide training programs. The Director stated that no one is designated as a training officer and "training is very primitive". Nursing Service submitted evidence of training and the outline of a two-week Orientation Program.

Mental Health Technician Training - The Missing Requirement

Position Descriptions for the Mental Health Technician II, III, and IV require a specific number of training hours as one of the minimal qualifications. These are:

MHT II - Completion of a 300 hour course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation.

MHT III - Completion of a 600 hour course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation.

MHT IV - Completion of a 900 hour course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation.

A mystery surrounds this required course curriculum in that content and evidence of completion were not obtainable. To the best of our knowledge, these training programs are not provided at all. The implications of that finding go beyond training issues.

V. Recommendations

A. The Position Descriptions for Directors should be revised so that they focus on administrative experience in mental health since these persons are required to be administrators first and foremost.

B. It is time for Nevada to become more sophisticated in its selection of top management officials and to start utilizing many of the innovative selection techniques being used in other areas of the country. When the time comes to replace key

administrators, the process of finding replacements should include at least the following elements:

1. careful analysis of the job to be filled and identification of criteria to be met by the person to fill the job considering all factors: education, experience, special skills, knowledge, abilities, personality factors, values;

2. appointment of a small, highly qualified group of specialists, including individuals who are not employees of the Division who can evaluate a person in terms of these criteria;

3. extensive and active recruitment, within and without the state;

4. development of an objective rating scale to provide for objective assessment of the applicants' vitae and to be used to select those who appear best qualified for the next stage of selection;

5. careful inquiry into the background of the applicants selected by the committee to be interviewed;

6. development of objective procedures to further evaluate the applicants who survive the previous screening. Some very innovative things are being done in this area, for instance the use of video tape in assessing the interviewing skill and knowledge of a potential therapist. An actual interview and therapy session is taped, viewed by a panel of peers and then rated. Similar job related testing techniques are feasible for administrative roles as well;

7. applicants who still qualify would then be interviewed by the committee members who would submit a ranked list of qualified candidates to the immediate supervisor of the position under consideration for final selection.

Such procedures are now being used elsewhere and do provide a better base for the appointing official to make his decision. The Director of Human Resources and ultimately the Governor and Legislature rely on the guidance supplied by their professional staff; it is essential that those key professionals be selected as rigorously as the faith placed in their advice mandates.

C. It is recommended that Facility Directors be "classified" in regard to their continuing tenure as employees but "unclassified" in regard to their role as Directors. Thus a career civil

service mental health professional might be appointed as the Director of a State Mental Health Facility, but if a new administration takes over the direction of the Division of Mental Hygiene and Mental Retardation and finds the approach of some existing facility Directors to be basically incompatible with the new Division-wide philosophy, such directors can be removed from their administrative role without the individuals losing their status and tenure as career psychiatrists, psychologists, etc. for the State. Such career security makes professional employment for the State more attractive while the nontenured, noncivil service nature of the administrative role of Facility Director would allow the Division Administrator to more effectively determine and direct the State-wide mental health program.

All Division level administrators, i.e. the Administrator and his or her Deputy and Associate Administrators should be "unclassified" employees.

D. A study should be made of salaries paid to State employed psychiatrists in other Western states in order to determine whether such positions in Nevada are even close to competitive. In order to make these positions more attractive, and they are very unattractive now, discussions should begin with the School of Medical Sciences, University of Nevada, to develop a system of joint appointments that would permit State employed psychiatrists to receive part time faculty appointments at the Medical School. Such an arrangement would markedly enhance the appeal of these positions.

E. The term "psychologist" should be restricted to individuals who are certified or licensed by the State as psychologists. Individuals who do not meet these requirements should be classified as psychology assistants.

F. "Psychiatric Social Worker" State position descriptions should be rewritten.

G. The ratio of Professional Nursing Staff (R.N.'s) to nonprofessional staff (LPN/MHT) should be adjusted. R.N. coverage "around the clock" should be available on each inpatient unit. Entering R.N.'s even at the "Psychiatric Nurse Trainee" level have completed a psychiatric nursing affiliation including formal classroom instruction and clinical experience as part of the R.N. basic preparation and have successfully passed State Board Examinations which includes a specific portion entitled "Psychiatric Nursing". Ratio suggested is one R.N. to every two nonprofessional positions.

H. Mental Health Technicians are assigned duties and tasks which they have not been trained to perform such as "in charge" and "primary therapist". They are in dire need of formal training. It is recommended that the State of Nevada and the Division explore the possibility of having these employees formally trained using the model currently available in the Junior colleges for the training of L.P.N.'s.

I. Position Descriptions for the Mental Health Technician II, III, and IV look good on paper, however, the 300, 600, and 900 hours of training required for these positions appear to be a myth. Required hours of training should be reasonable and attainable and resources should be made available to provide this training.

J. The Legislative Sub-Committee should consider appointing a Task Force of Mental Health Professionals (not employed by the Division) to assist in establishing staffing patterns and numbers of employees required in various programs. The total number of employees currently involved in direct patient care appears adequate, however, glaring discrepancies were observed in assignment and level of available manpower.

K. Mental Health Facilities should have the power to not only select qualified candidates, but also to negotiate salaries, within guidelines, for those persons with demonstrably Superior qualifications.

L. Consideration should be given to using Medical School residents to help meet the manpower needs of the Mental Health System and at the same time providing incentive for new MD's from the School of Medical Sciences, University of Nevada to remain in Nevada.

After a medical student has completed four years of training and received the M.D. degree, he or she goes on to post graduate training, i.e. a residency in a field of specialization. The School of Medical Sciences is currently planning residencies in Internal Medicine, Pediatrics, and Family Medicine to begin in the summer of 1979. Consideration is also being given to starting a residency program in psychiatry.

Negotiations should begin between the Division of Mental Hygiene and Mental Retardation and the School of Medical Sciences with the goal of placing or rotating residents in pediatrics in the Children's Behavioral Services and residents or clerks

(3rd or 4th year medical students) in psychiatry in NMHI, Lakes Crossing, and the Las Vegas Mental Health Center, all of which have the necessary inpatient populations. Other possible placement sites for psychiatry residents and clerks would be the proposed Adolescent Units and the Children's Behavioral Services but only if the latter broadened the scope of treatment services available.

Chapter 6

PROGRAM EVALUATION IN THE DIVISION OF MENTAL HYGIENE/MENTAL RETARDATION

I. Introduction

The evaluation of the effectiveness of all human services programs, not just mental health programs, should be a key element in management decisions about development, funding, and staffing of such programs.

Far too little is known about the impact, both long and short term, of mental health treatment to assume that because a service is provided a particular effect will occur. Thus program evaluation becomes a vital tool for management decisions about the provision of such services.

Not too long ago it was believed that simply monitoring the delivery of services, i.e., being able to provide assurance that a defined set of services was delivered to a particular target group, was an adequate system of accountability. Such a model served as the basis for audits in hospitals and provided the criteria for reviewing most human service programs including mental health programs.

While it is far more difficult to measure the effectiveness of services, it has come to be generally accepted that central to any system of program evaluation is the effort to determine whether the outcomes that were sought were actually achieved. Thus any system of program evaluation in mental health, to be minimally acceptable, must include statements, in any number of possible formats, of the goals or results that the treatment program is intended to accomplish and some kind of objective measure of the degree to which these results or goals were achieved

This requirement can be met in a wide variety of ways including measures of the reduction in frequency or intensity of target symptoms, improvement in level of functioning, development of sought after coping skills, or the attainment of individual mental health treatment goals. Common to all is the establishment

of the goals or objectives for the mental health treatment of each client at the start of treatment and the measurement of outcome on those goals, variables, symptoms or behaviors at the end of treatment in order to determine whether the treatment or services were effective.

Aggregating the results from the treatment of all individual clients or patients in a particular facility or in a specific program provides necessary information for the administrators on the effectiveness of the specific program or the particular facility. With such information higher level management is in a better position to make informed decisions about where to put resources and what kinds of programs seem to warrant support.

In addition to having a method for measuring the effectiveness of a program, the administration must be able to determine what types of services appear to be most needed. A minimally adequate program evaluation system will include means to accurately gauge the service needs of the population to be served.

It is possible, of course, for a Mental Health agency to accurately assess needs and carefully measure the influence of a treatment program on targeted behaviors, symptoms, or goals and then do nothing with the data collected. Thus the final and essential link that gives meaning to the whole process is the utilization by management of the results of program evaluation efforts. For example if it was found that a particular treatment approach for acute schizophrenia was not useful, but management allocated additional funds and assigned extra manpower to the demonstrably ineffective approach, it should be concluded that the program evaluation system had no practical utility. Thus intrinsic to the successful development of a system of program evaluation must be a management commitment to make use of the data and results in making program decision.

These three basic elements of a comprehensive program evaluation effort: an assessment of service needs, an attempt to measure impact or effectiveness of treatment, and evidence that program decisions are influenced by the results of the evaluation served as benchmarks against which were judged the program evaluation efforts of each State run mental health facility and the Division of Mental Hygiene and Mental Retardation as a whole.

II. How the Study was Conducted

The Director of each State operated mental health facility that was included in this study (Henderson Mental Health Center, Children's

Behavioral Services, Clark County, Las Vegas Mental Health Center, Reno Mental Health Center, Lakes Crossing, Nevada Mental Health Institute, and Children's Behavioral Services, Washoe County) was individually contacted and asked for the name of the person responsible for program evaluation at that facility. In some cases there was a professional staff member designated for that role, typically called the program evaluator, in other cases the facility director himself took the major responsibility.

Each of the individuals responsible for program evaluation, whether the director or more often a designated professional, was asked to submit copies of all program evaluation plans, reports and documents for their facility. In some cases revised evaluation plans were under development and the facility provided drafts of the new materials as soon as they became available.

Site visits and personal interviews were conducted at all but Henderson Mental Health Center. Opportunities were provided for the program evaluators to comment on or supplement the written materials provided the Task Force.

With only one exception all facilities provided rapid and cooperative responses to the requests and furnished voluminous written materials.

The administrative office of the Division of Mental Hygiene and Mental Retardation supplied copies of the reports prepared by the Administrator on the results of site visits by audit teams to four facilities. The Division had recently undertaken the auditing of its facilities in order to monitor their programs. The audit teams were appointed by the Division and composed of several members from agencies other than the one being audited and a few members from the Division administration. The composition of the team varied for each audit. One of the major topics covered in the two or three day site visits by the audit team was the program evaluation efforts of the audited facility. An analysis of the audit effort is included in the section describing the central office's evaluation program.

III. How the Data were Analyzed

The materials submitted for each facility along with the information gained from site visits and personal interviews were reviewed to determine what was available in each of the four categories described below. Judgments were then made about the quality and appropriateness of the materials and efforts. For purposes of this study it is assumed that for a system of program evaluation to be reasonably comprehensive and useful it should contain the following described elements:

A. Management Information System

This refers to the set of records, forms, and other data inputs used to track the services provided to clients. At a minimum such a system should include information on:

1. The client (basic demographic data should be provided as well as information on the services needed).

2. The services (information should include the type and amount of services and when they were provided to the client).

3. The service providers (this input should include by name and discipline the individuals who provided the services).

It is important to distinguish between the clinical case record which is maintained for every client at any organized health care delivery facility and the forms and records used to input into a management information system. This system includes the processing and analysis of the data, either manually or by computer, and the generation of reports for management. Such reports, which ordinarily could not be economically produced from clinical case records, provide on a regular basis information on the operation of the facility such as the number of clients seen by individual staff members, and a breakdown of the types of services being provided.

Management Information Systems vary enormously in complexity and magnitude. Sophisticated systems may include elaborate profiles of the personality characteristics of the clients as well as details on an almost unlimited number of other variables. The inclusion of such information allows management to investigate quite easily problems such as a comparison of the personality characteristics of those who remain in treatment vs those who drop out.

The review of the Management Information System of each agency was less concerned with the quality or complexity of the system than with whether there exists a working system.

B. Needs Assessment

For a Program Evaluation System to provide adequately broad information, it should include a reasonable, workable method of determining the mental health needs of the residents in the geographical area served. Again emphasis was not on the elegance of a method but its existence.

C. Program Effectiveness

At the heart of any program evaluation system are the measures which provide objective information on the impact or effectiveness of the services provided. When considering the effect of mental health treatment, the measurement of change or of condition after treatment must start with the individual patient or client. General observations about a program seeming good or effective are of no value in such an enterprise.

As part of an approach to measuring the effectiveness of a program, clients or "consumers" are often questioned, usually by means of a consumer satisfaction rating scale, about their impressions of the quality, or other features, of the services provided. This appears to be a more useful approach for rating toasters or toothpaste than mental health services. Many years of experience with such scales has convinced most program evaluation experts that the principle use of such scales is to convince legislators or higher level administrators that a program justifies its funding. It is doubtful that any study of consumer satisfaction with mental health services ever conducted in this country showed less than 90% of the respondents being "very satisfied" or "satisfied". Such ratings have no demonstrable relationship to clinical effectiveness of treatment.

Nonetheless Federal and State regulations often mandate their use. Sole reliance on such an approach does not qualify an agency as having an adequate method of measuring program effectivenes.

D. Management Utilization of Data

The effort at Program Evaluation is wasted if management does not make use of the data in its program decisions. Evidence of such a link was sought in the review of each facility.

IV. Results

A separate review of the Program Evaluation efforts of each State operated mental health facility is provided according to the format described previously. Observations about aspects of the evaluation program that do not fit under these four categories are also included. A summary judgment about each facility's program is given. The results of the assessment of the program evaluation efforts at the Division's central office are provided separately.

HENDERSON MENTAL HEALTH CENTER

A. Management Information System

Based on the information provided by the facility, it appeared that the major emphasis has been on documenting the amounts and types of services provided with some effort to begin to characterize the types of patients receiving these services. Such efforts are, of course, of basic importance to rationale management of the center.

B. Needs Assessment

No evidence was presented of systematic efforts to determine the mental health service needs of the population to be served so that programs could be developed which responded to those needs.

C. Program Effectiveness

A few symptoms and symptom clusters have been listed on a form; both clients and counselors check off whether there has been any improvement in these areas. Unfortunately there is no way of knowing whether these symptoms relate to the problems that brought the client into treatment or whether reduction of these symptoms is in any way related to the goals of treatment.

A client satisfaction form is also employed.

D. Management Utilization of Data

There was no evidence to indicate any link between program evaluation data and management decisions.

E. Overall Judgment

The program evaluation efforts at this facility do not yet meet minimally acceptable standards; however, there is strong interest in establishing an effective evaluation program.

CHILDREN'S BEHAVIORAL SERVICES - CLARK COUNTY

A. Management Information System

Considerable effort has been expended to develop a management information system at CBS - Clark County. The system provides essential information on the demographic characteristics of the clients who are provided services by CBS - Clark County, and characteristics of the treatments that are given and by whom the services are rendered. The efforts of the evaluation staff appear to have produced a usable system.

B. Needs Assessment

The determination of the mental health needs of the children in the area served has been quite limited. A fragmentary, incomplete approach has not served to materially affect the programs offered.

C. Program Effectiveness

Special programs, i.e. a summer program, have collected data they believe to be relevant to treatment effectiveness but there is as yet no overall system for evaluating programs. The program evaluation procedures for specific time limited programs do not always appear as germane as they might be. For example in evaluating the effectiveness of a summer program for children whose behavior had been seriously disruptive in school, individual records were kept on numbers of incidents of inappropriate or other clinically significant behaviors during the course of the summer program. Unfortunately no information was provided on the extent of disruptive behaviors when the children returned to the classroom in September, yet that was the very thing the program was designed to affect.

Consumer satisfaction rating scales are widely employed at CBS - Clark County. There appears undo reliance on them as a way of estimating program effectiveness.

D. Management Utilization of Data

Management appears receptive to utilizing program evaluation data but thus far there have not been enough results generated to expect much influence on program decisions.

E. Overall Judgment

The program evaluation system testifies more to the good intentions of staff and management than to success in handling admittedly difficult evaluation tasks.

LAS VEGAS MENTAL HEALTH CENTER

A. Management Information System

Over the last two years or so the Las Vegas Mental Health Center has made impressive progress in developing and implementing a management information system. This system, which consists of a complex of records, forms, and other data inputs which are processed, analyzed, and fed back in the form of reports to various program managers, permits the Center to keep track of who it is treating, by which therapists, by what methods, and for how long. The details of each of these items allow the Center to provide accurate information for required reports as well as to respond to both internal and external requests for information.

B. Needs Assessment

The program evaluation staff has conducted a number of large studies designed to assess community mental health needs. The results of these studies have provided important guides to the direction Center programs should take to best meet the most pressing of these needs.

C. Program Effectiveness

The next, and perhaps most difficult, task that the evaluation staff will undertake is the development of a system of evaluating the effectiveness of the Center's treatment programs. Until now the only efforts in this area have been the limited employment of consumer satisfaction rating forms. The staff appears to have the skills necessary to develop and apply more appropriate measures of treatment outcome.

D. Management Utilization of Data

The administration of the Center has come to recognize the value of and depend upon the information supplied by the evaluation staff. Evidence was present that a number of important management decisions were strongly influenced if not entirely determined by the information generated by the program evaluation staff.

E. Overall Judgment

The program evaluation efforts of the Las Vegas Mental Health Center far exceed in scope and quality those currently underway in other State mental health facilities. The administration of the Center and the Program Evaluator and his staff should all be commended for their sustained and competent efforts.

RENO MENTAL HEALTH CENTER

A. Management Information System

A very limited amount of some very basic demographic data is recorded for each client. Unfortunately no information is recorded in the Management Information System on why the client has come to the Reno Mental Health Center, what he is being treated for, how he is being treated or what goals or expectations are intended to be met by the treatment. While much of this information may be in the client's clinical chart, its presence there will in no way aid the administration in evaluating the effectiveness of the programs and services which are offered.

