STUDY OF THE DIVISION OF MENTAL HEALTH / MENTAL RETARDATION

Bulletin No. 91-14

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

SEPTEMBER 1990

STUDY OF THE DIVISION OF MENTAL HEALTH MENTAL RETARDATION

BULLETIN NO. 91-14

Legislative Commission
of the
Legislative Counsel Bureau
State of Nevada

August 1990

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Assembly Concurrent Resolution No. 52—Assemblymen Spinello and Myrna Williams

FILE NUMBER.199....

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

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

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

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

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

RESOLVED, That the results of the study and any recommended legislation be submitted to the 66th session of the Legislature.

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SUMMARY OF RECOMMENDATIONS

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

The subcommittee recommends:

1. Support, through the budget process, of a completed Mental Health/Mental Retardation Child and Adolescent Service System which would contain the following:

   A. Crisis intervention for children and their families (emotionally disturbed and mentally retarded).

   B. Family outreach services to bring professional support to families in crisis.

   C. Adequate day-treatment services including special classrooms when necessary.

   D. Community based residential services of a temporary nature until a disturbed/retarded child can return home, if possible.

   E. Adequate acute hospital beds for severely disturbed/retarded adolescents who require 24-hour awake professional care.

2. Support the construction of a sexual offender program (facility; minimum 12 beds) to be located in Clark County.

3. Support the construction of a facility to house mentally disturbed adolescent offenders, possibly forty to fifty beds, located in Clark County.

4. Require the Division of Mental Health and Mental Retardation to submit, as part of their budget request to the 1991 Legislative Session, a plan to eliminate all waiting lists.

5. Require all services, provided by MH/MR, or services contracted by MH/MR, to meet appropriate licensing standards. The Bureau of Health Facilities or the Nevada State Welfare Division or other appropriate regulatory agency should develop appropriate licensing standards for those facilities of the Division that currently do not have licensure standards.

6. Develop a policy containing standards for those contractors with whom MH/MR contracts for services. The contractor should also be required to complete background checks on all employees.

7. Increase in the number of school counselors in primary schools. This increase should begin with a ratio of 600:1 and phase in over six years to improve the ratio to 350:1. Each school district, regardless of size, should add at least one new counselor per district. Some districts currently do not provide counselor services to primary schools.

8. Require MH/MR to provide for the improvement of vocational and supported employment programs for the mentally ill. This may include establishing Community Training Center (CTC) programs for the mentally ill similar to those operated for the mentally retarded. (The subcommittee feels the involvement of and coordination between MH/MR and the Rehabilitation Division will provide a greater variety of services to Mental Health/Mental Retardation clients.)

9. Expansion of the Advanced Information Management System (AIMS) to rural and northern Nevada.

10. Direct MH/MR to adopt active caseload standards based upon the needs of the clients and the types of review required. The committee felt that an average caseload Division-wide of one case manager to 35 clients was reasonable, however, some types of services may require a higher ratio (in-patient) or lower ratio (clients living independently in the community). The MH/MR Division should report the ratio of case managers to clients by type of service to each session of the Legislature. (Provide current ratio, the number of additional case managers required, if any, and the cost of bringing the ratio back up to the standard.)

11. Improve the coordination of drug/alcohol services for MH/MR clients. One position should be allocated to the two major Mental Health/Mental Retardation campuses (one in Reno, one in Las Vegas) to help coordinate these services.

12. Direct MH/MR and the Rehabilitation Division to work with other private and public agencies to facilitate the development of medical detoxification programs in southern and northern Nevada.

13. Direct MH/MR to work with the CTC's, group homes and developmental homes to develop a payment formula which will more adequately reflect reasonable costs (i.e., funding for all days in which services are provided). The payment level should be based upon levels of care provided. The Division of MH/MR should present its recommendations in this area to the Budget Office and the Legislature.

14. Relocate the Office of Protection and Advocacy from reporting to the Director of the Department of Commerce to reporting directly to the Governor.

15. Allow MH/MR to hire and retain both board eligible and board certified psychiatrists. (Same as the rest of state government including the Department of Prisons.)

16. Expand funding for respite care for Mental Health/Mental Retardation clients by one additional week.

17. Direct the Bureau of Health Facilities to develop separate licensing standards for Intermediate Care Facilities-Mental Retardation Small (ICF-MR).

18. Support the continued development of specialized foster care for extremely disturbed children as a joint effort between the Division of Mental Health/Mental Retardation and the Welfare Division.

19. Require MH/MR to complete a needs assessment and report findings and recommendations to the 1993 Legislature. (Include appropriation to assist with study.) The MH/MR Division should have the necessary staff and programs to deal with the needs of the increased aged population in this state.

20. Support required training for employees of facilities to whom the Division of Mental Health/Mental Retardation contracts for services.

21. Encourage MH/MR and private care providers to work closely together to ensure a smooth transition for clients from private to state facilities, whenever possible. Discharge planning from private facilities should involve state staff when appropriate.

REPORT OF THE LEGISLATIVE COMMISSION
TO THE MEMBERS OF THE 66TH SESSION
OF THE NEVADA LEGISLATURE

This report is being submitted in compliance with Assembly Concurrent Resolution No. 52 of the 65th Session of the Nevada Legislature which directs the Legislative Commission to conduct an independent study of the Mental Hygiene and Mental Retardation Division of the Department of Human Resources.

The legislative members of the subcommittee were:

Assemblyman James J. Spinello, Chairman
Senate William R. O'Donnell, Vice Chairman
Assemblyman Robert E. Gaston Assemblyman James W. McGaughey
Assemblyman Vincent L. Triggs

Legislative Counsel Bureau staff services for the subcommittee were provided by Robert A. Guernsey of the Fiscal Analysis Division, Principal Staff, Gary Ghiggeri of the Fiscal Analysis Division, Jan Needham, of the Legal Division (Legal Counsel) and Connie Davis of the Fiscal Division (Subcommittee Secretary). In addition, Assemblywoman Myrna T. Williams served as an ex officio member of the subcommittee providing valuable input in developing the subcommittee recommendations.

The subcommittee held a total of five meetings and had two additional meeting days devoted to touring community mental health and mental retardation programs in the Reno-Sparks area and Las Vegas area. The subcommittee reviewed a great deal of information and has attempted, in this report, to present its findings and recommendations briefly and concisely. Also, supporting documents and minutes are on file in the Fiscal Division of the Legislative Counsel Bureau. The subcommittee wishes to recognize and thank the many people who attended and participated in the meetings for their cooperation and assistance in providing valuable information about the operation of the Division of Mental Health and Mental Retardation.

This report is transmitted to the members of the 1991 Legislature for consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

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LEGISLATIVE COMMISSION

Assemblyman John E. Jeffrey, Chairman
Assemblyman Robert M. Sader, Vice Chairman

Senator Charles W. Joerg
Senator William R. O'Donnell
Senator Raymond C. Shaffer
Assemblyman Joseph E. Dini, Jr.
Senator Randolph J. Townsend
Senator John M. Vergiels
Assemblyman Louis W. Bergevin
Assemblyman James W. McGaughey
Assemblyman Danny L. Thompson

REPORT TO THE 66TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

I. INTRODUCTION AND BACKGROUND

The 65th Session of the Nevada Legislature, in 1989, adopted Assembly Concurrent Resolution No. 52 (File 179, Statutes of Nevada, 1989) which directed the Legislative Commission to conduct a comprehensive study of the Mental Hygiene and Mental Retardation Division of the Department of Human Resources, its management and its treatment of clients, with particular emphasis on outpatient services and community-based services.

The last major study of the Division of Mental Health and Mental Retardation took place after the 1987 Legislative Session as a result of Assembly Concurrent Resolution No. 59 (1987), contained in Bulletin #89-19. Other studies of the Division of Mental Health and Mental Retardation include a major study after the 1977 Legislative Session as a result of ACR 55 (1977), and Study Bulletin #79-6 was presented to the 1979 Legislature for their review. Additional studies of the Division include a Study of the Problems and Treatment of Mentally Retarded Adults, Bulletin #83-1, Mental Health Care Facilities and Programs, Bulletin #117, September 1974, and a major study conducted by the Rand Corporation, titled, Mental Health and Mental Retardation Services in Nevada, April 1976.

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

The results of the study are to be reported for further consideration by the 66th Session of the Nevada Legislature. The subcommittee has a total of 21 recommendations.

Subcommittee Meetings

The ACR 52 Subcommittee held a total of five meetings which took place in Las Vegas and Reno. The subcommittee had two additional meeting days where they toured mental health and mental retardation community facilities in Las Vegas and Reno.

Subcommittee Methodology

The ACR 52 Subcommittee conducted its study through the public hearing process. The subcommittee received considerable input on the operation of the Division of Mental Health and Mental Retardation from employees of the Division, the Department of Human Resources, concerned parents and relatives, practitioners in the field and from current and former clients.

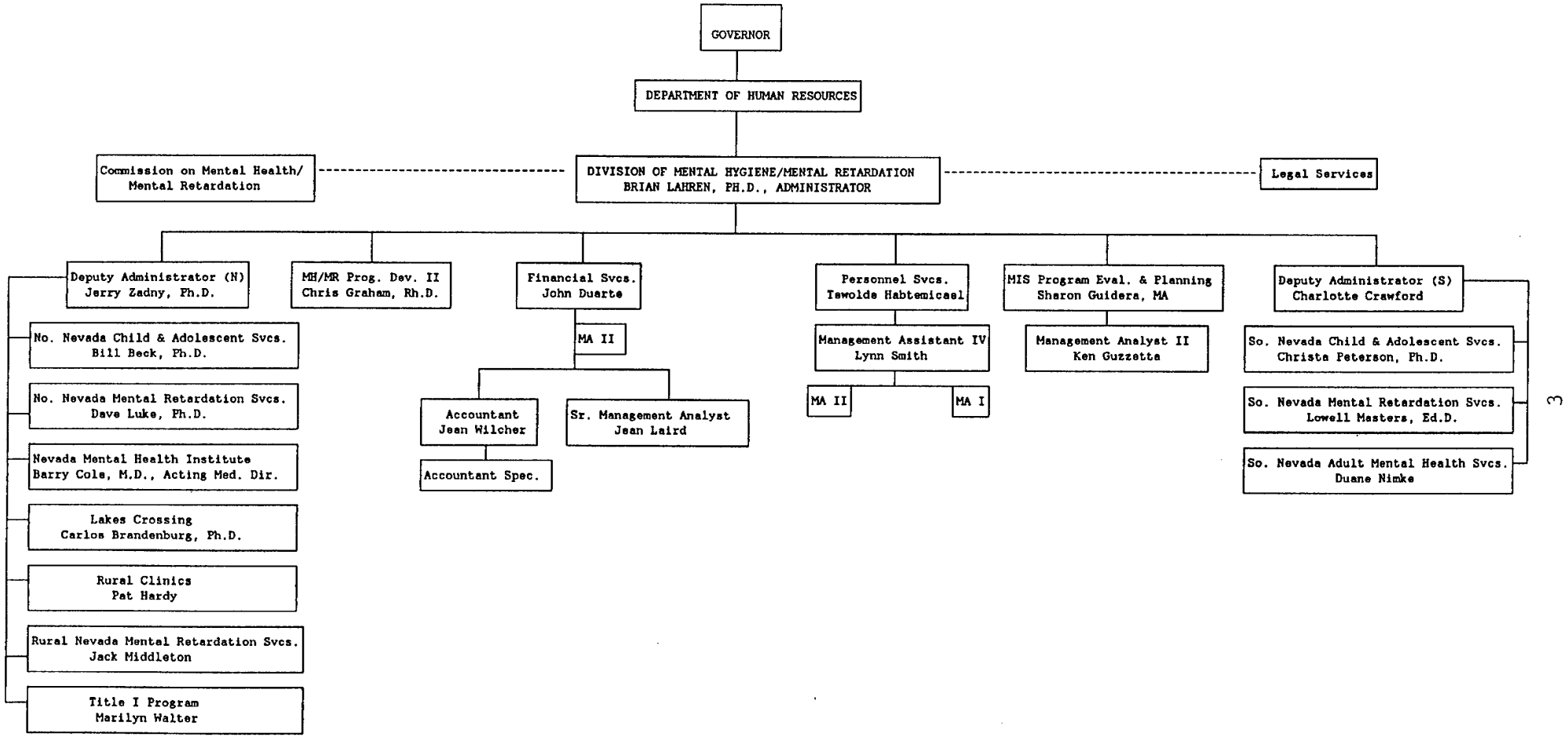
II. HISTORY AND OPERATION OF THE DIVISION OF MENTAL HEALTH AND MENTAL RETARDATION

The Division of Mental Health and Mental Retardation of the Department of Human Resources is charged with being the primary provider of public mental health and mental retardation care in the State of Nevada.

Prior to 1970, the operation of the Division consisted primarily of the state hospital located in Sparks, Nevada and limited outpatient services in the Las Vegas area. The framework for the current organization was implemented during the early and mid-1970's with additional programs being added to meet the growing demand for services. The Las Vegas Mental Health Center became a separate agency and separate services were added for children, adolescents and the mentally retarded. In addition, services to the rural citizens of the state were greatly expanded.

Organization

The Division of Mental Health and Mental Retardation is organized as a separate Division of the Department of Human Resources. It is responsible for administering Nevada's state funded programs for the mentally ill and mentally retarded pursuant to Chapters 178, 433, 433A and 435. The Division is responsible for the development, administration, coordination and evaluation of treatment and training programs for the mentally ill and mentally retarded citizens in the State of Nevada. The Division operates inpatient facilities primarily in Washoe and Clark County and provides additional limited inpatient beds in other parts of the state. There is an extensive network of outpatient services and day-treatment services in many parts of the state. The Division of Mental Health and Mental Retardation is divided along organizational lines as displayed in the following organizational chart, Exhibit 1.


GOVERNOR
DEPARTMENT OF HUMAN RESOURCES
Commission on Mental Health/ Mental Retardation
DIVISION OF MENTAL HYGIENE/MENTAL RETARDATION
BRIAN LAHREN, PH.D., ADMINISTRATOR
Legal Services
Deputy Administrator (N)
Jerry Zadny, Ph.D.
MH/MR Prog. Dev. II
Chris Graham, Rh.D.
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John Duarte
Personnel Svcs.
Tewolde Habtemicael
MIS Program Eval. & Planning
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Deputy Administrator (S)
Charlotte Crawford
No. Nevada Child & Adolescent Svcs.
Bill Beck, Ph.D.
No. Nevada Mental Retardation Svcs.
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Jack Middleton
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Sr. Management Analyst
Jean Laird
Management Assistant IV
Lynn Smith
MA II
MA I
Management Analyst II
Ken Guzzetta
So. Nevada Child & Adolescent Svcs.
Christa Peterson, Ph.D.
So. Nevada Mental Retardation Svcs.
Lowell Masters, Ed.D.
So. Nevada Adult Mental Health Svcs.
Duane Nimke

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

Funding History

Since the early 1970's the general fund appropriation for the Division has grown dramatically from approximately $3.7 million in Fiscal Year 1971 to a general fund appropriation in excess of $39 million in Fiscal Year 1991. A history of the general fund appropriations for the Division of Mental Health and Mental Retardation from 1971 through 1991 is displayed in Exhibit II as follows:

Exhibit II

Division of Mental Health and Mental Retardation
History of General Fund Appropriations

Fiscal Year	General Fund Appropriation	Fiscal Year	General Fund Appropriation
1990-91	$39,322,856		
1989-90	37,443,603		
1988-89	29,127,596	1978-79	$14,490,724
1987-88	28,528,283	1977-78	13,174,591
1986-87	20,083,828	1976-77	11,478,541
1985-86	19,238,070	1975-76	9,743,629
1984-85	20,213,308	1974-75	7,989,680
1983-84	18,845,520	1973-74	7,023,907
1982-83	18,192,951	1972-73	5,581,243
1981-82	17,189,738	1971-72	5,405,796
1980-81	15,764,974	1970-71	3,780,632
1970-80	14,458,480		

In recognition of the problems the Division of Mental Health and Mental Retardation was facing in dealing with the increasing demands for services, the 1989 Legislature increased the general fund appropriation by over $8 million. This amounted to an approximate 28 percent increase in the general fund appropriation level in Fiscal Year 1990 over the Fiscal Year 1989 level.

Total funding for the Division of Mental Health and Mental Retardation, including authorized and appropriated funds, is displayed in Exhibit III.

N E L I S

BUDGET COMPARISON
DEPARTMENT OF HUMAN RESOURCES
DIV MENTAL HYGIENE/MENTAL RETARDATION
Entire Subdepartment

Today's date: 7/26/90
Time: 11:03 a.m.
Leg. day: 85R
Data as of: 08/89
Page: 1

	1987-88 ACTUAL	1988-89 WORK PROGRAM	1989-90 LG. APPROVED	1990-91 LG. APPROVED
MH/MR-ADMINISTRATION	$824,291	$976,247	$997,677	$985,350
PASARR	$0	$0	$458,018	$745,692
CHILDREN'S SERVICES	$0	$0	$0	$0
MH/MR REGIONAL TRAINING	$19,754	$23,103	$71,545	$71,545
SO. NEVADA ADULT MENTAL	$9,924,291	$11,891,239	$13,718,412	$14,190,213
SO. NEVADA CHILD & ADOLE	$4,211,591	$4,591,029	$5,264,548	$5,793,465
SOUTHERN MH/MR FOOD SERV	$486,297	$561,042	$620,778	$636,945
NEVADA MENTAL HEALTH INS	$9,905,800	$10,492,516	$11,685,771	$11,990,938
NORTHERN NEV CHILD & ADO	$2,611,175	$2,594,943	$3,192,824	$3,700,832
LAKE'S CROSSING - MENTAL	$1,889,930	$1,905,157	$2,222,620	$2,266,684
SO NV FORENSIC FACILITY	$0	$0	$0	$0
RURAL CLINICS	$3,491,941	$3,843,749	$4,134,123	$4,377,308
SOUTHERN NEV MENTAL RETA	$5,706,806	$5,759,532	$7,427,927	$7,954,188
NORTHERN NEV MENTAL RETA	$4,838,825	$4,789,844	$6,482,890	$6,990,609
COMMUNITY TRAINING CENTE	$2,227,242	$2,507,970	$2,782,344	$2,672,398
RESIDENTIAL PLACEMENT	$2,751,470	$3,295,905	$3,603,123	$3,960,970
CHAPTER 1 - SPECIAL EDUC	$546,493	$997,876	$796,307	$699,768
HOME CARE	$157,214	$159,572	$178,478	$188,688
FOSTER GRANDPARENT PROGR	$377,263	$394,982	$402,209	$403,795
VICTIMS OF DOMESTIC VIOL	$757,624	$935,581	$840,000	$850,000
DIV MENTAL HYGIENE/MENTA	$50,728,007	$55,720,287	$64,879,594	$68,479,388

EXHIBIT III

Exhibit III points out that total funding for the Division of Mental Health and Mental Retardation has increased from an actual expenditure level of $50,728,007 in Fiscal Year 1988 to a legislatively approved level of $68,479,388 in Fiscal Year 1991. Total funding for the Division from the 1987-89 biennium to the 1989-91 biennium is over 25.3 percent.

Authorized Positions

Exhibit IV displays the authorized position strength of the Division of Mental Health and Mental Retardation from Fiscal Year 1988 through Fiscal Year 1991. The Division of Mental Health and Mental Retardation has grown from a total of 1,005.4 positions in Fiscal Year 1987 to in excess of 1,305 authorized positions for Fiscal Year 1991.

MHMR DIVISION

LEGISLATIVE APPROVED

BUDGET NAME	BUDGET NBR.	FY 87 ACTUAL	FY 88 ACTUAL	FY 89 WORK PROG	FY 90 CONTINUATION	FY 90 NEW/EXPAND	FY 90 TOTAL	FY 91 CONTINUATION	FY 91 NEW/EXPAND	FY 91 TOTAL
SOUTHERN FOOD SERVICE	3159	1.00	1.00	1.00	1.00	0.00	1.00	1.00	0.00	1.00
COMMUNITY TRAINING CENTER	3160	3.00	4.00	4.00	4.00	3.00	7.00	4.00	3.00	7.00
SO NV ADULT MENTAL HEALTH SV	3161	172.00	216.00	241.00	272.00	12.00	284.00	272.00	12.00	284.00
NV MENTAL HEALTH INSTITUTE	3162	229.50	267.00	268.00	268.00	11.50	279.50	268.00	11.50	279.50
MENTAL RETARDATION HOME CARE	3166	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
RESIDENTIAL PLACEMENT	3167	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MENTAL HYGIENE/RETARDATION	3168	12.50	12.50	12.50	13.00	2.00	15.00	13.00	2.00	15.00
REGIONAL TRAINING	3176	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MH/MR VICTIMS DOMESTIC VIOLE	3181	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MH/MR OLDER AMERICAN PROGRAM	3197	46.50	47.50	2.50	2.50	0.00	2.50	2.50	0.00	2.50
SPECIAL EDUCATION PROJECT	3276	2.00	1.70	1.70	1.70	2.00	3.70	1.70	2.00	3.70
SO NV MENTAL RETARDATION SVC	3279	143.50	164.00	164.00	163.00	20.50	183.50	163.00	41.00	204.00
NO NV MENTAL RETARDATION SVC	3280	124.40	144.90	144.90	144.40	17.00	161.40	144.40	39.00	183.40
NO NV CHILD & ADOLESCENT SVC	3281	58.50	60.50	62.50	62.50	4.00	66.50	62.50	4.00	66.50
SO NV FORENSIC FACILITY	3644	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FACILITY FOR THE MENTAL OFFE	3645	43.00	46.00	46.00	47.00	3.00	50.00	47.00	3.00	50.00
SO NV CHILD & ADOLESCENT SVC	3646	90.50	94.50	95.50	94.50	20.50	115.00	94.50	25.50	120.00
MH/MR CHILDREN'S SERVICES	3647	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
RURAL CLINICS	3648	79.00	79.00	79.00	79.50	7.50	87.00	79.50	9.00	88.50
		1,005.40	1,138.60	1,122.60	1,153.10	103.00	1,256.10	1,153.10	152.00	1,305.10

EXHIBIT IV
9

Caseload Data

The Division of Mental Health and Mental Retardation provides services to approximately 30,000 persons annually. During an average month, the Division has approximately 12,500 on their caseload.

Exhibit V displays the end-of-the-month average caseload for residential and community programs from Fiscal Year 1982 through Fiscal Year 1990. Prior to Fiscal Year 1992, the Division of Mental Health and Mental Retardation was keeping its data in a different format and much of the comparisons would be invalid today. During the time period Fiscal Year 1992--Fiscal Year 1990, there have been changes in the way the Division records community cases. The heading "Residential" includes both inpatients and transitional beds that the Division is paying for and "Community" includes all other cases such as outpatient and day treatment.

During this time period the two major adult inpatient facilities, the Nevada Mental Health Institute (NMHI) and the Southern Nevada Adult Mental Health Services (SNANHS), has experienced a significant increase in residential cases. The Southern Nevada Adult Mental Health Services has shown a much larger increase in residential cases due to a greater level of funding for transitional beds in the community. Both the 1987 and 1989 Sessions of the Legislature increased the funding for community beds both at the Nevada Mental Health Institute and at Southern Nevada Adult Mental Health Services. At the Nevada Mental Health Institute, the end-of-the-month average residential caseload in Fiscal Year 1986 was 101.5 and this has grown to 169.8 in Fiscal Year 1990. At Southern Nevada Adult Mental Health Services, the end-of-the-month average residential caseload, during this same time period, grew from 192.25 in Fiscal Year 1986 to 339.15 in Fiscal Year 1990.

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
COMPARISON OF AVERAGE MONTHLY CASELOADS: RESIDENTIAL AND COMMUNITY
FY 82 THROUGH FY 90 (JULY-APRIL 90)

BUDGET #	AGENCY	FY82 EOM CASELOAD	FY83 EOM CASELOAD	FY84 EOM CASELOAD	FY85 EOM CASELOAD	FY86 EOM CASELOAD	FY87 EOM CASELOAD	FY88 EOM CASELOAD	FY89 EOM CASELOAD	FY90 EOM CASELOAD
3162	NEVADA MENTAL HEALTH INSTITUTE									
	RESIDENTIAL:	78.00	82.00	87.00	96.00	101.50	123.66	117.83	170.00	169.80
	COMMUNITY:	849.00	890.00	846.00	858.00	849.00	858.67	672.83	990.65	1006.42
3161	SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES									
	RESIDENTIAL:	78.00	103.00	156.00	177.00	192.25	220.83	285.17	299.92	339.15
	COMMUNITY:	3980.00	4652.00	5095.00	5290.00	5613.58	6342.83	6109.17	6212.33	6320.17
3281	NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES									
	RESIDENTIAL:	31.00	36.00	38.00	38.00	42.42	41.25	40.17	37.67	34.73
	COMMUNITY:	503.00	606.00	676.00	633.00	423.09	401.09	383.83	443.75	572.09
3646	SOUTHERN NEVADA CHILD & ADOLESCENT SERVICES									
	RESIDENTIAL:	41.00	62.00	66.00	70.00	69.50	66.17	65.92	63.08	57.50
	COMMUNITY:	868.00	1065.00	1196.00	1177.00	904.67	981.24	823.83	958.65	980.90
3645	LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER									
	RESIDENTIAL: INPATIENT	21.00	24.00	23.00	25.00	27.08	30.17	31.67	30.00	28.55
3648	RURAL CLINICS									
	COMMUNITY:	1904.00	2055.00	2191.00	2375.00	2663.25	2803.58	2186.67	2505.83	3535.55

EXHIBIT V (1)

BUDGET #	AGENCY	FY82 EOM CASELOAD	FY83 EOM CASELOAD	FY84 EOM CASELOAD	FY85 EOM CASELOAD	FY86 EOM CASELOAD	FY87 EOM CASELOAD	FY88 EOM CASELOAD	FY89 EOM CASELOAD	FY90 EOM CASELOAD
3280	NORTHERN NEVADA MENTAL RETARDATION SERVICES									
	RESIDENTIAL:	74.00	75.00	75.00	75.00	79.00	80.92	77.83	79.08	79.45
	COMMUNITY:	167.00	149.00	147.00	173.00	182.42	199.25	211.75	221.00	248.36
3279	SOUTHERN NEVADA MENTAL RETARDATION SERVICES									
	RESIDENTIAL:	81.00	86.00	91.00	93.00	93.33	89.75	91.67	94.75	94.20
	COMMUNITY:	212.00	280.00	332.00	424.00	434.25	500.58	566.08	649.92	766.40
3167	RURAL NEVADA MENTAL RETARDATION SERVICES									
	COMMUNITY:	N/A	52.00	83.00	114.00	113.58	117.08	131.58	133.67	145.55
3160	COMMUNITY TRAINING CENTERS									
	COMMUNITY:	465.00	490.00	551.00	584.00	585.00	687.40	683.70	723.00	706.00
3166	FPP									
	AVERAGE # OF RECIPIENTS:				60.00	63.75	63.00	71.90	70.17	71.25

NOTES: Residential Includes Supportive Housing

DOC=CSLCOMP1.WK1
06/21/90

ABBREVIATIONS:

NMHI=NEVADA MENTAL HEALTH INSTITUTE

SNAMHS=SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

NNCAS=NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES

SNCAS=SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES

LAKES=LAKES CROSSING

RC=RURAL CLINICS

NNMRS=NORTHERN NEVADA MENTAL RETARDATION SERVICES

SNMRS=SOUTHERN NEVADA MENTAL RETARDATION SERVICES

RNMRS=RURAL NEVADA MENTAL RETARDATION SERVISES

CTC=COMMUNITY TRAINING CENTERS

FPP=FAMILY PRESERVATION PROGRAM

The community cases at Southern Nevada Adult Mental Health Services has grown significantly from 3,980 in Fiscal Year 1982 to 6,320.17 in Fiscal Year 1990. The data displayed in Exhibit V shows that all programs have shown an increase in caseloads during this time period including Northern Nevada Mental Retardation Services (NNMRS) and Southern Nevada Mental Retardation Services (SNMRS). Due to limited residential bed capacity, those facilities have been operating at close to maximum levels as has the Lakes Crossing Facility for the mentally disordered offender. Another program showing a significant increase is the cost effective community training centers (CTC) program which has grown from an average end of the month caseload of 465 in Fiscal Year 1982 to 706 in Fiscal Year 1990.

The Rural Clinics Program, which primarily provides out-patient therapy, has shown a dramatic increase in its caseload from 1,904 in Fiscal Year 1982 to 3,535.55 in Fiscal Year 1990.

With the increase in the resources allocated to community programs, the ACR 52 Subcommittee was interested in what effect the additional staff and resources had on the residential population of the two major adult psychiatric institutions. At the request of the subcommittee, the Division of Mental Health and Mental Retardation prepared comparative data in reference to the re-admission rate and the average length of stay. Data on admissions to hospital services, the percentages of first admission and/or repeated admissions and average length of stay (ALOS) is as follows:

	Fiscal Year 1988	Fiscal Year 1989
Total Admissions	576	1,042
Total Re-admissions	312	394
Percentage/Re-admissions	54%	38%

Re-admissions, above, represent any patient that has had a previous episode of inpatient care regardless of the time period. The number of patients who were re-admitted within thirty days of discharge is only 6 to 7 percent.