B. Needs Assessment

Although there was no evidence of any systematic efforts to assess the mental health needs of the area served, the administration and professional staff have had enough experience in the community they serve to be able to identify quite clearly many service gaps. While their list cannot claim the comprehensiveness that would come from a formal study, they have identified a number of major needs.

C. Program Effectiveness

A global estimate is made, with uncertain frequency, of the client's level of functioning on a nine point scale. There did not appear to be any record of a plan to integrate this into a system for assessing the impact or effectiveness of treatment.

An unsuccessful effort was made to get clients to fill out and mail back a consumer satisfaction rating scale. Unfortunately only 16 of 54 persons who terminated services sent back the form. Perhaps what is even more unfortunate is the fact that that result easily could have been predicted after a review of the form and method.

D. Management Utilization of Data

Since there is virtually no program evaluation information available, it is not possible for management decisions to be influenced by program evaluation results, even if management passionately wishes to be so influenced.

E. Overall Judgment

The present program evaluation effort is not likely to yield any very useful results nor should it be expected to provide the kinds of information which would be useful for management decisions.

LAKES CROSSING

Despite repeated promises, Lakes Crossing was the only State operated mental health facility that did not supply any written information on its program evaluation system. After the period for review had passed, a letter, with no supporting materials, was received from the facility describing its present efforts and its plans for future program evaluation approaches. In line with our policy of not evaluating intentions, our comments are restricted to what was actually being done. Based on personal interviews and site visits, it did not appear that Lakes Crossing had any method in operation, no matter how meager, for evaluating the effectiveness of its programs.

NEVADA MENTAL HEALTH INSTITUTE

When the Director of the Nevada Mental Health Institute was asked to describe his facility's program evaluation methods, he replied they didn't have any.

He was both candid and accurate. But for the largest, oldest, and most expensive mental health facility of the State to have no method of evaluating the effectiveness of its treatment and services must place that facility among a rapidly dwindling number of undistinguished counterparts in this country.

Over the years, of course, individual records have been maintained on patients and certain routine summary statistics, like numbers of admissions, have been prepared. In addition, as specific time limited programs were developed, usually through Federal grants, data necessary to the reporting requirements for those grants were secured. Retrospective audits, as mandated by JCAH requirements, have sometimes been conducted.

In addition over the long history of the hospital, strongly motivated staff members have made efforts to initiate information systems that could be of use to management. From time to time sporadic efforts have been reported of attempts to gather data on the impact of particular programs. At the present time an effort is being made to introduce Goal Attainment Scaling on the Transitional Unit.

Unfortunately since patients usually don't reach this unit until after a period of hospitalization on another unit, even successful introduction of Goal Attainment Scaling on the Transitional Unit will not permit evaluation of the effectiveness of the total course of treatment for the patient. Nonetheless this is an encouraging sign in an otherwise bleak picture.

Overall Judgment

The global assessment by the present Director is correct. There is no program evaluation system at the Institute.

CHILDREN'S BEHAVIORAL SERVICES - WASHOE COUNTY

Although reports on the program evaluation activities of each facility have been limited to those methods currently in use, in the case of the Children's Behavioral Services - Washoe County an exception must be made.

This facility is too new to expect a fully developed program evaluation system to be functioning. Instead consideration has been given both to what has been done and what is planned.

A. Management Information System

Initial efforts have gone, as they must, into the development of a management information system so that the services provided and the recipients can be tracked and necessary reports prepared.

B. Needs Assessment

As of this report there is no evidence that the evaluation program staff has concerned itself with assessing the mental health needs of the children in the area served by the agency, nor is there indication of any immediate plan to do so.

C. Program Effectiveness

In several ways the beginning efforts to assess program effectiveness appear to be considerably ahead of and more appropriate than such plans in other State mental health facilities.

The employment of the Behavior Inventory both before and after treatment and the utilization of Goal Attainment Scaling by CBS - Washoe County are likely to yield data with direct implications for the effectiveness of treatment. While there is a long way to go in successfully implementing these assessment procedures, they have a refreshing relevance to the issues that brought the child into treatment.

D. Management Utilization of Data

Substantial evaluation staff effort has gone into the development of procedures and forms designed to provide effective communication between individual employee and supervisor and among departments. This appears to suggest a major commitment of management to utilize the data and skills of its evaluation staff.

E. Overall Judgment

Realistically it will take another year before a fair determination can be made of the quality of the program evaluation effort; nonetheless it has gotten off to a good start.

THE DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Although the Rand Report dealt only indirectly with the topic of program evaluation, careful reading of that report suggests that the central office of the Division had no Division-wide program evaluation efforts underway during the 1974 and 1975 time periods covered by the report. Division confirmation of that lack, and its continuation at least through 1976, is indicated in two of the objectives the Division set in 1976 for its central office to accomplish by June 1977.

Objective: "Have a uniform data collection system in operation."

Outcome: (To be accomplished by 6/30/77.) "The Division central office will have a Division-wide data collection system in operation for mental health services."

Objective: "Design a system of program evaluation and need assessment to assist in making decisions about the future course of programs."

Outcome: (To be accomplished by 6/30/77.) "The Division central office will have a Division-wide quality control system in operation."

The results of the present study in regard to the four categories of information about program evaluation efforts permit a determination of whether the Division has achieved its objectives.

A. Management Information System

The Division of Mental Hygiene and Mental Retardation has over the years prepared a variety of reports for both the Executive Branch and the Legislature of the State. In common with other states they have prepared reports for HEW and other Federal agencies with monitoring authority. Often these reports were prepared at great cost in time and effort because the Division has never had a functioning management information system. Each time that a report required more than the routine statistics supplied by facilities it was necessary to contact each agency and order preparation of a special report. These reports would then start to come in, the tardy agencies would be reminded of the urgency of the need, and finally all the reports would be gathered and the information collated into a total report for the Division. While this unusually inefficient approach would typically allow for the preparation of a required report, the accuracy of the reports suffered in the process. An example from the Division's own files will illustrate the problem.

The Division was required to monitor compliance of its facilities with the patients rights portion of the Nevada Mental Health and Mental Retardation Law. The Division needed to report on the numbers of clients who had been informed of their rights under the law, the number who had had treatment plans prepared for them, the number who had consented to being treated and responses to several other related issues. If the Division had a Management Information System, a card or form would have been prepared for each new client at the facility providing treatment, and information of the kind needed to monitor compliance with the law would have been checked off on the form. Either a copy of the form or the information itself would have been sent to the central office where preparation of required reports would then have been a straight forward clerical task. Instead the Division had to order already

overcommitted facility staffs to go to the clinical files and pull large numbers of records which then had to be individually reviewed in order to abstract the information needed.

Since that process required large numbers of people with different training, experience, and understanding of the task to make a variety of judgments and decisions, errors were inevitable. It was only the magnitude of the errors that was surprising. The data cited came from the "Preliminary Summary of Division Agency Compliance with Guidelines, Nevada Mental Health and Mental Retardation Law". This undated document (estimated to have been prepared in 1976-1977) contains a note indicating that the reponses are approximations, but no later report was furnished to the Task Force.

In one section of the report it was stated that one in ten cases were reviewed to determine compliance with the requirement that clients be given a statement of their rights. The sample size was 186, implying that the total number of new cases was ten times the sample or 1,860. Three pages later similar sampling was conducted to determine if individual treatment plans had been developed as required. This time the sample size was reported as 329, and the total number of cases must be assumed to be 3,290. On the following page of this report the sample of one in ten cases was now listed at 233 with the consequent number of new cases presumed to be 2,330. Thus on the three pages that furnish information on the number of clients provided treatment by the Division in its facilities, during a given time interval, 1,860, or 3,290, or 2,330 clients received treatment - depending upon which page of the report is accepted.

Unfortunately examples such as these impair confidence in the accuracy of Division reports. The Division has expressed a desire to develop a Management Information System and has made some efforts in this direction but implementation did not occur by June 1977, the Division's own deadline, nor does it appear likely to occur for some time in the future.

B. Needs Assessment

The Division has been provided much valuable information on mental health needs by various citizens groups, the judiciary, physicians and other health care professionals and perhaps most significantly by its own professional staff members. However, the Division itself has not authored, developed, or instituted a system for ongoing determination of the mental health needs of the residents of Nevada.

C. Program Effectiveness

The Division presently has adopted no techniques for assessing the effectiveness of the services it provides. Individual facilities are making efforts of varying scope and appropriateness in this area, as described in the reports for each agency.

In order to provide a general review of the programs offered by each facility, the Division instituted an audit system described in an earlier section of this report. The audit team members reviewed client records, interviewed staff, clients, and administrators, and recorded their findings on a series of six different forms specifically designed for this purpose. The Administrator of the Division of Mental Hygiene and Mental Retardation personally prepared an audit report on each facility based on the reports of the audit team he had sent into that facility. He furnished the Task Force with copies of his summary reports.

Since the Task Force was committed to the position of reporting only on what it personally reviewed, it requested copies of the audit team findings. The Administrator refused to furnish them. Consequently the Task Force is unable to comment on whether the summary reports of the Administrator are consistent with or supported by the data from the audit teams. This was the only occasion on which a request for reports was met by a refusal. This refusal is particularly unfortunate since multiple and sometimes even contradictory interpretations of data are not unknown in the mental health field.

D. Management Utilization of Data

Evidence was sought for a link between program evaluation data and management decisions. No such relationship was found. It appeared that management decisions at the Division level were based primarily on the clinical acumen of the administrative staff, their perceptions of community mental health needs, and their judgments about how best to meet those needs.

Interviews with judges, police, physicians, community mental health professionals, and professional employees of the Division indicated that the Division had been consistently presented with felt needs for a secure facility at the Nevada Mental Health Institute, an inpatient adolescent unit at the Institute, an extended care unit at the Institute, and long term care for severely disruptive geriatric patients. Within the last few years the Division closed the security unit, closed the adolescent unit, closed intermediate and long term care units,

and is in the process of phasing out the geriatric unit. Whether these decisions prove to be wise or not, they appear clearly inconsistent with the limited data which was available to the Division.

E. Overall Judgment

The Division does not have a program evaluation system nor does it have functioning components of such a system.

V. Recommendations

The present study indicates that currently there is a large gap between the requirements for an acceptable system of program evaluation and the present performance of the Division of Mental Hygiene and Mental Retardation. The following recommendations are offered as a guide to developing a minimally adequate system.

A. Organization

Certain things can be done more effectively and efficiently at the facility level, other evaluation tasks require coordination and direction from the Division, and a few functions are much more appropriately conducted by the Department of Human Resources rather than by the Division or any of its employees.

1. The Facility Level

Each mental health facility should have a Program Evaluation Unit, consisting of an experienced program evaluator and a secretary, which would be responsible for contributing to the design of a management information system and locally implementing it. Each facility should be free to add items of data with local relevance or interest to a standardized set of data inputs developed at the Division level. The Program Evaluators should be called upon by a Division level Director of Program Evaluation to collaborate in the design of the information input to be required as the central core of each facility management information system.

The Program Evaluation Units at each facility should be responsible for preparing the reports necessary for the effective administration of that facility. In addition the Unit should provide to the Division the data from the facility which are required for preparation of Division-wide reports.

The Program Evaluation Unit should collect data on program effectiveness using an approach or measurement technique

applicable to all State mental health facilities. The selection of such an instrument or approach should be the responsibility of the group of Program Evaluators under the coordination of the Division's Director of Program Evaluation. Each Program Evaluation Unit should be encouraged to employ other measures of program effectiveness of interest to the facility and appropriate to its particular programs in addition to the mandated approach used by all facilities.

At a very minimum each Program Evaluation Unit would require the full time services of an experienced program evaluator and a full time secretary-clerk. Such limited manpower would not allow for collection of data, that would have to be done primarily by the clinical staff, but only for its processing and analysis.

2. The Division Level

Overall coordination and direction of the Program Evaluation System should take place at the Division level. While the Program Evaluators should be administratively responsible to the Directors of the facilities in which they are employed, they should be professionally accountable to the Director of Program Evaluation in the Division central office. The latter individual will be required to have both substantial administrative skills and a high level of competence in program evaluation.

Since this central office position will be responsible for the preparation of a number of Division-wide reports as well as exercising a leadership function, there will be required both professional and clerical support. Realistically to carry out the requirements of the position, the Program Evaluation Director would need two professional employees and two secretarial-clerical staff.

While a computer or access to one would be useful now, and required somewhat later, manpower is a more urgent funding priority than hardware.

3. The Department of Human Resources Level

The Department maintains ultimate accountability for the performance of the Division and all its facilities but has no effective way of monitoring such performance. The site visit by expert audit teams remains a reasonably efficient and sensitive method for determining overall functioning

of an agency. However if the audit is conducted by individuals who will soon be audited in turn by those they are auditing, the suspicion is created that candor may suffer in the process. In addition if the composition of audit teams changes from audit to audit it is quite likely that the standards and criteria employed will shift as well. For audits to have maximum usefulness, they should be conducted by the same small group of highly experienced and perceptive individuals who are not administratively responsible to the developers and managers of the programs they audit. It is strongly recommended that the regular and comprehensive review through audit of State mental health facilities become a major responsibility of the Department of Human Resources. To provide such a monitoring function, the Department would require additional personnel. Consideration should be given to the employment of a psychiatrist, a psychologist, a psychiatric social worker and a psychiatric nurse to serve in such roles. Auditing of mental health facilities would not require the full time services of such a group but consideration could be given to employing this approach with other Divisions of the Department where regular reviews of programs would be appropriate. If the psychologist in such a review group has, and he should have, expertise in program evaluation, he might well provide ongoing reviews of the Division's program evaluation efforts.

By making this overseeing function a major activity of the Department of Human Resources, the diversion of scarce clinical and administrative personnel in the Division for this purpose could be ended and such individuals could return to their clinical and program development roles.

B. Personnel Qualifications

Many of the recommendations would require employment of additional personnel. Although there are full time program evaluators employed in some facilities, the total number of such positions is inadequate to provide for the program evaluation needs of the Division. However, it would be very easy to hire people into these roles and still find that no adequate program is developed. While most Ph.D. level clinical psychologists have had some exposure to or training in program evaluation, it would be a grievous error to accept self designations of expertise in this area as evidence of appropriate skills. Most clinical psychologist do not have the necessary training and experience in program evaluation to make them appropriate candidates for the roles described. It is essential that any persons who are being seriously considered for such positions be able to demonstrate, usually through publications, that they have worked effectively and productively in this area.

Chapter 7

ADMINISTRATION OF THE DIVISION OF MENTAL HYGIENE/MENTAL RETARDATION

I. Introduction

The very foundation of any organization or system is its administration. The philosophy and style of the planning, leading, organizing and controlling functions of top management tend to permeate any organization. These technical aspects of management are critical in the successful completion of any system's mission. In a service delivery organization, issues of communication and personal relationships are also of major significance.

Given the time available for this study, the scope and geographical spread of the programs, and the number of administrators in the Division, it was elected to focus this evaluation primarily on management issues involving the Division's central administration and its relationships with its Mental Hygiene Program Directors and its parent Department.

II. How the Study was Conducted

A. Interviews

Interviews were held with seventeen Department, Division, Advisory Board, and Program administrators. The interviews were typically an hour or more in length and with the exception of three telephone evaluations, they were face to face. (See appendix for list.)

The interviewees were first asked to share their perspectives and knowledge of the study and then the purpose and scope of the interview was stated. An open-ended, non-directive approach was employed initially. Management style and philosophy, lines of authority and communication, policies and procedures regarding management, levels of participation in management decisions, and interagency management issues were pursued by direct questions if not volunteered by the administrator.

B. Documents Reviewed

1. Divisional Goals and Objectives.

2. Resumes of Administrators and Program Directors.

3. Position Descriptions of Administrators.

4. Rand Report.

III. Results

A. Overview

Appointments for interview were set up without difficulty and those interviewed were generally quite cooperative. Not unexpectedly, there was occasional guardedness, especially when issues were asked concerning possible criticism of superiors. Divisional Administrators expressed virtual unity in their views about management philosophy and needs for maximizing their efforts. All Program Directors were in agreement about their positive regard for growth of programs. Those in Northern Nevada expressed more negative sentiments about the management style of their superiors than did their Southern counterparts.

Of significant note was the protest expressed by the Division Director who was apprehensive about a possible "witch hunt". He alleged the following:

1. A representation from the Sub-Committee Chairman that he be able to review the Task Force membership list before it was made public was not honored.

2. A memo written two years ago by the Task Force Chairman, at the request of his Medical School Department, regarding an interpretation of a Program Director's published credentials, signified there was significant negative bias.

3. Several members of the Task Force are paid by another State agency (University of Nevada) and therefore should not be allowed to serve due to conflict of interest since typically one State agency does not evaluate another.

For these reasons he planned to protest any findings. In addition, he communicated to the Task Force Chairman the notion that the unstructured interviews were, in effect, invalid. He allegedly demanded formal feedback from each Program Director after any contact with Task Force Personnel.

The Division of Mental Hygiene and Mental Retardation, under its current administration, has been responsible for significant growth and program development resulting in increasing services to the citizens of the State of Nevada. Central Administration notes with pride that Nevada has moved from the "bottom three" in the United States to the "top ten" in per capita services. Division administrators and Program Directors are all in full agreement that the growth has been commendable and ascribe major responsibility for these results to the Division's Director.

The budget for the Division, since 1973, has grown from $8,700,000 to $20,000,000. There has been $10,500,000 in new Federal funds and $16,000,000 in Capital Improvements. The staff has grown from 450 to 1,000. There was little question and no doubt in the minds of those interviewed that Nevadans are receiving mental health care superior to that which was available only five years ago.