The average length of stay for Southern Nevada Adult Mental Health Services (SNAMHS) and Nevada Mental Health Institute (NMHI) is as follows:

	FY 1987--ALOS	FY 1988--ALOS	FY 1989--ALOS
SNMNS	27 days	32 days	21 days
NMHI	16 days	17 days	24 days

The average length of stay has decreased by 11 days between Fiscal Year 1988 and Fiscal Year 1989 at Southern Nevada Adult Mental Health Services. The Division of Mental Health and Mental Retardation indicates that this decrease can be attributed to the establishment of improved monitoring of outpatient care, i.e., counseling, supported housing, medical clinics, case management and also the sustained employment of additional psychiatrists. At the Nevada Mental Health Institute, the Division of Mental Health and Mental Retardation provided an explanation to the subcommittee that the primary reason for the increase in the average length of stay in Fiscal Year 1989 was due to the discharge of five long-term psychiatric inpatients during that fiscal year.

Exhibit VI displays the percentage of patients admitted for the first acute episode versus the repeat chronic client.

QUESTION 10, (11/13/89)
PERCENTAGE OF PATIENTS ADMITTED FOR FIRST ACUTE EPISODE VERSUS THE REPEAT CHRONIC CLIENT

NMHI - FY 88:	J	A	S	O	N	D	J	F	M	A	M	J	TOTAL
Readmissions	45	47	57	54	53	44	53	51	54	40	56	53	607
Total Admissions	107	94	109	101	92	79	101	95	105	88	116	112	1199
Percent Re-admits	42%	50%	52%	53%	58%	56%	52%	54%	51%	45%	48%	47%	51%

SNAMHS - FY 88:	J	A	S	O	N	D	J	F	M	A	M	J	TOTAL
Readmissions	35	35	22	29	26	20	19	17	28	28	23	30	312
Total Admissions	66	55	40	45	44	32	36	43	59	61	40	55	576
Percent Re-admits	53%	64%	55%	64%	59%	63%	53%	40%	47%	46%	58%	55%	54%

NMHI - FY 89:	J	A	S	O	N	D	J	F	M	A	M	J	TOTAL
Readmissions	42	42	16	28	8	24	25	11	18	22	23	23	282
Total Admissions	139	97	71	82	55	82	101	59	66	80	69	64	965
Percent Re-admits	30%	43%	23%	34%	15%	29%	25%	19%	27%	28%	33%	36%	29%

SNAMHS - FY 89:	J	A	S	O	N	D	J	F	M	A	M	J	TOTAL
Readmissions	15	29	30	39	36	31	32	33	34	35	44	36	394
Total Admissions	42	59	78	92	83	80	95	100	120	92	118	83	1042
Percent Re-admits	36%	49%	38%	42%	43%	39%	34%	33%	28%	38%	37%	43%	38%

NOTE: Readmissions above represent any patient that has had a previous episode of inpatient care regardless of the time period. Attached is a graph representing the percent of readmissions within 30 days of discharge from inpatient services. For the past 3 quarters only 6-7% of discharges returned within 30 days for both agencies.

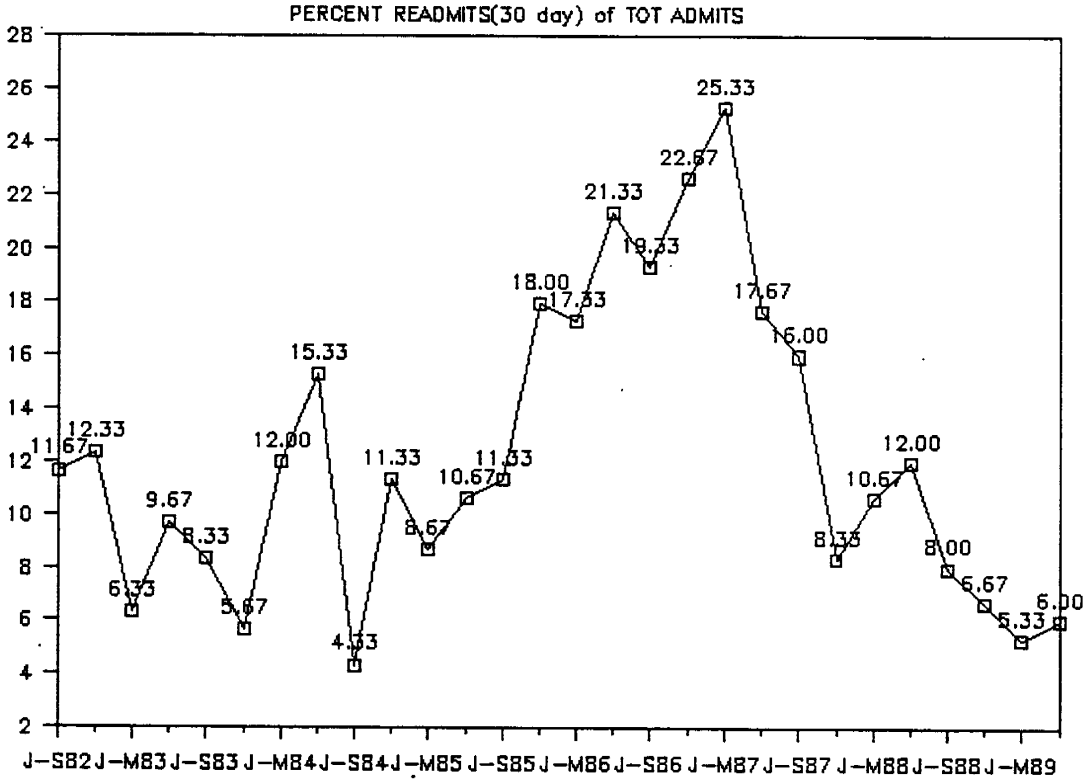
DOC=C:\123R3\WORKS\READMITS.WK3
02-Jan-90

EXHIBIT VI

Exhibit VII displays, in graph form, the percentage of re-admissions to the total admissions for Southern Nevada Adult Mental Health Services and the Nevada Mental Health Institute from 1982 to 1989.

SNAMHS HOSPITAL UNIT

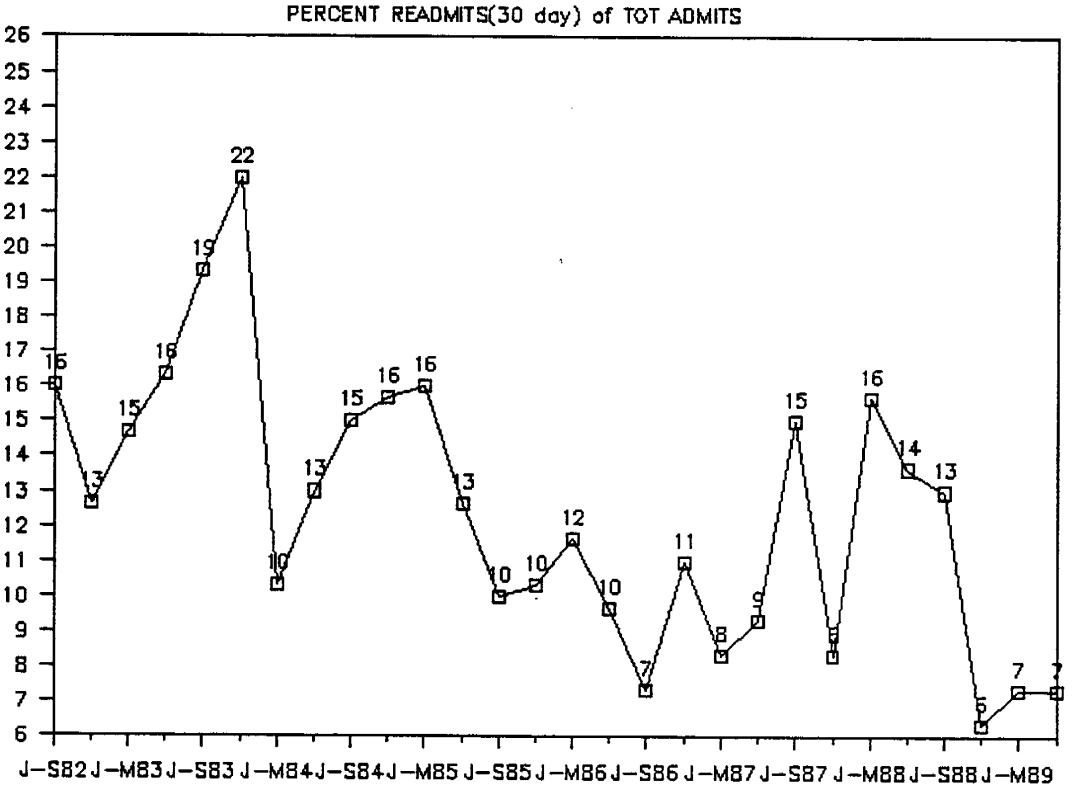
PERCENT READMITS(30 day) of TOT ADMITS



MEAN=12.23, UPPER=22.06, LOWER=2.4

NMHI GEN PSYCH UNIT

PERCENT READMITS(30 day) of TOT ADMITS



MEAN=12, UPPER=18, LOWER=6

EXHIBIT VII

III. PROGRAM DESCRIPTIONS

Overview

The Division of Mental Health/Mental Retardation provides a statewide comprehensive mental health and mental retardation system for the citizens of this state. The Division's delivery system is divided into three major service areas, Clark County, Washoe County and the remaining 15 counties. The Division has an unclassified administrator and two unclassified deputy administrators. The Division administrator, along with the northern area deputy are located in Carson City and the southern area deputy is located in Las Vegas.

The northern area deputy is responsible for supervising the overall operation of the Northern Nevada Adult Mental Health Services, the Northern Nevada Mental Retardation Services, Northern Nevada Child and Adolescent Services, the Lakes Crossing Facility and in addition, provides overall supervision to the operation of the Rural Clinics program, the Rural Nevada Mental Retardation Services program and the Title I Federal Grants program. The southern area deputy is responsible for overseeing the operation of Southern Nevada Adult Mental Health Services, Southern Nevada Mental Retardation Services and Southern Nevada Child and Adolescent Services.

The Division operates with a seven-member Commission on Mental Health and Mental Retardation, appointed by the Governor, with at least three members of whom have training or experience in dealing with mental retardation. The Commission operates as a policy-setting body to help ensure adequate development and administration of services for the mentally ill and mentally retarded. They also review the programs and finances of the Division and report at the beginning of each year to the Governor and at the beginning of each odd-numbered year to the Legislature on the quality of the care and treatment provided for mentally ill and mentally retarded persons in this state and any progress made toward improving the quality of that care and treatment.

The qualifications of the seven-member commission is required to be as follows: a psychiatrist licensed to practice medicine in Nevada; a psychologist certified to practice in Nevada and experienced in clinical practice; a physician other than a psychiatrist, licensed to practice medicine in Nevada, and who is experienced in dealing with mental retardation; a social worker who has a masters degree and experience in dealing with mental illness or mental retardation or both; a registered nurse, licensed to practice in Nevada, who has experience in dealing with mental illness or mental retardation or both; a representative of the general public who has a

special interest in the field of mental health; and a representative of the general public who has a special interest in the field of mental retardation.

Division Administration

The Division central administration provides for the overall management of mental health and mental retardation programs in the state. The functions of the Division's central office are to carry out state mental health and mental retardation management policies, regulations, coordinate operation and program development statewide, guarantee quality of care provided by agencies within the Division, and ensure agency fiscal responsibility. The Division operates under the guidance of the Commission on Mental Health and Mental Retardation established by the 1985 Legislature and operates as a Division of the Department of Human Resources answerable to the Director of the Department. Functions include establishing service and funding priorities with public input, monitoring the productivity and cost effectiveness of programs and responding to legal issues arising from service delivery. Organizational charts for individual agencies within the Division are displayed in Appendix A of this report.

Southern Nevada Adult Mental Health Services

Southern Nevada Adult Mental Health Services began serving the greater Las Vegas area from its current site in November, 1970. The agency received funding from the state and from the National Institute of Mental Health as a community and mental health center. The agency provided a full continuum of care ranging from outpatient counseling through inpatient residential care. In accordance with the community mental health center concept, the agency services were designed to provide for short-term treatment, with priority placed on the deinstitutionalization of clients where possible. The agency provides outpatient counseling, partial care (day-treatment program), a crisis program located at the University Medical Center, inpatient services totaling 106 beds broken down in a new 82-bed hospital and an older 24-bed facility located at West Charleston; vocational services, medication clinics, case management and community-based residential care. In Fiscal Year 1991 they will contract for approximately 274 community-based residential beds.

Northern Nevada Adult Mental Health Services

The delivery of adult mental health services in Washoe County is provided primarily through the administrative structure of the Nevada Mental Health Institute. The Nevada Mental Health Institute is an accredited institution serving mentally ill clients primarily from northern Nevada. The Institute offers services which include

inpatient, transitional living, partial hospitalization, geriatric services, outpatient services, community living services and emergency care.

The Institute also provides statewide backup and psychiatric inpatient services when local resources are inadequate or not available. The Institute has two forty-bed inpatient units and provides services to the geriatric population with an 18-bed inpatient unit. In addition, the agency operates two 16-bed cottages providing residential services for persons who continue to require ready access to more intensive services than are available in the community. The Institute also provides vocational services, medication clinics and case management services. In Fiscal Year 1991, the Institute will contract for approximately 132 community-based residential beds.

Southern Nevada Child and Adolescent Mental Health Services

Southern Nevada Child and Adolescent Mental Health Services provides assessment, diagnostic, and treatment services to approximately 2,200 emotionally disturbed children, adolescents and their families per year. Children and their families, throughout Clark County, access services through five community sites; Children's Behavioral Services, located on West Charleston, Henderson Counseling Center, Family Counseling Center, North Las Vegas Counseling Center, and the Westside Counseling Center. In addition, they operate in conjunction with the University Medical Center Crisis Unit. In Fiscal Year 1991 they will contract for approximately 25 community beds. New programs, supported by the 1989 Legislature, included a 12-bed sexual offender program and a six-bed autistic program.

Northern Nevada Child and Adolescent Services

The Northern Nevada Child and Adolescent Services provides mental health services to children, adolescents and their families in Washoe County and, to a limited extent, other northern Nevada counties. The mission of the agency is to provide a comprehensive complete range of mental health care that is both child centered and community based. The agency provides a range of treatment services for children ages 2 to 18 and their families. Services include inpatient residential care, community-treatment homes, day-treatment programs, outpatient, and emergency services. The agency also operates a limited program of therapeutic foster homes. In Fiscal Year 1991 they will contract for 15 community beds.

Lakes Crossing Center

The Lakes Crossing Center in Washoe County is currently Nevada's only program for the mentally disordered offender. The agency provides statewide residential services to individuals who have been evaluated as not guilty by reason of insanity, incompetent to stand trial, or requiring mental health services in a secure setting. The agency has a maximum residential capacity of 35 beds.

Southern Nevada Forensic Facility

The 1989 Legislature approved funding ($8,946,000 G.O. Bonds, and $503,094 General Fund) for the construction of a new fifty-bed secure forensic facility for the treatment of mentally disordered offenders to be located in the Las Vegas area.

Rural Clinics

Rural Clinics is mandated to provide a comprehensive range of quality mental health treatment, education and referral services to all ages within the 15 counties of rural Nevada. Service delivery to the approximately 200,000 people living in this 96,000 square mile area is accomplished through resident professionals working out of eight satellite offices, eight sub-satellite offices and several service sites visited on an itinerant basis. The main offices are located in Carson City, Gardnerville, Hawthorne, Ely, Fallon, Winnemucca, Elko, and Yerington. In addition, the agency assigns staff to help in Douglas County, Tonopah, Caliente, Lovelock, Battle Mountain, Wendover, Fernley and Dayton.

The agency provides services to individuals who are identified in need of service treatment and also to their families and, at times, to the communities as well. Services to children and adolescents are addressed through community development, inter-agency consultation and family therapy as well as individual work. Primary service is provided as outpatient care. In addition, the agency operates a time-limited supported housing program which began in June 1989, through a HUD grant and is located at the Stewart complex in Carson City. The program is funded for five years and has a capacity of 11. The program provides a therapeutic environment for up to 18 months focusing on preparing clients for a more independent level of living. Through a relationship with Rural Housing, permanent supported housing is provided for another 12 individuals and is augmented by mental health case management services. The agency provides day-treatment services in the Carson City area and is beginning to develop similar services in Ely and Elko. In addition, other services offered by Rural Clinics include 24-hour, seven-day a week emergency care, pre-screening for admission to a more intensive level of care, consultation and

education, special groups, minority services, geriatric care, special children's programs and chemical dependency programs, not otherwise available. Rural Clinics is certified as a substance abuse program by the Bureau of Alcohol and Drug Abuse. The 1989 Legislature added funding to establish a five-bed rural group home for the Elko area to begin operation in July 1990.

Southern Nevada Mental Retardation Services

Southern Nevada Mental Retardation Services provides services to people with mental retardation, their families, and community members residing in Lincoln, Nye and Clark Counties. Services provided include clinical, residential, family support and case management in an attempt to promote community integration while maximizing the quality of the client's life. The agency provides a broad range of services to meet the needs of the individuals who are developmentally disabled and their families. Services range from highly structured residential training and treatment programs to training and support activities for families with developmental disabilities individually residing in their natural homes. Residential services are provided primarily through the Desert Developmental Center (DDC) which is a 94-bed inpatient facility licensed and certified as an intermediate-care facility for the mentally retarded. The 1989 Legislature approved funding of $1,624,119 for construction of a new 12-bed dual diagnosis unit to treat persons who are both mentally ill and mentally retarded. A total of 28 new positions were added for the new dual-diagnosis program. The facility is certified for participation in Title XIX Medicaid program and, as such, provides active treatment to the residents on a seven-day, 24-hour basis. Services are provided to individuals of all ages and functional levels who are mentally retarded and require intensive training, supervision in a highly structured environment to develop basic living skills and appropriate social inter-action skills. Services are provided in small groups for six to 16 individuals living in a cottage environment. The agency goal is that each client participate in an off-campus educational or training program that is provided by the Clark County School District to school-age clients or to a community training center that is under contract with the Desert Developmental Center for the delivery of habilitation services to the adult population.

The Community Services Program of Southern Nevada Mental Retardation Services provides an array of services to clients who reside outside of Desert Developmental Center. Staff in the program are responsible for the recruitment, selection, training and monitoring of community home providers in southern Nevada. There are approximately 149 clients residing in licensed homes with each home providing care to one to six mentally retarded individuals. Case management services are provided to ensure that individualized development programs are provided to all clients.

Mentally retarded individuals living in skilled nursing or in intermediate care facilities are followed by case management staff as are clients living independently in the community or with their families. Additional services include intake evaluation, social histories, genetic counseling and family counseling. The agency also operates an early intervention program entitled "First Step" which provides parent training, parent counseling and a learning/training program for mentally retarded children ages birth to three years.

Northern Nevada Mental Retardation Services

Northern Nevada Mental Retardation Services is a comprehensive mental retardation center similar to the Southern Nevada Mental Retardation Services. The agency provides services to mentally retarded/developmentally disabled clients from Washoe County and the rural Nevada mental retardation services region. Primary residential services are provided by the Sierra Developmental Center (SDC) located in Sparks, Nevada which is a licensed ICF/MR facility also funded by Medicaid in state appropriations. The facility currently has a capacity of 84 beds which will increase to 96 upon completion of the 12-bed dual-diagnosed facility funded by the 1989 Legislature ($1,477,981). Residential services are provided in 14 home-like living settings with six clients each. A full array of professional and support services are provided to clients including clinical services such as speech, psychological occupational, physical and recreational therapies. Additional services include nursing service, day habilitation programming and dual-diagnosis service for persons having behavior disorders in addition to mental retardation.

Community services are also provided to clients through the purchase or coordination of service elements. Services included are community living alternatives such as developmental and group homes, supervised apartments and supported living programs. The community services staff also provide a full array of clinical services including psychological nursing and training services. Special day treatment/habilitation or independent skill training is also provided. In addition, the community services staff work with the community training centers to help provide day training in sheltered workshop services to all clients not participating in school programs.

Community Training Center Program

The purpose of the Community Training Center Program (CTC) is to aid mentally retarded persons who are not served by existing programs. This is accomplished through a program of subsidizing qualified community training centers which provide care and training to mentally retarded persons. Centers are located in major

communities of the state and are providing services to over 700 mentally retarded individuals. As of August, 1990, services to the pre-school population will be transferred from the Community Training Centers to the local school districts. The Division has recently implemented an intensive training program for community placements which is designed to move clients from the community training centers to independent employment in the community. Exhibit VIII lists the certified enrollment of the community training centers. Exhibit IX details the daily rate recommended to the 1989 Legislature in The Executive Budget and the rates approved by the Legislature for each year of the current biennium by type of service slot.

AGENCY: Community Training Centers

COMMUNITY TRAINING CENTERS
CERTIFIED ENROLLES

YEAR:	MONTH: J	A	S	O	N	D	J	F	M	A	M	J	Average
Regular:													
FY 87:	445.00	440.00	445.00	530.30	481.50	482.50	488.30	490.50	522.50	527.00	532.00	526.90	492.63
FY 88:	517.40	525.40	527.50	530.30	525.50	534.70	547.70	548.70	538.70	538.70	539.70	549.70	535.33
FY 89:	523.60	494.84	499.71	480.54	525.63	522.13	520.38	513.38	522.38	523.05	529.47	543.30	516.53
FY 90:	514.46	536.96	541.30	552.30	535.30	525.70							534.34
Pre-school:													
FY 87:	115.00	111.00	117.00	160.00	118.00	127.00	134.00	131.00	132.00	136.00	133.00	134.00	129.00
FY 88:	120.00	125.00	117.00	160.00	111.00	112.00	118.00	123.00	125.00	122.00	125.00	129.00	123.92
FY 89:	123.00	116.00	108.00	101.00	113.00	114.00	114.00	113.00	118.00	117.00	115.00	117.00	114.08
FY 90:	106.00	109.00	99.00	105.00	106.00	110.00							105.83
Preworks:													
FY 87:	16.00	16.00	16.40	35.00	32.00	32.00	32.00	31.00	33.00	34.00	36.00	36.00	29.12
FY 88:	34.00	34.00	35.00	35.00	34.00	35.00	29.00	29.00	22.00	22.00	21.00	20.00	29.17
FY 89:	26.00	42.67	42.00	45.00	45.00	47.00	47.00	49.00	53.00	51.00	54.00	55.00	46.39
FY 90:	53.50	49.00	53.00	55.00	52.00	56.97							53.25
Early Intervention:													
FY 87:	0.00	1.00	1.25	1.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	1.60
FY 88:	2.00	2.00	2.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.25
FY 89:	1.00	1.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	2.00	2.00	0.83
FY 90:	2.00	2.00	3.00	3.00	3.00	4.00							2.83
TOTAL:													
FY 87:	576.00	568.00	579.65	726.30	633.50	643.50	656.30	654.50	689.50	699.00	703.00	698.90	652.35
FY 88:	673.40	686.40	681.50	726.30	671.50	682.70	695.70	701.70	686.70	683.70	686.70	699.70	689.67
FY 89:	673.60	654.51	650.71	627.54	684.63	683.13	681.38	675.38	693.38	692.05	700.47	717.30	677.84
FY 90:	671.46	701.46	696.30	715.30	696.30	696.67							696.25

EXHIBIT VIII

Clark County School District indicates an increase of 120 for July 91 and an additional 130 for July 92
There is no current waiting list for CTC Services.

COMMUNITY TRAINING CENTERS

EXECUTIVE BUDGET
DAILY RATE

	FY 1988	FY 1989	FY 1990	FY 1991
Regular Adult	$15.02	$15.25 (1.5%)	$15.71 (+3%)	$16.18 (3%)
Pre Workshop	$24.39	$24.75 (1.5%)	$25.49 (+3%)	$26.25 (3%)
Pre School	$16.60	$16.85 (1.5%)	$17.36 (+3%)	$17.88 (3%)

LEGISLATURE APPROVES
DAILY RATE

	FY 1988	FY 1989	FY 1990[1]	FY 1991[2]
Regular Adult	$15.02	$15.25 (+1.5%)	$15.92	$16.56
Pre-Workshop	$24.39	$24.75 (+1.5%)	$25.85	$26.88
Pre-School	$16.60	$16.85 (+1.5%)	$17.60	$18.30

[1] 6% over FY 1988 Actual for FY 1990

[2] Additional 4% increase in FY 1991

EXHIBIT IX (1)
27

DESERT DEVELOPMENTAL CENTER

Pre-Workshop	66 clients X 238 days X $25.85 =	$406,052	65 X 238 X $26.88 =	$415,834
Intensive	6 clients X 238 days X $51.70 =	$ 73,828	7 X 238 X $53.76 =	$ 89,564
Summer Program	20 clients X 45 days X $25.85 =	$ 23,265	20 X 45 X $26.88 =	$ 24,192
Special Intensive	4 clients X 750 hours X $17.30 =	$ 51,900	4 X 750 hours X $17.99 =	$ 53,970
Dual Diagnosis (FY 1991)			12 clients X 88 days X$26.88 =	$ 28,385
DDC Total		$555,045		$611,945

SIERRA DEVELOPMENTAL CENTER

	FY 1990		FY 1991	
Pre-Workshop	64 clients X 238 Days X $25.85 =	$393,747	64 X 238 X $26.88 =	$409,436
Intensive	6.5 clients X 238 Days X $51.70 =	$ 79,980	7.5 X 238 X $53.76 =	$ 95,962
Summer Program	12 clients X 45 Days X $25.85 =	$ 13,959	11 X 45 X $26.88 =	$ 13,306
Special Intensive	3 clients X 750 hours X $17.30 =	$ 38,925	3 X 750 X $17.99 =	$ 40,478
Dual Diagnosis (FY 1991)			12 clients X 88 days X $26.88 =	$ 28,385
		$526,611		$587,567

COMMUNITY TRAINING CENTER BUDGET

Regular Adult	506 clients X 229 days X $15.92 =	$1,844,714	518 X 229 X $16.56 =	$1,964,380
Pre-Workshop	42 clients X 218 days X $25.85 =	$ 236,683	42 X 218 X $26.88 =	$ 246,113
Pre-School & Early Intervention	115 clients X 173 days X $17.60 =	$ 350,152	15 X 173 X $18.30 =	$ 47,489
Pre-School (July, August FY 1991)			100 X 29 X $18.30 =	$ 53,070
Special Intensive	3 clients X 750 hours X $17.30=	$ 38,925	3 clients X 750 hours X $17.99 =	$ 40,478
	Total	$2,470,474	Total	$2,373,497
Add Min. Level Payments		$ 43,136		$ 44,430
		$2,513,610		$2,395,960

89SD8/ctc

EXHIBIT IX (2)
28

Chapter I, Special Education

This budget supports a number of federal grant programs which provide a variety of educational training and development services to clients in various parts of the state. The 1989 Legislature increased the appropriation funding for the Home Activity Program for Parents and Youngsters (HAPPY) to expand home-based education and related services to handicapped children and their families residing in rural Nevada and Clark County.

Rural Mental Retardation Services

The Rural Mental Retardation Services provides residential and community mental retardation services to the 15 rural counties which include community residential care and case management. The Rural Mental Retardation Services attempts to provide services throughout rural Nevada in the local communities. Caseload at the time of the study was 144 clients with a waiting list of 86.

Resident Placement Program

The Resident Placement Program, was established by NRS 435.120 and provides the main financial resource within the Division of Mental Health and Mental Retardation for placement of mentally retarded citizens in a community living program. This account pays for the non-institutional placements of individuals outside their natural homes and is the largest residential program operated by the Division of Mental Health and Mental Retardation. Funding for the account is maintained through the use of collections from families, plus third-party payments, supplemental security income, collections from social services, Medicaid (Title XIX waiver) and a general fund appropriation. The program also provides for relief and respite care. The community placement continuum allows mentally retarded individuals to reside in the least restrictive environment possible. Funding is also provided for respite care to needy families whose retarded family members are at risk of institutionalization. End-of-month caseload data for the community homes supported by the residential placement fund is displayed in Exhibit X and the growth of the program is detailed in Exhibit XI.

RESIDENTIAL PLACEMENT FUND

COMMUNITY HOMES
END OF MONTH CASELOADS

YEAR:	MONTH: J	A	S	O	N	D	J	F	M	A	M	J	Average
Developmental Homes													
FY 87:	69	53	55	54	57	55	62	65	63	59	62	55	59.08
FY 88:	51	50	56	52	56	56	52	58	58	65	64	68	57.17
FY 89:	69	67	65	62	59	61	61	62	57	60	64	58	62.08
FY 90:	59	59	58	52	51	51							55.00
Group Homes													
FY 87:	93	111	111	109	105	105	95	90	92	98	98	106	101.08
FY 88:	114	111	109	118	120	119	118	114	118	111	112	107	114.25
FY 89:	107	105	109	116	119	118	121	124	123	119	118	128	117.25
FY 90:	136	133	134	135	137	138							135.50
Independent Placements													
FY 87:	36	36	36	36	36	36	37	41	41	41	42	42	38.33
FY 88:	40	40	41	40	37	35	35	36	36	35	37	36	37.33
FY 89:	38	38	37	35	36	37	41	39	38	41	40	53	39.42
FY 90:	53	53	52	53	52	52							52.50
Community Habilitation Homes:													
FY 87:	63	63	62	62	62	62	60	66	65	66	67	68	63.83
FY 88:	66	68	67	67	67	67	73	75	75	74	74	74	70.58
FY 89:	71	73	72	73	74	74	74	74	81	81	83	84	76.17
FY 90:	82	83	86	87	86	85							84.83
TOTAL:													
FY 87:	261	263	264	261	260	258	254	262	261	264	269	271	262.33
FY 88:	271	269	273	277	280	277	278	283	287	285	287	285	279.33
FY 89:	285	283	283	286	288	290	297	299	299	301	305	323	294.92
FY 90:	330	328	330	327	326	326							327.83

EXHIBIT X

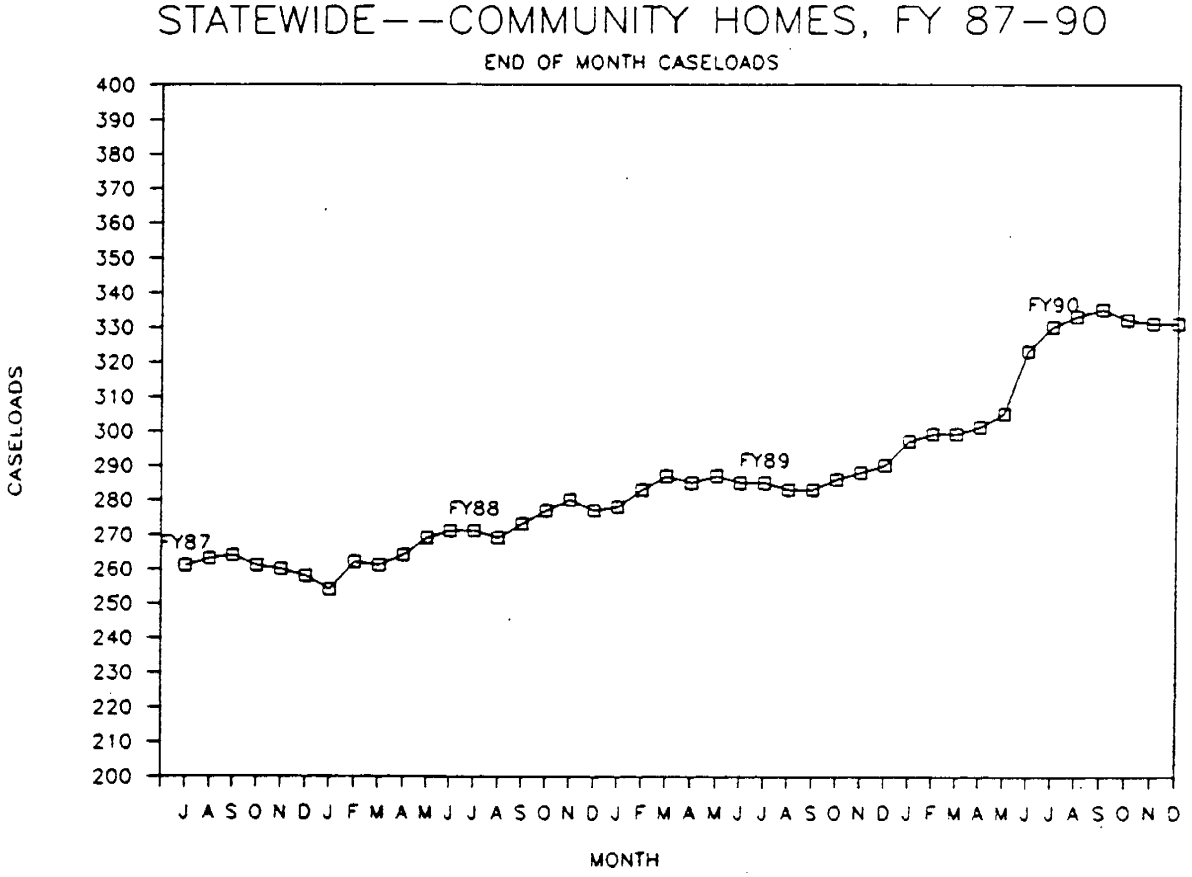

STATEWIDE--COMMUNITY HOMES, FY 87-90
END OF MONTH CASELOADS
CASELOADS
400
390
380
370
360
350
340
330
320
310
300
290
280
270
260
250
240
230
220
210
200
FY87
FY88
FY89
FY90
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
MONTH

EXHIBIT XI

Family Preservation Program

The Family Preservation Program (Home Care) was established in 1981 to provide financial assistance of up to a budgeted amount of $286 per month to aid individuals residing in Nevada and caring for their profoundly mentally retarded relatives in their own home. The purpose of this assistance is to prevent institutional placement of mentally retarded persons whose families might not otherwise be able to care for the family member in their home. Cash payments are made monthly by the Division based on financial need of the recipients. The program requires an annual re-determination of eligibility. The program serves as an alternative to institutional care and is a highly cost effective program which serves to maintain families and reduce the need for institutional care for severely and profoundly retarded individuals. Families who participate in this program also gain eligibility for other services under SSI and Title XIX that they may not otherwise receive because of family income.

Older Americans Program

The Division of Mental Health and Mental Retardation serves as the sponsor agency for two Older American volunteer programs. These programs are the Senior Volunteer Program and the Foster Grandparent Program. These services provide extensive services to state and local government agencies.

Domestic Violence Program

The Division of Mental Health and Mental Retardation serves as the responsible agency for administering the funds for Aid to Victims of Domestic Violence Program. Revenue for the program is provided by a $7 marriage license surcharge mandated under NRS 122.060 Sub-section 4. The surcharge is deposited in the state treasury by all counties and the Division is charged with the responsibility of awarding grants from the account for the aid to victims of domestic violence assuring compliance with the rules and regulations in NRS, quarterly monitoring program effectiveness and financial status, and providing a biennial report.

Ideal Services System

At the request of the ACR 52 Subcommittee, the Division of Mental Health and Mental Retardation developed, what they feel would be, an ideal service system for adult services for Mental Retardation Services and for Youth and Family Services. Those descriptions are provided in Appendix B. Central theme of the ideal service system is that it be readily accessible and have the capacity to deliver services appropriate to each client's needs and problems. Services should provide the minimum restrictive level of care designed to permit the client to continue or return to a productive life. The public service delivery system should be responsive to the needs of the clients, the concerns of citizens and integrated with private resources while at the same time being cost effective.

IV. FINDINGS AND RECOMMENDATIONS

The ACR 52 Subcommittee received considerable input from concerned individuals and groups regarding the operation of the Division of Mental Health and Mental Retardation. The subcommittee reviewed a great deal of information provided by the Division, concerned individuals/staff and received detailed testimony concerning the operation of the Division, its various programs, development and growth of its community programs.

The Division of Mental Health and Mental Retardation, along with a number of other state agencies, has experienced tremendous problems keeping pace with the growth of the population of the state. It's particularly a problem in the Clark County area where dramatic growth in the population has put a severe strain on almost all services provided by the Division of Mental Health and Mental Retardation. Appendix D through G displays Nevada's population by selected age groups by county from 1980 through a forecast for 1995. The subcommittee would like to acknowledge the receipt of this information from Mr. John Walker, of the Department of Administration. Appendix D, titled "Nevada's Population by Selected Age Grouping 1980", shows the statewide population was 800,508, with the Clark County total at 463,087 or approximately 57.8 percent of the state population. The forecast for 1995, displayed in Appendix G, anticipates a statewide population of 1,581,540 (a 97.5 percent increase statewide and 118.7 percent increase in Clark County) of which 1,013,020 citizens will reside in Clark County. This equates to in excess of 64 percent of the state population. This level of growth has affected all agencies of the Division of Mental Health and Mental Retardation.

In addition to the problems providing needed services in the adult and youth population, compounded by the rapid growth in the state, the subcommittee

expressed concern that with the aging population of the state, needed services should also be considered for the aged population. In 1980, those persons aged 65 and over comprised approximately 8.2 percent of the population; by 1995, this segment of the population is anticipated to grow in excess of 11.5 percent of the statewide total. Appendix H displays Nevada's age distribution from April 1980, to July 1989.

The subcommittee has a total of 21 recommendations which support the concept that the delivery of services should be based on the least restrictive level of care for the needs of the clients and the Division of Mental Health and Mental Retardation. The subcommittee recommends funding, through the budget process, a complete service delivery system with a fully developed continuum of community-based services. In reviewing the operation of the Division of Mental Health and Mental Retardation, it was evident to the members of the subcommittee that the cost-effective alternative of treating clients in the community, when appropriate, is a cost-effective alternative to the continuous state construction of residential beds. The subcommittee supports the need for more adult group home beds in the community. The subcommittee recommends:

1. **Support, through the budget process, of a completed mental health/mental retardation child and adolescent service system which would contain the following:**

   A. **Crisis intervention for children and their families (emotionally disturbed and mentally retarded).**

   B. **Family outreach services to bring professional support to families in crisis.**

   C. **Adequate day-treatment services including special classrooms when necessary.**

   D. **Community based residential services of a temporary nature until a disturbed/retarded child can return home, if possible.**

   E. **Adequate acute hospital beds for severely disturbed/retarded adolescents who require 24-hour awake professional care.**

   Extensive waiting lists exist for acute inpatient beds, residential services, family outreach and day-treatment programs. In December 1989 approximately forty children were placed out-of-state as a result of Nevada's inability to provide comprehensive services in the existing service system. The system has been

severely strained by the population growth being experienced by the state. The subcommittee feels that the service-delivery system should be completed and adequate resources put in place to assure efficient and humane treatment of clients. This should be accomplished as part of the normal budget process and the subcommittee strongly supports the completion of the service delivery system for children and adolescents.

2. **Support the construction of a sexual offender program (facility; minimum 12 beds) to be located in Clark County.**

The 1989 Legislature approved staffing and support costs for the operation of a 12-bed sexual offender program to be located jointly with Clark County Juvenile Services. Due to a number of problems, the anticipated program, as of August 1990, has yet to become operational and it may not be operational due to space limitations at Clark County Juvenile Services. In order to ensure the operation of this needed program, the subcommittee feels that the state should appropriate funds for construction of a minimum 12-bed sexual offender program to be located in Clark County. It may be possible to house this program jointly with additional Mental Health/Mental Retardation beds required for mentally disordered adolescent offenders.

3. **Support the construction of a facility to house mentally disturbed adolescent offenders, possibly forty to fifty beds, located in Clark County.**

The Division of Mental Health and Mental Retardation is proposing, to the Public Works Board, construction of a facility in Clark County which would accommodate forty adolescents. The structure of the building would be designed around 15 beds for evaluation, classification and referral to appropriate services and twenty-five beds for longer term treatment of difficult adjudicated offenders. The Division is anticipating that at least ten of these beds would be for the Sexual Offender Program, ten for non-sexual adolescent offenders and five beds possible for additional sex offenders or other purposes as demand dictates. Information pertaining to the construction of this facility is contained in Appendix I. The ACR 59 Subcommittee, from the 1987 Legislative Session, and the current ACR 52 Subcommittee received considerable testimony concerning the System's inability to handle youthful offenders who also have mental health problems. It was pointed out that there is a severe lack of appropriate bed space in Clark County to deal with youthful offenders who have severe emotional and/or mental health problems. Sending the youthful offender to Elko, where psychological and psychiatric assistance is limited, has proved to be a less than desirable option for the courts and the

juvenile probation officials. It should be noted that if a forty to fifty bed facility is constructed in Clark County, including the sexual offender beds, it would be in lieu of recommendation #2.

4. **Require MH/MR to submit, as part of their budget request, to the 1991 Legislative Session, a plan to eliminate all waiting lists.**

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

5. **Require all services provided by the Division MH/MR, or services contracted by MH/MR, to meet appropriate licensing standards. The Bureau of Health Facilities or the Nevada State Welfare Division or other appropriate regulatory agency should develop appropriate licensing standards for those facilities of the Division that currently do not have licensure standards.**

   The State Health Division supports this recommendation. The financial impact may result in an additional cost of approximately $10,000 so the Health Division could contract with a psychiatrist to assist with the inspection of the facilities. The establishment of licensing standards should ensure all clients are receiving quality consistent services.

6. **Develop a policy containing standards for those contractors with whom MH/MR contracts for services. The contractor should also be required to complete background checks on all employees.**

7. **Increase the number of school counselors in primary schools. This increase should begin with a ratio of 600:1 and phase in over six years to improve the ratio to 350:1. Each school district, regardless of size, should add at least one new counselor per district. Some districts currently do not provide counselor services to primary schools.**

   The ACR 52 Subcommittee received considerable testimony on the complex problems facing today's youth and the more demanding roles placed on the school districts in dealing with the children. The subcommittee felt that if many of the problems, being faced by children, could be addressed at the earliest opportunity, it would prevent a number of children having to enter the mental health system at a later date. It was explained that elementary school counselors are trained to use early intervention strategies to help children

achieve their potential and to identify children in need of additional assistance. Factors such as divorce, parental substance abuse, working parents, illiterate parents and abuse or neglect places a severe hardship on a child. The subcommittee was told that Nevada's children are facing problems of a critical nature that can only be addressed by trained school counselors and comprehensive guidance and counseling programs in the schools. A school counselor is a key person in the schools to help address such issues as prevention of dropouts, drug abuse, teen pregnancy, suicide and child abuse.

The subcommittee was provided a definition of a school counselor which is as follows: "School counselors are specifically credentialized professionals who work in school settings with students, parents, educators and others within the community. They design and manage comprehensive developmental and guidance programs to help students acquire skills in the social, personal, educational, and career areas necessary for living in a multi-cultural society. School counselors accomplish this by employing such interventions as guiding and counseling students individually or in small groups, by providing information through group guidance, by contributing to the development of effective learning environments, through student advocacy and through counseling with others." (Adopted Fall, 1989, American School of Counseling Association. Appendix J is a letter from Carol Aalbers, representing Nevada School Counselors Statewide Committee indicating their support for the need of additional school counselors.)

The subcommittee felt that the Legislature should take an immediate step in funding additional school counselors to achieve a district-wide ratio of one counselor to 600 elementary students. The anticipated cost of implementing such a program is approximately $8.5 million. The long-term goal is to begin with the ratio of 600:1 and phase in additional counselors over six years to improve the ratio to 350:1. Each school district, regardless of size, should add at least one new counselor per district. It was pointed out that some districts currently do not provide counseling service to primary schools. The anticipated cost to achieve a ratio of 350:1 was estimated to be $17.7 million. Appendix K is a memo from Marcia Bandera, Deputy Superintendent of Instruction, Department of Education, providing backup information on the development of the cost. The subcommittee was provided with a copy of a publication titled, Children Achieving Potential, An Introduction to Elementary School Counseling and State Level Policies prepared by the American Association of Counseling and Development. A copy of this publication is available for review in the Fiscal Analysis Division of the Legislative Counsel Bureau.

8. **Require MH/MR to provide for the improvement of vocational and supported employment programs for the mentally ill. This may include establishing Community Training Center (CTC) programs for the mentally ill similar to those operated for the mentally retarded. (The subcommittee feels the involvement of and coordination between MH/MR and the Rehabilitation Division will provide a greater variety of services to Mental Health/Mental Retardation clients.)**

It was pointed out that vocational services to the mentally ill are limited and this is an important training component for the mentally ill to provide the support necessary to them to prepare for gainful employment or to return to the world of work after the acute phase of their illness has been treated. This support should include pre-vocational training, help with preparation for job seeking and interviews, possible sheltered employment and supported employment in community-based jobs. The Division of Mental Health and Mental Retardation stated, "there is really no way we can re-integrate former patients into the community and hope to see them be successful without jobs and the support they may need to keep them. An increase in stipend funds will allow our mental health agencies to extend to the mentally ill the same support we now offer to the mentally retarded." The subcommittee feels that this should be a recommendation addressed as part of the budget process and reviewed by the Senate Finance and Assembly Ways and Means Committees.

9. **Expansion of the Advanced Information Management System (AIMS) to rural and northern Nevada.**

The 1989 Legislature recognized the lack of automation and data collection within the Division of Mental Health and Mental Retardation and passed Senate Bill 158, Chapter 732, which appropriated $494,464 to the Division of Mental Health and Mental Retardation for the purchase and installation of an advanced institutional management system (AIMS) computer package. The package was designed as a turn-key system which would provide the Division of Mental Health and Mental Retardation with the capabilities to automate such functions as client billing, integrated client data base management, client scheduling, event processing, pharmacy functions and drug utilization review, trust fund accounting, inventory management and psychological testing. The appropriation was designed to allow the southern region of the Division of Mental Health and Mental Retardation to implement the system including hardware, software, installation, training and system use. It was anticipated that once the system is installed and operational in southern Nevada, the

system would be expanded to rural and northern Nevada. At the time of the 1989 Legislature, the anticipated additional cost was $980,000. The latest cost projections, provided by the Division of Mental Health and Mental Retardation, indicate the cost to expand the system statewide to be almost $1.4 million and the cost to complete basic elements of the AIMS system, which were not included in the original appropriation, to be $526,000, equating to a total cost of $1,922,330. Appendix L deals with the backup information provided by the Division of Mental Health and Mental Retardation concerning full implementation of the AIMS system.

10. **Direct the Division of MH/MR to adopt active caseload standards based upon the needs of the clients and the types of review required. The committee felt that an average caseload Division-wide of one case manager to 35 clients was reasonable, however, some types of services may require a higher ratio (in-patient) or lower ratio (clients living independently in the community). The Division of MH/MR should report the ratio of case managers to clients by type of service to each session of the Legislature. (Provide current ratio, the number of additional case managers required, if any, and the cost of bringing the ratio back up to the standard.)**

The 1987 Session of the Nevada Legislature began working closely with the Division of Mental Health and Mental Retardation to develop suitable staffing ratios to ensure consistent quality treatment throughout the Division's agencies. The Division of Mental Health and Mental Retardation worked closely with the ACR 59 Study Committee, from the 1987 Session, and with the ACR 52 Study Committee to further develop suitable ratios for other types of service. The Division in 1981 adopted an out-patient standard which requires 25 hours of direct client services per work week. The standard for 67 percent of clinical time applies to all clinicians in the out-patient department. Medical records recording times are factored in the calculations. Recording allowances include ten minutes per client per fifty minutes of face-to-face contact and sixty minutes per hour of testing up to a maximum of ninety minutes per test battery. Full-time equivalent is based on net full-time equivalent available after sick and annual leave are deducted. New hires are recorded at half a full-time equivalent for the first two months following hire date. This allows new staff to build a caseload and become oriented to the agency's policies and procedures. The administrative portion of the program director's full-time equivalent is not included in the full-time equivalent available. The full-time equivalent for administration varies across programs but usually accounts for .5 full-time equivalent.

The Division pointed out the standard utilized in Nevada ranks among the most stringent of entities that have adopted similar standards. In a 1987 report done on outpatient productivity standards, the average standard across 14 states required 60 percent of a clinician's time to be in direct service. The range of the standards adopted were 55 percent to 67.5 percent. Additional information on productivity measurements is attached as Appendix M.

The ACR 52 Subcommittee felt strongly that case-management service is an important component of the service-delivery system. The service helps maintain contact with community-based clients and aids them in assessing social service support systems for which they are eligible. Case managers function in the community as well as being active with clients beginning with admission into a residential facility. They also work to help ensure adequate placements of clients back into the community once the need for hospitalization is complete.

The ACR 52 Subcommittee worked closely with the Division of Mental Health and Mental Retardation in assessing what a reasonable balanced caseload would be for case managers in the system. The case management staffing standard of one case manager to 35 clients was developed in 1986, based on a survey of experts identified at the National Institute of Mental Health. It was pointed out to the Division that recommended staffing ratios ranged as low as one to four (for a time limited intensive program). The consensus was that the most cases a case manager could carry and still effectively deliver direct services to clients was 35. Beyond that level, the experts felt that there would be only time for paper management of cases. The 1:35 ratio also assumes a balanced caseload so that extremely difficult and demanding cases are evenly distributed among case mangers. The estimated cost of moving the Division to a standard of one case manager division wide to 35 clients is approximately $2.4 million per year. Appendix N deals with a case management study requested by the Division of Mental Health and Mental Retardation and also provides additional information in reference to a description of the services provided by case managers serving the chronically mentally ill.

11. **Improve the coordination of drug/alcohol services for MH/MR clients. One position should be allocated to the two major Mental Health/Mental Retardation campuses (one in Reno, one in Las Vegas) to help coordinate these services.**

The ACR 52 Subcommittee had great concern about the impact of drug and alcohol abuse on the caseload of the Division and the need for closer coordination between the Division of Rehabilitation Bureau of Alcohol and Drug Abuse and the Division of Mental Health and Mental Retardation and ensuring that dual-diagnosed clients are identified and treatment provided whenever possible. At the request of the subcommittee, the Division of Mental Health and Mental Retardation surveyed their caseload data and found that a significant number of clients admitted to the two adult facilities have a primary problem of substance abuse. Data concerning the primary problem of substance abuse by agency from Fiscal Year 1986 through Fiscal Year 1989 is displayed in Exhibit XII.

AGENCY ADMISSIONS WITH PRIMARY PROBLEM OF SUBSTANCE ABUSE:

YEAR	AGENCY	TOTAL ADMITS	ALCOHO ADMITS	DRUGS ADMITS	% OF ADMITS
FY 86	SNAMHS	4065	360	247	14.9%
	NMHI	1602	155	58	13.3%
FY 87	SNAMHS	3890	453	287	19.0%
	NMHI	1738	211	112	18.6%
FY 88	SNAMHS	3889	355	252	15.6%
	NMHI	1564	182	121	19.3%
FY 89*	SNAMHS	2884	327	196	18.1%
	NMHI	1499	129	103	15.5%

Not only do these clients require additional treatment and services while inpatients, it was also pointed out that clients in an outpatient setting, with substance abuse problems, typically require additional and more intensive treatment than clients who do not have complications from substance abuse. According to the Nevada Mental Health Institute Community Services Program, these clients require smaller more frequent prescriptions, appointments must be scheduled more frequently, more intensive case management must be provided, and often treatment outcome is significantly less positive. The ACR 52 Subcommittee found the administration of the Rehabilitation Division willing to work with the Division of Mental Health and Mental Retardation in ensuring that improved alcohol and drug abuse services are provided to clients with substance abuse problems served by the Division of Mental Health and Mental Retardation. The Bureau of Vocational Rehabilitation has been working closely with the Division of Mental Health and Mental Retardation and provided data contained in Appendix O indicating these disabling conditions constituted 20 percent of the total cases (845) rehabilitated from July 1, 1988 to June 30, 1989. Bureau offices are co-located with mental health agencies at Southern Nevada Mental Health Center, North Las Vegas, Truckee Meadows Hospital, Elko, Fallon and Henderson. Recently, the Bureau also began placing staff resources at the Nevada Mental Health Institute.

12. **Direct MH/MR and the Rehabilitation Division to work with other private and public agencies to facilitate the development of medical detoxification programs in southern and northern Nevada.**

With a large percentage of clients having substance abuse problems, the ACR 52 Subcommittee became acutely aware of the lack of a medical detoxification program to help stabilize these clients prior to service. The ACR 52 Subcommittee worked closely with the Bureau of Alcohol and Drug Abuse and the Division of Mental Health and Mental Retardation in attempting to determine what services are available and what additional steps could be taken to help bring about medical detoxification programs both in the northern and southern parts of the state. Appendix P is a response from Liz Breshears, Chief Bureau of Alcohol and Drug Abuse pertaining to information requested by the subcommittee. The attachment deals with a short explanation of (1) the Bureau of Alcohol and Drug Abuse' capacity to participate in the medical detoxification program; (2) the history of detoxification services in northern Nevada; and, (3) an explanation of the difference between detoxification and civil protective custody. The ACR 52 Subcommittee felt that the Division of Mental Health and Mental Retardation and the Bureau of Alcohol and Drug

Abuse should work closely with the city and county officials to assist in the development of a medical detoxification program. The city and county jails are dealing with a number of individuals incarcerated and in need of some form of detoxification services.

13. **Direct MH/MR to work with the Community Training Centers, group homes and developmental homes to develop a payment formula which will more adequately reflect reasonable costs (i.e., funding for all days in which services are provided). The payment level should be based upon levels of care provided. The Division of MH/MR should present its recommendation in this area to the Budget Office and the Legislature.**

It was pointed out to the subcommittee by officials of the community training centers that many times, due to budgetary limitations, they have not been provided payment for services provided to clients of the Division of Mental Health and Mental Retardation, and that payment levels have not kept pace with the costs of providing those services. The ACR 52 Subcommittee recommends that the Division of Mental Health and Mental Retardation work closely with the community training centers and other contract care providers in developing rate schedules for different types of service to be provided to the clients. The ACR 52 Subcommittee recommends that Division of Mental Health and Mental Retardation report to the chairmen of the two money committees concerning the development of a payment formula which more adequately reflects reasonable costs taking into consideration that the payment levels should be based upon the levels of care provided.

14. **Relocate the Office of Protection and Advocacy from reporting to the Director of the Department of Commerce to reporting directly to the Governor.**

The ACR 52 Subcommittee received testimony from officials of the community training centers and from the Northern Nevada Alliance for the Mentally Ill (NNAMI) in reference to their concern that the Office of Protection and Advocacy could not always act totally independently being part of the Executive Branch of Government. They pointed out that since the office has been placed under the Director of the Department of Commerce, which deals with regulatory functions, that the high profile and support of the Governor cannot always be assured. The stated that the office should be totally removed from state government and be a non-profit agency. The ACR 52 Subcommittee did not agree with this recommendation but felt that the office should be in more direct contact with the Governor and should be returned administratively to answer directly to the Governor, as it formerly did.

Appendix Q is a letter from Holli Elder, Office of Protection and Advocacy indicating that she has no plans, on behalf of the office or as an individual, to submit a proposal to change the placement of the office.

15. **Allow MH/MR to hire and retain both board eligible and board certified psychiatrists. (Same as the rest of state government including the Department of Prisons.)**

The Division of Mental Health and Mental Retardation has historically had considerable problems recruiting staff psychiatrists to work for the Division of Mental Health and Mental Retardation. Frequently the Division of Mental Health and Mental Retardation has to resort to moving salary dollars to contract services in order to provide the necessary medical psychiatric coverage for clients of the Division. The contract costs historically average twice the rate of staff psychiatrists, and it is felt that reliance on contract psychiatrists, in lieu of staff psychiatrists, is a less than desirable option to provide the ongoing care required of clients of the Division. One of the major recruitment burdens, faced by the Division of Mental Health and Mental Retardation, is a requirement that all psychiatrists working for the Division of Mental Health and Mental Retardation either be board certified or receive board certification after five years of employment. It was pointed out to the subcommittee that of the approximately 18,000 to 19,000 psychiatrists in the United States, only about 7,000 are board certified. The rest of state government, including the Department of Prisons, recruits on an ongoing basis, not only board-certified psychiatrists but also are permitted to fill psychiatric positions with those who are board eligible. The ACR 52 Subcommittee put the question to the Division of Mental Health and Mental Retardation of whether the hiring of board-eligible psychiatrists versus board certified would reduce the quality of care provided to clients.

The Division of Mental Health and Mental Retardation felt that there would not be a necessary lowering of their standards by recruiting board eligible versus board certified. Allowing them to recruit board eligibles, as does the rest of state government, would go a long way in ensuring that the state positions would be filled by qualified psychiatrists that are staff positions rather than contract. The Division's response is contained in Appendix R.

16. **Expand funding for respite care for Mental Health/Mental Retardation clients by one additional week.**

The ACR 59 Subcommittee, from the 1987 Session, and the ACR 52 Subcommittee, from the 1989 Session, studying the Division of Mental Health and Mental Retardation both received testimony that one of the best forms of treatment and most cost efficient is to provide services to clients in the family or contract home. With the ongoing, 24-hour-a-day, demand placed on the family by having a mentally retarded or emotionally disturbed client residing within the home, respite care provided by the Division is of great importance to that family. Respite care provides a break for the family giving ongoing 24-hour-a-day care to the client; goes a long way in ensuring the successful placement within the home setting; and helps prevent numerous cases of institutionalization of clients. Currently, the Division of Mental Health and Mental Retardation provides respite relief of up to two weeks a year, and the ACR 52 Subcommittee recommends that this be expanded by one additional week for those wishing to avail themselves of this service. The Division of Mental Health and Mental Retardation estimates that the cost of an additional week would range between $30-$40,000 per year. Appendix S provides additional information concerning the respite care program that was implemented in July 1989.

17. **Direct the Bureau of Health Facilities to develop separate licensing standards for Intermediate Care Facilities-Mental Retardation Small (ICF-MR).**

The Division of Mental Health and Mental Retardation is facing a problem with licensing of intermediate-care-mentally retarded (ICF-MR) small facilities for 15 or fewer residents who are treated differently than intermediate care facilities by federal law. The Division pointed out that state requirements must parallel the federal requirements in order to maintain Medicaid funding. Present licensing under intermediate care standards provide an expensive and unnecessary level of care for clients who do not need the additional requirements. The possibility of developing separate licensing requirements for the intermediate care-mentally retarded facilities was discussed with the administrator of the Health Division who agreed with the need for some possible changes in the current licensing of these facilities.