A number of administrative and morale problems described below may be related to the very launching of the Division as an entity in the Fall of 1971. Until that time, the Superintendent of the Mental Health Institute (a psychiatrist) also served as the Division Administrator. The former Department of Human Resources Director noted that major changes were made in an attempt to move away from an "institutional philosophy" of mental health care. Changes were made in the requirements for Division and Institute administrators to expand eligibility beyond psychiatry. A psychologist was appointed (the current administrator) as Division Director. In addition since there was no funding for the office, staff and monies were diverted from the Institute. The physicians were apparently alienated and after five staff psychiatrists quit, emergency measures were taken to replace them. Subsequently the Institute's Director resigned in a reportedly dramatic and embarrassing fashion. The wounds incurred have remained open and Institute-Division and psychology-psychiatry rifts continue. The initial lack of fiscal support for the Division is likely responsible for the current "catch-up-ball" situation regarding staffing problems.

B. Administrative Philosophy/Style

Each Divisional administrator interviewed described a "participatory" style of management, suggesting significant "decentralization" and "autonomy" for program directors. The rationale that "people closest to the problems make decisions within parameters" was offered.

Program directors essentially agreed about their "autonomy" and some described this as "being left alone". Others felt this to be more an issue of "neglect" and though they appreciated being "my own man" felt they could use more support from central administrators. It was the sentiment of some that attention was paid mainly to development of new programs and very little to the established programs.

Administrative decisions and program development may be guided or biased by the clinical orientation of those in office. Until recently the three major central administrators with clinical background (one recently accepted the Institute Directorship) represented a rather homogeneous orientation. All were trained in clinical psychology, at the same university, at about the same time and all had worked in the same clinical setting (i.e. Rural Clinics) before taking on Divisional duties. Of note is that six of the current eight major program directors (Mental Hygiene) are psychologists who trained in programs thought to be primarily behavioral in orientation. Two Program Directors are social workers and one of them claimed an attempt to oust him some years ago.

There are no physicians or nurses in any significant line authority role at the present time. Review of official State documents (Code, regulations) suggests that there was little, if any, input from mental health disciplines other than psychology. A recent administrative change at the Institute is suggestive of even further reducing the influence of medicine and nursing in the planning and decision making process. The Institute's former Superintendent, Acting Director and current "Medical Director" claimed he was not involved at all in the selection of the new director and wondered whether there was indeed such a process at all.

C. Division Perspectives

Despite a more than doubling of overall budget and staff in the last five years, central administration's budget has increased from $211,000 to $313,000 and staff from eight to ten. It was felt that the priority to develop new programs was greater than ongoing management issues (this is reflected by some of the Program Directors' complaints below). The Division's sentiment is clearly that promotional issues take precedence and often the choice is to write a grant rather than visit a program. Unfortunately, in the eyes of many program directors, this has resulted in a "crisis management" orientation and may, in part, contribute to, rather than alleviate a number of management problems.

Central administrators and many program directors identified major administrative staff deficiencies in the following areas:

1. Program evaluation.

2. Prevention.

3. Personnel.

4. Research.

It was pointed out by the Administrator (but not confirmed) that while the Division has one management analyst, the Welfare Division with two-thirds the staff has five such positions. In addition in the face of increasing legal issues in the mental health field, there is only one attorney available to the Division while Welfare has five. Even if current administrators could be more efficient, the growing population of Nevada with consequent increased needs for human services and the present need for extra "management hands" demands some attention.

A major area of concern for the Administrator was, "the bind dealing with quality of service. Everybody wants it but it's difficult getting legislative support." It was felt that the budget process is "administratively limiting". Although there is "enough money appropriated", the problem is in its being appropriated in line item fashion which forces a structural rather than functional orientation. All administrators felt the need for more latitude in this regard.

Another limitation expressed by virtually all administrators is in dealing with State Personnel. More flexibility was desirous especially in reassigning resources. There was also much criticism about difficulties in recruiting out of state which often limits recruitment of highly qualified personnel.

In regard to data retrieval and evaluation, the Division felt a significant need exists for electronic data retrieval. Obviously machines don't solve problems without some design regarding input of data (which is sorely needed) but the claim is that Nevada may be the only state lacking an electronic data processing system in the area of mental health. It was noted that access to the State's computer is poor. A study completed in 1976 lead to a proposal requesting a Department-wide data system with provisions to each Division for staffing. Apparently the requests never got to the Legislature and the Division has submitted its own request to the Fleishman Foundation.

D. Program Perspectives

The concept of "participatory" management was challenged by several Directors in the North. There was significant sentiment that major decisions are made centrally without significant input from Program Directors. The following statements may be relevant:

"Feels like they have the answers before they ask the questions."

"No chance to impact the broader picture."

"Unilateral actions."

"Fait accompli decisions."

"Vindictive...if you're not their friend, you're the enemy."

"Loyalty is more important than competence."

"If you resist, you're labeled a troublemaker."

E. Advisory Board Perspectives:

Review of the Division's organizational charts, suggests that the only civilian/consumer input into administrative decision making is the Governor's Mental Hygiene/Mental Retardation Advisory Board, which relates in a broken line fashion to the Division Administrator. Of note is that none of the administrators interviewed volunteered anything about this Board. The members of the Board are appointed by the Governor, probably in consultation with the Division. The membership has recently been reduced from 11 to 7 members. Statutes indicate that two be expert in Mental Health, two in Mental Retardation, and three from the General Public. The Board reports to the Governor via an annual report. The Division staff are not responsible to the Board and there is a question of the Board being somewhat responsible to the Division. A recent example of uncertain authority was the Division Administrator's rewording a Board memo and distributing it without Board review. The Chairman was told, "I just cleaned it up for you."

The Board apparently has no significant decision making powers regarding personnel, budget, or programs. They have some "influence" by asking questions and raising issues. According to the Chairman,

the unclear legislative mandate along with the way the Administrator uses the Board, provokes much public sentiment that the Board is merely a "rubber stamp". Other factors which detract from the Board's effectiveness include lack of travel funds to have more than quarterly meetings and inspect programs. Time available to the volunteers is another limiting factor. The Board's budget is not separate from the Division and Spartan travel funds have resulted in several members having to pay "out-of-pocket" for their visiting and monitoring efforts.

The only specific functions that are clear to the Board are to review denial of client rights and to recommend dispersal of funds for adult Mental Retardation training centers.

In most other instances, it appears that the Board is informed of major decisions after they are made (i.e. the recent appointment of the Nevada Mental Health Institute Director).

The Board's chairman feels that more autonomy and authority along with greater utilization of the Board would be necessary for significant consumer advocacy.

IV. Conclusions and Recommendations

A. Lack of Management Plan

Careful review of all relevant documents and interviews with involved administrators indicated that the Division had no particular plan or approach for assuring the coordinated delivery of comprehensive mental health services. Overlapping, sometimes conflicting approaches to mental health care with serious gaps in service arise when each mental health facility is relatively free to choose its own mission. There is need for central determination of priorities and unambiguous assignment of missions and responsibilities to facilities.

B. Poor Coordination of Services

A major responsibility of the administration of the Division is the coordination of services. The section of the Task Force Report, "Entry into the Mental Health System, Coordination of Services and Long Term Care", provides a review of the more serious problems in coordination. The Division Administration must be held accountable for their amelioration.

C. Lack of Multidisciplinary Input

One must consider that given the present state of knowledge of

mental health care, no one model or approach is suitable for all mental health problems. If one accpets this premise, then the inclusion of psychiatric, nursing, and social work input in administrative decision making and policy development is essential. No one mental health discipline should be permitted a monopoly on decision making.

D. Lack of Consumer Input

The current national emphasis on accountability will not abate. Realistic reassessment of Advisory Board functions must be undertaken and a strengthened role for consumer input must be found.

E. Poor Morale Among Program Directors

Little opportunity for direct contact among Facility Directors exist and regular meetings with Division Administrators are rare. Division Planning efforts should more effectively utilize the skills and knowledge of Facility Directors.

F. Needed Increase in Division Administrative Staff

The requirements for improved, broadened and better coordinated services call for an increase in administrative staff to provide necessary management services.

G. Regionalization Not Advised

In a memo dated February 10, 1977 from the Division Administrator to the Honorable James Kosinski regarding a "proposed reorganization of the Northern Nevada Mental Health Services and Southern Nevada Mental Health Services" the rationale was attached:

> "...to maximize efficiency of program delivery and management functions. ...This would reduce the present span of control for top level management, and allow for a more geographical approach to program management, evaluation and development."

An "article" was similarly transmitted on January 9, 1978, apparently in support of a revised proposal for regionalization. It is a chapter of a book (the title of which is unknown) entitled, "Regional Human Services Delivery Systems." It was written by Schulberg, H.D. and Demone, H.W., in 1973. Since further rationale for regionalization is not in available documents,

it is assumed that the "article" may be supportive of the philosophy of the Division in this regard. The purposes of regionalization, outlined by Schulberg and Demone include:

1. To ensure delivery of services to all persons residing within the area.

2. To ensure representative citizen participation in program planning, development and policy setting.

3. To provide comprehensive solutions to pressing problems by linking or merging programs.

4. To enhance quality care, permit specialization where needed, and increase agency accountability for program effectiveness, service delivery, and fiscal allocations.

5. To provide a means for administratively centralizing a disparate group of programs while also decentralizing services within a centralized system.

All of these "purposes" could reasonably be considered as goals for the delivery of mental health care in Nevada. We are a state with two clearly defined geographical regions with a major population center in each. The regions are similar in some respects and clearly different in others. Virtually every major issue raised in the Task Force report suggests setting such goals for the mental health care delivery system for the citizens of our State. Clinicians and politicians, consumers and providers, the staff working in the system and those who supervise their ministering to those in need have all supported such goals in interviews, testimony, documents, phone calls, and memos. Regionalization, then, needs to be considered as a <u>possible</u> means to achieve such goals. We must remember that the authors talked about the "purposes" of regionalization. One would have to read on before concluding that the purposes of regionalization are also synonymous with achievable goals in Nevada, at this time, or in the immediate future.

The authors go on to note that there are also complications created by regionalization...some "rational" and others "nonrational":

1. Any change in the balance of power in any system affects domains and statuses.

2. Local autonomy often is a barrier to functional program analysis.

3. Ownership of certain services (or even clients) in an area could obstruct the development of other forms of helpful services.

4. Interregional rivalries might be accentuated.

5. Parts of the State not in major metropolitan areas might have more difficulty defending their interests.

6. Interstate problems might be worsened.

There is evidence, inuendo, and strong suggestion from all quarters that each of these "complications" is either a good possibility or already apparent in Nevada at this time. The authors do not even mention issues of cost, "bureaucratization", and "layering" raised by those interviewed by the Task Force or the elected officials of the Assembly Ways and Means Committee who turned down the Division's Regionalization Plan.

The authors also suggest that the key question in considering regionalization is:

> How can we best organize human services to guarantee the highest quality to all who use them?

They go on to explain:

> Functional analysis should become the necessary study tool for accepting or rejecting regionalization. It should be stressed that regionalization has little merit when it is arbitrarily undertaken as an approach with inherent magical values. Rather, it should be viewed as an alternative administrative strategy permitting a contemporary approach to problems which cannot be resolved without coordinated effort on a larger territorial base.

The closest thing to the recommended "functional analysis", available to the Task Force, is the very report we are writing. Admittedly an extensive functional analysis in this regard was not possible given the time frame and multi-focal nature of the study. Nevertheless, the data generated by the Task Force's efforts are the most comprehensive available to make recommendations about "Regionalization".

One obvious conclusion is that Nevada could neatly be divided into two regions and that there could be significant improvements in some areas of mental health care delivery. An equally obvious conclusion is that the size of the programs and population

served, the costs involved and the further beauracratizing of services may not be right for Nevada at this time.

Could we achieve some of the proposed goals mentioned above without the feared complications? The Task Force feels that this may be possible and suggests the following:

1. Increase Divisional staff to include Associate Administrators for:

    a) Adult Services.

    b) Child and Adolescent Services.

    c) Training.

    d) Evaluation and Research.

2. These administrators, in collaboration with Program Directors, would be responsible for the planning and implementation of the policies and procedures to deal with problems that require "regional" solutions.

3. Each "region", centered in Las Vegas and Reno would have an Executive Committee of Program Directors with a consumer board. The Executive Committee chairperson would be the Senior Program Director of the "region" and would preside over monthly meetings. The Associate Administrators would rotate through these meetings providing expertise and coordinating guidance in their special areas.

4. Quarterly meetings of all administrators and Program Directors should be held alternately in Reno and Las Vegas.

The separate entity of a Rural Clinics Program may have been crucial in achieving its significant program growth. From a management standpoint and in order to achieve some of the goals of "regionalization," consideration should be given to total reorganization in this area. Rural Clinics could be considered satellite clinics and relate to the major Community Mental Health Clinic closest to it.

It is possible that the growth of Nevada and consequent increasing complexity of the delivery of service may require the development of Regional offices in the future. The Associate Administrator for Evaluation and Research should assume (among initial tasks) the functional analyses necessary to advise our elected representatives about Regionalization with far greater wisdom than we are currently able to provide.

Chapter 8

SUMMARY OF RECOMMENDATIONS

Below are listed in capsule form the 46 recommendations which are described in greater detail in the indicated sections of the report.

Entry into the Mental Health System, Coordination of Services and Long Term Care

1. Facilities should be viewed and administered as components of a single mental health system and not as autonomous agencies.

2. Regional Mental Health Evaluation Offices should be established in Reno and Las Vegas to serve as the single points of entry for all facilities and services in those areas.

3. Three comprehensive Community Mental Health Centers should be developed, two in Las Vegas and one in Reno. The Las Vegas Mental Health Center and the Henderson Mental Health Center should be expanded to fill those roles in the South and the Reno Mental Health Center should undergo major expansion in the North.

4. New adolescent inpatient units, with gradations of physical security, should be established in the North and South, away from adult inpatient facilities.

5. The Nevada Mental Health Institute should be utilized as a state-wide facility providing: a) a secure unit for severely disturbed, dangerous or suicidal clients who cannot be treated at the Community Mental Health Centers and have not been charged or convicted of a crime; b) a facility for the long term care of persons who require more than 60 days treatment; c) an expanded geriatric facility; and d) possibly an expanded alcoholism treatment facility and a drug abuse program.

6. Intermediate care facilities such as day treatment centers and half-way houses should be established in the North and South in easy proximity to the Community Mental Health Centers. The Mental Health Centers should provide mental health treatment and consultation to group care homes, and nursing homes.

7. Formal, well publicized agreements should be arranged between

State mental health facilities and other providers of mental health treatment in the state.

8. Private facilities and their staffs should be utilized on a contract basis to provide treatment and care for patients when state facilities are overloaded.

9. Mental Health Councils consisting of the directors of all public and private mental health facilities or programs should be established in Reno and Las Vegas.

Treatment of the Patient who is a Management Problem or Security Risk

1. The exact number of adult beds that should be provided in required secure facilities can only be roughly estimated without further study. There is an estimated need for 40 such beds in Las Vegas, about 20 of which are currently available at Southern Nevada Memorial Hospital.

2. The recommended inpatient facility for adolescents in the South should have about 12 beds in its secure section.

3. The Division should work with large local jails as well as with the Nevada State Prison to provide high quality mental health services within those facilities.

4. The mission of Lakes Crossing should be more narrowly defined and the selection of clients should be based on that mission.

5. The Division should manifest a greater concern for the safety of the patients, the public, and its treatment staffs.

6. Patients who are court committed for treatment should be provided such treatment even if they object, otherwise there is no point to the commitment process.

Availability of All Major Mental Health Treatment Approaches

1. Mental health services should be developed for middle aged and older adults.

2. Mental health services for adolescents are critically needed but their development should not be planned exclusively around behavior modification as was done with children.

3. The services available to children should be broadened to include more non behavior modification techniques.

4. Methods should be developed for reducing the drop out rate at all facilities.

5. Required standards for treatment plans should be enforced at all facilities.

6. Planning of treatment programs for secure adult facilities should begin at an early date so that programs will be ready when the facilities are available.

7. Quality mental health programs are particularly needed at Nevada Mental Health Institute.

Staffing: Requirements, Qualifications and Training

1. Position descriptions for directors of mental health facilities should focus on administrative experience.

2. Improved selection techniques should be utilized in picking top administrators. A possible method is outlined.

3. Facility Directors should be "classified" in regard to their continuing tenure as professional mental health employees of the Division but should be "unclassified" in regard to their role as Directors.

4. A salary study should be made of psychiatrists employed by other western states with the goal of making such salaries in Nevada competitive. Discussion should begin with the Medical School about permitting psychiatrists to receive part time faculty appointments in order to make these positions more attractive.

5. The term "psychologist" should be restricted to individuals who are certified or licensed as psychologists.

6. Position descriptions for psychiatric social workers should be rewritten along nationally accepted standards.

7. Coverage should be provided by R.N.'s, 24 hours per day in each inpatient unit. The ratio of R.N.'s to nonprofessional nursing staff should be substantially improved.

8. Mental Health Technicians should not be assigned duties for which they have not been trained.

9. Mental Health Technician training programs, which currently exist on paper only, should be revised and implemented.

10. A group of mental health professionals, not employed by the Division, should study and make recommendations on the numbers

of positions needed in each mental health classification and at each facility.

11. Starting salaries should be negotiable, within guidelines, for superior or unusually well qualified new employees.

12. Negotiations should begin with the School of Medical Sciences, University of Nevada/Reno, for Rotating residents and clerks in specialty areas such as pediatrics and psychiatry, beginning in August 1979, through appropriate programs of the Division.

Program Evaluation in the Division of Mental Hygiene and Mental Retardation

1. Each mental health facility should have a Program Evaluation Unit consisting of a program evaluator and a secretary to implement a management information system at the local level and to collect and analyze data on program effectiveness.

2. There should be an Associate Administrator for Program Evaluation and a staff of two professionals and two secretaries in the Division central office to develop and implement a division-wide system of program evaluation.

3. The Department of Human Resources should monitor the performance of the facilities and the Division by means of regular site visits by a small audit team made up of a non-Division psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse.