18. **Support the continued development of specialized foster care for extremely disturbed children as a joint effort between MH/MR and the Welfare Division.**

The Nevada State Welfare Division and the Division of Mental Health and Mental Retardation have worked jointly in developing a placement model for therapeutic foster homes. The primary goal of the program is a permanent home where adjustment gains can be maintained. The program is an

alternative to more restrictive placements for continued long-term placement in an institution. The median length of stay, as experienced by Southern Nevada Child and Adolescent Services, is twelve months. The program is used for seriously emotionally disturbed children, between the ages of 4 and 16, with prior histories of multiple placements. It was pointed out that these children typically lack viable family resources, possess a history of poor school performance and some have been physically, sexually and/or emotionally abused. The responsibilities for the program are broken down with the Welfare Division being responsible for payment to the therapeutic family care professional parent for specialized services provided to children in their care, provision of medical and dental care, and provision of a case manager. The Division of Mental Health and Mental Retardation would be responsible for recruitment of homes, screening, referrals for placement, negotiating and completing individual treatment agreements, development of a treatment plan and coordinating visits with parents, providing initial and ongoing training and providing ongoing counseling for the child in placement. The subcommittee felt that this was a viable program that has been demonstrated to be working effectively in southern Nevada and the Division of Mental Health and Mental Retardation, and the Welfare Division should be encouraged to expand this program statewide.

19. **Require MH/MR to complete a needs assessment and report findings and recommendations to the 1993 Legislature. (Include appropriation to assist with study.) The Division of MH/MR should have the necessary staff and programs to deal with the needs of the increased aged population in this state.**

It has been pointed out that with the rapid growth in the state population, especially with the anticipated increased growth in the aged population, the State of Nevada and the Division of Mental Health and Mental Retardation should be in a position to plan for specialized mental health services for the geriatric population. The Nevada Mental Health Institute currently operates an 18-bed geriatric program without a similar program in place in southern Nevada. The subcommittee felt that with the expanding population of senior citizens, the Division needs to be in the forefront of dealing with the current problems of this population and be in a better position to deal with them in the future. The Division of Mental Health and Mental Retardation feels that they could do a detailed needs assessment on the mental health/geriatric services at a cost of $10,000 for a specialized consultant to assist staff in this study. The study should be completed and its findings and recommendations reported to the 1993 Legislature.

20. **Support required training for employees of facilities to whom MH/MR contracts for services.**

The subcommittee expressed concern that contractors providing residential services may have employees who lack the training and experience required by standards maintained by the Division of Mental Health and Mental Retardation. It was felt that the Division of Mental Health and Mental Retardation should work closely with the contractor to allow employees to participate in training provided to direct care staff of the Division of Mental Health and Mental Retardation. The subcommittee felt that additional costs incurred by contract staff participating in required training should be taken into consideration by the Division of Mental Health and Mental Retardation, the administration and the legislative money committees in developing final recommended budgets.

21. **Encourage MH/MR and private care providers to work closely together to ensure a smooth transition for clients from private to state facilities, whenever possible. Discharge planning from private facilities should involve state staff when appropriate.**

The ACR 52 Subcommittee received a number of complaints concerning inappropriate discharge planning from private facilities to state facilities. The Division of Mental Health and Mental Retardation is working with private hospitals to ensure a reasonable transition which is clinically sound and not wait until insurance funds run out on patients and then attempt to commit them to the Division. The subcommittee recommends that the Division of Mental Health and Mental Retardation report to the chairmen of the two money committees regarding necessary changes in statute to ensure a smooth transition from private to state facilities.

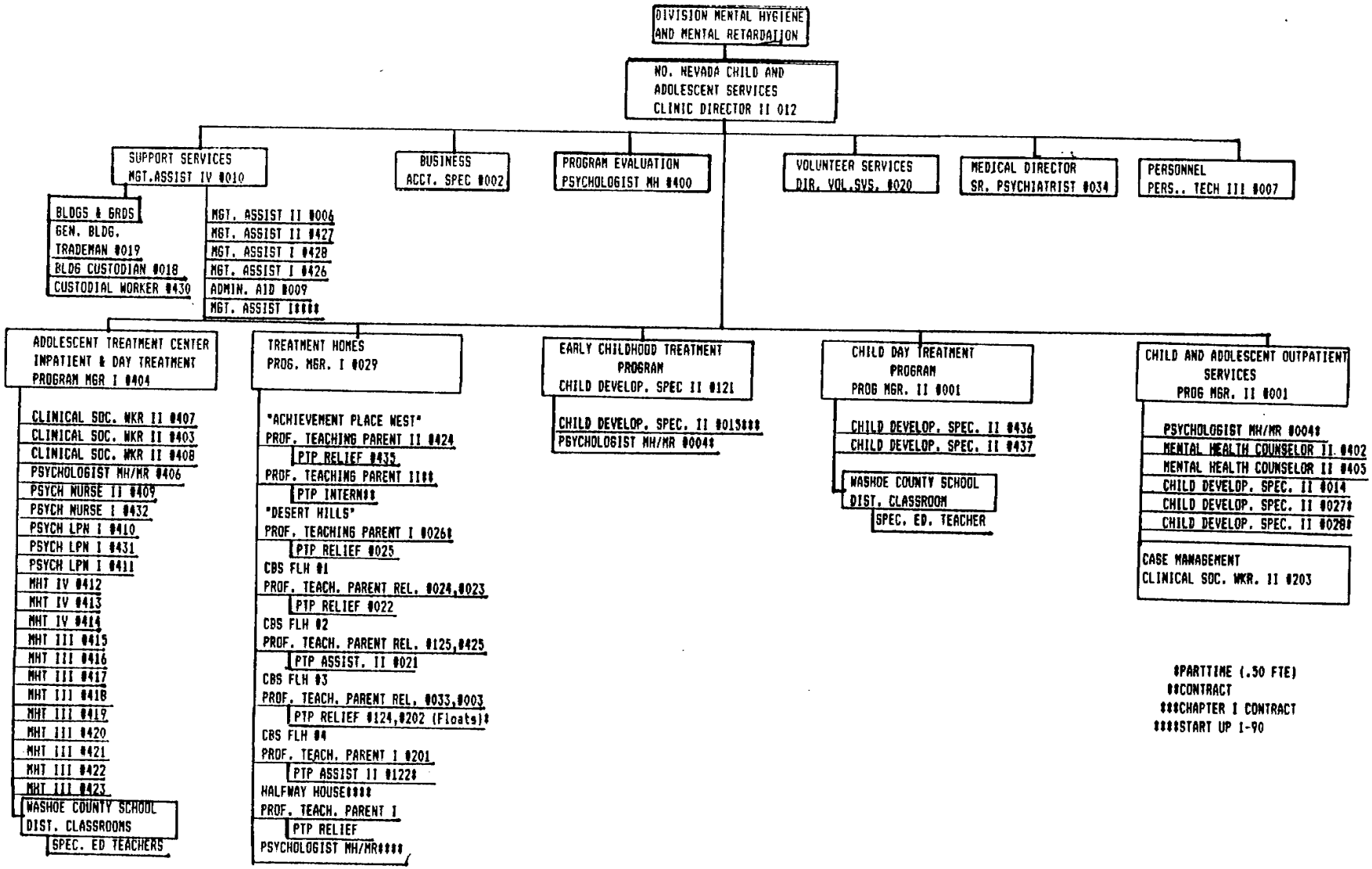
V. APPENDICES

BILL DRAFT REQUESTS

APPENDIX A
ORGANIZATION CHARTS

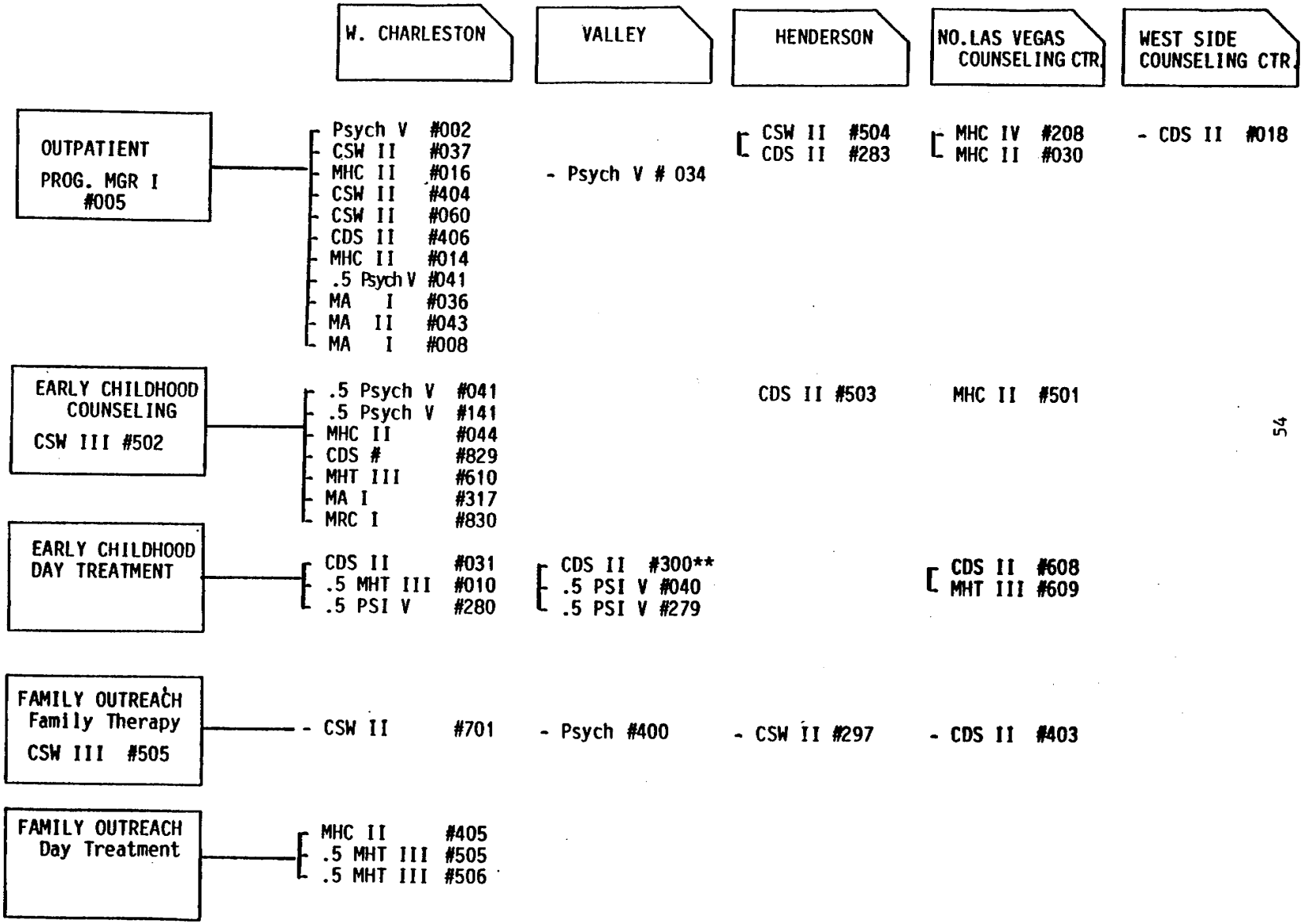
ORGANIZATION CHART

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES

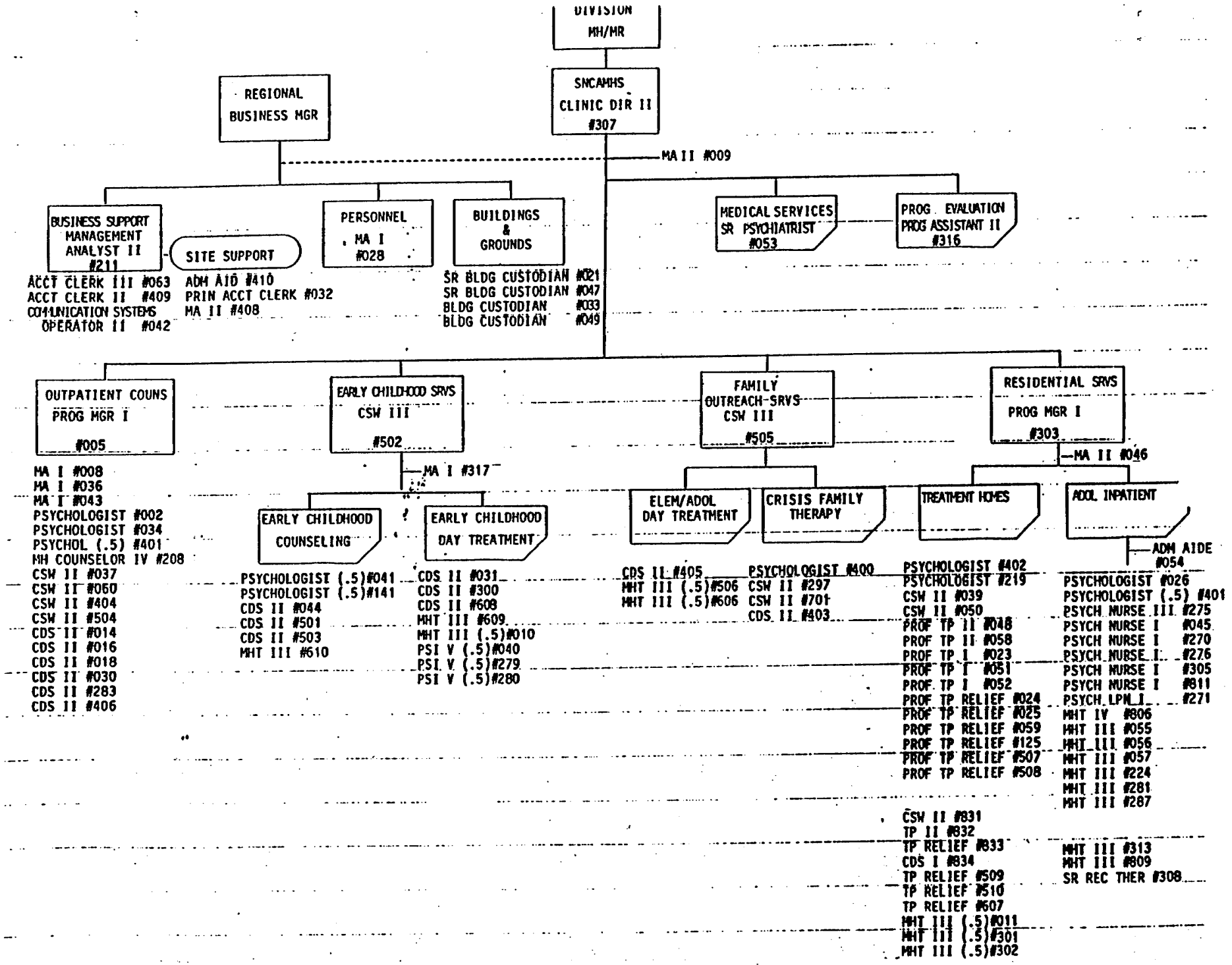


#PARTTIME (.50 FTE)
##CONTRACT
###CHAPTER I CONTRACT
####START UP 1-90

ORGANIZATIONAL CHART
BY SITE*



*ALL RESIDENTIAL STAFF LOCATED AT W. CHARLESTON SITE
**UNLV SITE


DIVISION
MH/MR
REGIONAL
BUSINESS MGR
SNCAMHS
CLINIC DIR II
#307
MA II #009
BUSINESS SUPPORT
MANAGEMENT
ANALYST II
#211
SITE SUPPORT
PERSONNEL
MA I
#028
BUILDINGS
&
GROUNDS
MEDICAL SERVICES
SR PSYCHIATRIST
#053
PROG EVALUATION
PROG ASSISTANT II
#316
ACCT CLERK III #063
ACCT CLERK II #409
COMMUNICATION SYSTEMS
OPERATOR II #042
ADM AID #410
PRIN ACCT CLERK #032
MA II #408
SR BLDG CUSTODIAN #021
SR BLDG CUSTODIAN #047
BLDG CUSTODIAN #033
BLDG CUSTODIAN #049
OUTPATIENT COUNS
PROG MGR I
#005
EARLY CHILDHOOD SRVS
CSW III
#502
FAMILY
OUTREACH-SRVS
CSW III
#505
RESIDENTIAL SRVS
PROG MGR I
#303
MA II #046
MA I #317
MA I #008
MA I #036
MA I #043
PSYCHOLOGIST #002
PSYCHOLOGIST #034
PSYCHOL (.5) #401
MH COUNSELOR IV #208
CSW II #037
CSW II #060
CSW II #404
CSW II #504
CDS II #014
CDS II #016
CDS II #018
CDS II #030
CDS II #283
CDS II #406
EARLY CHILDHOOD
COUNSELING
EARLY CHILDHOOD
DAY TREATMENT
ELEM/ADOL
DAY TREATMENT
CRISIS FAMILY
THERAPY
TREATMENT HOMES
ADOL INPATIENT
ADM AIDE
#054
PSYCHOLOGIST (.5)#041
PSYCHOLOGIST (.5)#141
CDS II #044
CDS II #501
CDS II #503
MHT III #610
CDS II #031
CDS II #300
CDS II #608
MHT III #609
MHT III (.5)#010
PSI V (.5)#040
PSI V (.5)#279
PSI V (.5)#280
CDS II #405
MHT III (.5)#506
MHT III (.5)#606
PSYCHOLOGIST #400
CSW II #297
CSW II #701
CDS II #403
PSYCHOLOGIST #402
PSYCHOLOGIST #219
CSW II #039
CSW II #050
PROF TP II #048
PROF TP II #058
PROF TP I #023
PROF TP I #051
PROF TP I #052
PROF TP RELIEF #024
PROF TP RELIEF #025
PROF TP RELIEF #059
PROF TP RELIEF #125
PROF TP RELIEF #507
PROF TP RELIEF #508
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TP II #832
TP RELIEF #833
CDS I #834
TP RELIEF #509
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TP RELIEF #607
MHT III (.5)#011
MHT III (.5)#301
MHT III (.5)#302
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PSYCHOLOGIST (.5) #401
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PSYCH NURSE I #045
PSYCH NURSE I #270
PSYCH NURSE I #276
PSYCH NURSE I #305
PSYCH NURSE I #811
PSYCH LPN I #271
MHT IV #806
MHT III #055
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MHT III #057
MHT III #224
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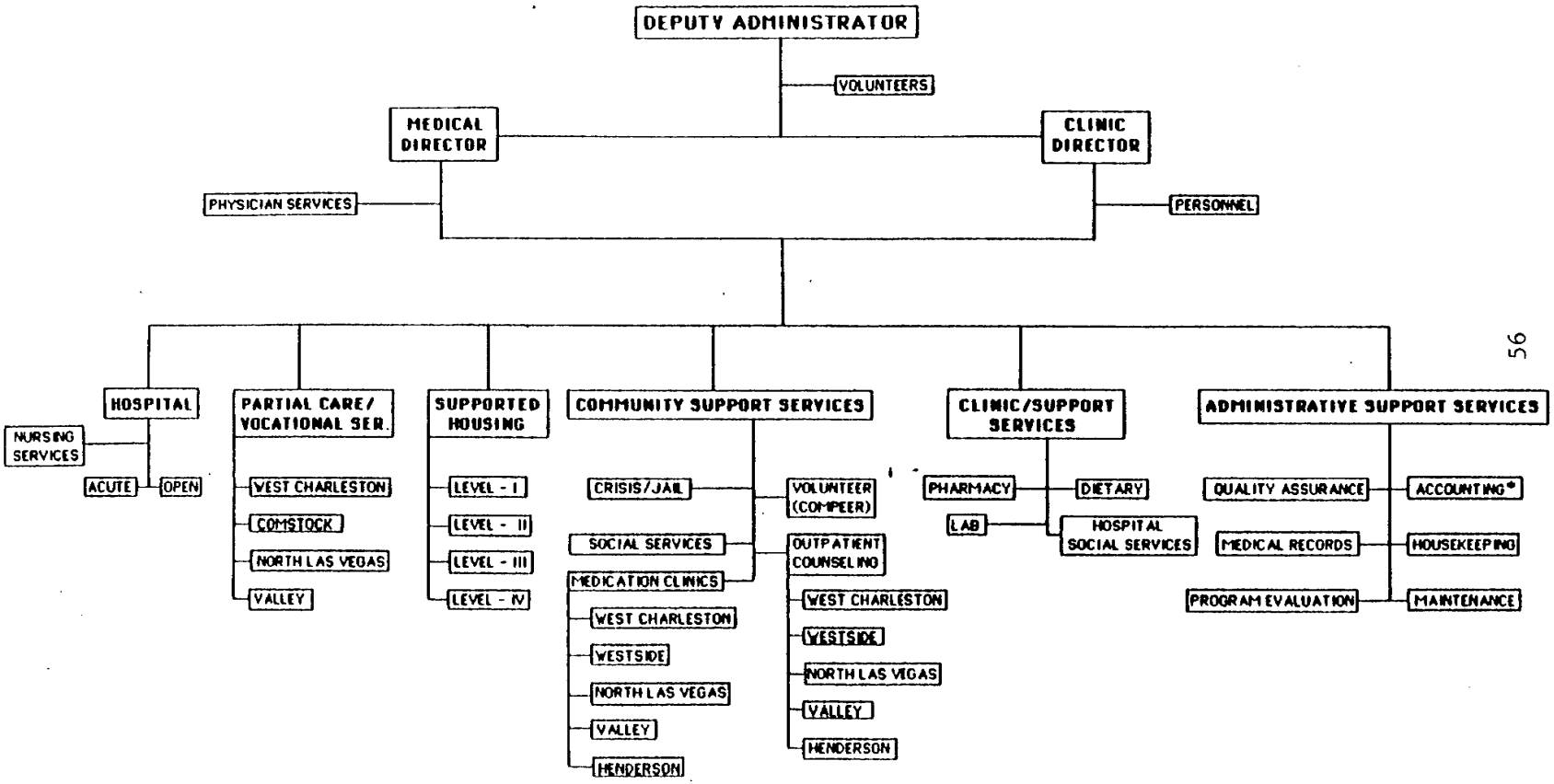
MHT III #809
SR REC THER #308

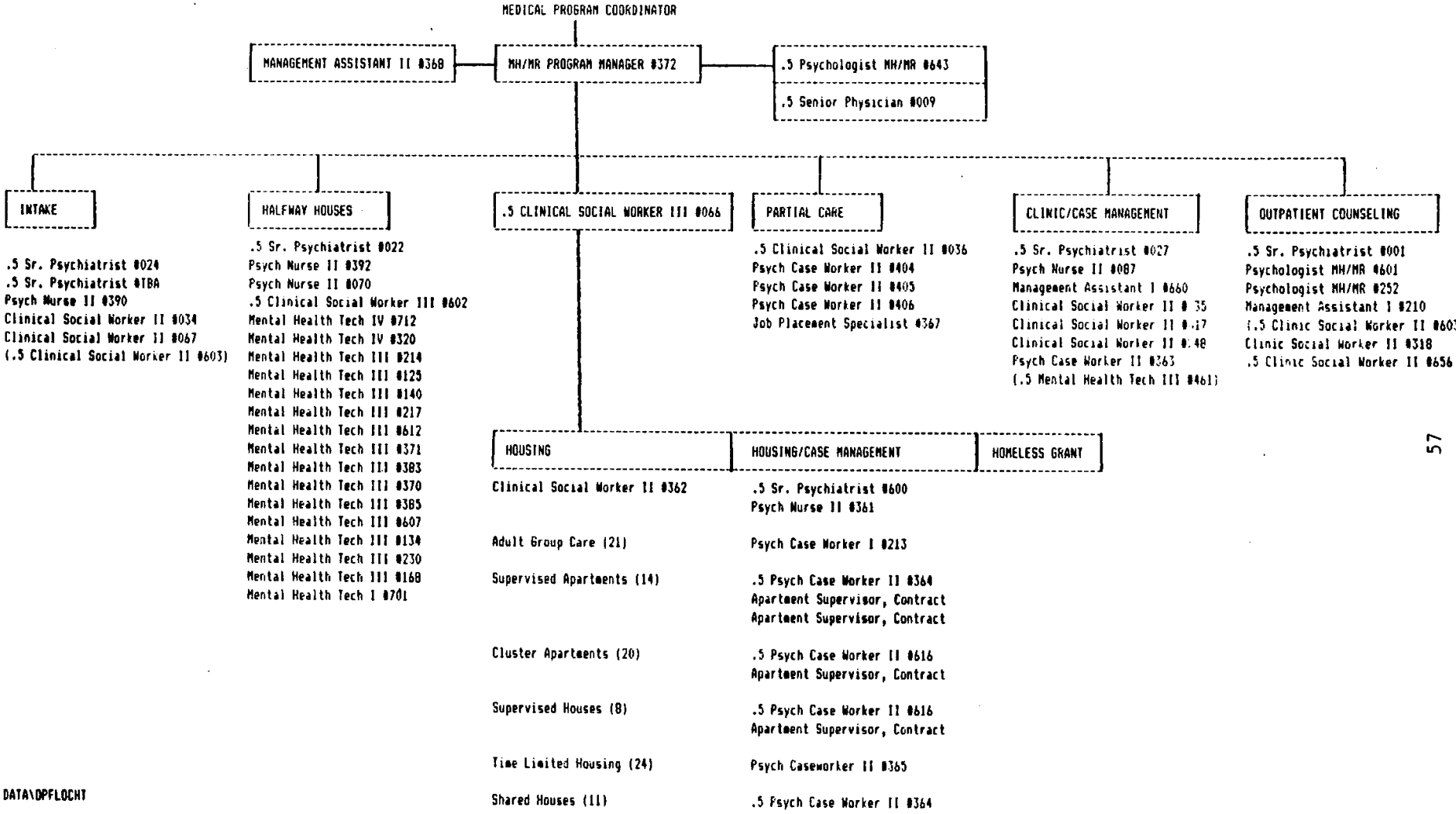
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES ORGANIZATIONAL CHART



10/4/89

*Supervision of Business Manager is provided through Chief Accountant, Division MH/MR