4. Personnel qualifications for program evaluation staff should be strengthened.

Administration of the Division of Mental Hygiene and Mental Retardation

1. There should be central determination of priorities and assignment of missions and responsibilities to facilities.

2. The Division Administration should be held accountable for the coordination of the now mostly uncoordinated delivery of mental health services.

3. Psychiatry, nursing, and social work in addition to psychology should have input into policy development and administrative decision making.

4. A strengthened role for consumer input should be developed.

5. Division planning efforts should more effectively utilize facility Directors. Quarterly meetings of facility Directors and Administration should take place.

6. Increases should be provided in the size of the administrative staff.

7. Regionalization of the Division should not be undertaken but a reorganization of the Division Administration along functional rather than geographic lines should be implemented. Four new positions of Associate Administrators for Adult Services, Child and Adolescent Services, Training, and Program Evaluation and Research should be established with state-wide program responsibility in the designated areas.

8. The feasibility of reorganizing the Rural Clinics' administrative structure should be considered. Each of the rural clinics might be viewed as a satellite of the closest Community Mental Health Center and the central administration of the Rural Clinics Program incorporated into the single mental health system for the state.

APPENDIX

Individuals Interviewed for the Study

The following individuals were interviewed by the Mental Health Task Force and contributed the data, experiences, and viewpoints which form an important part of the study. In addition, a number of other people were interviewed but requested their names not be listed. We have honored that request but do include them in our personal list of people to whom we feel grateful.

Pat Armstrong, Ph.D
(Acting) Director
Henderson Mental Health Center

Jerome Blankenship, M.S., M.D.V.
Chairman
Mental Health Advisory Board

Tom Brasfield
Office Manager
Washoe County District Attorney's Office

Honorable Peter Breen
Washoe County District Judge

Tom Brennan
Deputy District Attorney
Washoe County

Kathy Brown, R.N.
Head Nurse - Emergency Room
Southern Nevada Memorial Hospital
Las Vegas, Nevada

Joe Burnett, Director
Las Vegas Mental Health Center
Las Vegas, Nevada

Patricia Chatham, Ph.D.
Training Coordinator, Mental Health Service
Veteran's Administration Hospital
Reno, Nevada

Harry Clemons
Management Analyst
Division of Mental Hygiene and Mental Retardation

Captain Conger
Commander
Clark County Jail
Las Vegas, Nevada

Charles Dickson, Ph.D.
Administrator
Division of Mental Hygiene and Mental Retardation

David Dixon, Ph.D.
Executive Director
Nevada Health Care Association

Betty Easton, Director of
Social Services
Physicians Hospital
Reno, Nevada

Jean Estrada
Director of Social Services
Sierra Convalescent Center
Carson City, Nevada

Roger Glover, M.S.W.
Director
Rural Clinics Program
Division of Mental Hygiene and Mental Retardation

Honorable James Guinan
Washoe County District Judge

Honorable Addeliar Guy
Judge, Clark County

Ruth Hawkins, Personnel Officer
Reno Mental Health Center
Reno, Nevada

Larry Hicks, District Attorney
Washoe County

Robert Hiller, Ph.D.
Director
Lakes Crossing Center
Sparks, Nevada

John Hinkle, Ph.D.
Director of Training and
Community Consultation
Las Vegas Mental Health Center

Jack Holbrook, M.S.W.
Coordinator of Training
Henderson Mental Health Center

George Holt
District Attorney
Clark County, Nevada

Emily Herbert Jackson, Ph.D.
Program Evaluation and Research
Children's Behavioral Services,
Washoe County

Don Johnson, M.S.
Child Development Specialist
Children's Behavioral Services,
Clark County

Vera Johnson, Manager
Peaceful Acres Group Care Facility
Las Vegas, Nevada

William Kelly, M.D.
Private Practice, Psychiatry
Reno, Nevada

Robert Kieffer, M.S.W.
Director, Reno Mental Health Center
Reno, Nevada

Lieutenant Richard Kirkland
Reno Police Department

Joel Levy, Ph.D.
Program Evaluator
Las Vegas Mental Health Center

Commander Lewis
Las Vegas Metropolitan Police Department

Mrs. Little, Director
Daytime Club
Reno, Nevada

Gordon Livingston, Administrator
Sierra Health Care Center
Sparks, Nevada

Victor Locicero, M.D.
Medical Director
Nevada Mental Health Institute
Sparks, Nevada

David Luke, Ph.D., Director
Children's Behavioral Service
Las Vegas, Nevada

Franklin Master, M.D.
Staff Psychiatrist
Southern Nevada Memorial Hospital
Consultant, Clark County Jail

William Mayville, Ph.D., Director
Children's Behavioral Services,
Washoe County
Reno, Nevada

John Megara, Administrator
Beverly Manor Convalescent Center
Las Vegas, Nevada

Michael Melner, Director
Department of Human Resources
State of Nevada

Honorable John Mendoza
Judge, Clark County

Larry Miller, Ph.D.
Former Director
Las Vegas Mental Health Center

Andrew Myerson, Ph.D.
Clinical Psychologist
Lakes Crossing
Sparks, Nevada

Gwenyth O'Brien, Ph.D.
Assistant Administrator and Program Coordinator
Division of Mental Hygiene and Mental Retardation

Harold Orchow, M.D.
Chief, Department of Psychiatry
Southern Nevada Memorial Hospital
Las Vegas, Nevada

David Parraguirre
Chief, Deputy Public Defender
Washoe County

Thomas Piepmeyer, Ph.D.
Former Director
Nevada Mental Health Institute
Sparks, Nevada

Alethea Preston, R.N.
Nurse Administrator
Nursing Home Care Unit
Veterans Administration Hospital
Reno, Nevada

Captain Ken Pulver
Reno Police Department
Reno, Nevada

Jean Rambo, R.N.
Chief Matron
Clark County Jail
Las Vegas, Nevada

Fred Randall
Mental Health Technician
Lakes Crossing
Sparks, Nevada

Mujahid Rasul, M.D.
Chairman, Executive Committee
Nevada Mental Health Institute
Sparks, Nevada

George Riesz
Administrator
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Las Vegas, Nevada

Kenneth Sharigian, Ph.D.
Administrator
Nevada Mental Health Institute
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Martha Shea, R.N.
Head Nurse - Emergency Room
Washoe Medical Center
Reno, Nevada

Thomas Stapleton, M.D.
Psychiatrist - Private Practice
Reno, Nevada

William Stone, M.D.
Staff Psychiatrist
Las Vegas Mental Health Center

Coleen Stotler, M.A.
Director, Crisis Line
Reno, Nevada

Charles Strehl, M.S.W.
Chief of Social Services
Nevada Mental Health Institute
Sparks, Nevada

Mary Stubbs, R.N.
Head Nurse - Emergency Room
St. Mary's Hospital
Reno, Nevada

Eleanor Swink, R.N.
Director of Nursing Service
Nevada Mental Health Institute
Spark, Nevada

William Thomason, D.D.S.
Administrator - Bureau of
Health Facilities
State of Nevada

Lieutenant Tone
Sparks Police Department
Sparks, Nevada

Roger Trounday, Former Director
Department of Human Resources
State of Nevada

Marion Unis, M.S.W.
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Psychiatric Ward 500
Southern Nevada Memorial Hospital
Las Vegas, Nevada

Chuck Vernon, M.A.
Child Development Specialist
Children's Behavioral Services,
Clark County

Kathy Wagner, Assistant Administrator
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MIKE O'CALLAGHAN
Governor

CHARLES R. DICKSON, PH.D.
Administrator
MENTAL HYGIENE AND
MENTAL RETARDATION

JACK MIDDLETON
Associate Administrator for
Mental Retardation

B. Division's Press Release on Task Force Report:

PRESS RELEASE: MENTAL HEALTH ADMINISTRATORS REACT - TASK FORCE REPORT

A legislative sub-committee task force report on mental health in Nevada was labeled "repressive and antiquated" today by Dr. Charles Dickson, Administrator of the Nevada Division of Mental Hygiene and Mental Retardation (MH-MR).

"This report, if followed literally, would be a step backwards into the nineteenth century," said Dickson. "The Division should not be an agency designed to run a prison for persons with mental health problems."

"The national standard in mental health, as stated in the 1978 President's Commission on Mental Health, is that people should be treated in the least restrictive environment possible."

"If this report is totally accepted it would undo all of the good work done for the past seven years and revert us back to the 'Cuckoo's Nest' treatment of the mentally ill," Dickson said.

His reactions came today after Assemblyman Jim Kosinski's (D-Sparks) sub-committee chairman received the task force report in Carson City.

Dickson said the five-member task force made some recommendations he agreed with, but he condemned the report for its unenlightened philosophy. "We find the direction of the report to be unacceptable," Dickson said. "I would have hoped for some creative, sophisticated mental health treatment suggestions more appropriate for clients today. This report would shove the mentally ill back into a warehousing model."

The report criticizes the division for not providing more services to adolescent and geriatric populations of Nevada. Dickson said he agreed more resources were needed in those areas, "But the report ignores all of the strides we have made in these areas."

Nevada Mental Health Institute (NMHI) Director Dr. Ken Sharigian said the report was inaccurate and outdated in that it fails to acknowledge the significant changes which were being developed and implemented during the course of the study. For example, the Institute has program evaluation and training positions which were created during the study and yet the report criticizes the Institute for lack of these resources.

"The Institute is undergoing a major reorganization which includes bringing in up to 12 new professional positions," Sharigian said. Sharigian said, "The report has identified numerous problems at the Institute, but does a disservice to the staff by not noting some of the significantly good work being done. The report implies the Institute rejects applicants for services. This is untrue. We are by law required to carefully evaluate all persons who will be confined against their will to insure they meet the criteria set by law. This practice is necessary to protect people from unneeded confinement and restriction of their rights. In the last three months, we rejected only 9 of 68 applicants. Staff should be commended, not chastised for protecting our clients rights as citizens," Sharigian said.

Dickson said he agreed with the reports recommendations for community mental health centers in Reno and East Clark County; adolescent services, intermediate care facilities, and additional administrative staff for improved evaluation.

"I agree with the expansion of services in all of these areas," he said. "What I disagree with is the framework in which the task force recommends these programs be implemented. I am very mindful of the public's need to be protected from a violent element of society, but the repressive recommendations of this report would do violence to the vast majority of clients seeking treatment in an open therapeutic environment. Secure programs should be available, but should not be allowed to set the tone for other mental health services."

Dickson continued, "We are also very opposed to denying people a right to participate in treatment decisions, as recommended in the task force report."

Dickson said 26 studies have been done since 1972 on MH-MR programs in Nevada. "This latest task force study recommends another study on coordination and follow-through of mental health services. We developed a statewide coordination plan which was turned down by Mr. Kosinski in the 1977 Legislative session.

"These reports cost the taxpayers money," Dickson said. "And when it comes to statewide coordination I think it is time to act, not to become involved in additional studies."

Dickson's said he would formalize his response to Assemblyman Kosinski in a written response to the legislative study committee in July.

C. Division's Response to Task Force Recommendations:

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
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(702) 784-4071

MIKE O'CALLAGHAN
Governor

CHARLES R. DICKSON, Ph.D.
Administrator
MENTAL HYGIENE AND
MENTAL RETARDATION

JACK MIDDLETON
Associate Administrator for
Mental Retardation

August 3, 1978

Mr. James Kosinski
Chairman, Legislative Subcommittee for
Mental Hygiene and Mental Retardation
Post Office Box 1129
Reno, Nevada 89504

Dear Mr. Kosinski:

We have carefully reviewed the Report of the Mental Health Task Force. The report contains some constructive criticism and positive suggestions. We agree with many of the recommendations. Funds will be requested to implement a number of the proposals.

However, we disagree with some of the philosophy expressed in the report. Some of the Task Force's comments and observations are contrary to current, progressive mental health theory and practice, such as published in the Report of the President's Commission on Mental Health in April, 1978. In addition, some statements are misleading and based on incomplete information.

Enclosed is a statement of our position on each of the recommendations contained in the report. In some cases where there is concurrence, we have not provided comments, although we may not be in complete agreement with the discussion in the report upon which the recommendation is based.

Sincerely yours,

Gwen O'Bryan

Gwen O'Bryan, Ph.D., Administrator
Division of Mental Hygiene and Mental Retardation

GO:kay
encl.
cc: Mr. Michael Melner, Director
Department of Human Resources (w/enc.)

Mr. Ed Schorr, Fiscal Analysis Division
Legislative Counsel Bureau (w/enc.)

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
RESPONSE TO RECOMMENDATIONS CONTAINED IN THE
REPORT OF THE MENTAL HEALTH TASK FORCE
Aaron Smith, Ph.D., Chairman
June 1, 1978

A. Entry into the Mental Health System, Coordination of Services and Long Term Care

1. Facilities should be viewed and administered as components of a single mental health system and not as autonomous agencies.

We Concur.

2. Regional Mental Health Evaluation Offices should be established in Reno and Las Vegas to serve as the single points of entry for all facilities and services in those areas.

We Concur, in general. However, we do not endorse a single entry point in Clark County for all mental health referrals. Such a proposal would counter the progress that has been made in developing increased accessibility through the operation of satellite community centers that have been developed in Henderson, North Las Vegas, Paradise Valley, Westside, and the downtown area. See additional related comments concerning recommendations 4 and 7.

3. Three comprehensive Community Mental Health Centers should be developed, two in Las Vegas and one in Reno. The Las Vegas Mental Health Center and the Henderson Mental Health Center should be expanded to fill those roles in the South and the Reno Mental Health Center should undergo major expansion in the North.

We Concur. Funding will be requested.

4. New adolescent inpatient units, with gradations of physical security, should be established in the North and South, away from adult inpatient facilities.

We concur, in general. However, the Las Vegas Mental Health Center has submitted a capital improvement proposal aimed at significantly upgrading the total range of adolescent services. This proposal emphasized the need for graduated physical security in residential programs as well as adequate space for day care and special educational services. The recommendation, which includes an adolescent outpatient facility, a less secure inpatient facility, and remodeling of the existing adolescent residential building in order to provide a secure adolescent facility, has been assigned third highest priority in the Department of Human Resources capital improvements recommendations to the Public Works Board. In this regard, the Task Force has proposed that adolescent facilities be placed at a location away from adult inpatient facilities. Should such a proposal be accepted, it would be necessary to build a new secure unit in addition to the two new units previously mentioned. We believe that the best use of the existing adolescent facility is to convert it to a secure unit. Such action would suggest that the new adolescent facilities be built adjacent to the existing Las Vegas Mental Health

Center complex in order to maintain program continuity and coordination within the adolescent services component of the center.

Again, in Northern Nevada, we would concur with total community based adolescent facilities as an ideal. Because of cost effective considerations, we have modified the ideal to some extent. A 16-bed residential facility at the Nevada Mental Health Institute has been submitted as a capital improvement for adolescent services. Support personnel already on the Nevada Mental Health Institute campus can help reduce expenses of this new unit to some degree. Additionally, transitional homes in the community will be requested, which will provide a community based, more normalized part of the service continuum.

Funds will be requested to implement this proposal.

5. The Nevada Mental Health Institute should be utilized as a state-wide facility providing; a) a secure unit for severely disturbed, dangerous or suicidal clients who cannot be treated at the Community Mental Health Centers and have not been charged or convicted of a crime; b) a facility for long term care of persons who require more than 60 days treatment; c) an expanded geriatric facility; and d) possibly an expanded alcoholism treatment facility and a drug abuse program.

In general, the recommendation seems to argue for the further development of a State Hospital model for the Nevada Mental Health Institute. This is contrary to the great majority of thinking in the mental health field today. The President's Commission on Mental Health report appearing in April, 1978, recommends the continued phasing down of State Hospitals and increasing resources for integrated systems of care that include community based service in smaller residential settings. In no way can a statewide service offered by the Institute be viewed as fitting into this national standard of service set by the Commission. Further, it must be recognized that as Nevada grows, additional mental health resources must be found. These resources, if properly allocated and developed, would result in community alternative networks which have shown themselves to dramatically reduce the need for hospitalization. In Utah, for example, one such program has reduced State hospital placements to 3 per 100,000 persons per year. The use of the Institute as a statewide service center in this sense is not economical. Dr. Merrill Eaton, a psychiatrist writing in the 1975 American Handbook of Psychiatry, states, "The traditional emphasis on in-patient care neglects the fact that home care, outpatient treatment, or partial hospitalization often may be preferable, and that even those patients requiring inpatient service require it only at certain stages of illness." The Institute should be encouraged to utilize its resources in these alternative service methods, not as a custodial backup. The concept of transferring persons from all over the state to the Institute, even if the highest quality of treatment were offered would, without doubt, negatively affect service to these individuals by restricting their contact with their home communities, their families and their jobs.

Agreement is expressed regarding the need for a more secure intensive setting for some hard to handle clients at the Institute. But since the duration of these episodes can be limited it does not seem useful to transfer such persons from all over the state for such treatment. Clark County should have its own resources for these clients. The same comments are relevant to the recommendation that the Institute serve long term clients. This is a major gap in services. But with proper

resource allocation and development, a long term system of service can also be created that would allow these clients to remain in their home communities. Consideration should be given to a treatment system of long term care which includes sheltered work, leisure time activities, group homes and a small intensive program for crisis management of the clients.

With regard to expanded geriatrics facility and expanded alcohol treatment facility, we agree that these services are needed but question the utility of placing these services with the mental health system. If, however, a decision was made that these services belong rightfully with the mental health system, much additional resources would be needed to carry out these functions.

6. Intermediate care facilities such as day treatment centers and half-way houses should be established in the North and South in easy proximity to the Community Mental Health Centers. The Mental Health Centers should provide mental health treatment and consultation to group care homes, and nursing homes.

We Concur. This Division plans to request funds to provide various types of transitional housing for adults, adolescents and children throughout the state.

7. Formal, well publicized agreements should be arranged between State mental health facilities and other providers of mental health treatment in the state.

We concur. In Clark County, an alternative to the existing emergency and pre-screening system has been developed. The proposed alternative included conversion of the existing adult inpatient unit at Las Vegas Mental Health Center to a facility that would provide emergency services, offer pre-commitment screening, and serve as a short-term crisis hospitalization unit. It is further proposed that local mental health facilities outside the state system be contracted to meet needs of clients needing moderate term hospitalization and serve as resources whenever the existing adult inpatient unit fills to capacity and can no longer accept clients. This alternative is preferred over the Task Force recommendation that adult psychiatric beds in Clark County be expanded by converting the existing adolescent unit at Las Vegas Mental Health Center to an adult unit. The reasons for this preference include better integration between the public and private sectors, emphasis on community cost containment through use of existing empty beds in contrast to construction of new beds (i.e., secure beds for adolescents) at a time when the trend is toward provision of mental health services in non-hospital settings (as attested to by the goals of HEW to reduce hospitalization in psychiatric facilities by 10%), and the federal mandate for improved catchment area balance. The latter would be achieved through Henderson Mental Health Center contracting for intermediate psychiatric hospital services in the east catchment area. This alternative would also allow for a single point of entry for evening, night, and week-end emergencies, crisis hospitalization, and pre-commitment screenings. In these instances, we support the single entry points recommended by the Task Force.

8. Private facilities and their staffs should be utilized on a contract basis to provide treatment and care for patients when state facilities are overloaded.

We concur. It should be pointed out that some additional staff will be required to monitor and maintain the contracts and services provided by the non-state facilities. Also see additional related comments in our response to recommendation 7.

9. Mental Health Councils consisting of the directors of all public and private mental health facilities or programs should be established in Reno and Las Vegas.

We Concur.

B. Treatment of the Patient who is a Management Problem or Security Risk

1. The exact number of adult beds that should be provided in required secure facilities can only be roughly estimated without further study. There is an estimated need for 40 such beds in Las Vegas, about 20 of which are currently available at Southern Nevada Memorial Hospital.

The need for secure beds cannot be appropriately evaluated until there are sufficient alternatives available to accurately assess the capacity of secure resources currently available. Information available on each of the existing resources within the state suggests that these resources are currently being utilized for individuals who would best be served through alternative resources that are currently unavailable. (Excepting the development of a secure adolescent unit, it is recommended that the focus at this time be placed on developing alternatives so that individuals may be appropriately staffed into secure facilities and needs assessment can continue in light of appropriate placement.) Funds will be requested for transitional homes.

2. The recommended inpatient facility for adolescents in the South should have about 12 beds in its secure section.

We concur. See additional comments in response to recommendation A-4 above. Funds are being requested.

3. The Division should work with large local jails as well as with the Nevada State Prison to provide high qualtiy mental health services within those facilities.

We concur, in general. However, we recommend that mental health programs in these facilities be provided and supervised through in-house staff and that Division resources be directed to areas of consultation, pre-release planning, and follow-up services.

4. The mission of Lake's Crossing should be more narrowly defined and the selection of clients should be based on that mission.

Lake's Crossing Center's mission is defined in terms of the state's need for forensic inpatient services. It is true that Lake's Crossing initially was plagued by inappropriate admissions but that problem is

a minor one now especially in regard to the extensive need for services that Lake's Crossing does offer. It should be pointed out that for many individuals, Lake's Crossing offers the only treatment alternative available. To more narrowly define Lake's Crossing's mission would operationally mean excluding individuals from any treatment whatever in the State of Nevada at this time. We believe that the people in the state would find this unacceptable.

5. The Division should manifest a greater concern for the safety of the patients, the public, and its treatment staffs.

It is our position that Division staff, from program directors to clinical and operation staff, continually have exhibited the highest concern for clients, staff and community safety. However, the legitimate rights of all clients within the system are also recognized, but never knowingly to the detriment of others. In any mental health system, there is always the possibility of an individual's being hurt or hurting others. Caution has been exercised and will continue to be.

6. Patients who are court committed for treatment should be provided such treatment even if they object, otherwise there is no point to the commitment process.

Historically and up until the mid 1970's, most states recognized that the court ordered admission to a mental health facility was also a declaration of incompetency and therefore the right to refuse treatment or make a choice was negated. This concept has been altered in the past several years with the passage of new mental health statutes in many states and federal court decisions upholding the right of each individual, regardless of his or her admission status, to refuse treatment or select an alternative treatment method.

The change in the statutes of many states occurred as a result of a trend throughout the mental health field itself: contractual treatment and informed consent as opposed to forced treatment of a client. This trend is reflected in the 1975 Mental Health and Mental Retardation Act of Nevada (NRS 433-433A). Currently, a majority of states recognize the patient's right to refuse treatment if they are "legally competent." Those states do not recognize the judicial commitment as an inherent decree to treat involuntarily admitted clients without their consent. (See "Statutory Survey of the Rights of Mental Patients to Refuse Treatment," Northwestern University School of Law, 1978).

The President's Commission on Mental Health attempted to address itself to the right of the mentally ill to refuse treatment without much success. The end result of endless hours of testimony and opinion was a statement that reflected the bitter dispute within the medical and legal community over the question: The right to refuse treatment is complex. Consensus does not exist regarding this right.

However, Bruce J. Ennis, a noted legal expert in the problems of the mentally ill person cited cases before the Sub-committee on Constitutional Rights, 91st Congress, where patients often respond more favorably to treatment when they feel that they are being treated fairly and

as intelligent human beings. This seems to bear out the argument held by several Federal District Courts that involuntary treatment only causes the client to become even more rigid and unwilling in his right to refuse reasonable forms of treatment ordered by a competent professional.

The change in the current law of Nevada that would permit the automatic treatment of those persons, involuntarily committed, has the same effect of a declaration of incompetency. This may then lead to a drastic curtailment of the personal rights of the individual such as to marry, vote, execute legal documents and hold a driver's license.

Most recently, the concept of forced treatment of the involuntarily committed mentally ill client has been tested in the Federal Courts in several districts in the United States. The right to refuse treatment has received increasing judicial protection, at least where extreme procedures have been involved. In a recent order, applied to both the voluntary and civilly committed clients, the court in Wyatt v. Aderholt cut short the "increasing rate" of sterilization by mental institutions of the mentally disabled persons. The court required strict procedural protections that in a sense confirmed the right of the individual to refuse treatment and that the right may only be abrogated as a last resort when alternative forms of treatment failed. In an important case, Bell v. Wayne County General Hospital, the Second Circuit Court of Appeals reversed the civil commitment laws of Michigan that permitted "physically intrusive forms of treatment designed to alter or modify a person's behavior" - among which the court included, in detail. surgery, electro-shock and chemotherapy - before a final declaration of incompetency. The court did not find that a simple adjudication of mental illness was sufficient to allow involuntary treatment. The court in Winters v. Miller, reversed the dismissal of a damages suit by a mental health client who was a Christian Scientist and who was subjected to medication against her wishes. It stressed that the plaintiff, though mentally ill, had never been found incompetent to decide matters such as whether to accept medication and that with respect to the "non-dangerous patient", the state had not the right to force treatment.

We have already seen attempts by certain Nevada courts, particularly the Clark County District Court, to order mandatory treatment of involuntarily admitted clients. Technically, this would empower the physician to order not only chemotherapy but also other forms of aversive and perhaps dangerous techniques such as surgery, electro-shock therapy and certain behavioral therapy techniques not widely accepted. This would be done without the client's consent. Fortunately, the court orders have not been utilized to force treatment without consent; however, the danger exists.

The recommendation would essentially bring about a dramatic reversal of the progress of the rights of clients in Nevada. Not only would it permit involuntary treatment but also may open the door for lengthy and prolonged legal actions and damage the trust relationship that we all have attempted to establish with our clients.

This recommendation requires extensive evaluation and should not be accepted at present. This matter is now before the courts in Massachusetts, and we suggest that the outcome of this case be one of the guidelines used in making any decision regarding change in the current law. Another statement in opposition to the Task Force view in this regard is provided in the attached articles by Thomas Szasz on "The Ethics of Therapy". This article, published in Phi Kappa Phi's Journal, contrasts the political process involved in court commitment with the contractual agreement associated with treatment. The author points out that in the free society, treatment comes into being through mutual agreement between client and clinician because the client claims he has an illness and the clinician claims he has a treatment for it. Quite a different situation occurs, according to the author, when treatment is carried out against the expressed wishes of the individual being treated.

He goes on to point out that dangerousness to self and others is a political concept and not a "medical disease"; and therefore, while dangerousness may result in justifiable loss of liberty, it cannot justify treatment.

C. <u>Availability of All Major Mental Health Treatment Approaches</u>

1. Mental health services should be developed for middle aged and older adults.

We Concur. Additional funds in community mental health centers will be required.

2. Mental health services for adolescents are critically needed but their development should not be planned exclusively around behavior modification as was done with children.

We Concur. However we take issue with the Task Force implication that inasmuch as there are a variety of treatment approaches, each program within the Division should strive to develop a "smorgasbord" approach to treatment modalities. Decisions regarding treatment approaches in each given area should be based on treatment approaches that have empirically demonstrated effectiveness and not on efforts to indiscriminately achieve a diversified mix. Prior to the implementation of new programs, there should be resources available to review treatment models and identify the model(s) with the best empirical support.

3. The services available to children should be broadened to include more non behavior modification techniques.

In addition to our comments in response to the preceding recommendation, we have enclosed a copy of a paper prepared by Emily Herbert-Jackson, Ph.D. which deals with treatment philosophy at Children's Behavioral Services-Washoe County.

4. Methods should be developed for reducing the drop out rate at all facilities.

We agree that efforts should be directed toward reducing inappropriate drop-outs. However it should not be assumed that short term treatment, information and referral services, and crisis intervention involving only one or two visits are not valuable mental health services. As neighborhood service centers develop, it may be anticipated that there will be an increase in this type of service and it is important that the perceived drop-out problems not be used to discourage these important elements of service. (Reference: Littlepage, G.E., Kosloski, K.D., Schnelle, J.F., McNess, N.P.. and Gendrich, J.C. "The problem of early outpatient terminations from Community Mental Health Centers: A Problem for Whom?" Journal of Community Psychology, 1976, Vol. 4 issue 2, page 164-176).

5. Required standards for treatment plans should be enforced at all facilities.

We concur. We believe that significant improvements in treatment plans have been made during the last year, in part as the result of program audits.

6. Planning of treatment programs for secure adult facilities should begin at an early date so that programs will be ready when the facilities are available.

We Concur.

7. Quality mental health programs are particularly needed at Nevada Mental Health Institute.

There is no question that the Nevada Mental Health Institute, after a long tradition of occupying the role of State Hospital, which implies a warehousing of clients, needs to further develop the quality of its services. Along these lines additional professional staff have been recruited and are presently being hired. It is the intention of the Institute to further seek support for professional staff to oversee and develop quality mental health programs. It is our hope that the 1979 State Legislature will be supportive of this request to further develop quality programs at the Institute. It must also be noted that the environment of the Institute has over the past five to ten years evolved dramatically from a highly institutionalized campus to one which contributes positively to the therapeutic attempts to deal with clients.

D. Staffing: Requirements, Qualifications and Training

1. Position descriptions for directors of mental health facilities should focus on administrative experience.

We Concur. We further suggest that a personnel system be developed which would allow staff working for the existing mental health facilities to receive training and experience in administrative areas and not result in their being excluded from consideration for administrative positions.

2. Improved selection techniques should be utilized in picking top administrators. A possible method is outlined.

We have no comment at this time. The suggested method of selection should be referred to the Department of Administration for review and comment.

3. Facility Directors should be "classified" in regard to their continuing tenure as professional mental health employees of the Division but should be "unclassified" in regard to their role as Directors.

We do not concur with this recommendation. It is considered to be impractical. Further this recommendation is contradictory to the Task Force's other suggestions regarding the selection and management of agency directors. (Throughout the report, the Task Force is critical of the Division Administrator for what is described as his refusal to allow diverse opinions and focus on loyalty as a primary issue. The Task Force proposal, in regard to unclassification of directors respecting their administrative duties, would specifically support the type of administrative model that is being critized.)

Within the past several years the administrative, professional, and paraprofessional Human Resource employees have been classified, in increasing numbers, due to substitution of standards of professional qualifications for those emphasizing political patronage. In Nevada, the directors of most Human Resource Divisions are classified employees. The classification of Directors recognizes administration as one professional specialty and allows for stability within agencies during times of change in the political offices.

4. A salary study should be made of psychiatrists employed by other western states with the goal of making such salaries in Nevada competitive. Discussion should begin with the Medical School about permitting psychiatrists to receive part time faculty appointments in order to make these positions more attractive.

We agree with the need to upgrade salaries to attract the most highly qualified mental health professionals. It is further suggested that salaries of other mental health disciplines such as psychologists, social workers and psychiatric nurses also be upgraded in addition to those salaries of psychiatrists. For example, these mental health disciplines when employed by the Veterans Administration Hospital in Reno, Nevada, and by the University of Nevada Medical School receive substantially higher salaries than provided by the state system. For example, in the Veterans Administration Hospital a Ph.D. level psychologist position can be compensated up to $33,825.00, while in the Medical School a psychologist or social worker could be paid $39,000.00. In the Veterans Administration system a social worker could receive up to $28,444.00. Part-time faculty appointments should not be limited to psychiatrists. For example in Clark County the potential for part-time faculty appointments in psychology, social work, nursing, etc., at UNLV may be more feasible. Related to this subject, consideration should be given to establishing working relationships with schools in other states (e.g., UCLA).

5. The term "psychologist" should be restricted to individuals who are certified or licensed as psychologists.

Do not concur. We agree that high standards should be maintained in all professional positions. The State as an employer not only selects psychologists through a competitive process by testing the applicants, but exercises control over performance by means of work performance standards and periodic performance evaluations. Licensure alone does not ensure quality performance.

In addition, it is important to point out that psychologist specialties include areas other than clinical psychology. At present, certification and licensing pertains mainly to individuals in the clinical psychologist category. We strongly disagree that people trained as psychologists who specialize in evaluation, social psychology, etc., should no longer be termed psychologists in the State of Nevada.

The current certification of licensing procedure for psychologist in the State of Nevada uses a nationally developed test in determining eligibility for licensing. Although this test has not been demonstrated to be relevant to clinical skill, there is a high correlation between scores on the exam and recent graduation from a doctoral program. This should not be construed to imply that individuals who have practiced psychology for a longer period of time are less qualified clinicians.

6. Position descriptions for psychiatric social workers should be rewritten along nationally accepted standards.

We concur with the recommendation regarding proper utilization of the psychiatric social worker classification to MSW's, however, it will be essential to develop other classifications which allow for the variety of specialization and general expertise of individuals trained in behavioral science fields other than social work and psychology.

7. Coverage should be provided by R.N.'s, 24 hours per day in each in-patient unit. The ratio of R.N.'s to non-professional nursing staff should be substantially improved.

Although no one denies the desirability of involving psychiatric nursing in Division programs, some concern exists regarding the recommendation that R.N.'s be on duty on each in-patient unit. This requirement severely limits the programmatical alternatives for a 24 hour care program. One example which is incompatible with this recommendation is the professional parent model which has proven successful in the two CBS programs, the Achievement Place West Program and various mental retardation programs around the State. It is further noted that no similar requirement for the other mental health disciplines is mentioned in the Task Force report and it is our belief that none should be recommended. There is a definite need to be flexible in staffing requirements on the basis of program content. The Task Force recommendation fails to recognize this need.

8. Mental Health Technicians should not be assigned duties for which they have not been trained.

We concur.

9. Mental Health Technician training programs, which currently exist on paper only, should be revised and implemented.

We concur that training programs for Mental Health Technicians should be revised. At the present time, a training manual for use by supervisors of Mental Health Technicians is being prepared. This manual will contain information on case management and basic psychotherapy techniques. Also, a teaching and training package is being prepared for use of newly employed Mental Health Technicians. During the last year, all agencies of the Division which employ Mental Health Technicians have assigned a high priority to the training of Mental Health Technicians. In May 1978, a Training Council consisting of representatives of all Division agencies was established. A subcommittee of this council is reviewing the training needs and programs for Mental Health Technicians. This subcommittee will submit a plan of action to improve the training of Mental Health Technicians in November 1978. Funds will be requested.

10. A group of mental health professionals, not employed by the Division, should study and make recommendations on the numbers of positions needed in each mental health classification and at each facility.

A number of studies of the organization and use of personnel of this Division have been made. The State Personnel Division is currently conducting an Operations Analysis (productivity study of this Division). Additional studies are considered unnecessary at this time and may be an inappropriate infringement upon the assigned responsibilities of the Administrator and program directors.

Any studies in the future regarding the number of positions in each mental health classification should include input from knowledgeable individuals within the community mental health system. In order to minimize biases, the Task Force recommends that the group of mental health professionals conducting this study should not be employees of the Division. We feel that the Division should not be restricted from input on the selection of individuals conducting independent studies. We suggest that such studies be conducted by individuals who have demonstrated proficiency and have acquired national recognition. These individuals may be recruited through national organizations such as the Association of Mental Health Administrators, the National Institute of Mental Health, and the National Council of Community Mental Health Centers.

11. Starting salaries should be negotiable, within guidelines, for superior or unusually well qualified new employees.

We Concur. Additional funds will be required.

12. Negotiations should begin with the School of Medical Sciences, University of Nevada/Reno, for rotating residents and clerks in specialty areas such as pediatrics and psychiatry, beginning in August 1979, through appropriate programs of the Division.

We Concur. In addition, we suggest that these internships be expanded beyond the medical field to include psychologists, social workers, and other mental health professionals. In order to select well-qualified trainees as well as to bring a variety of training experiences to the situation, recruitment should be conducted nationally.