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES-COMMUNITY SERVICES



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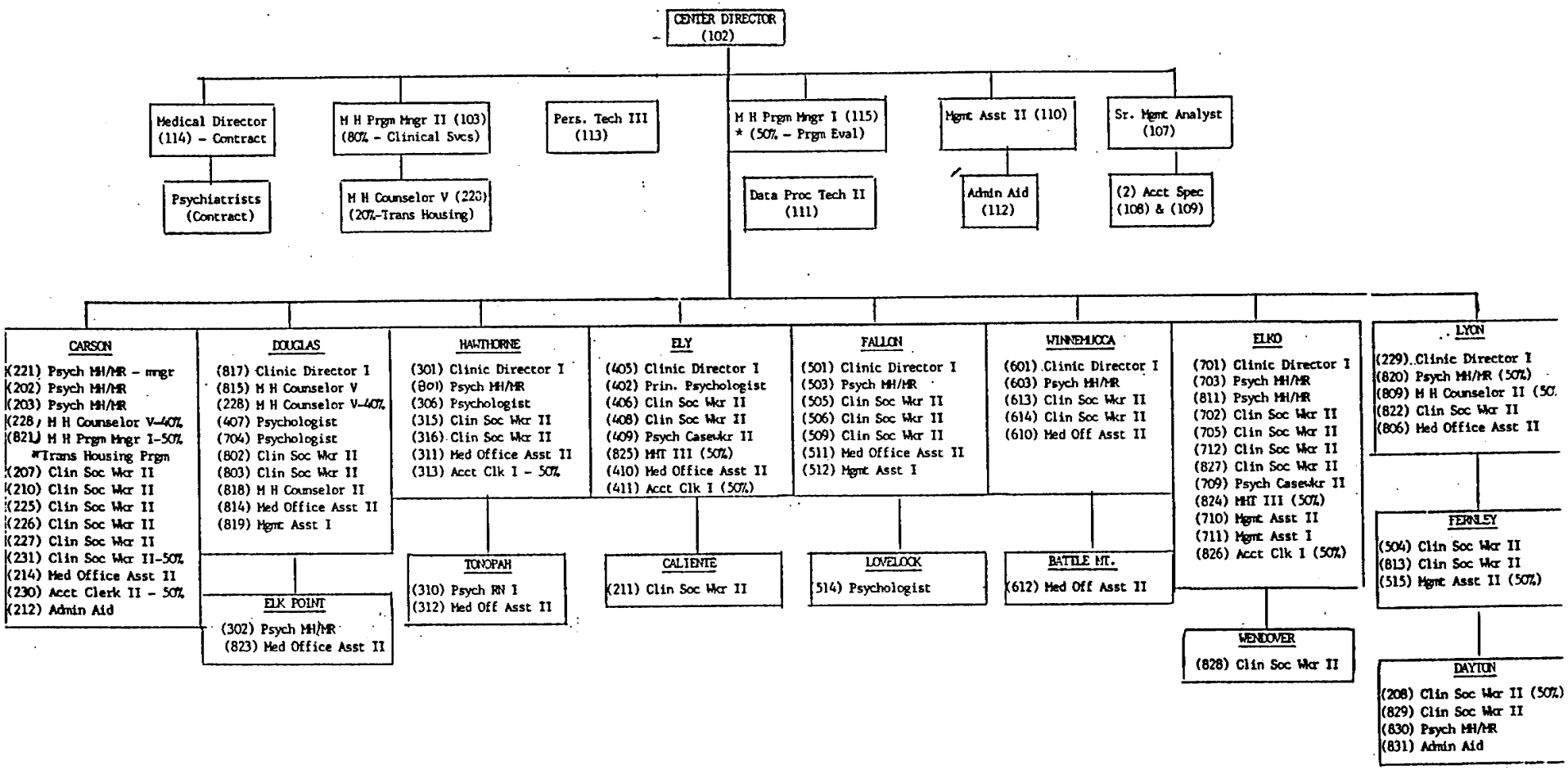
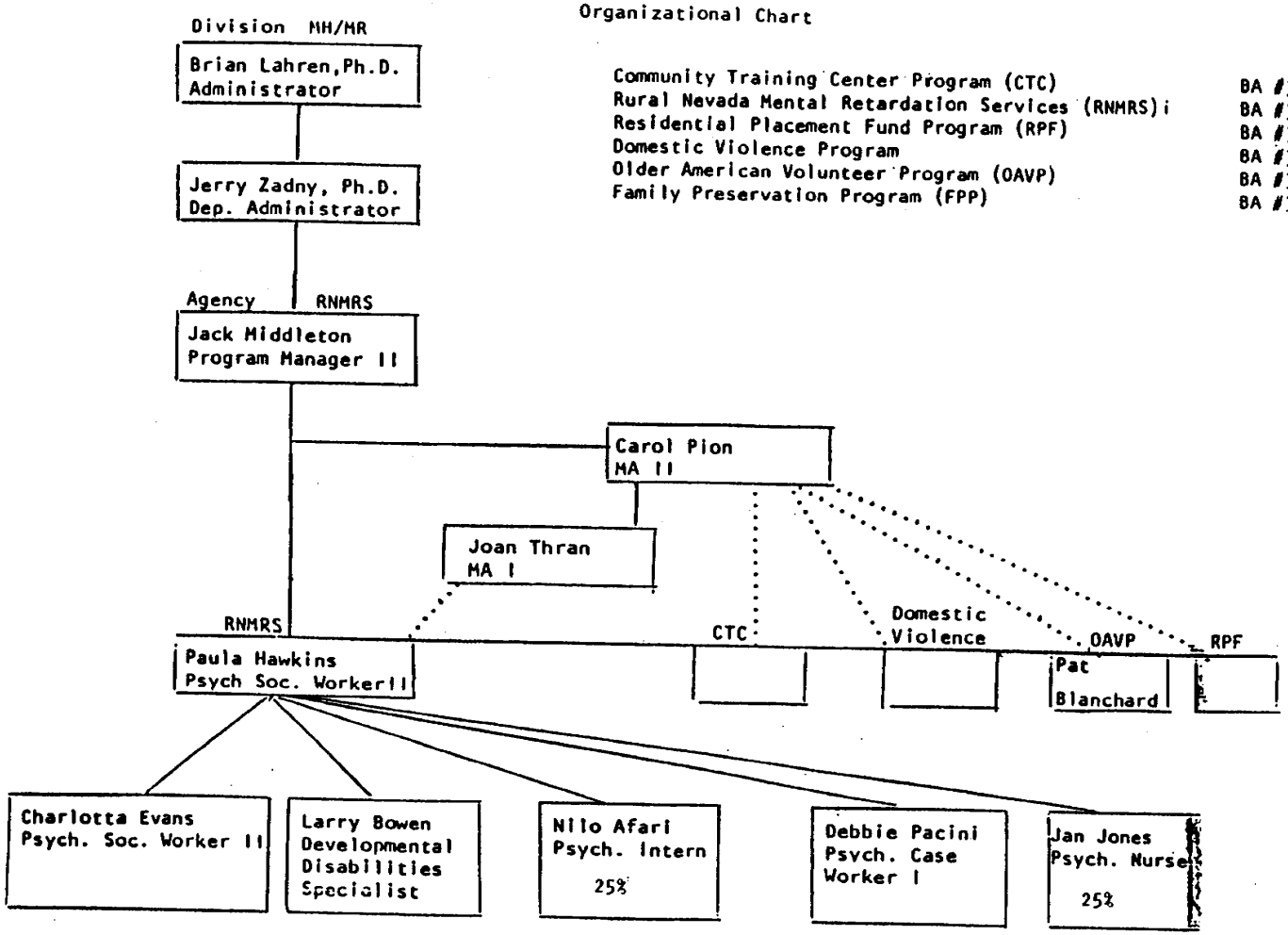
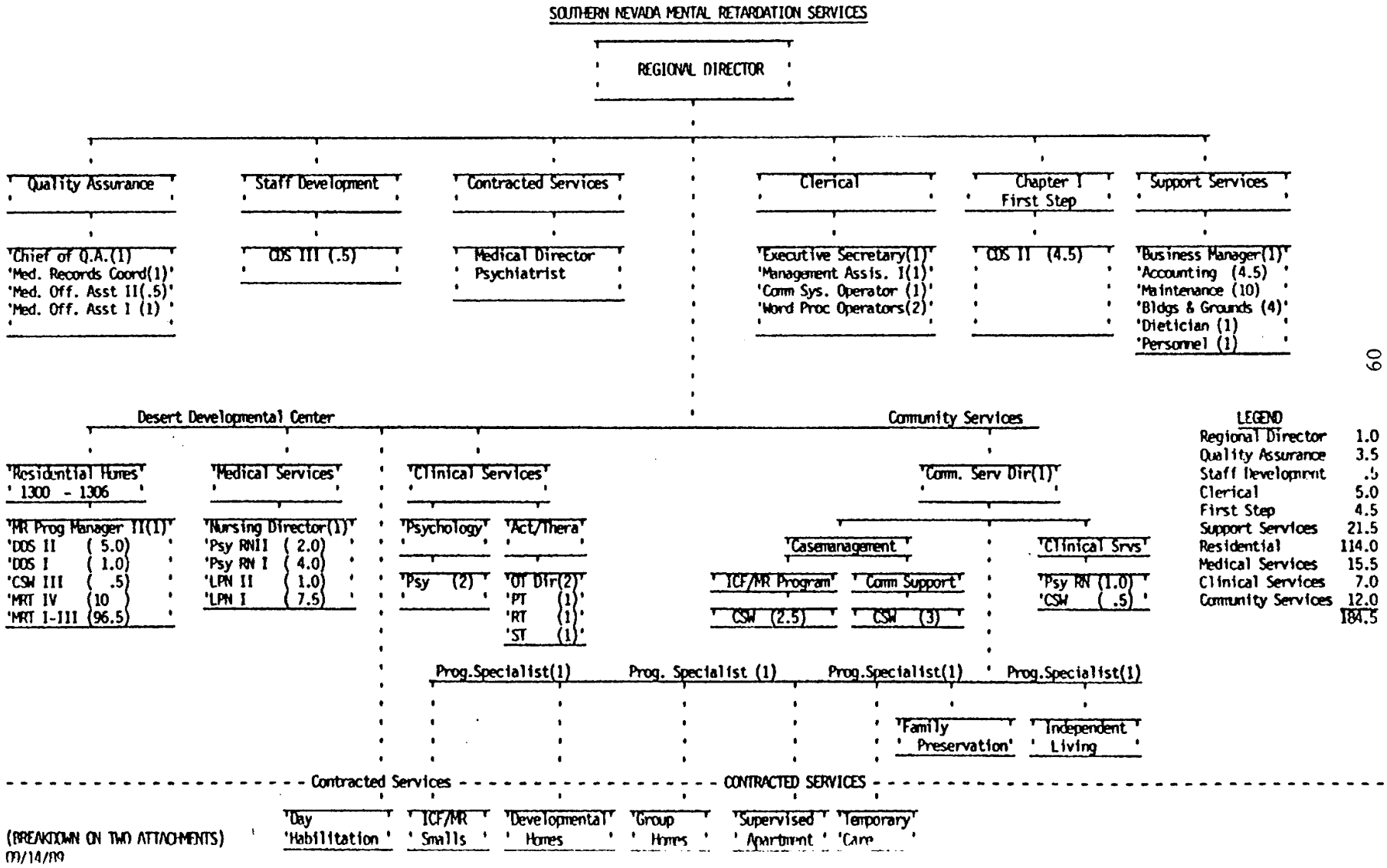

CENTER DIRECTOR
(102)
Medical Director
(114) - Contract
Psychiatrists
(Contract)
M H Prgm Mngr II (103)
(80% - Clinical Svcs)
M H Counselor V (220)
(20%-Trans Housing)
Pers. Tech III
(113)
M H Prgm Mngr I (115)
* (50% - Prgm Eval)
Data Proc Tech II
(111)
Mgmt Asst II (110)
Admin Aid
(112)
Sr. Mgmt Analyst
(107)
(2) Acct Spec
(108) & (109)
CARSON
(221) Psych MH/MR - mngr
(202) Psych MH/MR
(203) Psych MH/MR
(228) M H Counselor V-40%
(821) M H Prgm Mngr I-50%
#Trans Housing Prgm
(207) Clin Soc Wkr II
(210) Clin Soc Wkr II
(225) Clin Soc Wkr II
(226) Clin Soc Wkr II
(227) Clin Soc Wkr II
(231) Clin Soc Wkr II-50%
(214) Med Office Asst II
(230) Acct Clerk II - 50%
(212) Admin Aid
DOUGLAS
(817) Clinic Director I
(815) M H Counselor V
(228) M H Counselor V-40%
(407) Psychologist
(704) Psychologist
(802) Clin Soc Wkr II
(803) Clin Soc Wkr II
(818) M H Counselor II
(814) Med Office Asst II
(819) Mgmt Asst I
ELK POINT
(302) Psych MH/MR
(823) Med Office Asst II
HAWTHORNE
(301) Clinic Director I
(801) Psych MH/MR
(306) Psychologist
(315) Clin Soc Wkr II
(316) Clin Soc Wkr II
(311) Med Office Asst II
(313) Acct Clk I - 50%
TONOPAH
(310) Psych RN I
(312) Med Off Asst II
ELY
(405) Clinic Director I
(402) Prin. Psychologist
(406) Clin Soc Wkr II
(408) Clin Soc Wkr II
(409) Psych Case-Wkr II
(825) MHT III (50%)
(410) Med Office Asst II
(411) Acct Clk I (50%)
CALIENTE
(211) Clin Soc Wkr II
FALLON
(501) Clinic Director I
(503) Psych MH/MR
(505) Clin Soc Wkr II
(506) Clin Soc Wkr II
(509) Clin Soc Wkr II
(511) Med Office Asst II
(512) Mgmt Asst I
LOVELOCK
514) Psychologist
WINNEMUCCA
(601) Clinic Director I
(603) Psych MH/MR
(613) Clin Soc Wkr II
(614) Clin Soc Wkr II
(610) Med Off Asst II
BATTLE MT.
(612) Med Off Asst II
ELKO
(701) Clinic Director I
(703) Psych MH/MR
(811) Psych MH/MR
(702) Clin Soc Wkr II
(705) Clin Soc Wkr II
(712) Clin Soc Wkr II
(827) Clin Soc Wkr II
(709) Psych Case-Wkr II
(824) MHT III (50%)
(710) Mgmt Asst II
(711) Mgmt Asst I
(826) Acct Clk I (50%)
WENDOVER
(828) Clin Soc Wkr II
LYON
(229) Clinic Director I
(820) Psych MH/MR (50%)
(809) M H Counselor II (50%
(822) Clin Soc Wkr II
(806) Med Office Asst II
FERNLEY
(504) Clin Soc Wkr II
(813) Clin Soc Wkr II
(515) Mgmt Asst II (50%)
DAYTON
(208) Clin Soc Wkr II (50%)
(829) Clin Soc Wkr II
(830) Psych MH/MR
(831) Admin Aid

DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

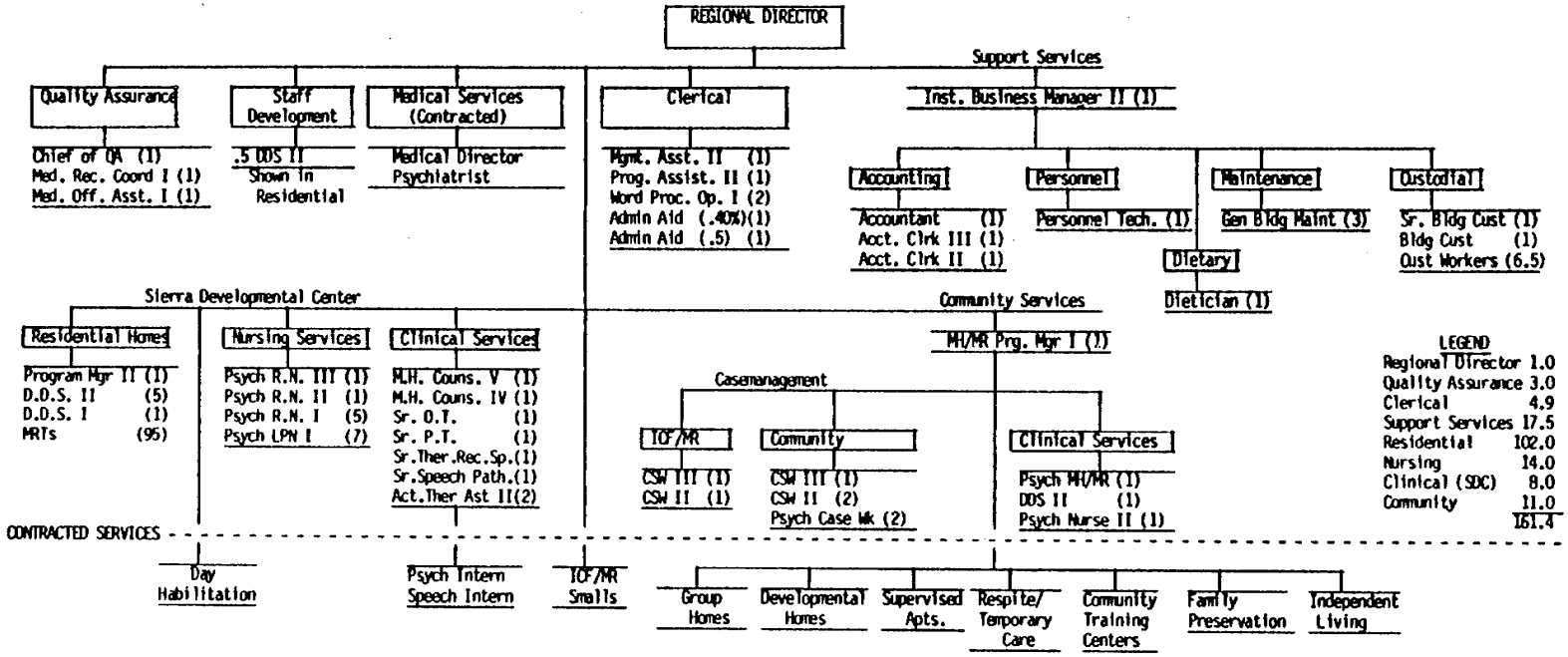
Organizational Chart



Community Training Center Program (CTC)	BA #3160
Rural Nevada Mental Retardation Services (RNMRS)	BA #3160
Residential Placement Fund Program (RPF)	BA #3167
Domestic Violence Program	BA #3181
Older American Volunteer Program (OAVP)	BA #3197
Family Preservation Program (FPP)	BA #3166


SOUTHERN NEVADA MENTAL RETARDATION SERVICES
REGIONAL DIRECTOR
Quality Assurance
Chief of Q.A.(1)
Med. Records Coord(1)
Med. Off. Asst II(.5)
Med. Off. Asst I (1)
Staff Development
CDS III (.5)
Contracted Services
Medical Director
Psychiatrist
Clerical
Executive Secretary(1)
Management Assis. I(1)
Comm Sys. Operator (1)
Word Proc Operators(2)
Chapter I
First Step
CDS II (4.5)
Support Services
Business Manager(1)
Accounting (4.5)
Maintenance (10)
Bldgs & Grounds (4)
Dietician (1)
Personnel (1)
Desert Developmental Center
Residential Homes
1300 - 1306
MR Prog Manager II(1)
CDS II (5.0)
CDS I (1.0)
CSW III (.5)
MRT IV (10)
MRT I-III (96.5)
Medical Services
Nursing Director(1)
Psy RNII (2.0)
Psy RN I (4.0)
LPN II (1.0)
LPN I (7.5)
Clinical Services
Psychology
Psy (2)
Act/Thera
OT Dir(2)
PT (1)
RT (1)
ST (1)
Community Services
Comm. Serv Dir(1)
Casemanagement
ICF/MR Program
CSW (2.5)
Comm Support
CSW (3)
Clinical Srvs
Psy RN (1.0)
CSW (.5)
Prog.Specialist(1)
Prog. Specialist (1)
Prog.Specialist(1)
Prog.Specialist(1)
Family Preservation
Independent Living
Contracted Services
CONTRACTED SERVICES
Day Habilitation
ICF/MR Smalls
Developmental Homes
Group Homes
Supervised Apartment
Temporary Care
(BREAKDOWN ON TWO ATTACHMENTS)
09/14/89
LEGEND
Regional Director 1.0
Quality Assurance 3.5
Staff Development .5
Clerical 5.0
First Step 4.5
Support Services 21.5
Residential 114.0
Medical Services 15.5
Clinical Services 7.0
Community Services 12.0
184.5

NORTHERN NEVADA MENTAL RETARDATION SERVICES



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9/21/89

APPENDIX B
ADULT MENTAL HEALTH SERVICE DEFINITIONS
AND
MENTAL RETARDATION SERVICE DEFINITIONS

ADULT MENTAL HEALTH SERVICE DEFINITIONS

Pre-Screening and Evaluation:	Prescreening and evaluation determine what services a client needs and makes an appropriate disposition.
Crisis:	Crisis services provide intake and sufficient immediate therapy to stabilize a person so that they may be referred to another treatment modality.
Inpatient:	Inpatient programs provide 24-hour supervision and care to mentally ill adults who are a danger to themselves or others. Inpatients may receive medication, counseling, occupational therapy, and recreational therapy. The goal is to stabilize behavior so that the person may be treated in a less restrictive setting.
Casemanagement:	Casemanagement plans and monitors the delivery of therapy and other support services for clients who are unable to manage their own affairs. The purpose of case management is to maintain persons in the community who otherwise would require institutional care.
Residential:	Residential programs offer supported housing to persons unable to afford a place to live or unable to live on their own or with their families.
Partial Care:	Partial care programs provide training in self help and social skills to persons having serious and persistent mental illness. The goal is to improve the person's ability to function independently.
Medication Clinics:	Medication clinics provide clients with access to a psychiatrist to diagnose their mental illness, to prescribe and monitor compliance in taking medication, and to provide medical supervision of other treatment modalities.
Vocational Services:	Vocational services accustom persons with histories of serious mental illness to working and assist them in finding jobs.
Outpatient Counseling:	Counseling provides advice and insight to persons suffering emotional or adjustment problems that interfere with their ability to function effectively at work, in school, socially or at home.

Forensic Services: Forensic services are provided in a secure unit and include evaluation of competency to stand trial, treatment of person found not competent to stand trial, and treatment of persons found not guilty by reason of insanity. Treatment is intended to help clients charged with crimes to regain competency and to render persons found not guilty by reason of insanity not dangerous to themselves or others.

Jail Services: Jail services includes identifying inmates who are mentally ill, providing treatment in the jail, recommending to jail staff how a mentally ill inmate must be managed, and providing advice as to which persons can be safely deflected out of the criminal justice system to mental health care. The goal of jail services is to assure that inmates receive appropriate mental health care.

MENTAL RETARDATION SERVICE DEFINITIONS

Prescreening and Evaluation: Prescreening and evaluation determine what services a person needs and makes an appropriate disposition.

Intermediate Care Facilities for the Mentally Retarded [ICF/MR]: Facilities providing a 24 hour program of active treatment in a closely supervised living setting.

- Developmental Center: State run ICF/MR's located in Clark and Washoe Counties.
- Dual Diagnosis Programs: Specialized ICF/MR's that address treatment of problem behaviors or mental health disorders that occur in addition to mental retardation.
- ICF/MR Small: Small living homes in the community that also meet the standards for intermediate care for the mentally retarded.

Case Management: Planning, coordination and monitoring of living arrangements, benefits, therapies, and other support services for persons who need assistance to manage their own affairs.

Community Living Alternatives: Supported housing placements within the mainstream of the community that provide assistance for independent living.

- Group Home: A staffed residential home with 4 to 6 adults and live-in staff and trainers.
- Developmental Home: Family-operated residential homes with 6 or fewer beds.
- Supervised Apartments: Apartments where additional assistance, counseling or guidance is provided to enable persons to live as independently as possible.
- Supported Living Program: An individualized service program purchased to maintain a person in their home.
- Respite/Relief Care: Temporary day or overnight care to relieve the burden on the family or provider. Respite is for natural families. Relief is for providers.

Day Training: Training to develop greater independence such as self-help, social and prevocational skills.

Community Training Center: Private non-profit organizations that provide habilitation, sheltered work and vocational services.

Family Preservation Funding: Financial assistance to needy families who maintain severely retarded persons in their home.

Clinical Services: Specialty services such as physical, occupational, recreational and speech therapy and psychological counseling.

CHILD AND ADOLESCENT SERVICES MENTAL HEATH SERVICES DEFINITION

PROGRAM NAME	DEFINITION
PRE-SCREENING AND EVALUATION:	Pre-screening and evaluation determines what services a client may need, whether those services are available, and establishes an intake time for the client.
INPATIENT:	Inpatient programs provide 24-hour supervision and care for mentally ill adolescents who are a danger to themselves or others. Inpatients may receive medication, individual, group, family therapy, and academic therapy. The goal for the program is to stabilize and modify behavior so that the adolescent may be treated in a less restrictive setting.
TREATMENT HOMES:	Treatment homes provide 24-hour supervised mental health care in a family-like setting. Usually, the homes are composed of four to five children or adolescents and the teaching couple who provide the care, supervision, and treatment. The homes are usually located in the community. The goal of this level of care is to provide intensive, 24-hour treatment in an environment less restrictive than inpatient and provide a normalized setting for the residents.
DAY TREATMENT:	Day treatment provides a level of care less restrictive than inpatient to adolescents, children, and preschoolers who are unable, because of emotional problems, to manage in community school settings. Day treatment provides several hours of care during the day involving individual, group, family therapy, and academic therapy. The goal is to provide an intensive level of treatment for children who do not need 24-hour supervision, but cannot profit from less intensive outpatient therapy.

OUTPATIENT COUNSELING:

Outpatient counseling provides individual, group and family therapy to children and adolescents experiencing mild to moderate emotional problems which interfere with their ability to effectively function at home or in school. The problems are not so severe as to preclude the child's attendance in school or ability to live at home. The goal of outpatient counseling is to restore the child's functioning within the community while allowing him to continue in his day to day activities.

APPENDIX C
IDEAL SERVICE SYSTEMS

IDEAL SERVICE SYSTEMS

An ideal service system is readily accessible and has the capacity to deliver services appropriate to each client's presenting problems. The services provided are minimally restrictive and designed to permit the client to continue or return to a productive life. Services are interdisciplinary and coordinated over time so that they remain appropriate to the client's changing condition. More generally, public systems should be responsive to citizen concerns, integrated with private resources, and cost-effective.

Adult Mental Health

The components of an ideal adult mental health system are

-centralized intake
-crisis services
-inpatient care
-casemanagement
-supported housing
-partial care
-medication clinic
-vocational services, and
-outpatient counseling.

The function of intake is to determine what services a client needs and to make an appropriate referral in a timely manner. Often intake is combined with crisis services designed to provide sufficient immediate therapy to stabilize the client before referral to other treatment. Most mental health problems can be addressed by outpatient counseling. Inpatient care is reserved for those persons who are dangerous to themselves or others and then only for as long as is necessary to permit them to be stabilized before discharge to a less restrictive setting. Most inpatients after discharge only require outpatient counseling and referral to a medication clinic. Persons

having severe and persistent mental illness, however, need additional assistance with housing, with structuring their time, with relearning basic self-care and social skills, and with starting or returning to work. Because most seriously mentally ill adults are indigent and estranged socially, they also require various supports, including income assistance, medical and dental care, counseling for their families, limited guardianships, and access to normalizing leisure activities. Casemanagement coordinates such services and provides the guidance and encouragement chronically mentally ill persons need to lead meaningful lives despite periodic crises and rehospitalizations. An ideal system anticipates the wide range of therapies and assistance mentally ill adult might require and assures that all elements are readily available and delivered in ways consistent with the changing state of the art in mental health programming.

IDEAL SERVICE SYSTEM FOR PERSONS WITH MENTAL RETARDATION

Consumer Oriented System - The system responds to each individual's unique needs; it offers supports where and when the person needs them. It maintains the person in the least restrictive environment and is flexible in addressing the individual's need for support.

An ideal service system provides the following components:

1. Access for Persons in Need - All persons with Mental Retardation are not required to leave their home or community, or wait months and years to receive assistance.

2. Individualized Assessment, Planning and Funding - An individual service plan is developed by professionals, family and the consumer. Full exercise of consumer rights and choices are stresed. Once developed, the plan is implemented by a case manager who coordinates, locates and monitors resources and services to achieve the plan's objectives.

3. Home and Community Based Support Services - Services integrate the person physically and socially into their community. Residential assistance is provided in the person's home or in the least restrictive and most normalized home-like setting. Living arrangements are determined by the planning team and reflect the needs and choices of the person with Mental Retardation and their family. Training and vocational assistance is integrated into the community.

4. Promotes Self-Sufficiency - The plan improves or maintains the person's ability to function as independently as possible and to contribute to society.

References:

"Community Living for Adults" - News Bulletin on Community Living, 1-9-90, Center on Human Policy. Syracuse University, Syracuse, New York (315-443-3851).

"Community Living for Adults in North Dakota: A Case Study of an Apartment Program."
"North Dakota Expands the Use of Supported Living Arrangements"- the Community Services Reporter, 113 Oronco St., Alexandrea, Virginia.

IDEAL/SERV
2/15/90

The Ideal Mental Health System for Youth and Families

The ideal mental health system for youth and families is, in many ways, significantly different from one for adults. Some of the reasons include the reliance on family involvement (family focused and child centered), the complexity of needs of a multi-individual family system, major variance in service needs between family members because of age and problem type as well as between families themselves, unique delivery problems related to the family's inability to access service because of transportation, schedules, etc. and traditional reluctance on the part of society to infringe on the family system even though it may be clearly dysfunctional.

Clearly an ideal mental health system must be accessible to the population it serves if it is to be of any value. Likewise it must be programmatically responsive to the needs of the population in ways which may not follow traditional thinking. Innovation and creativity are essential elements of the ideal mental health system. These elements rely heavily on flexibility within the mental health system i.e., flexibility to rechannel resources to meet emerging needs, flexibility to implement new service components without unnecessary delays and flexibility to improvise in a creative sense in dealing with treatment issues.

For youth and families then, the ideal mental health system must be broad enough, flexible enough, and creative enough to meet the complex and variable problems dysfunctional families or family members present. Services must be perceived by these families as beneficial and most importantly as having an immediate impact on the family problem. In order to accomplish the latter quickly and efficiently, the mental health system must provide a guide, an advocate, a "broker" for youth and families who will enhance their opportunities to maximize therapeutic change by assuring their quick access to quality services. This "broker" would be the case manager.

The following system of care is suggested as one approach to meeting the foregoing recommendations.

Youth and Family Service System

The components of the ideal youth and family mental health service system are listed below each with a brief description. When a component is currently available within NNCAS or SNCAS it is indicated. Services are listed beginning with the least restrictive. Additionally, a "flow" chart is attached describing the system in terms of client movement between programs. There is no "perfect" route. The routes described are reflective of various possibilities only.

Central Intake: This is the entrance point into the system. It includes triage, assessment, and the assignment of an interim case manager to assist the family in connecting with services. Central Intake also includes non-residential emergency services. The Department of Human Resources Child Resource Bureau is an initial step toward establishing this type of program in the community.

Prevention Services: Prevention Services have the goal of reducing the incidence of emotional problems in children and in their families. Within this context we are referring to primary prevention including the promotion of positive mental health skills, increasing available self-help groups and support systems, and modifications of systems to increase the likelihood that individuals will encounter favorable outcomes. Prevention services could operate out of a central intake unit with adequate staffing. Neither SNCAS nor NNCAS have this component in place.

Home Based Services: Home based services are crisis oriented services provided on an outreach basis to work with children and families in their homes. Home based services are relatively brief, deal with the immediate crisis, and if necessary, provide for continuity of care by connecting the family with other available longer term services. This service is provided on a limited basis at SNCAMHS in its Family Outreach program.

Early Identification and Intervention: Early Identification and Intervention focuses on the identification problems at the earliest point in the child's development where intervention can be more effective and more economically applied. Generally speaking, at this point the duration and severity of the problem is reduced more quickly and the over-all prevalence of later emotional disturbances in children can be decreased. This aspect of the mental health system works closely with public health in terms of providing the broadest level of intervention to the family system. The NNCAS EARLY CHILDHOOD TREATMENT PROGRAM is a limited example of this type of program while SNCAS has a broader range outpatient early childhood services.