E. Program Evaluation in the Division of Mental Hygiene and Mental Retardation

1. Each mental health facility should have a Program Evaluation Unit consisting of a program evaluator and a secretary to implement a management information system at the local level and to collect and analyze data on program effectiveness.

We concur. Organizational structure for evaluation within the Division and in agencies must take into account the differential requirements for evaluation at each level. As illustration, at Las Vegas Mental Health Center stringent federal guidelines formally obligate the Center to commit significant resources in areas of quality assurance of clinical services, agency self-evaluation, and resident review. Additionally, substantive evaluation effort is necessary to establish agency entitlement for Medicare reimbursement, while accreditation bodies, notably Joint Commission on Accreditation of Hospitals, include evaluation as an additional functional area in the new standards for community mental health centers.

Evaluation activity within all agencies is necessary to meet quality assurance requirements mandated by State of Nevada client rights legislation and to facilitate assessment of performance with respect to accomplishment of agency/Division goals and objectives. Finally, internal agency program management needs require evaluation input to the extent that the operation of locally useful management information systems can provide significant information which impacts on decision-making at all major organizational levels: service providers, program directors, and agency administrators.

At the Division level program evaluation would be of a broader nature encompassing such areas as a uniform management information system; a statewide quality control and care review operation; and overall agency review and evaluation. The Division Central Office would need to evaluate individual programs in light of the total service system in relation to meeting statewide and regional needs. In addition the Central Office would provide technical assistance and consultation to agencies on evaluation planning and operation; aid in the development of evaluation manpower; and coordinate evaluation efforts with other governmental agencies.

Funds for evaluation will be requested.

2. There should be an Associate Administrator for Program Evaluation and a staff of two professionals and two secretaries in the Division central office to develop and implement a division-wide system of program evaluation.

We fully concur that additional personnel are required on the Central Staff to accomplish division-wide program evaluation. See the preceding paragraph for a discussion of evaluation functions. We are not sure that the organizational structure proposed is the best and will consider alternative organizational systems to carry out this recommendation.

3. The Department of Human Resources should monitor the performance of the facilities and the Division by means of regular site visits by a small audit team made up of a non-Division psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse.

We have no objection to being monitored by the Department of Human Resources. Regular site visits should be mutually beneficial to the Division and Department. Of course such monitoring will not diminish the Division's responsibility to evaluate its programs and services. Members of the Departmental monitoring team should be fully objective and not involved in the politics of Nevada mental health. Consideration should therefore be given to selecting team members from outside the state who have no relationship with the existing public or private mental health programs in Nevada.

4. Personnel qualifications for program evaluation staff should be strengthened.

We concur that additional training of program evaluation staff is desirable. However we disagree with the implication that present evaluation staff is not qualified.

Since few, if any, program evaluation graduate training programs exist in the United States, and Nevada lacks any fully trained program evaluation staff in either public or private sectors, it is recommended that the state provide funds to potential program evaluation staff for post graduate training in this speciality area. It is further recommended that adequate salary be provided these staff. Because of the paucity of "certified" experts in program evaluation, the state should recognize that staff exhibiting potential and interest in this area should be subsidized in their training.

F. Administration of the Division of Mental Hygiene and Mental Retardation

1. There should be central determination of priorities and assignment of missions and responsibilities to facilities.

We concur that final determination of policies, decision-making and assignment of responsibilities is a function of the Division Administration. However participation of agency directors in goal setting, program development etc., is considered essential. Participatory management is used successfully in private industry (for example see the story about Texas Instruments in the Spring 1973 issue of "Organizational Dynamics" published by American Management Associations). We will continue to follow this practice.

2. The Division Administration should be held accountable for the coordination of the now mostly uncoordinated delivery of mental health services.

We concur that the Division Administration be accountable. We disagree that services are mostly uncoordinated. Providing a full continuum of mental health services throughout Nevada to all groups of residents in need of these services can best be accomplished by having comprehensive community mental health centers established in each of the four catchment areas. We have only two now: Las Vegas Mental Health Center and Rural Clinics. In addition it is necessary to have facilities and services for special population groups (eg., Lake's Crossing for the Mentally Disordered Offender). Funds will be requested to expand the availability of services.

3. Psychiatry, nursing and social work in addition to psychology should have input into policy development and administrative decision making.

We concur with this concept. We disagree with the implication that this is not being done now.

4. A strengthened role for consumer input should be developed.

We Concur.

5. Division planning efforts should more effectively utilize facility Directors. Quarterly meetings of facility Directors and Administration should take place.

We Concur.

6. Increases should be provided in the size of the administrative staff.

We Concur. Funds will be requested.

7. Regionalization of the Division should not be undertaken but a reorganization of the Division Administration along functional rather than geographic lines should be implemented. Four new positions of Associate Administrators for Adult Services, Child and Adolescent Services, Training, and Program Evaluation and Research should be established with state-wide program responsibility in the designated areas.

We will continue to study alternatives for reorganization. We are not convinced that establishing Associate Administrators along functional lines is the best organization. We do agree that if regionalization is not approved, additional staff is required in the Division Central Office.

Funds will be requested.

8. The feasibility of reorganizing the Rural Clinics' administrative structure should be considered. Each of the rural clinics might be viewed as a satellite of the closest Community Mental Health Center and the central administration of the Rural Clinics Program incorporated into the single mental health system for the State.

We do not concur. Being a separate entity clearly has its advantages as noted by the Task Force. However their suggestion to eliminate that separateness runs counter to the advantages referred to and clearly contradicts the opinions expressed. Obviously the report has failed to recognize that the Operations Grant is based on the concept of Rural Clinics as an integrated Comprehensive Mental Health Center and not as separate and unrelated clinics. Continuity of program goals as well as service provision to rural Nevada must be coordinated on the basis that rural Nevada is one continuous catchment area. To place the clinics under separate Mental Health Centers in Washoe and Clark Counties (outside the catchment area) would violate the integrated concept as well as violate both the Operations Grant service delivery plan and the catchment area concept in service delivery. By placing the administration of the rural programs under urban mental health centers planning, it is most unlikely that they would support the rural needs with any amount of enthusiasm. They would frequently see urban problems as first priority.

Another point needs to be made with regard to rural needs and that has to do with the regionalization concept proposed by the Task Force. It clearly excludes rural interests in favor of those of urban Nevada. Regionalization is not based upon a North and South concept but upon a Reno and Las Vegas focus of control. No mention is made of rural Nevada. The regionalization proposal of the Division of Mental Hygiene and Mental Retardation does recognize that rural mental health problems must be addressed as a separate and viable entity. If regionalization is to become a useful concept in Nevada, rural Nevada must be a separate regional area.

In summary then, the report notes Rural Clinics' growth as a result of the Operations Grant (Page 1, Paragraph 2) but fails to fully comprehend what that means programmatically. Their suggestions for regionalization are both superficial and lacking in understanding of the problems related to service delivery in the vast rural areas of Nevada. This recommendation reflects a flagrant disregard for the Task Force's original disclaimer on Page 1. The Task Force Report was presented to the Rural Clinics' Governing Board on July 6, 1978. The Governing Board felt unanimously the recommendations would adversely affect mental health care in rural Nevada.

APPENDICES

Appendix A--Rand Corporation Report Recommendations.

Appendix B--Summary of Programs of the Division of Mental Hygiene and Mental Retardation.

Appendix C--Summary Data, Division of Mental Hygiene and Mental Retardation Positions, Funding and Capital Improvements.

Appendix D--Reply of State Personnel to Subcommittee Concerning Employee Training.

APPENDIX A

RAND REPORT RECOMMENDATIONS

#1 Establish Regional Direction Centers.

While it is recognized that the identified problems that led to this recommendation need to be addressed, the subcommittee did not attempt to determine whether or not the establishment of regional direction centers is the best solution. The subcommittee limited its review to the Division of Mental Hygiene and Mental Retardation. This recommendation relates to the organization of the Department of Human Resources. However, the subcommittee acknowledges that regional "human service centers" might resolve, or at least alleviate many of the coordination problems which presently exist within the Department of Human Resources.

#2 Strengthen State Advisory Boards.

See subcommittee's recommendation number 11.

#3 Expand Genetic Counseling with Respect to Mental Retardation.

Such counseling is being expanded. However, the subcommittee did not have adequate resources to review the genetic counseling program.

#4 Ensure Provision of Immunizations, Rh Desensitization and PKU Screening.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#5 Expand Family Planning Services, and Create a High-Risk Registry for Newborns.

The subcommittee has been advised that action is underway on this recommendation. However, the subcommittee did not have adequate resources to review the genetic counseling program.

#6 Assign Specific Responsibility for Prevention of Mental Retardation.

Prevention of mental retardation has received greater emphasis. The subcommittee recognizes the importance of prevention in mental retardation, but does not believe that further legislative intervention is appropriate at this time. The division presently has a federal grant to provide preventative services.

#7 Establish Health and Developmental Screening of New School Enrollees.

See subcommittee's recommendation number 12.

#8 Improve Medicaid Early Screening and Followup.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. However, the subcommittee reiterates its belief that resources are most efficiently allocated to prevention programs. See subcommittee's recommendation number 12.

#9 Expand Special Children's Clinics' Mental Retardation Diagnostic Services.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 12.

#10 Provide Behavioral and Psychological Screening Once for Each Young School Child.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 12.

#11 Screen High-Risk Groups for Mental Health Disorders.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 12.

#12 Increase the Number of Special Education Units Funded.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#13 Allocate Special Education Funds by Specific Handicap and Enforce Current Standards.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#14 Increase State Special Education Technical Advisory Staff and Provide Technical Assistance to Rural Counties.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#15 Provide Appropriate Special Education and Training to Mentally Retarded Nevada Mental Health Institute (NMHI) Residents.

The Division of Mental Hygiene and Mental Retardation advises that, "The Grayberry School, located on the Institute's grounds, has provided an educational program to all residential clients between the ages of 3 and 18 years since September, 1976." The subcommittee had no way of evaluating this program. Testimony received by the subcommittee suggests that existing programs, particularly for adults, are inadequate. However, the subcommittee had insufficient resources to extend its study into this area.

#16 Revise Preschool Program Focus in Community Training Centers.

The Division of Mental Hygiene and Mental Retardation advises as follows:

"Preschool programs now exist in Panaca, Hawthorne, Elko, Carson City, and Yerington. Rural CTC's still serve preschoolers between the ages of 3 and 5 years because the school districts are not mandated to serve this age group. The Reno and Las Vegas CTC programs continue to serve preschoolers in conjunction with Special Children's Clinics.

Presently there is no emphasis being given to meet this recommendation. However, it will be federally mandated that school districts begin serving handicapped children between the ages of 3 and 21 years in 1980."

The subcommittee heard testimony from the Nevada Department of Education concerning problems in implementing this federal mandate.

The subcommittee makes no recommendation in this area.

#17 Revise Preschool Program Focus in Special Children's Clinics.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 12.

#18 Increase Referrals from Schools to Other Service Agencies.

The subcommittee believes that the coordination of "human services programs" in Nevada is inadequate. This often results in inefficient and ineffective services. However, this recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#19 Obtain Better Information on Special Education and Training Programs.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#20 Fill Authorized Professional Staff Positions at the Las Vegas Mental Health Center.

The Division of Mental Hygiene and Mental Retardation advises that this recommendation has been accomplished.

#21 Provide 24-hour-a-day Emergency Crisis-Intervention Service in Mental Health Centers and Rural Clinics.

The Division of Mental Hygiene and Mental Retardation advises that, "Twenty-four-hour-a-day emergency-crisis service is currently provided in Clark and Washoe Counties and will be provided by Rural Clinics, with the new Federal Operations Grant."

#22 Upgrade Rural Mental Health Staff, and Add Part-time Traveling Service Teams Based at NMHI.

The NIMH staffing grant to Rural Clinics has changed the nature of services and increased the staff beyond this recommendation. The recommendation of the Rand Corporation may have been a more economical and efficient way to expand services.

#23 Increase Rural Clinics Efforts for People with Substantial Mental Health Disorders.

See Rand recommendation number 22.

#24 Establish a Second Community Mental Health Center in Clark County.

The subcommittee has recommended that current programs first be consolidated and provided with better administrative direction as a part of overall reorganization of

#24 (Continued)

the Division of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 5.

#25 Expand the Reno Mental Health Center into a Full Community Mental Health Center.

The subcommittee has recommended that current programs first be consolidated and provided with better administrative direction as a part of overall reorganization of the Division of Mental Hygiene and Mental Retardation. See subcommittee's recommendation number 5.

#26 Revise the Las Vegas Children's Behavioral Services Staff and the Service Focus.

The subcommittee has been told that this program has changed substantially since 1974 and that this recommendation no longer is applicable. However, the subcommittee's task force advised, "The services and treatments available to children should be broadened. Special efforts should be made to explore the potential contributions that might be made by child psychiatrists and child psychologists who do not have a behavior modification orientation. Recruitment of new professional personnel should emphasize selection of individuals with a variety of viewpoints."

This problem does not seem amenable to legislative intervention. It can be summarized that a stronger Mental Hygiene and Mental Retardation Advisory Board and a qualified division administrator would alleviate this frequent criticism.

#27 Provide Mental Health Services to Mentally Retarded People, if Needed.

The Division of Mental Hygiene and Mental Retardation advises that, "Essentially, there has been no change in this area since the Rand Study. Individual cases are treated, but the problem still exists." See subcommittee's recommendation number 15.

#28 Establish an Upgraded Mental Technician Personnel Classification and a University-Based Training.

The Division of Mental Hygiene and Mental Retardation has stated the following:

"The division is studying the generalist series and a career ladder for mental health workers. A number of other states have been contacted regarding their personnel classification of mental health workers. The mental health personnel system in Illinois appears to be one of the best and we will probably pattern our mental health worker series after theirs. This does not entail the upgrading of mental health worker positions to Masters degree level as recommended by the Rand Report. This would be too costly and is unnecessary."

The subcommittee concurs in the goals of the division but believes that the division administration has been negligent in its failure to implement these goals. This program should be one of the top priorities of the division. (See subcommittee's recommendation number 21.)

#29 Provide Specified Staff Mix and Client Focus in Children's Behavioral Services Residential Programs.

See Rand Report Recommendation number 26. Without question, there are gaps in services.

#30 Correct Major Deficiencies in Mental Health Services Noted in the NMHI Accreditation Report.

These problems still exist. The subcommittee has recommended reorganization of and new leadership for the Division of Mental Hygiene and Mental Retardation.

#31 Improve Follow-Up Treatment of People Released from Residential Mental Health Programs.

The Division of Mental Hygiene and Mental Retardation advises as follows:

#31 (Continued)

"The Nevada Mental Health Institute; the Las Vegas Mental Health Center; the Children's Behavioral Services, Clark County and the Children's Behavioral Services, Washoe County now have follow-up programs for clients released from residential services. The Institute utilizes three community liaison staff and Las Vegas Mental Health Center has an after-care unit staffed with four personnel."

The subcommittee's task force reported that what little follow-up is provided "is not only inadequate, but is frequently incomplete."

The subcommittee has recommended reorganization of the division and its various agencies to provide better coordination of services.

#32 Create Programs to Provide an Intermediate Level of Mental Health Services Over an Extended Time Period for Children and Adults.

The Division of Mental Hygiene and Mental Retardation advises as follows:

"In conjunction with Nevada State Welfare, the Las Vegas Mental Health Center, Henderson Mental Health Center and Children's Behavioral Services, Clark County have formed a community-based group home consortium. The community-based group homes of Southern Nevada Group Home Consortium provide a less restrictive residential treatment option for youth who have been placed in an institutional environment but no longer need that environment and whose behavioral history indicates that they are not yet ready to return to their natural or foster homes, and for youths who are currently residing in their natural or foster homes but whose behavioral history indicates that they need a structured residential treatment program. The consortium is quite similar in procedure and intent to the Oasis Residential Program at Children's Behavioral Services, Clark County. The consortium program differs in that it provides longer term treatment in a more natural surrounding.

"Each of the four community-based group homes serves four youths. These youths are referred from CBS, the Las Vegas Mental Health Center and Henderson Mental Health Center. Three homes serve boys and one home

#32 (Continued)

serves girls. One home serves boys who range in age from 5 through 12; two of the other boy's homes serve youth who range in age from 13 through 17; the girl's home serves youth who range in age from 5 through 17. The youth live for a period of from 8 to 12 months with a professionally trained teaching parent couple.

"The Reno Mental Health Center operates Achievement Place West with accommodations for six adolescents; two additional adolescent placements are available on a short-term basis."

The subcommittee recommends the establishment of transitional and group care facilities for adolescents and adults. (See subcommittee's recommendation number 26.)

#33 Establish Halfway Houses for People with Mental Health Disorders.

The Division of Mental Hygiene and Mental Retardation advises as follows:

"At the Nevada Mental Health Institute, Building 11 was recently remodeled to provide a transitional living unit for persons not ready to assume complete independent living off campus, but who are beyond the need for a highly supervised living environment. This unit has a capacity for 16 clients. The Institute also has a day care program.

"The Las Vegas Mental Health Center has been notified that National Institute of Mental Health funding for a transitional unit has been approved as of April 1, 1978. The transitional home will provide a level of residential care between the highly structured psychiatric hospital and independent community living. This level of care currently does not exist in Clark County. The primary target group for the program is the group of clients released from the 24-hour residential care at the Las Vegas Mental Health Center and/or Clark County residents released from the Nevada Mental Health Institute. The facilities will accommodate 16 clients." (See subcommittee's recommendation number 26 and Rand Report recommendation number 32.)

#34 Restrict Use of Mentally Disordered Offender Facility to Prisoners.

The subcommittee recommends that the Lake's Crossing Facility should be used only for persons who have been in contact with the criminal justice system. This restriction is sometimes breached because of the lack of a secure facility for persons severely disturbed but not in the criminal justice system. (See subcommittee's recommendation number 25.)

#35 Provide Specified Mental Health Services in Nevada State Prison.

The Rand Report "suggests" that increased mental health staff positions to serve prisoners be under the administrator of the Mentally Disordered Offender facility rather than under the sole supervision of the warden.

Increases in staff are being provided within the prison system. The subcommittee did not weigh the merits of placement of administrative responsibility.

#36 Provide a Physically Secure Mental Health Unit at NMHI.

The subcommittee strongly recommends that a secure unit be established at the NMHI to serve the severely disturbed from throughout the state. (See subcommittee's recommendation number 25.)

#37 Revise the Role of NMHI to fulfill Four Specified Functions.

The subcommittee's task force made a similar recommendation. The Division of Mental Hygiene and Mental Retardation has stressed community services during recent years, apparently to the detriment of inpatient programs at the Nevada Mental Health Institute.

#38 Obtain Better Information on Mental Health Programs.

The report of the subcommittee's task force, chapter 7, points out a lack of management information and conflicts

#38 (Continued)

in data reported. The subcommittee has made recommendations for management changes that will facilitate a better management information system.

#39 Improve the NMHI Mental Retardation Program to Meet JCAH Accreditation Standards.

The Division of Mental Hygiene and Mental Retardation comments as follows:

"The Sierra and Desert Developmental Centers are pursuing JCAH accreditation by December, 1978. Separation of mental retardation services (SDC) from the Institute in July, 1977, and transfer of clients to the DDC were significant milestones in the accreditation process."

The subcommittee concluded that the increased resources provided mental retardation programs during the past 4 years has had a significant impact on the quality of care to mentally retarded clients. The subcommittee believes that a failure by the division to obtain JCAH accreditation prior to January 1, 1980, can only be attributed to the quality of administration within the division.

#40 Do not Reduce Existing NMHI Mental Retardation Staff Size when Desert Developmental Center Opens.

The staff was not reduced.

#41 Provide the Equivalent of the Desert Developmental Center Services to Northern Nevadans, but Defer Major Facility Construction.

Similar services are available in the north and a new northern facility is under construction.

#42 Consolidate State Mental Retardation Program Control by Removing Control of Mental Retardation Services from the NMHI Director.

This has been done.

#43 Improve Training of State "Technicians" Serving Mentally Retarded People.

The 1977 Legislature provided substantially more money for training during fiscal years 1977-1979. However, the division has failed to implement adequate training programs. (See subcommitttee's recommendation number 21.)

#44 Expand Special Education and Training, as Appropriate, for Eagle Valley Children's Home Residents.

The subcommittee believes that the division should provide assistance to the administration of the Eagle Valley Children's Home in developing needed educational and training programs.

#45 Provide Special Services to Mentally Retarded Prisoners.

The subcommittee did not look into this problem. The Division of Mental Hygiene and Mental Retardation advises as follows:

"An LEAA grant was written to screen the prison population and design programs, including release, but the grant was denied. A Region IX Developmental Disabilities grant was written to provide five workshops to law enforcement officers for the purpose of acquainting them with mental retardation and the law. Four workshops were held in northern Nevada and the other one is scheduled to be held in southern Nevada this spring. Participants included judges, policemen, probation officers and attorneys. A second LEAA grant to aid mentally retarded offenders is being prepared.

#46 Obtain Better Information on Mental Retardation Programs.

Comments of the Division of Mental Hygiene and Mental Retardation are as follows:

"The Pomona Data Base System is still in operation and has been expanded to include all division facilities serving mentally retarded individuals. There are approximately 600 mentally retarded individuals currently in the system. It has not been expanded to agencies as recommended nor has it been relocated in Nevada. The data is not totally accurate and the system has not completely served the purpose for which it was intended."

The subcommittee made extensive recommendations concerning a management information system within the division, and the need for a procedure to measure the quality of the division programs. (See subcommittee's recommendation number 3.)

#47 Obtain Better Information on Alcohol and Drug Abuse Programs and Prevalence Rates.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation. However, the need for information system and program evaluation systems appear critical throughout state government.

#48 Streamline the Organizational Structure for Alcohol and Drug Abuse Programs.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#49 Create a Comprehensive Alcohol Abuse Treatment Program for the Las Vegas Area.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#50 Provide Alcohol and Drug Detoxification Services Throughout Nevada.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#51 Establish Rehabilitation Houses for Rural Alcohol and Drug Abusers.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#52 Establish a Full Inpatient Treatment Program for Drug Abusers.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#53 Provide Specified General Vocational Services in Rural Areas, with Short-Term more Specialized Services in Urban Areas for Rural Residents.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#54 Double the Community Training Center Minimum Funding per Client.

Money has been provided for increases. However, the subcommittee believes that present funding remains inadequate. (See subcommittee's recommendation number 16.)

#55 Consolidate the Vocational Training Program with Specified Vocational Program.

The subcommittee did not review this recommendation. The Division of Mental Hygiene and Mental Retardation comments follow:

"The recommended organizational change was accomplished in the spring of 1977. The vocational training programs operated by the division were taken over by private industry. Two additional supervised sheltered workshops were established in Reno. These programs work in cooperation with the Rehabilitation Division."

#56 Provide Vocational Education for Emotionally Disturbed Youth.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#57 Increase Referrals from Employment Security to the Vocational Rehabilitation Program.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#58 Obtain Better Information on Vocational Service Programs.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#59 Increase Referrals from Nonvocational to Vocational Service Programs.

The subcommittee did not review this area. Comments of the Division of Mental Hygiene and Mental Retardation are as follows:

#59 (Continued)

"This recommendation, of course, involves other agencies too. However, adult clients being referred to the maximum CTCs are referred to Vocational Rehabilitation prior to placement. Additionally, adult clients in the SDC and DDC are involved in Vocational Rehabilitation Programs. Three new CTCs providing adult vocational services were established and current CTC enrollment statewide is 350."

#60 Expand the Vocational Rehabilitation Program or Shift the Caseload Emphasis to Serve more Severely Handicapped Clients.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#61 Study the Effects of Mandatory Mental Health and Mental Retardation Service Coverage in Private Health Insurance.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#62 Supplement State-Operated Program Funds by Billing Private and Public Health Insurance to Extent Feasible.

The Division of Mental Hygiene and Mental Retardation states that, "This recommendation is currently being accomplished." The reorganization recommended by the subcommittee should facilitate this.

#63 Double the Size of the Developmental Home and Sheltered Apartment Living Programs.

According to the division, these services have been expanded.

#64 Establish Standards for Developmental Homes and Sheltered Living Apartments.

Standards have been developed by the Department of Human Resources.

#65 Consolidate Developmental Home Supervision Responsibility.

The response of the Division of Mental Hygiene and Mental Retardation is as follows:

"Consolidation of the group and developmental home program was accomplished in July, 1977, with the regionalization of mental retardation services. Developmental home program responsibilities have been assigned to the Community Service coordinators in each region."

#66 Implement Standards and Supervision for Foster Homes and Adult Group Care and Family Care Facilities Serving Mentally Handicapped People.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#67 Refer Mentally Handicapped Foster Children for Services as Appropriate.

The reorganization proposed by the subcommittee will improve coordination with other agencies.

#68 Screen Residents of Youth Services Agency Facilities for Mental Handicaps, Followed by Services as Appropriate.

The division has recently been instructed by the Director of the Department of Human Resources to provide additional mental health services to these programs.

#69 Identify Financial Assistance Recipients with Mental Handicaps, and Refer for Services as Appropriate.

The Department of Human Resources does not have a client tracking system. Though not within the scope of this study, the subcommittee believes that a comprehensive management information system should be established throughout the human services programs.

#70 Transfer Mentally Handicapped Aid to Dependent Children Recipients to the Supplemental Security Income Program, if they Qualify.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

#71 Provide a State Supplement to the SSI Payments to Mentally Handicapped People.

This recommendation does not fall within the scope of the Study of the Administration of Mental Hygiene and Mental Retardation.

APPENDIX B

PROGRAMS OF THE DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Mental Hygiene and Mental Retardation Administration is the central administrative staff of the division.

Number of Positions: 9

Nevada Mental Health Institute provides inpatient and outpatient mental health programs.

Number of Positions: 251
Number of Beds: 157
Programs and Services:
- -General Neuropsychiatric (3 housing units with 16 beds each)
- -Geriatric (16-bed ward)
- -Alcohol and substance abuse (28-bed alcohol ward)
- -Industrial therapy program
- -Family support project
- -Genetics Laboratory
- -Transitional living unit (14 beds)
- -Medical unit (16 beds)
- -Back-up unit (35 beds in old ward not in use)
- -Space provided for:
  - Adult basic education program run by Washoe County - G.E.D. can be earned by clients.
  - Rehabilitation Division personnel.
  - Sierra Developmental Center - mental retardation patients will be moved to the new facility approved for construction by the 1977 Legislature.
  - Neuroscience - a nonprofit group conducting research and staff education.
- -NEON (New Employment Opportunities for Nevadans) - Sheltered workshop
- -Senior Companion Program
- -Occupational and recreational therapy

Reno Mental Health Center provides nonresident mental health treatment programs.

Number of Positions: 24.5
Programs and Services:
- -Nonresidential treatment for adults
- -Nonresidential treatment for adolescents
- -Day-care treatment for adolescents
- -Runaway youth shelter program
- -Transitional homes for adolescents

Children's Behavioral Services, Washoe County provides residential and outpatient mental health services for children under the age of 13.

Number of Positions: 32
Number of Beds: 16
Programs and Services:
-Clinical services for children and families
-Education services
-Evaluation, research and medical services

Lake's Crossing Center for the Mentally Disordered Offender is a residential mental health treatment facility.

Number of Positions: 43
Number of Beds: 32
Programs and Services:
-Treatment in secure facility
-Bed capacity - 3 wings each having 9 regular beds, plus 1 security room. Two additional security rooms provided in the medical facility.

Rural Clinics provides rural mental health services under the concept of comprehensive community mental health center.

Number of Positions: 97.4
Programs and Services:
-A new federal grant is providing for expansion of the mental health services provided to rural Nevada to include the 12 basic community mental health services required by federal guidelines. New services to be provided to the rural areas include inpatient, partial hospitalization, transitional care, follow-up services, and specialized elderly services. The services would be provided and administered in accordance with both state and federal regulations for community mental health centers.

Las Vegas Mental Health Center is a community mental health center providing inpatient and outpatient mental health programs.

Number of Positions: 144
Number of Beds: 44
Programs, Services and Facilities:
-Westside Counseling Center (satellite program)
-Emergency services
-Inpatient adult services
-Outpatient adult services
-Adolescent residential services
-Adolescent outpatient services

Programs, Services and Facilities: (Continued)
-Family care homes
-Adolescent group homes
-Adult day program
-Activity therapy
-Adult aftercare
-Adolescent aftercare
-Community and special services
-Food service provided to Children's Behavioral Services and Desert Developmental Centers
-Participates in community group home program with Children's Behavioral Services and Henderson Mental Health Center

Children's Behavioral Services, Clark County provides residential and outpatient mental health services for children under the age of 13.

Number of Positions: 36
Number of Beds: 16
Programs and Services:
-Clinical services for children and families
-Education services
-Evaluation, research and medical services
-Participates in community group home program with Las Vegas Mental Health Center
-C.B.S. Model Orthogenic Development program - Clark County School District reimburses C.B.S. for the salaries of 3 teachers and 3 teacher aides located at C.B.S.

Henderson Mental Health Center provides nonresident mental health treatment programs.

Number of Positions: 16.5
Programs, Services and Facilities:
-Neighborhood offices, Henderson and North Las Vegas and Paradise Valley
-Outreach services in unincorporated areas and Boulder City
-Nonresidential treatment for adults
-Nonresidential treatment for adolescents
-Residential community homes for adolescents
-Education and training
-Participates in community group home program with C.B.S. and Las Vegas Mental Health Center

Mental Retardation Administration is the administration of Nevada's mental retardation programs.

Number of Positions: 34.5

Programs and Facilities:
- -Desert Developmental Center (Southern Nevada)
- -Sierra Developmental Center (Northern Nevada)
- -Mental Retardation Foster Home program and residential placement
- -Community Training Centers
- -Community Awareness program
- -Retired Senior Volunteer program
- -Foster Grandparent program
- -Senior Companion program

Sierra Developmental Center is the consolidation of northern Nevada's mental retardation services.

Number of Positions: 112.5
Number of Beds: 99
Programs and Services:
- -Shelter, treatment and training
- -Outpatient programs
- -Community programs

Desert Developmental Center is the consolidation of southern Nevada's mental retardation services.

Number of Positions: 108
Number of Beds: 72
Programs and Services:
- -Shelter, treatment and training
- -Outpatient programs
- -Community programs

APPENDIX C

DIVISION OF MENTAL HYGIENE & MENTAL RETARDATION
FULL-TIME EQUIVALENT POSITIONS, AUGUST, 1978

Budget	FTE Positions
Division of Mental Hygiene & Mental Retardation	9
Nevada Mental Health Institute	248
Family Support Project - Mental Health Institute	3
Reno Mental Health Center	22.5
Reno Mental Health Transitional Homes	2
Lake's Crossing Facility	43
CBS - Washoe	32
Las Vegas Mental Health Center	144
Henderson Mental Health Center	16.5
CBS - Clark	36
Rural Clinics	97.4
Mental Retardation	9
Community Awareness Project	21
Community Training Center Fund	1.0
Community Relevant Planning	3.5
Sierra Developmental Center	112.5
Desert Developmental Center	108
	908.4

Source: Nevada State Department of Administration, Personnel Division Position Roster of 8/8/78.

TABLE I

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
OPERATING APPROPRIATIONS AND AUTHORIZATIONS

	1971 Legislature		1973 Legislature		1975 Legislature		1977 Legislature	
	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79
ADMINISTRATION								
Division Administration								
General Fund	$ -0-	$ -0-	$ 210,649	$ 178,926	$ 248,335	$ 232,130	$ 312,644	$ 310,609
Federal Funds	-0-	-0-	-0-	-0-	-0-	19,533	-0-	-0-
	$ -0-	$ -0-	$ 210,649	$ 178,926	$ 248,335	$ 251,663	$ 312,644	$ 310,609
MENTAL HEALTH PROGRAMS*								
Mental Health Institute								
General Fund	$3,583,274	$3,660,516	$4,154,498	$4,259,751	$ 5,211,404	$ 5,343,175	$ 4,683,059	$ 4,799,078
Federal Funds	131,000	131,000	123,963	123,803	-0-	-0-	-0-	-0-
Other Funds	222,844	222,844	225,000	225,000	261,670	265,837	105,000	105,000
	$3,937,118	$4,014,360	$4,503,461	$4,608,554	$ 5,473,074	$ 5,609,012	$ 4,788,059	$ 4,904,078
Institute Land Exchange								
Other	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 420,343	$ -0-
Reno Mental Health								
General Fund	-0-	-0-	349,642	371,437	433,368	436,780	502,557	510,702
Federal Funds	-0-	-0-	-0-	-0-	30,000	30,000	35,800	35,800
Other	-0-	-0-	7,000	7,000	15,000	15,000	21,500	23,000
	$ -0-	$ -0-	$ 356,642	$ 378,437	$ 478,368	$ 481,780	$ 559,857	$ 569,502
C.B.S. Washoe								
General Fund	$ -0-	$ -0-	$ -0-	$ -0-	$ 81,097	$ 76,669	$ 497,492	$ 434,615
Federal Funds	-0-	-0-	-0-	-0-	-0-	-0-	125,000	200,000
Other	-0-	-0-	-0-	-0-	-0-	-0-	33,750	45,000
	$ -0-	$ -0-	$ -0-	$ -0-	$ 81,097	$ 76,669	$ 656,242	$ 679,615
Lake's Crossing Facility								
General Fund	$ -0-	$ -0-	$ -0-	$ 149,375	$ 552,127	$ 570,244	$ 778,670	$ 796,901
Rural Clinics								
General Fund	$ 204,724	$ 205,639	$ 215,986	$ 237,556	$ 401,205	$ 416,842	$ 584,820	$ 623,265
Federal Funds	65,000	65,000	196,472	181,864	148,425	145,922	138,056	138,056
Other	-0-	-0-	-0-	-0-	9,000	9,000	10,000	11,000
	$ 269,724	$ 270,639	$ 412,458	$ 419,420	$ 558,630	$ 571,764	$ 732,876	$ 772,321

	1971 Legislature		1973 Legislature		1975 Legislature		1977 Legislature	
	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79
L. V. Mental Health								
General Fund	$ 884,649	$ 901,100	$ 913,755	$ 954,674	$ 898,188	$ 1,114,911	$ 1,483,529	$ 1,380,060
Federal Funds	20,000	20,000	-0-	-0-	834,815	666,868	823,224	990,381
Other	-0-	-0-	20,000	20,000	62,600	62,600	448,697	546,712
	$ 904,649	$ 921,100	$ 933,755	$ 974,674	$ 1,795,603	$ 1,844,379	$ 2,755,450	$ 2,917,153
C.B.S. - Clark								
General Fund	$ -0-	$ -0-	$ 178,176	$ 266,046	$ 410,685	$ 406,962	$ 502,583	$ 534,715
Federal Funds	-0-	-0-	129,748	171,881	172,428	179,267	207,000	207,700
Other	-0-	-0-	-0-	-0-	45,000	45,000	45,000	45,000
	$ -0-	$ -0-	$ 307,924	$ 437,927	$ 628,113	$ 631,229	$ 754,583	$ 787,415
C.B.S. - Ed. Program								
Other	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 74,325	$ 78,108
Clark County Group Homes								
Federal Funds	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 250,000	$ 271,053
Henderson Mental Health								
General Fund	$ -0-	$ -0-	$ 129,408	$ 128,422	$ 180,165	$ 184,329	$ 276,108	$ 278,268
Federal Funds	-0-	-0-	-0-	-0-	-0-	-0-	68,730	68,350
Other	-0-	-0-	-0-	-0-	23,335	23,668	11,850	14,220
	$ -0-	$ -0-	$ 129,408	$ 128,422	$ 203,500	$ 207,997	$ 356,688	$ 360,838
Subtotal M. H. Programs								
General Fund	$4,672,647	$4,767,255	$5,941,465	$6,367,261	$ 8,168,239	$ 8,549,912	$ 9,308,818	$ 9,357,604
Federal Funds	216,000	216,000	450,183	477,548	1,185,668	1,022,057	1,647,810	1,911,340
Other	222,844	222,844	252,000	252,000	416,605	421,105	1,170,465	868,040
	$5,111,491	$5,206,099	$6,643,648	$7,096,809	$ 9,770,512	$ 9,993,074	$12,127,093	$12,136,984