Outpatient Services: Outpatient treatment is the least intensive and typically the most used intervention in the mental health field. Clients living in the community meet with an outpatient therapist one or more times weekly to deal with problems which may be disrupting the internal family system as well as the family's relationships with other community based programs such as the schools and law enforcement. Both NNCAS and SNCAS have outpatient services for families and children.

Day Treatment Services: Day treatment programs are the most intensive of the non-residential services. Children typically remain in Day Treatment for one semester to one school year, attending the program several hours per day, five days per week.

A variety of programming occurs in day treatment including traditional psychodynamic therapy, academics, and for adolescents; independent living services. NNCAS has Day Treatment Services for children and adolescents ages 3 to 18. SNCAS has preschool day treatment services and some limited after-school day programs for elementary children and adolescents. Neither SNCAS or NNCAS have independent living services available.

Therapeutic Foster Care: Therapeutic foster care is the least restrictive residential option in a system of care for emotionally disturbed children. Therapeutic foster care involves the placement of a child with foster parents who have been specifically recruited and trained to work with an emotionally disturbed child. Professional clinical staff work closely with each child and with the foster parents, and if possible with the biological parents to deal with the problems which brought the child into treatment, with the eventual goal of returning that child to his natural home. Therapeutic foster care must be flexible, serve youngsters of varying ages, and with a variety of problems. Therapeutic foster care is relatively easy and inexpensive to start and are typically the least expensive of the residential alternatives. NNCAS, SNCAS, and Nevada State Welfare Division are in the early stages of setting up therapeutic foster care facilities in the north and south.

Therapeutic Group Care: Therapeutic group care (treatment homes) provides a therapeutic environment and treatment program for youngsters with emotional and behavioral problems. Typically, homes provide services to 5 to 10 youngsters and an array of therapeutic interventions. The primary mission of therapeutic care is treatment and the eventual return of the child to his natural home or to independent living. SNCAS and NNCAS currently have both on-campus and community-based treatment homes.

Independent Living Services: Independent Living Services are those services made available to programs such as day treatment, therapeutic foster care, therapeutic group care, residential care, and inpatient hospital for the purpose of enhancing the ability of adolescents to transition into independent living situations. These transition services include preparation to live independently as well as preparation for paid employment. Independent living services are delivered directly to the residential programs in much the same way as academic services are. The residential programs then provide the supportive basis from which adolescents may practice and develop the necessary skills. Neither SNCAS or NNCAS have independent living services at this time.

Residential Treatment: Residential treatment services provide 24-hour treatment and care for more severely disturbed children and adolescents. Unlike therapeutic group care, residential

treatment centers have a greater medical orientation, generally serves a larger population and is more restrictive in that most therapeutic services are contained on the unit. NNCAS contracts for residential services. SNCAS currently has no residential services of this kind.

Crisis Residential Care: Crisis residential care is designed to promote rapid stabilization and the return of the youth to his home and community. Crisis residential care provides residential placement during an acute crisis, is short-term, provides acute and intensive treatment, averts long-term hospitalization, and is community based. Services are available on a 24-hour basis. NNCAS and SNCAS currently operate limited versions of this in the form of two beds each located at the Adolescent Treatment Center and Youth Hospital respectively.

Inpatient Care: Inpatient is typically the most expensive, most closely supervised and restrictive service, as well as having the highest percentage of medical staff. There are three basic reasons for inpatient care including short-term treatment and crisis stabilization; conducting comprehensive evaluations; and long-term treatment. SNCAS Youth Hospital provides short-term, acute 14-bed, inpatient care. The Adolescent Treatment Center currently provide all three of these services in a limited 16 bed unit. Neither SNCAS nor NNCAS inpatient services meet JCAH-O standards because of staffing and other deficiencies. JCAH-O presurvey as mandated by the Legislature has been initiated.

Case Management: Although considered an operational component of an Ideal Mental Health System rather than a service component, provides an invaluable service acting to unify the service delivery system for the benefit of the child and family. Case management serves the youngsters involved in both residential and non-residential programs. Case management advocates on behalf of the family ensuring that an adequate treatment plan is developed, implemented and is coordinated with other needed services or agents.

NNCAS and SNCAS have very limited pilot programs in case management.

System Flow

Within the ideal system, clients enter through central intake for the purpose of assessment, triage, and assignment of the case manager. Crisis would be dealt with at this point, with referral either to crisis residential care, home-based services, or crisis outpatient services. For non-crisis referrals, triage and assessment determines what level of care is most appropriate-residential or non-residential services. The intake case manager assures that the family moves to the appropriate-level of care and makes connection with that service. Where residential care is considered appropriate, further evaluation will be carried out to determine what level of care within the residential system is needed. A program case manager is assigned who will follow the client throughout the residential experience. For the mental health system to be responsive to a family's needs, that family and the individuals within it must be able to move freely from one level of service to another. The flow chart reflects that movement in a variety of ways, from less restrictive to more restrictive levels of care, and vice versa.

As can be seen, the overlap between the various components of the ideal mental health system quite frequently makes the decisions regarding the level of treatment difficult. However, only when the services are part of well coordinated system will the needs of the severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

APPENDIX D
NEVADA'S POPULATION
BY SELECTED AGE GROUPING
1980

Nevada's Population
by Selected Age Grouping

1980

County	Selected Age Groupings						
	Under 5 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	65 Years & Over	75 Years & Over	Total
Carson City	1,835	2,005	2,503	2,956	3,313	983	32,022
Churchill	1,091	1,032	1,147	1,228	1,727	643	13,917
Clark	33,568	33,675	36,702	40,916	35,112	9,926	463,087
Douglas	1,260	1,293	1,470	1,498	1,550	427	19,421
Elko	1,386	1,393	1,494	1,628	1,543	518	17,269
Esmeralda	58	52	49	52	86	27	777
Eureka	110	82	99	111	80	35	1,198
Humboldt	841	691	770	813	698	223	9,449
Lander	422	349	322	369	217	54	4,076
Lincoln	397	327	325	412	478	137	3,732
Lyon	1,104	1,040	1,094	1,073	1,559	476	13,594
Mineral	459	487	587	519	669	216	6,217
Nye	712	632	722	832	818	217	9,048
Pershing	296	243	238	272	390	130	3,408
Storey	114	75	111	109	131	22	1,503
Washoe	11,811	11,625	13,464	16,686	16,402	5,358	193,623
White Pine	669	688	649	691	984	366	8,167
Statewide	56,133	55,689	61,746	70,165	65,757	19,758	800,508

SOURCE: U.S. Department of Commerce, Bureau of the Census, General Population Characteristics, 1980.

APPENDIX E
NEVADA'S POPULATION
BY SELECTED AGE GROUPING
1985 ESTIMATE

Nevada's Population
by Selected Age Grouping
1985 Estimate

County	Selected Age Groupings						
	Under 5 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	65 Years & Over	75 Years & Over	Total
Carson City	2,001	2,191	2,739	3,235	4,006	1,188	35,400
Churchill	1,200	1,135	1,260	1,351	2,070	760	15,450
Clark	41,110	41,249	44,949	50,103	48,084	13,650	572,140
Douglas	1,585	1,625	1,847	1,885	2,167	601	24,660
Elko	1,820	1,828	1,961	2,136	2,245	747	22,850
Esmeralda	104	91	87	92	167	51	1,380
Eureka	131	99	118	133	112	46	1,450
Humboldt	1,050	861	960	1,013	980	312	11,880
Lander	464	383	352	402	279	71	4,500
Lincoln	446	366	361	459	578	166	4,200
Lyon	1,382	1,302	1,368	1,343	2,118	646	17,170
Mineral	442	468	564	500	709	226	6,030
Nye	1,158	1,023	1,173	1,348	1,516	408	14,850
Pershing	314	258	252	290	453	150	3,660
Storey	139	91	137	134	175	31	1,850
Washoe	13,517	13,304	15,415	19,129	21,146	6,854	224,340
White Pine	614	632	595	634	977	359	7,560
Statewide	67,477	66,906	74,138	84,187	87,782	26,266	969,370

NOTE: The 1985 age grouping estimate was based on the State of Nevada's 1985 official population estimates revised in July, 1989.

SOURCE: Nevada Department of Administration, Planning Division, Population by Age & Sex for Nevada and Counties, 1980 to 2000.

APPENDIX F
NEVADA'S POPULATION
BY SELECTED AGE GROUPING
1990 AND 1995 FORECASTS
1990

Nevada's Population
by Selected Age Grouping
1990 and 1995 Forecasts

1990

County	Selected Age Groupings						
	Under 5 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	65 Years & Over	75 Years & Over	Total
Carson City	2,301	2,522	3,157	3,732	5,146	1,528	41,330
Churchill	1,573	1,487	1,653	1,769	2,972	1,074	20,490
Clark	56,278	56,475	61,531	68,570	76,913	22,003	794,140
Douglas	2,028	2,084	2,371	2,411	3,234	906	32,080
Elko	2,876	2,891	3,098	3,375	4,036	1,327	36,560
Esmeralda	94	84	79	82	163	50	1,260
Eureka	208	153	185	207	204	82	2,310
Humboldt	1,339	1,097	1,223	1,290	1,458	460	15,340
Lander	671	553	510	582	489	129	6,580
Lincoln	473	390	383	486	671	194	4,500
Lyon	1,832	1,724	1,812	1,772	3,124	950	23,030
Mineral	549	583	702	619	976	311	7,590
Nye	1,541	1,363	1,561	1,796	2,229	606	19,990
Pershing	438	357	349	401	697	228	5,150
Storey	198	129	193	189	289	57	2,670
Washoe	15,299	15,057	17,459	21,686	27,247	8,748	257,660
White Pine	779	801	753	802	1,372	495	9,700
Statewide	88,477	87,750	97,019	109,769	131,220	39,148	1,280,380

APPENDIX G
NEVADA'S POPULATION
BY SELECTED AGE GROUPING
1990 AND 1995 FORECASTS
1995

Nevada's Population
by Selected Age Grouping
1990 and 1995 Forecasts

(Continued)

1995

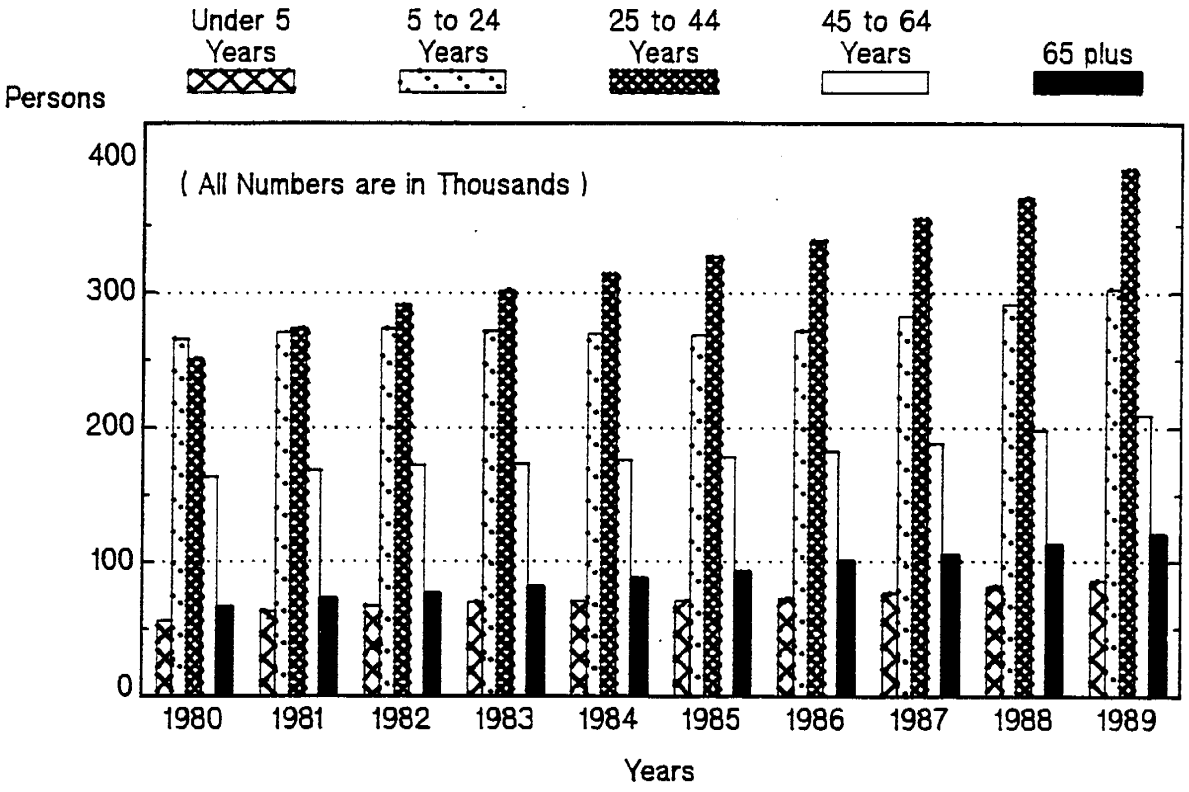
County	Selected Age Groupings						
	Under 5 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	65 Years & Over	75 Years & Over	Total
Carson City	2,609	2,860	3,586	4,240	6,505	1,934	47,590
Churchill	1,803	1,703	1,894	2,027	3,727	1,326	23,770
Clark	70,732	70,992	77,333	86,164	111,770	32,193	1,013,020
Douglas	2,560	2,632	2,997	3,044	4,707	1,333	41,180
Elko	3,660	3,679	3,939	4,292	5,801	1,886	47,110
Esmeralda	103	90	85	88	190	58	1,370
Eureka	216	159	192	215	247	96	2,450
Humboldt	1,670	1,366	1,522	1,607	2,107	660	19,390
Lander	776	640	588	673	682	187	7,710
Lincoln	537	441	431	548	826	240	5,140
Lyon	2,312	2,175	2,287	2,232	4,369	1,325	29,480
Mineral	551	586	706	621	1,083	345	7,710
Nye	1,557	1,374	1,576	1,810	2,496	686	20,400
Pershing	526	428	417	479	920	298	6,240
Storey	260	169	254	248	433	92	3,560
Washoe	17,120	16,849	19,552	24,313	34,658	11,026	293,010
White Pine	985	1,014	949	1,012	1,910	676	12,410
Statewide	107,977	107,157	118,308	133,613	182,431	54,361	1,581,540

NOTE: The 1990 and 1995 age grouping forecasts were based upon the State of Nevada's official population estimates and preliminary forecasts issued in April, 1990.

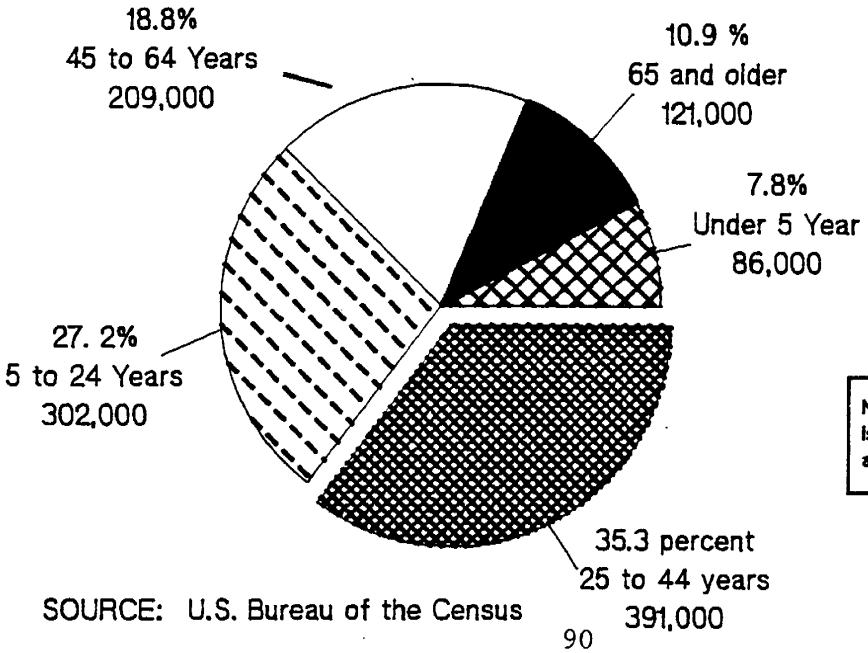
SOURCE: Nevada Department of Administration, Planning Division, Population by Age & Sex for Nevada and Counties, 1980 to 2000.

APPENDIX H
NEVADA POPULATION ESTIMATES BY AGE
APRIL 1980 TO JULY 1989

Nevada Population Estimates By Age
April 1980 to July 1989



Age Distribution — 1989



Although Nevada has one of the fastest growing elderly populations in the country, the proportion of elderly persons in the state is smaller than the national average, i.e. 10. 9 % versus 12. 5 %

Nevada's "baby boom generation" is slightly larger than the national average — 35. 3 % versus 32 %

SOURCE: U.S. Bureau of the Census

APPENDIX I
ADOLESCENT SEXUAL OFFENDER PROGRAM--CIP

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
Kinkead Building, Room 403
505 E. King Street
Carson City, Nevada 89710
(702) 687-5943

BOB MILLER
Governor

JERRY GRIEPENTROG
Director

June 14, 1990

MEMORANDUM

TO: BOB GUERNSEY, PRINC. DEPUTY FISCAL ANALYST
FISCAL ANALYSIS DIVISION - LCB

FROM: BRIAN LAHREN, Ph.D.
ADMINISTRATOR

RE: ADOLESCENT SEXUAL OFFENDER PROGRAM--CIP

The attached letter to Mr. Ferrari is the first step in initiating a CIP request for a facility to serve adolescent sexual offenders and other mentally disordered adolescent offenders.

As currently conceived, the building would accommodate forty (40) adolescents. The structure of the building would be designed around the following units:

--15 beds for evaluation, classification and referral to appropriate services.

--25 beds for longer term treatment of difficult adjudicated offenders. The mix of beds would include 10 beds dedicated for sexual offenders, 10 beds for non-sexual adolescent offenders, and 5 beds for females or swing beds to accommodate additional sexual offenders as demand dictates. Dr. Beck has indicated that additional numbers of sexual offenders could be served in the non-sexual offender unit depending on the nature of the individual's history of offenses and types of victims.

The rough estimate of construction costs are based on 23,000 square feet at $170.00 per square foot = $3,910,000.00. Staffing costs for the 68 staff would be approximately $1,285,579.00 per full year of operation. Operating costs would add an additional $100,000.00 approximately.

I hope this information will be helpful to the Subcommittee. This is obviously a very important program in terms of State needs and any support will be appreciated.

BL/ls

cc: John Duarte
Jerry Griepentrog
Judy Matteucci
Rob Farr

Attachments

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

JOHN R. CROSSLEY, *Director*
(702) 687-6800
Fax No.: (702) 885-5962

LEGISLATIVE COMMISSION (702) 687-6800
JOHN E. JEFFREY, *Assemblyman, Chairman*
John R. Crossley, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Acting Legislative Auditor* (702) 687-6815
ROBERT E. ERICKSON, *Research Director* (702) 687-6825
LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

June 5, 1990

MEMORANDUM

TO: Brian Lahren, Ph.D., Administrator
Division of Mental Health/Mental Retardation

FROM: Bob Guernsey, Principal Deputy Fiscal Analyst
Fiscal Analysis Division

SUBJECT: Proposed Sexual Offender Program
Southern Nevada Child and Adolescent Services

Brian, as we have discussed, the ACR 52 Subcommittee and the Interim Finance Committee have placed a high priority on the opening of the new Sexual Offender Program located in Clark County (originally scheduled to open January 1, 1990). With the problems encountered, through denial by the county commissioners of housing the new program in vacant space at the juvenile detention facility, the subcommittee requests your input as to viable options in getting the program operational.

Specifically, if temporary space (rental) could be found to house the program, there would be a need in the future for the construction of a long-term rental of a permanent facility to house such a program. In discussing this with Chairman Spinello, the question came up as to whether you will be proposing construction of a facility utilizing state funds for the Sexual Offender Program. If this is an option you are considering, it would be helpful to have something submitted to the subcommittee prior to its June 25 meeting when final recommendations will be developed. Please be prepared to address size, location, estimated construction cost, etc.

If you have any questions or need additional information, please contact me.

ACR52PSOP/cd
MH/MR
cc: Chairman Jim Spinello and
Members ACR 52 Subcommittee
Assemblywoman Myrna Williams
Gary Ghiggeri
Jan Needham

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
Kinkead Building, Room 403
505 E. King Street
Carson City, Nevada 89710
(702) 885-5943

BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director

BRIAN LAHREN, Ph.D.
Administrator

June 7, 1990

MEMORANDUM

To: Bob Ferrari, Secretary-Manager
Public Works Board

From: Brian Lahren, Ph.D., Administrator BL
Division of Mental Hygiene and Mental Retardation

Re: Adolescent Inpatient CIP

With the refusal of the Clark County Commission to agree to the location of the Adolescent Sexual Offender Program on the grounds of the Clark County Juvenile Detention Center and the possibility that our joint CIP with the Youth Services Division may not be supported, we are faced with the need to develop a contingency plan involving our own adolescent CIP.

The attached description for a 40 bed program is our current view of the type of service we would need to deliver. Although the program description does not specifically address the building of an appropriate facility, Dr. Bill Beck suggests that approximately 23,000 square feet of new construction will be required to house the program. The facility would house both adjudicated adolescent offenders with mental disorders and moderate to high risk adolescent sexual offenders. The building would need to be secure and possess electronic surveillance capabilities. A rough guess at construction costs by Dr. Beck is that $170.00 per square foot would encompass what would be required for the level of security and technology he envisions. Of course, your agency's expertise might suggest a very different, and hopefully lower, cost.

Please let me know how we should proceed to assure this request is reviewed for possible inclusion in the 92-93 biennium CIP projects.

cc: Judy Matteucci
Jerry Griepentrog
Christa Peterson
Bill Beck
John Duarte

Attachment

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

DONALD A. RHODES, *Director*
(702) 687-6800

LEGISLATIVE COMMISSION (702) 687-6800
JOHN E. JEFFREY, *Assemblyman, Chairman*
Donald A. Rhodes, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

JOHN R. CROSSLEY, *Legislative Auditor* (702) 687-6815
ROBERT E. ERICKSON, *Research Director* (702) 687-6825
LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

March 6, 1990

MEMORANDUM

TO: BRIAN LAHREN, PH.D., ADMINISTRATOR
DIVISION OF MENTAL HEALTH/MENTAL RETARDATION

FROM: BOB GUERNSEY, PRINCIPAL DEPUTY FISCAL ANALYST
FISCAL ANALYSIS DIVISION

SUBJECT: JOINT RESIDENTIAL FACILITY SERVICES

Brian, as you are aware, Bob Cavakis, Administrator of the Division of Youth Services made a presentation to the ACR 52 Study Subcommittee at its January 25, 1990, meeting in Las Vegas, Nevada. During his presentation he discussed a proposal for the Divisions of Youth Services and Mental Health/Mental Retardation to share a facility with 100 beds for chronic/violent youth offenders. Attached is a copy of a January 9, 1990, memo from Mr. Cavakis to Mr. Ferrari of the Public Works Board outlining the major new construction request.

Mr. Cavakis indicated the proposal was developed after discussions with you and that the new facility, if constructed, would meet joint needs of Youth Services and MH/MR. It would be helpful for the ACR 52 Study Subcommittee to have your analysis on the need for this facility and how many beds the Division of MH/MR feels it needs at this point in time and the number of beds needed by FY 1993. Please include any detailed needs assessment and your projections indicating population growth and any supporting data you have for a joint facility with the Youth Services Division.

Thank you in advance for your assistance. If you have any questions, please contact me.

acr52jrsl/cd
MH/MR
cc: Chairman and Members
of the ACR 52 Subcommittee
Gary Ghiggeri
Jan Needham

BOB MILLER
Acting Governor

STATE OF NEVADA

JERRY GRIEPENTROG
Director
Department of Human Services

ROBERT A. CAVAKIS
Administrator
Youth Services Division

DEPARTMENT OF HUMAN RESOURCES
YOUTH SERVICES DIVISION
505 E. King Street, Suite 606
Carson City, Nevada 89710
Telephone: (702) 885-5982

January 9, 1990

MEMO

TO : Robert Ferrari, Manager
Public Works Board

FROM : Robert A. Cavakis, Administrator

SUBJECT : Major New Construction Request

The Youth Services Division has through a formal planning process determined that there is a need for a maximum security facility for chronic/violent juvenile offenders in Nevada. The number of juvenile offenders eligible for such a program today ranges between 10 and 20. The juvenile justice system in Nevada is experiencing a disproportionate increase in the number of chronic/violent offenders and it would appear that we could expect to require a secure facility of 40 beds by FY1993.

Recent conversations with Brian Lahren, Administrator, Division of Mental Hygiene and Mental Retardation (MH/MR), have led to discussions regarding a proposal for a co-located facility to be shared by Youth Services and MH/MR. The Division of MH/MR indicates a need for 40 beds for mentally disordered juvenile offenders and 10 beds for classification and treatment of juvenile offenders with serious mental health concerns. It would appear that a facility design that would include shared kitchen and dining space, classroom space, office space, reception area, library, medical examination rooms, and visiting rooms, with five 20-bed residential wings, would serve the needs of the juvenile justice system in Nevada for at least a 5 year period.

Dr. Lahren indicates that Dr. Bill Beck had submitted to the Public Works Board at some time in the recent past a proposal for a classification and treatment program for MH/MR. That proposal contains justifications and suggestions that could be incorporated into this proposal. If this proposal is successful it would at least in the short term eliminate the need for that smaller classification and treatment facility.

I believe that if in fact the Public Works Board initiates this project, the American Correctional Association Standards for Juvenile Training Schools should be used as a guideline. Those Standards include 70 square feet of

sleeping space per inmate, 35 square feet of day room space, 100 square feet of indoor activity space, and 15 square feet of dining space for each inmate. The Standards also require one acre of outdoor activity area for every 25 beds in the facility. There is also a requirement for 20 cubic feet of storage space per inmate. I have included with this memorandum a copy of the American Correctional Association Standards and at your request have available the National Institute of Justice/American Correctional Association National Directory of Corrections Construction to assist in the design phase. Dr. Lahren and I are prepared to provide additional response including technical assistance as you determine the need.

RAC/cs
enc

Corrections Corporation of America

John S. Robinson
Director
Juvenile Services Development

102 Woodmont Boulevard
Nashville, Tennessee 37205
Phone: (615) 292-3100
FAX: (615) 269-8635

May 7, 1990

Mr. Larry Peri, Program Analyst
Fiscal Analysis Division
Nevada Legislative Counsel Bureau
Legislative Building
401 South Carson
Carson City, Nevada 89710

Dear Larry:

Thank you for your telephone call last week. I am writing this letter to follow-up and describe in more detail Corrections Corporation of America's recent efforts in developing a new juvenile program in the State of Nevada.

First, you had asked me about the status of the Division of Youth Services contracting for secure beds at Shelby Training Center. Earlier this year we were informed by the Juvenile Court of Memphis and Shelby County that they had a need for the 10 beds we were using for out of state referrals. After meeting with Bob Cavakis and getting his commitment on the need for continued contract services at STC, we sought and obtained local approval to expand the bed capacity of the facility. The expansion is scheduled to be completed late this summer; however, this will not impact our ability to continue accepting referrals prior to the completion date. We are in the process of working with Bob in renewing our contract for the upcoming fiscal year.

Regarding a new juvenile program for the state, our discussions have shifted to developing a co-located, multi use facility. I have had meetings with Bob Cavakis, Brian Lahren, Assemblywoman Jan Evans and Assemblyman Jim Spinello and all have shown an interest in this concept in light of the state's juvenile justice system needs in treating the chronic and violent offender, children with mental health and mental retardation diagnosis and children who have committed a crime but who have been diagnosed as severely emotionally handicapped or mentally ill.

The program we are discussing is a 100-bed co-located facility with a 40-bed campus for adjudicated youth committed to the Youth Services Division and a 60-bed campus for youth under the care of the Mental Health and Mental Retardation Division. The campuses would be separated but would utilize certain core facilities housing administration, support services and a gymnasium. The direct care and professional staff for each campus would be hired and assigned

to the respective campus based on their qualifications and client needs. The support and administrative staff would provide services to both campuses. The housing units and program space would be designed to meet the specific needs of each population. One recommendation we heard for the mental health campus was to designate one unit for assessment and classification. This facility design, besides being more cost effective, would prove suitable for dealing with the "dual diagnosed" clients. The merger or consolidation of professional correctional and mental health staff would help to fill a gap that currently exists in your juvenile justice system.

Last month CCA opened a new juvenile program that could serve as a prototype for the proposed facility in Nevada. Our facility, located in East Tennessee and operated for the Tennessee Department of Youth Development, is a 144-bed co-located facility providing delinquency treatment programs to male and female offenders. There are two separate campus both having access to a central core building housing the administrative and support functions. There is also a full size gymnasium utilized by both campuses. I have enclosed information regarding this facility for your review and future reference.

CCA is suggesting that requests for proposals be let to the private sector for the design, construction, financing and management of the proposed new juvenile program. In addition to advantages the private sector can offer in cost, speed and flexibility, the State of Nevada would not use their bonded indebtedness to build the facility and would make no payments on the project until the first youth is placed in the program. The per diem price to the state would include the cost of construction, debt service and operations.

A broad range of financing alternatives could be considered for this project if the state was agreeable to entering a long term lease agreement for the facility and a separate management services contract. This arrangement would permit the exploration of tax exempt financing which would offer the state the best cost. Additionally, it would permit mechanisms for public or private ownership of the facility. If the state decided to terminate the management services contract with the operator, they would retain access to the facility and either contract with another manager or operate it themselves.

CCA considers this proposed program and financing alternative beneficial to the State of Nevada and the youth it would serve. We remain committed to working with state officials in developing this project and seek your guidance as to our next step.

I hope this information is helpful and I look forward to seeing you the next time I am in Carson City.

Sincerely,

John S. Robinson

Enclosures

cc: Gary Ghiggeri
Bob Cavakis
Brian Lahren

MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER

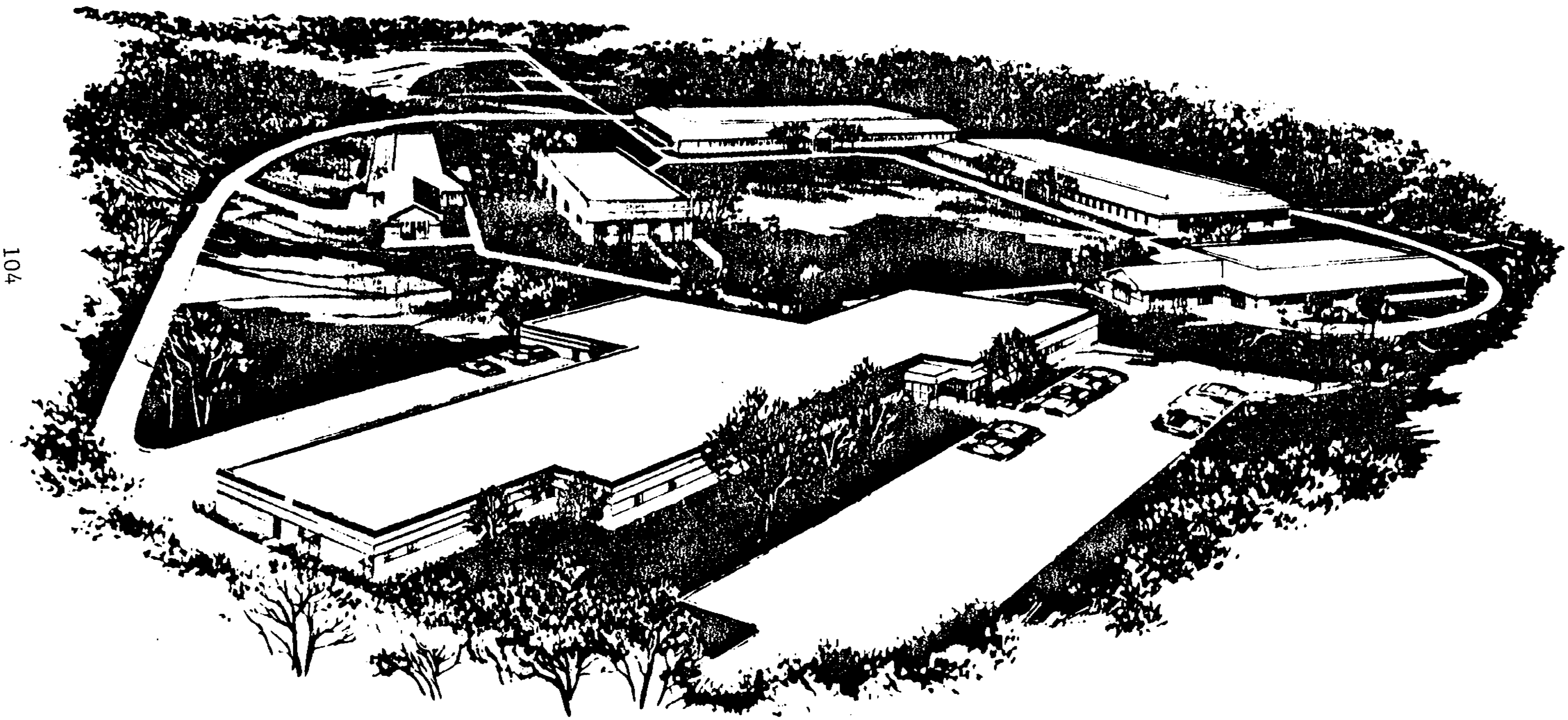
This 144-bed facility, which was constructed in 11 months and opened in April, 1990 in Dandridge, Tennessee, was designed and built by CCA for the Tennessee Department of Youth Development. The center provides a comprehensive array of treatment programs designed to meet the needs of male and female juvenile offenders from East Tennessee who require placement in a juvenile correctional facility. The center also serves as the state's regional institutional classification center.

The design of the 106,000 square-foot, $7.5 million center includes six separate buildings positioned in a campus style plan. A distinct separation between the male and female housing buildings is provided. The total center consists of a core center building, three separate male housing buildings, one female housing building and a gymnasium.

Programs and services offered include reception, classification and orientation services; a full educational and vocational program; counseling services including individual, group and family counseling, an extensive substance abuse education, counseling and treatment program, law-related education and conflict management, and life skills; a comprehensive recreation program; and active community volunteer program; health care services; a resident employment program; program economy and canteen; storeroom and laundry services; and, food and dietary services.

The center is designed and operated in accordance with American Correctional Association Standards for Juvenile Training Schools and will be fully accredited within the first two years of operation.

The per diem cost to the State of Tennessee is $84.43. This price includes cost of construction, debt service and operations. The current operating cost for housing a juvenile in a state operated facility is approximately $103.00.



CCA MOUNTAIN VIEW YOUTH DEVELOPMENT CENTER

This 144-bed juvenile correctional complex, scheduled to open April 1990 in Dandridge, Tennessee, will provide a comprehensive array of treatment programs designed to meet the needs of male and female juvenile offenders from East Tennessee who require placement in a juvenile correctional facility. The complex will serve as the state's regional institutional classification center. The treatment program is designed as a complete systems approach utilizing a "normalized environment" to effect a positive change in the student's identified antisocial behavior.

The design of the youth development center includes six separate buildings positioned in a campus style plan. A distinct separation between the male and female housing buildings is provided. The total complex consists of a core center building, three separate male housing buildings, one female housing building and a gymnasium.

The core center building includes a full kitchen, food preparation area and small dining area, academic and vocational classrooms/laboratories/shops, full service medical area with separate male and female day wards, central control center, reception/classification area, large multi-purpose room, administrative offices, central laundry and facility maintenance area.

The living units are designed to house no more than 12 students each. These 12-bed living units are grouped in two typical building designs: a 24-bed or a 48-bed building. Each living unit has 12 individual sleeping rooms with toilet/sink and appropriate furnishings, a central dayroom, quiet room, dining/multi-purpose room with kitchenette, shower room and laundry with washer/dryer for cleaning of personal clothing. The housing buildings contain other space shared by the living units in that building such as visiting, multi-purpose, offices, classroom and a custodial room.

The fully equipped gymnasium is accessible from both male and female housing buildings and includes a regulation size basketball court, bleachers, weight area, locker rooms and office space. Ample outside recreation space is also available for physical education and recreational activities. A canteen is located at one end of the gymnasium.

Operator:
Corrections Corporation of America
for the Tennessee Department of Youth Development
Nashville, Tennessee

Architect:
Barber & McMurry
Knoxville, Tennessee

Builder:
Ray Bell Construction Company
Brentwood, Tennessee

APPENDIX J
LETTER FROM CAROL AALBERS
NEVADA SCHOOL COUNSELOR STATEWIDE COMMITTEE

May 14, 1990

Assemblyman James J. Spinello
%Jeanne Botts
Legislative Counsel Bureau
Legislative Building
401 S. Carson Street, Room 341
Carson City, Nevada 89710

Dear Assemblyman Spinnello:

The newly formed Nevada School Counselor Statewide Committee met on Tuesday, May 8, 1990, at the University of Nevada, Reno to discuss needs and set goals for the future of school guidance and counseling in our state. Counselors and administrators were present from 14 county school districts, as well as representatives from the State Department of Education, both state universities, the community colleges, the Professional Standards Commission and the Nevada professional counseling associations.

This committee urges you to consider that Nevada's children are facing problems of a critical nature that can be addressed by trained school counselors and a comprehensive guidance and counseling program in the schools. The following is a statement by the American School Counselor Association which clearly defines why a school counselor is a key person needed in our schools to address such issues as prevention of drop-outs, drug abuse, teen pregnancy, suicide, and child abuse. Our children are experiencing these and other high risk issues which threaten the self-esteem they need to successfully complete their education and move on to satisfying and productive careers and citizenry.

Definition of School Counselor Adopted

School counselors are specifically credentialized professionals who work in school settings with students, parents, educators and others within the community. They design and manage comprehensive developmental guidance programs to help students acquire skills in the social, personal, educational, and career areas necessary for living in a multi-cultural society. School counselors accomplish this by employing such interventions as guiding and counseling students individually or in small groups, by providing information through group guidance, by contributing to the development of effective learning environments, through student advocacy and through consulting with others.

Adopted Fall, 1989
American School Counselor Association

Legislation has been presented in the last three sessions to fund more counselors, yet these efforts have died each time because of, among other things, a lack of consensus of how to solve the problem. We feel that the time is now and our children can wait no longer. We are recommending the following legislation to address the counseling and guidance needs of the children in Nevada:

1. Set a goal and provide funding to establish a ratio of one counselor for every 350 students in grades K-12 in the state of Nevada by 1997. Because of the fiscal impact, we suggest this be phased in over a 3 biennium period as follows:

   1: 600 by 1993
   1: 450 by 1995
   1: 350 by 1997

2. Each county should be allotted at least one new counseling position immediately because ratio numbers do not always best serve the rural counties where small numbers of students are housed in schools which may be widely separated by many miles.

3. Priority should be given to hiring of new counselors at the elementary level during the phase-in period. The greatest impact of a preventive nature can be made at the elementary level.

4. Funding is essential to promote and provide training to assure licensure of enough personnel to fill the needed counseling positions.

We urge you to support legislation that would support guidance and counseling delivered by a trained professional school counselor through a comprehensive developmental guidance program. Most counties in the state are writing comprehensive guidance programs and the State Board of Education has recently adopted a 7-12 Comprehensive Guidance and Counseling Course of Study to be implemented by September of 1992. These programs, managed by a trained school counselor who has an appropriate number of students to serve, will make a positive difference for the future of our students and will bring Nevada into the 21st century with a capable, responsible, and empowered citizenry. We cannot afford to wait any longer to serve these crucial needs of all our children.

Sincerely,

Carol Aalbers

Carol Aalbers
representing
Nevada School Counselor Statewide Committee

Enclosure

Bert Elliott, Assistant Superintendent
Elko County School District
P.O.Box 1012
Elko, Nevada 89801
738-5196

Harold Tokerud, Superintendent
Esmeralda County School District
P. O. Box 546
Goldfield, Nevada 89013
485-6382

Dianne Hamilton, Counselor
Eureka High School
Eureka County School District
P. O. Box 237
Eureka, Nevada 89316
237-5361

Sandy Walth, Counselor
Lowry High School
Humboldt County School District
P. O. Box 831
Winnemucca, Nevada 89445
623-8130

Harvey Estes, Counselor
Mary Black Elementary School
Lander County School District
P. O. Box 1390
Battle Mountain, Nevada 89820
635-2889

Leo Prestwich, Assistant Superintendent
Lincoln County School District
P.O. Box 118
Panaca, Nevada 89041
728-4471

Lorell Bleak, Counselor
Lincoln County Jr-S : High School
Lincoln County S hool District
P. O. Box 268
Panaca, Nevac : 89041
728-448 1

Nolan Greenburg, S, ecial Services
Lyon County School District
25 E. Goldfield Avenue
Yerington, Nevada 89447
463-2205

THE NEVADA SCHOOL COUNSELOR CONNECTION
Tuesday, May 8, 1990
Senate Chambers, Jot Travis Student Union
University Of Nevada, Reno

Revised 5/15/90

Name, Title, Representing

Carol Aalbers, Counselor
Bordewich Complex
Carson City School District
P.O. Box 603
Carson City, Nevada 89702
885-6322

Nancy Haywood, Counselor
Eagle Valley Junior High School
Carson City School District
4151 E. 5th Street
Carson City, Nevada 89701
995-7570

Nancy Stewart, Counselor
Churchill County School District
1222 South Taylor
Fallon, Nevada 89406
423-2181

Dorothy Robinson, Coordinator of Counselor Center
Curriculum & Instruction
Clark County School District
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Las Vegas, Nevada 89101
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Vickie Butler, Counselor
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Douglas County School District
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John Dorf
Director Special Services
Douglas County School District
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Minden, Nevada 89423

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Lyon County School District
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Hester Williams, Counselor
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Nye County School District
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Pershing County School District
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White Pine County School District
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Lyn Bennett, President
NACD
Traner Middle School
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323-0382

Sue Rusk, President
Greater Nevada School Counselor's Association (GNSCA)
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Jane Kadoich, President
Southern Nevada School Counselor's Association (SNSCA)
444 West Brooks Avenue
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Karen Smith, President
Committee on Professional Standards
Traner Middle School
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Truckee Meadows Community College
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887-3081

Carole Gribble, Consultant
Occupational Guidance and Counseling
Nevada State Department of Education
400 West King Street, Capitol Complex
Carson City, Nevada 89710
687-3144

APPENDIX K
INFORMATION FROM MARCIA BANDERA ON SCHOOL COUNSELORS

EUGENE T. PASLOV
Superintendent of Public Instruction

400 W. King Street
Capitol Complex
Carson City, Nevada 89710
Fax: (702) 687-5660

STATE OF NEVADA

SOUTHERN NEVADA OFFICE
1850 E. Sahara, Suite 200
State Mailroom Complex
Las Vegas, Nevada 89158
Fax: (702) 796-3475

DEPARTMENT OF EDUCATION

June 19, 1990

MEMORANDUM:

TO: Jeanne L. Botts, Program Analyst
Fiscal Analysis Division

FROM: Marcia R. Bandera, Deputy Superintendent
Instruction, Research and Evaluative Services

SUBJECT: Additional Information Requested on School Counselors

As requested, please note Attachment A for responses to items 1 through 3. Attachment B contains responses to items 4 and 5.

I have also provided copies of a report Children Achieving Potential - An Introduction to Elementary School Counseling and State-Level Policies prepared by the American Association of Counseling and Development. This is an excellent report. Please note pages 31 and 32 for a summary of the 50 state's policies for elementary school counselors.

MRB/da
Attachments
cc: Eugene T. Paslov
Marty Sample
Carole Gribble
Bob McCord
Debbie Alviar
School District Superintendents
State Board of Education Members

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

JOHN R. CROSSLEY, *Director*
(702) 687-6800
Fax No.: (702) 885-5962

LEGISLATIVE COMMISSION (702) 687-6800
JOHN E. JEFFREY, *Assemblyman, Chairman*
John R. Crossley, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Acting Legislative Auditor* (702) 687-6815
ROBERT E. ERICKSON, *Research Director* (702) 687-6825
LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

May 24, 1990

MEMORANDUM

TO: Marcia Bandera, Deputy Superintendent of Instructional, Research and Evaluative Services Department of Education

FROM: Jeanne L. Botts, Program Analyst
Fiscal Analysis Division

SUBJECT: Additional Information on School Counselors

In preparation for their work session, the ACR 52 Committee, which is studying the Division of Mental Hygiene and Mental Retardation, is requesting additional information on the following:

1. Estimate of the number of elementary school counselors needed by each school district to achieve a district-wide ratio of one counselor to 600 elementary students.

2. Revised estimates of the cost to the state general fund for these additional counselors. In addition to salaries and fringe benefits for the counselors, you may wish to include operating costs, equipment, space needs, training, and clerical or paraprofessional help needed. Estimates should be adjusted for inflation, salary increases, and enrollment growth.

3. In addition, please estimate the cost of providing seventeen counselors so each of the county school districts might receive at least one new elementary counselor. Incorporate projected salary increases into your estimate.

4. How does the job of an elementary school counselor differ from a secondary school counselor? Are elementary counselors required to complete different

college programs or to hold a different license/endorsement than secondary counselors?

5. Do you have information to justify a ratio of 350 students per counselor? What is the ratio in other states? Are there national standards?

If you have any questions, please call me.

ACR52 SC:JLB/tc
ACR52

ATTACHMENT A

ASSUMPTIONS

A. 1) Base Salary and Benefits for an Elementary Counselor in FY 90 - $43,000; increased by 5% for FY 91; plus 5% for FY 92; plus 5% for FY 93 ($49,778.00).

2) Base Salary and Benefits for Clerical Support for FY 90 - $25,000; plus 5% for FY 91; plus 5% for FY 92; plus 5% for FY 93 ($28,941.00).

3) Elementary Enrollment for FY 90 - 100,976; increased by 5% for FY 91; plus 5% for FY 92; plus 5% for FY 93.

4) Cost for Equipment, Office Furnishings and Operating per each new elementary counselor - $7,150.00:

Equipment

The school counselor needs a private office for one-on-one and small groups counseling sessions as well as access to a school wide Career Resource Center.

Desk	$ 600
3 Chairs	600
Shelving	200
1 Computer/Printer	2,500
Clerical Typewriter	500
TOTAL:	$4,400

Operating

Office Space	$ 500
Postage	500
Telephone	700
General Supplies/Software	1,000
	$2,750

B. Cost to provide one new elementary counselor for each school district in FY 93 ($967,776.00). ($846,226.00 salary/benefits, plus $121,550.00 for equipment, furnishings and operating ($7,150 x's 17).

C. Training:

In-Service

Considering the myriad of children's issues school counselors address (substance abuse, child abuse, suicide, career development, teen pregnancy, academic achievement, interpersonal relationships, divorce, etc.) regular in-service is required to keep school counselors current in the process and delivery of service.

	Estimated Cost
In-service Workshops (4) on Comprehensive Guidance and Counseling Issues	$ 2,000
BUDGET TOTAL	**$108,700**

Pre-Service

In order to attract more people to the school counselor profession, particularly males and minorities, pre-service incentive scholarships for potential school counselor candidates could be offered at a statewide cost of $145,000 to be used at either UNR or UNLV, with priority being given to students who would serve as school counselors in the rural school districts.

	Estimated Cost
Pre-service training (scholarships) for school counselor candidates statewide	$145,000
TOTAL TRAINING (including pre-service scholarships)	**$253,700**

6/19/90

600:1 PUPIL/COUNSELOR RATIO (DISTRICTWIDE)

	FY 90		FY 93								
	ELEMENTARY ENROLLMENT	NUMBER OF ELEMENTARY COUNSELORS	ESTIMATED ELEMENTARY ENROLLMENT	EST.TOTAL COUNSELORS REQUIRED FOR 600:1	EST. NEW COUNSELORS REQUIRED FOR 600:1	ESTIMATED COST PER DISTRICT FOR NEW COUSELORS	ESTIMATED COST PER DISTRICT FOR EQUIPMENT AND OPERATING FOR NEW COUNSELORS	NUMBER OF CLERICAL REQUIRED (FTE)	COST FOR CLERICAL SUPPORT FOR EACH 3 NEW COUNSELORS	TOTAL COST PER DISTRICT
CARSON	3,448	5	3,991	7	2	$99,556	$14,300	0.67	$19,390	$133,246
CHURCHILL	1,976	3	2,288	4	1	$49,778	$7,150	0.33	$9,551	$66,479
CLARK	58,312	16	67,503	113	97	$4,828,466	$693,550	32.33	$935,663	$6,457,679
DOUGLAS	2,629	5	3,043	5	0	$0	$0	0	$0	$0
ELKO	4,619	6	5,348	9	3	$149,334	$21,450	1	$28,941	$199,725
ESMERALDA	152	0	176	0	0	$0	$0	0	$0	$0
EUREKA	172	0	200	0	0	$0	$0	0	$0	$0
HUMBOLDT	1,545	0	1,788	3	3	$149,334	$21,450	1	$28,941	$199,725
LANDER	823	1	952	2	1	$49,778	$7,150	0.33	$9,551	$66,479
LINCOLN	492	0	570	1	1	$49,778	$7,150	0.33	$9,551	$66,479
LYON	1,852	4	2,144	4	0	$0	$0	0	$0	$0
MINERAL	831	1	963	2	1	$49,778	$7,150	0.33	$9,551	$66,479
NYE	1,869	4	2,163	4	0	$0	$0	0	$0	$0
PERSHING	491	0	569	1	1	$49,778	$7,150	0.33	$9,551	$66,479
STOREY	152	0	176	0	0	$0	$0	0	$0	$0
WASHOE	21,225	24	24,570	41	17	$846,226	$121,550	5.67	$164,095	$1,131,871
WHITE PINE	907	0	1,050	2	2	$99,556	$14,300	0.67	$19,390	$133,246
TOTALS	101,495	69	117,494	198	129	$6,421,362	$922,350	43	$1,244,175	$8,587,887

JUNE 19, 1990
FILE NAME: COUNSELORS, NDE

ATTACHMENT B

#4 HOW DOES THE JOB OF AN ELEMENTARY SCHOOL COUNSELOR DIFFER FROM A SECONDARY SCHOOL COUNSELOR? ARE ELEMENTARY COUNSELORS REQUIRED TO COMPLETE DIFFERENT COLLEGE PROGRAMS?

The programs for counseling at UNR and UNLV are essentially the same for preparing elementary and secondary school counselors with the exception of the practicum.

Students participate in a practicum at either the secondary or elementary level. If the student is planning on obtaining a K-12 counseling license then they participate in a practicum at both the elementary and secondary level.

Please note pages 7 through 14 in attached report for a discussion of the role of elementary school counselors.

#5 DO YOU HAVE INFORMATION TO JUSTIFY A RATIO OF 350 STUDENTS PER COUNSELOR? WHAT IS THE RATIO IN OTHER STATES? ARE THESE NATIONAL STANDARDS?

There is no national standard per se. You will note in the attached report that of the twelve states with a mandate for elementary counseling - four states do not have a mandated ratio, the remaining states have mandated ratios varying from 400:1 to 500:1.

APPENDIX L
ADVANCED INFORMATION MANAGEMENT SYSTEM (AIMS)

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
Kinkead Building, Room 403
505 E. King Street
Carson City, Nevada 89710
(702) 687-5943

BOB MILLER
Governor

JERRY GRIEPENTROG
Director

BRIAN LAHREN, Ph.D.
Administrator

June 11, 1990

MEMORANDUM

TO: BOB GUERNSEY, PRINCIPAL DEPUTY FISCAL ANALYST
FISCAL ANALYSIS DIVISION - LCB

FROM: BRIAN LAHREN, Ph.D. BL
ADMINISTRATOR

RE: ADVANCED INFORMATION MANAGEMENT
SYSTEM (AIMS)

Attached is the information you requested in your June 5, 1990 memorandum. I believe the packet contains all the information you requested, but if there are areas that need additional clarification, please let me know.

BL/ls

Attach.

cc: Jerry Griepentrog
Rob Farr

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

JOHN R. CROSSLEY, *Director*
(702) 687-6800
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LEGISLATIVE COMMISSION (702) 687-6800
JOHN E. JEFFREY, *Assemblyman, Chairman*
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Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

Wm. GARY CREWS, *Acting Legislative Auditor* (702) 687-6815
ROBERT E. ERICKSON, *Research Director* (702) 687-6825
LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

June 5, 1990

MEMORANDUM

TO: Brian Lahren, Ph.D., Administrator
Division of Mental Health/Mental Retardation

FROM: Bob Guernsey, Principal Deputy Fiscal Analyst
Fiscal Analysis Division

SUBJECT: Advanced Information Management System (AIMS)

Brian, at the May 21, 1990, meeting of the ACR 52 Subcommittee, there was discussion regarding the status of the current appropriation for AIMS in southern Nevada and the potential expansion of the system statewide. The lack of a centralized data system has been a significant problem for the Division of Mental Health and Mental Retardation, and this has been recognized by the Legislature through the 1989 appropriation and the possibility of an additional appropriation by the 1991 session.

The ACR 52 Subcommittee will be making its recommendations at its June 25th meeting, and the expansion of the AIMS system is one of the possible recommendations. You indicated at the May 21, 1990, meeting that the potential cost of expanding the system statewide is approximately $1.8 million. Included in that are continuation and expansion costs for the south. Prior to making a recommendation, the subcommittee will need to know how the $1.8 million figure was developed and what is included in that total, i.e., equipment, software for northern, rural and southern Nevada and whether the Department of Data Processing was involved in the development of these costs. Also, what expansion plans are considered under the new appropriation that were not initially considered as part of the initial AIMS package by the 1989 Session. Also, if any new positions are being considered in that $1.8 million, please indicate.

ACR52AIMS/cd
MH/MR
cc: Chairman Jim Spinello and
Members ACR 52 Subcommittee
Myrna Williams
Gary Ghiggeri
Jan Needham

PROGRAM BUDGET: NEW [ ] EXPANDED [X]

DIVISION: MENTAL HYGIENE AND MENTAL RETARDATION

AGENCY: DIVISION/STATE-WIDE

BUDGET ACCOUNT: 3100

I. CURRENT PROGRAM DESCRIPTION

The Division of MHMR has responsibility for the administration of statewide programs for mentally ill and mentally retarded persons. The Administrator under NRS 433.254 and the Commission on Mental Health and Mental Retardation (NRS 433.314) are empowered to ensure adequate development and administration of services. The Department of Data Processing in coordination with the Division developed an Automated Systems Plan to address the management information needs of the Division. In order to adequately perform this mission, the Division received funding in FY 90-91 to implement the Southern phase of the Automated Systems Plan. The system included personnel (Management Analyst II), central site hardware, workstations and AIMS software. The software purchased will provide information on the clients we serve, the services received, the staff providing the services and the revenues generated by service, client and staff. Additional management tasks such as incident /accident reporting, client/staff appointment scheduling and inpatient staff workshift scheduling are also available on this system.

II. EXPANDED PROGRAM REQUESTS

The Division, in order to adequately perform administrative functions, needs to expand the management information system (MIS) to the Northern and Rural regions of the state. Currently the Division does not have the capacity to integrate and analyze data state-wide. Rural Clinics, Northern Nevada Child and Adolescent Services, Nevada Mental Health Institute, Lakes Crossing, Northern Nevada Mental Retardation Services and Rural Nevada Mental Retardation Services will be included in the expansion request. In addition, the Southern system will be expanded to include software applications

identified in the Automated Systems Plan and not purchased in FY 90-91. These modules include: pharmacy inventory, trust fund accounting, fixed asset inventory, purchasing, individual client plans, doctor/team orders and recall scheduling. The Southern central site hardware will be upgraded and the existing hardware will be transferred to the Rural Region. Other costs included in the expanded request that were not included in last biennium's budget are: software monthly support fees, data conversions costs, DDP support costs and site preparation and communications.
Workstation costs can be potentially reduced if IBM equipment can be substituted with clones.

III. TARGET POPULATION

During any given month the Division agencies have approximately 12,500 persons on their caseloads and provide services to 30,000 persons annually. Mental Health and Mental Retardation services cover several programs including community, inpatient, and residential care. Tracking of clients through the various services and evaluating service delivery with the number of clients and the variety of programs requires automation.

IV. SUPPORTING NEEDS ASSESSMENT DATA

In order for the Division to adequately manage resources and provide the services mandated in NRS 433 information is needed regarding the client (who do we serve), staff (who provides the services), fiscal (at what cost) and events (what and how much services are provided). This information is crucial for the assessment of the appropriateness, adequacy, efficiency and effectiveness of the Division's programs. Management information should exhibit the following characteristics to support decision-making, evaluation and planning activities: relevance (support decision-making), timeliness (rapid retrieval), integrated (allow the examination across data components and agencies), accuracy (reliable and valid data). The existing data systems in Northern and Rural regions are largely manual and do not meet the above requirements. The Division does not have the capability to track clients or services state-wide and cannot without a huge manual effort track or evaluate service delivery to the most seriously impaired populations. Implementation of the Division Automated

Systems Plan will fully address the information needs of the Division.