	1971 Legislature		1973 Legislature		1975 Legislature		1977 Legislature	
	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79
MENTAL RETARD. PROGRAMS								
Mental Retardation								
General Fund	$ 533,149	$ 563,988	$ 621,793	$ 679,951	$ 767,366	$ 804,316	$ 221,958	$ 226,104
Federal Funds	-0-	-0-	108,495	108,237	130,848	130,848	-0-	-0-
Other	10,000	10,000	-0-	-0-	-0-	-0-	-0-	-0-
	$ 543,149	$ 573,988	$ 730,288	$ 788,188	$ 898,214	$ 935,164	$ 221,958	$ 226,104
Sierra Develop. Center								
General Fund	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 1,640,168	$ 1,683,295
Federal Funds	-0-	-0-	-0-	-0-	-0-	-0-	142,880	143,880
	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 1,783,048	$ 1,827,175
Desert Develop. Center								
General Fund	$ -0-	$ -0-	$ -0-	$ -0-	$ 72,582	$ 89,128	$ 1,095,902	$ 1,142,212
Federal Funds	-0-	-0-	-0-	-0-	-0-	-0-	478,160	479,160
	$ -0-	$ -0-	$ -0-	$ -0-	$ 72,582	$ 89,128	$ 1,574,062	$ 1,621,372
Resident Placement								
General Fund	$ -0-	$ -0-	$ -0-	$ -0-	$ 60,000	$ 117,200	$ 61,831	$ 106,187
Federal Funds	-0-	-0-	-0-	-0-	108,000	118,000	249,258	312,918
Other	-0-	-0-	-0-	-0-	-0-	-0-	60,000	60,000
	$ -0-	$ -0-	$ -0-	$ -0-	$ 168,000	$ 235,200	$ 371,089	$ 479,105
Community Train. Center								
General Fund	$ 200,000	$ 250,000	$ 250,000	$ 250,000	$ 395,947	$ 452,122	$ 494,030	$ 556,624
Federal Funds	25,000	25,000	75,000	75,000	75,000	75,000	209,523	240,300
	$ 225,000	$ 275,000	$ 325,000	$ 325,000	$ 470,947	$ 527,122	$ 703,553	$ 796,924
Foster Grandparents								
General Fund	$ -0-	$ -0-	$ -0-	$ -0-	$ 31,160	$ 31,324	$ 39,240	$ 39,050
Federal Funds	-0-	-0-	-0-	-0-	148,000	148,000	185,552	186,938
	$ -0-	$ -0-	$ -0-	$ -0-	$ 179,160	$ 179,324	$ 224,792	$ 225,988

	1971 Legislature		1973 Legislature		1975 Legislature		1977 Legislature	
	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79
Community Awareness								
Federal Funds	$ -0-	$ -0-	$ 90,275	$ 97,181	$ 144,469	$ 149,625	$ 225,670	$ 234,740
Other	-0-	-0-	-0-	-0-	-0-	-0-	19,000	19,000
	$ -0-	$ -0-	$ 90,275	$ 97,181	$ 144,469	$ 149,625	$ 244,670	$ 253,740
Retired Srs. Volunteers								
Federal Funds	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-	$ 53,027	$ 58,340
Community Relevant Plng.								
Federal Funds	$ -0-	$ -0-	$ -0-	$ -0-	$ 48,758	$ 50,928	$ -0-	$ -0-
Subtotal M. R. Programs								
General Fund	$ 733,149	$ 813,988	$ 871,793	$ 929,951	$ 1,327,055	$ 1,494,090	$ 3,553,129	$ 3,753,472
Federal Funds	25,000	25,000	273,770	280,418	655,075	672,401	1,544,070	1,656,276
Other	10,000	10,000	-0-	-0-	-0-	-0-	79,000	79,000
	$ 768,149	$ 848,988	$1,145,563	$1,210,369	$ 1,982,130	$ 2,166,491	$ 5,176,199	$ 5,488,748
Total M.H./M.R. Programs								
General Fund	$5,405,796	$5,581,243	$7,023,907	$7,476,138	$ 9,743,629	$10,276,132	$13,174,591	$13,421,685
Federal Funds	241,000	241,000	723,953	757,966	1,732,743	1,595,991	3,191,880	3,567,616
Other	232,844	232,844	252,000	252,000	524,605	539,105	1,249,465	947,040
Grand Total	$5,879,640	$6,055,087	$7,999,860	$8,486,104	$12,000,977	$12,411,228	$17,615,936	$17,936,341

* The Mental Health Institute budgets for fiscal years 1971 through 1973 included administration of all programs. The fiscal years 1971 through 1977 budgets included a mental retardation ward.

TABLE II

CAPITAL IMPROVEMENTS
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

Approved 1971 Legislative Session		Authorized or Appropriated
Project 71-HE-1	Remodel and repair nine buildings--Mental Health Institute	$ 1,000,000
Project 71-HE-2	Construct central supply building--Mental Health Institute	159,300
Project 71-HA-1	Site development--Las Vegas Mental Health Center (General Fund: $101,200, Federal: $73,320)	174,520
Total - 1971 Capital Improvements	General Fund: $1,260,500 Federal Funds: $ 73,320	$ 1,333,820

Approved 1973 Legislative Session		
Project 73-2	Construct CBS Clark--a 16-bed inpatient facility with outpatient unit including offices, classrooms, therapy rooms and observation rooms. (Interim Finance: $170,876)	$ 1,160,876
Project 73-3	Construct Lake's Crossing--a 32-bed security facility including individual rooms and visiting, exercise, class and therapy rooms. (Interim Finance: $587,374)	1,815,374
Project 73-9	Construct 1,000 sq. ft. storage facility and 10 additional offices--Las Vegas Mental Health Center. (General Fund: $219,400, Federal: $100,000)	319,400
Project 73-11	Phase I--Mental Health Institute--includes remodeling and improvements to the geriatrics building, neuropsychiatric wards (Bldgs. 3 and 4), Mental Retardation building, central heating plant, adolescent day care (Bldg. 6), children's ward (Bldg. 7) and grounds improvements.	990,000

Approved 1973 Legislative Session (Continued)		Authorized or Appropriated
Project 73-16	Phase II--Mental Health Institute--includes air conditioning and renovation of the heating systems in the administrative building (Bldg. 1), commissary (Bldg. 10), Rural Clinics and Mental Retardation (Bldg. 11), carpeting in Bldg. 11 and enclosed entry to the commissary.	408,000
Total - 1973 Capital Improvements General Fund: $4,593,650 Federal Funds: $ 100,000		$ 4,693,650

Approved 1975 Legislative Session		
Project 75-17	Construct Desert Developmental Center--includes facilities for 48 inpatients and outpatient/day care facilities.	$ 2,494,800
Project 75-19	Construct CBS - Washoe--includes two residential units for 16 inpatients and a classroom outpatient facility.	1,450,800
Project 75-20	Site development Mental Health Institute--includes landscaping, security lights and parking lot.	675,000
Project 75-21	Improvements--Mental Health Institute--includes carpeting buildings 3, 4, 7, 8, 9 and 10 and new furniture and equipment and air conditioning for building 10.	540,900
Project 75-22	Construct day activities facility--Mental Health Institute--a 5,700 sq. ft. building which includes a meeting room, group therapy room, patient store, lounge, and beauty and barber shops.	391,500
Project 75-34	Construct inpatient facility--Mental Health Institute--includes three buildings each accommodating 16 inpatients.	1,335,600
Project 75-35	Renovate building 11--Mental Health Institute--changes facility to a 16 patient self-supervised transitional living unit.	135,900

Approved 1975 Legislative Session (Continued)		Authorized or Appropriated
Project 75-G1	Construct kitchen facility--Las Vegas Mental Health Center. (General Fund: $310,011, Federal: $178,470)	488,481
Total - 1975 Capital Improvements	General Fund: $7,334,511 Federal Funds: $ 178,470	$ 7,512,981

Approved 1977 Legislative Session		
Project 77-4	Construct Sierra Developmental Center--includes five buildings for mentally retarded children and adults, inpatient facilities for 48 clients.	$ 1,649,000
Project 77-14	Miscellaneous improvements--Mental Health Institute including, renovated electrical services, paging system, new central heating equipment, painting five buildings, genetics lab in building 3, new roof for building 7, repairs to building 6 and demolition of the farm and old warehouse buildings.	995,200
Total - 1977 Capital Improvements	General Fund: $2,644,200 Federal Funds: - 0 -	$ 2,644,200

Grand Total:	General Fund	$ 15,832,861
Grand Total:	Other Funds	351,790
Grand Total - Capital Improvement Funds Since 1971		$ 16,184,651

NEVADA APPENDIX D

STATE PERSONNEL DIVISION

MEMORANDUM

TO: Ed Schorr, Deputy Fiscal Analyst

FROM: Jim Wittenberg, Administrator

DATE: June 8, 1978

SUBJECT: Your request for information for the Sub-Committee on Mental Hygiene and Mental Retardation.

The justification for the State to pay the tuition for [redacted] is determined by agency administrators who exercise administrative discretion on the subject. The Board of Examiner's policy indicates the college credit course may be approved and paid for by the employer for course work which is work related or in keeping with career development.

This particular example does not constitute a common practice. The common practice involves course work credit not leading to a degree in areas that are considered job related.

The information that we have indicates that at least six other clerical employees within the Mental Hygiene/Mental Retardation agency had requested that the employer pay college credit. Of those six, four received approval.

The criteria for an employee to qualify is developed by the individual administrators and we were unable to get that information from the Division of Mental Health and Mental Retardation.

We were also unable to get the information requested regarding budget account 3168 in the Division of Mental Hygiene and Mental Retardation.

Attached are the copies of the TR-17 which you requested.

JFW/sm
Attachments

5. RECOMMENDED LEGISLATION

SUMMARY--Limits changes in personnel of executive agencies.
(BDR 31-211)
Fiscal Note: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to state financial administration; imposing conditions upon changes in the authorized numbers and grades of state employees; 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 353 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. As submitted to the legislature, the budget estimate for each agency of the executive department of the state government must contain a statement of the number of persons to be employed in that agency, arranged according to function in the same manner as other estimates of expenditure, and the grades of their respective positions if within the classified service of the state. As the budget is altered or approved by committees of the legislature, any change in these numbers or grades must be noted.

2. The head of an agency shall not change the number of permanent positions of employment within the agency, or the grade assigned to any such position, from the number or grade specified in the budget as finally approved unless the change is approved:

(a) By concurrent resolution of the legislature, if approval is requested during a regular session of the legislature.

(b) By the interim finance committee of the legislative counsel bureau, if approval is requested at any other time.

Sec. 2. NRS 353.215 is hereby amended to read as follows:

353.215 Subject to the further limitation imposed by section 1 of this act:

1. Not later than June 1 of each year the governor shall require the head of each department, institution and agency of the executive department of the state government to submit to him through the chief a work program for the ensuing fiscal year. Such program shall:

(a) Include all appropriations or other [funds] money from any source whatever made available to the department, institution or agency for its operation and maintenance and for the acquisition of property.

(b) Show the requested allotments of appropriations or other [funds] money by month or other period as the chief may require for the entire fiscal year.

2. The governor, with the assistance of the chief, shall review the requested allotments with respect to the work program of each department, institution or agency, and the governor shall, if he deems it necessary, revise, alter or change such allotments before approving [the same.] them. The aggregate of such allotments shall not exceed the total appropriations or other [funds] money from any source whatever made

available to the department, institution or agency for the fiscal year in question.

3. The chief shall transmit a copy of the allotments as approved by the governor to the head of the department, institution or agency concerned, to the state treasurer, to the state controller and to the fiscal analysis division of the legislative counsel bureau.

4. All expenditures to be made from the appropriations or other [funds] money from any source whatever shall be made on the basis of such allotments and not otherwise, and shall be broken down into such classifications as the chief may require.

Sec. 3. NRS 353.220 is hereby amended to read as follows:

353.220 Subject to the further limitation imposed by section 1 of this act:

1. The head of any department, institution or other agency of the executive department of the state government, whenever he [shall deem] deems it necessary by reason of changed conditions, may request the revision of the work program of his department, institution or agency at any time during the fiscal year, and submit such revised program to the governor through the chief with a request for revision of the allotments for the remainder of that fiscal year.

2. Every such request for revision shall be submitted to the chief on such form and with such supporting information as he may prescribe.

3. Prior to the encumbering of funds appropriated or authorized, every such request for revision [shall] must be approved or disapproved in writing by:

(a) The governor; or

(b) The chief, if the governor has by written instrument delegated this authority to the chief. Any such delegation may be revoked by written instrument.

SUMMARY--Reduces statutory designation of facilities of mental hygiene and mental retardation division of department of human resources. (BDR 39-105)
Fiscal Note: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental hygiene and mental retardation; reducing the statutory designation of separate facilities; 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 433.094 is hereby amended to read as follows:

433.094 [1.] "Division facility" means any unit or subunit operated by the division for the care, treatment and training of clients.

[2. The division facilities providing mental health services shall be known as:

(a) Nevada mental health institute;

(b) Las Vegas mental health center;

(c) Henderson mental health center;

(d) Reno mental health center;

(e) Rural clinics;

(f) Children's behavioral services; and

(g) Mentally disordered offender program.

3. The division facilities providing services for mentally retarded persons shall be known as:

(a) Northern Nevada mental retardation center;

(b) Southern Nevada mental retardation center;

(c) Nevada mental health institute; and

(d) Desert developmental center.

4. Division facilities established in the future shall be named by the administrator, subject to the approval of the director of the department.]

Sec. 2. NRS 433.114 is hereby amended to read as follows:

433.114 "Institute" means the Nevada mental health institute [.] <u>located in Sparks, Nevada.</u>

Sec. 3. NRS 433.254 is hereby amended to read as follows:

433.254 1. The administrator shall:

(a) Serve as the executive officer of the division;

(b) Make an annual report to the director of the department on the condition and operation of the division, and such other reports as the director may prescribe; and

(c) Employ, within the limits of available [funds] <u>money</u> and in accordance with the provisions of chapter 284 of NRS, the assistants and employees necessary to the efficient operation of the division.

2. The administrator shall appoint the administrative personnel necessary to operate the state mental hygiene and mental retardation programs, including [a clinic director for each mental health center,] the institute director for the Nevada mental health institute and an associate administrator for mental retardation. He shall delegate to the administrative

officers of division facilities the power to appoint medical, technical, clerical and operational staff necessary for the operation of their respective division facilities. Such appointments by administrative officers shall be made in accordance with the provisions of chapter 284 of NRS.

3. If the administrator finds that it is necessary or desirable that any employee reside at a division facility or receive meals at such facility, perquisites granted or charges for services rendered to such person shall be at the discretion of the governor.

4. The administrator may accept persons referred to the division for treatment pursuant to the provisions of NRS 458.290 to 458.350, inclusive.

SUMMARY--Limits acceptance of grants for mental hygiene and treatment of mental retardation. (BDR 39-210)
Fiscal Note: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental health and mental retardation; imposing conditions on the acceptance of grants; 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 433.394 is hereby amended to read as follows:

433.394 1. [For] Except as otherwise provided in subsection 2, for the purposes of this Title, the department may accept:

[1. Moneys] (a) Money appropriated and made available by any act of the Congress of the United States;

[2. Moneys] (b) Money and contributions made available by a county, a city, a public district or any political subdivision of this state; and

[3. Moneys] (c) Money and contributions made available by a public or private corporation, a private foundation, an individual or a group of individuals.

2. A grant which exceeds $50,000 may be accepted only if it is first approved:

(a) By concurrent resolution of the legislature, if the request for approval is made during or within 3 months before a regular session of the legislature.

(b) By the interim finance committee of the legislative counsel bureau if the request is made at any other time.

SUMMARY--Broadens access to clinical records of mental patients. (BDR 39-54)
Fiscal Note: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental health; authorizing certain persons to examine the original records of clients to evaluate the performance of 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. NRS 433A.360 is hereby amended to read as follows:

433A.360 A clinical record for each client shall be diligently maintained. The record shall include information pertaining to the client's admission, legal status, treatment and individualized habilitation plan. The clinical record [shall not be] is not a public record and no part of [shall] may be released, except:

1. The record may be released to physicians, attorneys and social agencies as specifically authorized in writing by the client, his parent, guardian or attorney.

2. The record shall be produced in response to a subpena or released to persons authorized by order of court.

3. The record or any part thereof may be disclosed to : [a] (a) A qualified staff member of a division facility or an employee of the division when the administrator deems it necessary for the proper care of the client.

(b) A qualified staff member of a division facility appointed

by the administrator or a qualified person appointed by a committee of the legislature or the legislative commission to evaluate the performance of the division.

flush The persons described in paragraphs (a) and (b) shall not identify, directly or indirectly, any individual client in any report of such evaluation, or otherwise disclose the identity of a client in any manner.

4. Information from the clinical records may be used for statistical and evaluation purposes if the information is abstracted in such a way as to protect the identity of individual clients.

5. To the extent necessary for a client to make a claim, or for a claim to be made on behalf of a client for aid, insurance or medical assistance to which he may be entitled, information from the records may be released with the written authorization of the client or his guardian.

Sec. 2. NRS 449.200 is hereby repealed.