V. ANTICIPATED REVENUES

Sources: State General Funds (one-shot appropriation)

	FY 92 NEW	FY 93 EXPANDED
	1,395,658	526,672
NEW & EXPANDED TOTAL:		1,922,330

VI. ANTICIPATED EXPENDITURES

AIMS SOFTWARE	511,667	110,687
CENTRAL SITE HARDWARE	306,809	295,699
WORKSTATIONS	577,183	105,286
DDP SUPPORT		15,000
	1,395,659	526,672

AIMSSOTH.WK3
MHHR DIVISION
AIMS SYSTEMS ESTIMATED COST
FY 92-93

	NEW							EXPANDED		
	UNIT COST	NORTH	ANNUAL MAINTENANCE	TOTAL	RURAL	ANNUAL MAINTENANCE	TOTAL	SOUTH	ANNUAL MAINTENANCE	TOTAL
AIMS SOFTWARE										
BASIC SYSTEM										
ADT/CENSUS	30,000	30,000	5,000	35,000	30,000	5,000	35,000	0	6,000	6,000
CLIENT DATABASE										
DATA ELEMENT GENERATOR										
RECALL SCHEDULING	5,000	5,000	833	5,833	0	0	0	5,000	833	5,833
BILLING: ACCOUNTS RECEIVABEL	40,000	40,000	6,667	46,667	40,000	6,667	46,667	0	8,000	8,000
PERSONNEL & DATABASE GENERATOR	5,000	5,000	833	5,833	5,000	833	5,833	0	1,000	1,000
TOTAL BASIC SYSTEM	80,000	80,000	13,333	93,333	75,000	12,500	87,500	5,000	15,833	20,833
OPTIONAL FEATURES										
APPOINTMENT SCHEDULING	10,000	10,000	1,667	11,667	10,000	1,667	11,667	0	1,000	1,000
PHARMACY	50,000	50,000	8,333	58,333	0	0	0	0	8,000	8,000
PHARMACY INVENTORY	5,000	5,000	833	5,833	0	0	0	5,000	833	5,833
TRUST FUND ACCOUNTING	7,500	7,500	1,250	8,750	7,500	1,250	8,750	7,500	1,250	8,750
FIXED ASSET INVENTORY	6,000	6,000	1,000	7,000	6,000	1,000	7,000	6,000	1,000	7,000
PURCHASING/INVENTORY	8,000	8,000	1,333	9,333	8,000	1,333	9,333	8,000	1,333	9,333
TOTAL OPTIONAL FEATURES	86,500	86,500	14,417	100,917	31,500	5,250	36,750	26,500	11,417	37,917
ADDITIONAL FEATURES										
INDIVIDUAL CLIENT PLANS	20,000	20,000	3,333	23,333	20,000	3,333	23,333	20,000	2,000	22,000
CASE MIX ASSESSMENT	0	0	0	0	0	0	0	0	0	0
DOCTOR'S/TEAM ORDERS	6,000	6,000	1,000	7,000	0	0	0	6,000	600	6,600
INCIDENT REPORTING	5,000	5,000	833	5,833	5,000	833	5,833	0	1,000	1,000
STAFF WORKSHIFT SCHEDULING	8,000	8,000	1,333	9,333	0	0	0	0	200	200
TOTAL ADDITIONAL FEATURES	39,000	39,000	6,500	45,500	25,000	4,167	29,167	26,000	3,800	29,800
TOTAL AIMS SOFTWARE	205,500	205,500	34,250	239,750	131,500	21,917	153,417	57,500	31,050	88,550
VOLUME DISCOUNT (.15)		174,675	29,113	203,788	111,775	18,629	130,404	48,875	30,187	79,062
INSTALLATION & TRAINING (20%)		41,100			26,300			11,500		
SOFTWARE TAILORIZATION (10%)		20,550			13,150			5,750		
DATA ENTRY		5,000								
CONVERSION (RURAL CLINICS)					20,000					
AIMS SURCHARGE .25, AS/400 MODEL 45 OR 50		51,375			0			14,375		
TOTAL AIMS COSTS		292,700	29,113	321,813	171,225	18,629	189,854	80,500	30,187	110,687
GRAND TOTAL AIMS SYSTEM - NEW	511,667				GRAND TOTAL AIMS SYSTEM - EXPANDED			110,687		

* Monthly maintenance charge for new modules (20 months)

AINS PROJECT	NEW				EXPANDED		
CENTRAL SITE		UNIT COST	NORTH	UNIT COST	RURAL**	UNIT COST	SOUTH
CENTRAL SITE HARDWARE							
9406-B45 AS/400	1	130,920	130,920		1	130,920	130,920
9335-A01 DEVICE FUNCTION CONTROLLER	1	9,180	9,180		1	9,180	9,180
9335-B01 DASD 855MB	3	22,950	68,850		3	22,950	68,850
9309-002 9125 RACK ENCLOSURE (9125 & 9128)	2	3,400	6,800		2	3,400	6,800
5853 2400 BPS MODEM	1	782	782		1	782	782
5394-010 REMOTE CONTROLLER + POWER CORD	1	4,755	4,755		1	4,755	4,755
9348-001 MAGNETIC TAPE UNIT	1	22,680	22,680		1	22,680	22,680
3477-FC3 TERMINAL , 9131 KEYBOARD	1	1,800	1,800		1	1,800	1,800
4234-012 DOT BAND PRINTER (TWINAXIAL)	1	14,330	14,330		1	14,330	14,330
6041 ASCII WORKSTATION CONTROLLER	1	2,700	2,700		1	2,700	2,700
6042 ASCII 12 PORT WORKSTATION ATTACH.	1	1,610	1,610		1	1,610	1,610
TOTAL CENTRAL SITE HARDWARE	14	215,087	264,387		14	215,087	264,387
VPA DISCOUNT RATE .15			39,658				39,658
TOTAL CENTRAL SITE HARDWARE (W/DISCOUNT)			224,729				224,729
** RURAL UTILIZES AS/400 B20E (SOUTH)							
MAINTENANCE							
9406-B45 AS/400	1		3,108		1		3,108
9335-A01 DEVICE FUNCTION CONTROLLER	1		240		1		240
9335-B01 DASD 855MB	3		2,016		3		2,016
9309-002 9125 RACK ENCLOSURE (9125 & 9128)	2		96		2		96
5853 2400 BPS MODEM	1		0		1		0
5394-010 REMOTE CONTROLLER + POWER CORD	1		259		1		259
9348-001 MAGNETIC TAPE UNIT	1		1,980		1		1,980
3477-FC3 TERMINAL , 9131 KEYBOARD	1		0		1		0
4234-012 DOT BAND PRINTER (3 YR WARRANTY)	1		1,476		1		1,476
TOTAL CENTRAL SITE MAINTENANCE	12		9,175	8,110	12		9,175
IBM SYSTEM SOFTWARE							
5728-SS1 IBM OPERATING SYSTEM/400	1		20,870		1		20,870
5728-RG1 AS/400 RPG/400	1		5,540		1		5,540
5728-PT1 PERFORMANCE TOOLS	1		4,385		1		4,385
5728-PW1 APPLICATION DEVELOPMENT TOOLS	1		5,540		1		5,540
5728-QU1 AS/400 QUERY	1		4,116		1		4,116
5728-PC1 AS/400 PC SUPPORT	1		7,792		1		7,792
TOTAL CENTRAL SITE SOFTWARE	6		56,242	0	6		56,242
VPA DISCOUNT .16			8,436				8,436
TOTAL CENTRAL SITE SOFTWARE (W/DISCOUNT)			47,806				47,806
TOTAL CENTRAL SITE HARDWARE							
HARDWARE (W/AC)			233,718	0			233,718
SOFTWARE			47,806	0			47,806
MAINTENANCE			9,175	8,110			9,175
SUPPLIES			5,000	5,000			5,000
TOTAL CENTRAL SITE			295,699	11,110			295,699

GRAND TOTAL CENTRAL SITE - NEW	306,809	
WORKSTATIONS	NEW	EXPANDED
HARDWARE	357,982	76,245
MAINTENANCE	36,044	11,928
SOFTWARE	43,434	5,841
EQUIPMENT	33,723	5,972
SUPPLIES	6,000	4,000
SITE PREP	100,000	1,300
TOTAL WORKSTATIONS	577,183	105,286
TOTAL AIMS SYSTEM	1,395,658	
DDP SUPPORT		511,672
		15,000
GRAND TOTAL		1,922,330

PROGRAM BUDGET: NEW EXPANDED

DIVISION: MH/MR

AGENCY: MH/MR ADMINISTRATION

BUDGET ACCOUNT: 3168

REQUEST: EXPANDED AUTOMATED INFORMATION SYSTEMS

1. NARRATIVE DESCRIPTION OF PROGRAM

The AIMS automated system is being placed in the South. The system is to enhance the data collection and distribution necessary to manage the various Division programs.

2. TARGET POPULATION

3. SUPPORT NEEDS ASSESSMENT DATA

The Department of Data Processing had completed a study which was presented to the 1989 Legislature. Approximately $500,000 was allocated to begin the AIMS system in the South. The one shot request approved included a Management Analyst position. It was the desire of the Legislature to remove the position from the request, but not enough time remained to transfer the position to another budget account.

4. REQUEST

The Central Office request includes a request for three new positions to provided support for the implementation of the AIMS system in the North and Rural areas:

1. DATA PROCESSING PLANNING ANALYST - This position would coordinate the automated data processing functions for the Division.

2. MANAGEMENT ANALYST II - This position would operate the data processing system for the North.

3. MANAGEMENT ANALYST II - This position would operate the data processing system for Rural Clinics.

NEW AND EXPANDED REQUESTS
AUTOMATED INFORMATION SYSTEMS

	FY 92 REQUEST	FY 93 REQUEST

01 PERSONNEL SERVICES

POSITIONS	NO.	GR/ST	SALARY	FRINGE PERCENTAGE	FRINGE	GROUP INSURANCE	SALARY + FRINGE	TOTAL
D P PLANNING ANALYST	1.00	38-15	40,745	25.16%	10,252	2,325	53,322	53,322
MANAGMENT ANALYST II	2.00	35-09	31,192	25.16%	7,848	2,325	41,365	82,730
TOTAL	3.00							136,052

	FY 92 REQUEST	FY 93 REQUEST
03 IN-STATE TRAVEL	17,200	18,060

CIP INCREASE = 5.00%

STAFF	UNITS PER MONTH FY 90 LV/CARSON	LOCAL	
NORTH			
D P PLANNING ANALYST	1.00	8.00	
MANAGEMENT ANALYST II	0.25	4.00	
RURAL			
MANAGEMENT ANALYST II	2.00	2.00	
TOTAL UNITS PER MONTH	3.25	14.00	
UNIT COSTS	321.80	22.80	
COST PER MONTH	1,045.85	319.20	
COST PER YEAR	12,550.20	3,830.40	16,381
TOTAL TRAVEL COSTS			16,381
FY 90 TRAVEL COSTS PLUS CPI %			17,200
FY 91 TRAVEL COSTS PLUS CPI %			18,060

UNIT COST BASIS (SEE CONTINUATION FOR DETAIL)

04 OPERATING EXPENSES

NEW AND EXPANDED REQUESTS
AUTOMATED INFORMATION SYSTEMS

						FY 92 REQUEST	FY 93 REQUEST
	UNLESS OTHERWISE NOTED THE FOLLOWING CPI INCREASE WAS USED:						
	CPI INCREASE: 5.00%						
7020	OPERATING SUPPLIES	COST PER POSITION 150		3 POSITIONS		450	495
7050	INSURANCE EXPENSE					123	129
				FY 92	FY 93		
	RISK MANAGEMENT:						
	POSITIONS	3.00					
	FY 92	3.00					
	FY 93	3.00					
	BONDS /FTE	3.13					
	FY 92	3.44		10.32			
	FY 93	3.61			10.83		
	TORT CLAIMS	34.12					
	FY 92	37.53		112.59			
	FY 93	39.41			118.23		
	TOTAL			122.91	129.06		
7290	TELEPHONE					924	970
	TOLLS STATE SYSTEM/POSITION						
	FY 90	0.00	140.00				
	FY 91	0.00	140.00				
	FY 92	6.00	154.00	924	0		
	FY 93	6.00	161.70	0	970		
				924	970		
03	EQUIPMENT					8,589	0

		UNIT COST	FY 90 UNITS	FY 90 COST	FY91 COST	FY 91 UNITS
8240	EXECUTIVE UNITS	2,463	3	7,389	0	0
	SECRETARIAL UNITS	2,177	0	0	0	0
	TELEPHONES	300	1	300	0	0
	WORKSTATIONS	300	3	900	0	0
				8,589	0	

NEW AND EXPANDED REQUESTS
AUTOMATED INFORMATION SYSTEMS

		UNIT COST	FY 92 UNITS	FY 92	FY 93	FY 93 UNITS	FY 92 REQUEST	FY 93 REQUEST
12	AUTOMATED PROCESSING						11,309	1,160
7020	OPERATING SUPPLIES			300	300			
	RIBBON'S, DISKETTES, PAPER, ETC.							
7070	OTHER CONTRACT SERVICES							
	MAINTENANCE AGREEMENTS							
	PRINTERS	120	3	360	360	3		
	TOTAL OTHER CONTRACT			360	360			
7770	COMPUTER SOFTWARE							
	WORDPERFECT	225	3	675	0	0		
	DBASE IV	695	3	2,085	0	0		
	LOTUS	315	3	945	0	0		
	UPGRADES	500	1	500	500	1		
	TOTAL COMPUTER SOFTWARE			4,205	500			
8370	COMPUTER HARDWARE							
	PS/2 30	1,300	3	3,900	0	0		
	DOT MATRIX PTR	750	3	2,250	0	0		
	SURGE PROTECTORS	98	3	294	0	0		
	TOTAL COMPUTER HARDWARE			6,444	0			
	TOTAL AUTOMATION EXPANSION			11,309	1,160			

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
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Carson City, Nevada 89710
(702) 885-5943

BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director

BRIAN LAHREN, Ph.D.
Administrator

May 14, 1990

TO: BRIAN LAHREN, Ph.D.
ADMINISTRATOR, MHMR

FR: SHARON GUIDERA
CHIEF OF PROGRAM EVALUATION

RE: AIMS UPDATE REQUEST, ACR52

The following is an outline of major areas of the project, accomplishments to-date including estimated time frames for implementation of other steps in the project. Each agency has a steering committee developed that meets to plan implementation; an overall steering committee for the 3 agencies meets to deal with issues concerning all users.

CENTRAL SITE HARDWARE:

Initial hardware proposed for the project was not sufficient to support the processing needs projected (# of users or RAM requirements). IBM, AIMS and the Department of Data Processing (DDP) consulted with the Division to reconfigure the system. The central site computer was delivered in January 1990 shortly after the authorized position was hired (01/02/90). The system is located in Southern Nevada Adult Mental Health Services (SNAMHS) and will not be moved during the scheduled asbestos abatement (June 1990). The computer room will be sealed during this project from the main building and an outside door into the room will allow access for the operator.

SITE PREPARATION:

The initial estimates for site preparation ($5,000) fell considerably short of the two bids received for the project ($30,000 and $66,000). Options for workstation connections for on-campus locations and remote locations have been identified with technical assistance from DDP. Options include twinax, twisted-pair and remote (modem) connections. Electrical, telephone and conduit work has been in progress since December and is expected to be complete for all sites by July.

WORKSTATIONS:

All terminal and PC locations have been identified and the equipment is ordered with delivery expected in late May or early June. Installation will be completed in June. An initial order for twelve terminals and two PC's has allowed software training and an initial program site (inpatient units at SNAMHS) to proceed with implementation.

AIMS SOFTWARE:

The client admission, transfer and tracking (ADT) module and the billing/accounts receivable (AR) modules have been delivered and are loaded on the system. Training has occurred for the ADT module and billing specifications are under-development for the billing system. Inpatient clients (SNAMHS) are loaded and census and admissions for the inpatient unit are beginning this week.
The Crisis Unit will begin admitting clients on the AIMS system by the end of this month. Outpatient client registration will occur in June and July. Several thousand clients are receiving community services and the implementation plan for registering clients on the system is still under development. Some additional coding is needed to accomplish tracking functions for community clients. AIMS is providing coding specifications this month and will tailor the ADT module to meet the concerns we have identified to date. Billing will begin in the inpatient program following completion of the specifications and coding by AIMS.

It is expected by the end of this summer that most operations on the AIMS system will be functioning. Fine tuning of the operations, procedures and coding is anticipated to be completed by December. Initial coding problems, difficulty in developing the billing specifications and the handling of the site preparation tasks have delayed implementation. Solutions for each difficulty, however, have been carefully considered with input from AIMS, agency steering committees, MHMR, DDP and IBM. Two positions in Central Office are assigned to the AIMS system project. Sharon Guidera is identified as the project manager and considerable amount of her time is involved in overseeing the details of this operation. Recently, Jean Laird has been assigned to coordinate billing implementation. Fiscal and legal support are provided by John Duarte, Chief Accountant and Cindy Pyzel, DAG. Daily operations are handled by the Management Analyst II position and a MH Program Manager both located at SNAMHS. Mike Cuccaro (DDP) has provided a considerable amount of technical assistance.

STATEWIDE IMPLEMENTATION:

Initial cost estimates for state-wide implementation (North and Rural) and completion of the Automated Systems Plan in the South are approximately 1.8 million dollars. This includes continuation and expansion dollars for the South. A planning committee with representatives from each agency, DDP, IBM, MHMR and consultation with AIMS has identified hardware and software requirements. Site preparation estimates are in progress. DDP has assigned a communications specialist to assist in this effort.

cc: Jerry Griepentrog
Hale Bennett
John Duarte

APPENDIX M
PRODUCTIVITY MEASUREMENTS

ACR52 Study Committee
Question 7 (08/22/89)
Workload Indicators

"Workload indicators the division is utilizing to measure staff activity for services other than in-patient services."

CONTEXT OF EVALUATION:

Workload indicators are one of several measures necessary to evaluate the performance of mental health programs. Administration of a statewide system requires relevant and timely information for management decision making, resource allocations (staff and fiscal), strategic planning and accountability. Information for assessment at the Division level is focused on agency and program (e.g., inpatient, outpatient) performance across the system. Agency directors, on the other hand, are typically more interested in a micro-level of evaluation, for example, how effectively is each clinician in delivery services? The following response focuses on Division level assessments.

Performance assessment is often conceptualized across four dimensions (Kamis-Gould, 1983):

> Appropriateness of services: in terms of conformance to legal mandates and Division philosophy and goals such as providing functionally-based services in the least restrictive environment and relevance of the types of service to the population's mental health needs.
>
> Adequacy of agency and program operations: Are the resources adequate to meet the demands of the agency? For example, do we have enough clerical staff to provide support services to clinicians? Are the resources (staff and fiscal) distributed in the most effective manner? Are quality assurance, utilization reviews and other monitoring processes used effectively? Is staff training adequate for job performance?
>
> Efficiency of services: Are programs at or near capacity or are programs under-utilized (e.g., low occupancy rates)? Is staff time used productively (workload indicators)? Are program costs reasonable? Are revenue collection efforts reasonable?
>
> Effectiveness of services: Do client problems improve as a result of the services? Are programs goals achieved? Are we increasing the level of functioning of the seriously mentally ill through casemanagement and partial care services?

Evaluation across all of the above dimensions is important for assessing the performance of the mental health or mental retardation services. Staff can be working at 100% effort and capacity but if the services are not appropriate to the client's needs or the services do not actually produce a positive outcome for the client then the workload indicator is inconsequential!

The Division is focusing considerable time and effort with the support of administration and the legislator in developing the capacity to evaluate the systems performance. Evaluation of any of the above dimensions assumes accurate, valid, reliable and timely data. The funding of an automated management information system for the Southern Region is a major step in developing this capacity. The Division presently monitors performance through statistical and program reports, systems reviews and special studies.

CURRENT EFFICIENCY MEASURES (WORKLOAD INDICATORS):

Several indicators are utilized by the Division in monitoring program and staff activity levels. Data includes caseloads, number of cases not seen in over 90 days, admissions, terminations, hours of face-to-face contacts, and FTE available. Indicators are collected on a monthly and/or quarterly basis. Comparisons are made over-time within agencies and between agencies with similar programs.

OUTPATIENT PROGRAM:

The Outpatient Program is the only service that has a standard to achieve by agency. The Division in 1981 adopted an outpatient standard which requires an average of 25 hours of direct client service per clinician. The standard for 67% of clinical time applies to all clinicians in the outpatient department. Medical records recording times are factored in the calculations. Recording allowances include: ten minutes per client per 50 minutes of face-to-face contact and 60 minutes per hour of testing up to a maximum of 90 minutes per test battery . FTE is based on the net FTE available after sick and annual leave are deducted. New hires are recorded as half an FTE for the first two months following hire date. This allows the new staff to build a caseload and become oriented to the agency's policies and procedures. The administrative portion of a program director's FTE is not included in the FTE available. The FTE for administration varies across programs but usually accounts for .5 FTE.

Outpatient Standard Formula

$$\frac{\text{TOTAL CONTACT HOURS}}{[67\% \times \text{DAYS} \times 7.5 \text{ HOURS}] \times \text{FTE}}$$

TOTAL CONTACT HOURS = Total hours spent by outpatient staff in face-to-face contact with clients plus recording allowances.

67% STANDARD = 25 hours per 37.5 hours work week (excluding breaks)

DAYS = Working days in the quarter

7.5 HOURS = Workday excluding 2 (15 minute) breaks

FTE = FTE available minus vacancies, sick, administrative leave and new hire adjustments

The standard utilized in Nevada ranks among the most stringent of entities that have adopted similar standards. In a 1987 report on Outpatient Productivity Standards the average standard across fourteen state required 60% of a clinician's time to be in direct services. The range for the standards adopted were 55% to 67.5%

PARTIAL CARE PROGRAM:

The following data are monitored on a quarterly basis for partial care services: Total FTE, Total Contact Hours (face to face care), and contact hours per FTE. The Division is utilizing a 1 to 10 staff/client ratio in this service. Eight states that have adopted staff ratios are as follows: GA(1:8), NC (1:8), MD (1:8), IL (1:10), MT (1:10), and MO (1:16). The Division has not yet developed satisfactory measures for this program that will allow comparisons across agencies. This is primarily due to the variations of services within and between agencies.

CASEMANAGEMENT SERVICES:

Starting in FY 90 the Division will be monitoring the following data for casemanagement services by program: FTE, total client contacts, total hours of direct care services, average hours of service per FTE and average hours of service per case. This data will be collected quarterly. Although this is a major improvement in monitoring direct services provided to clients, a significant proportion of services are indirect (such as contacting other agencies in behalf of a client, contacts with the client's family, etc.). A few agencies are currently collecting indirect service information but most do not have the capacity to track and analyze this data. As the Division develops the Management Information System (MIS) and evaluation capacities, monitoring of this program will be expanded.

States who are considered in the forefront of evaluation efforts (California, New Jersey, New York, Colorado) utilize program indicators that measure the appropriateness, adequacy, efficiency and effectiveness of programs. These states collect data on several program indicators, establish a baseline of performance and norms for expected performance. Programs that significantly perform above or below the expected levels are more extensively evaluated, corrections are made, or practices adapted for programs that perform exceedingly above expectations. In some states mental health divisions contract for services and expected performance levels and fiscal resources are tied to performance. California's legislator increased appropriations significantly to inpatient programs, however, future appropriations were tied to development of evaluation of services, establishment of baselines of performance and levels of achieved performance over a several year period.

Listed on the next page are a number of efficiency program indicators utilized by several other states, some of the indicators are currently utilized in Nevada.

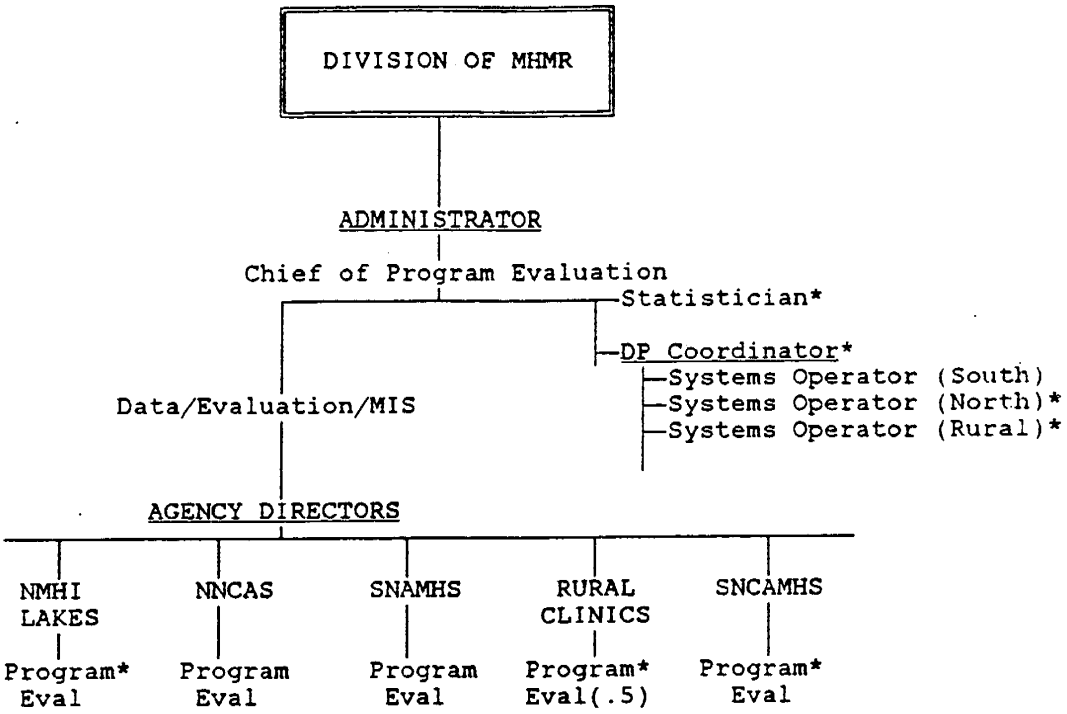
Performance Indicators for Measurement of Efficiency

INDICATOR	FORMULA	PROGRAM	DIVISION
Caseload per FTE	Caseload/FTE	Outpatient	yes
		Partial Care	yes
		Casemanagement	yes
Percent of Clinician's time in face to face contact w. th client	Hours of contact Total hours worked	Outpatient	yes
		Casemanagement	yes
Percent of Clinician's time in indirect or administrative services	Total hours of indirect services/Total hours worked	Outpatient	no
		Casemanagment	no
		Partial Care	no
			special studies
Average units of Service Per FTE	Quarterly units of service/FTE	Outpatient	yes
		Casemanagement	yes
		Partial Care	yes
Average unit of services per month for open cases	Total units of service/Total caseload	Outpatient	yes
		Partial Care	yes
Utilization of capacity:	Average daily census/daily capacity	Supportive Housing	no
	Average daily attendance/ daily capacity	Partial Care	no
	Outpatient standard	Outpatient	yes
Cost per Client Served	Total expenditures/total served	Outpatient	no
		Partial Care	no
		Casemanagement	no
		Supportive Housing	no
Ratio of amount billed to total expenditures	Amount billed/total expenditures	Outpatient	no
		Partial Care	no
		Casemanagement	no
		Supportive Housing	no
Ratio of 3rd part, and client fee revenue to amount billed	3rd party and client fee collections/amount billed	Outpatient	no
		Partial Care	no
		Casemanagement	no
		Supportive Housing	no
Ratio of 3rd party and client fee revenue to total expenditures	3rd party and client fee revenue / total expenditures	Outpatient	no
		Partial Care	no
		Casemanagement	no
		Supportive Housing	no

Fiscal information is not readily available utilizing program element cost centers. Line item expenditures are appropriated and reported by agency not programs (e.g., outpatient). The above indicators utilize revenue, expenditures and amount billed by program element. The division will have the capacity to evaluate program revenues and billings with the proposed automated system, however expenditures will not be readily available by program.

Comparison of the above efficiency indicators will allow the Division to establish baselines and performance expectations. The indicators are dependent on the existence of a sound data base. These indicators alone without measurements of program appropriateness, adequacy and effectiveness are not sufficient for assessing the performance of the mental health system.

Future plans for continuing efforts to build the capacity of the Division to evaluate program performance are contingent on Phase II of the Automated Systems Plan and expansion of positions to provide program evaluation and management information system services. The attached chart details existing and proposed postions.



* New Positions, convert existing position at NMHI
RC has existing (.5) FTE for Program Evaluation

FUNCTIONS

MANAGEMENT INFORMATION SYSTEM	PROGRAM EVALUATION	PLANNING RELATED NEEDS ASSESSMENTS
computer operations data collection data retrieval data quality control staff training reports	analysis of program performance: >appropriateness >adequacy >efficiency >effectiveness develop program indicators conduct special studies	population needs assessment projections of program service utilization and bed needs identification of unmet needs/gaps in services

BOB MILLER
Acting Governor

STATE OF NEVADA

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION
Southern Nevada Child and Adolescent Mental Health Services
6171 West Charleston Boulevard
Las Vegas, Nevada 89158
(702) 486-6100

October 9, 1989

MEMORANDUM

To: Sharon Guidera

From: Christa Peterson

Re: Thoughts on Productivity Measurements

My thoughts on productivty measurements are consistent with the division-wide, outpatient productivity study we participated in last year.

As you may recall, the study found that the 25 hour standard for outpatient therapists to be a reasonable standard, as long as modifications were made to include hours of direct service to other, non-outpatient programs and services provided in non-traditional forms (i.e. telephone contacts, client transportation and screening). The standard of inclulding only "billed" hours as opposed to "billable" hours was determined to be unreasonable, based on the fact that many state agencies are mandated to provide non-billable service hours to other entities, such as schools, social service agencies, etc. Although the study recommended that adjunctive services not be included in the outpatient productivity standards, it is clear that other non-outpatient clinicians make extensive use of adjunct services and that this service category may change over time based on the population served in outpatient programs. Therefore, the study recommended that the division periodically collect data on adjunctive services to monitor the percent of time that outpatient therapists or other types of clinicians spend in this type of service.

If you have any further questions please let me know.

CRP/dt

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

NORTHERN NEVADA
CHILD AND ADOLESCENT SERVICES
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Reno, Nevada 89512
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Director
Department of Human Resources

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Director

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Adolescent Treatment Center
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Sparks, Nevada 89431-5574
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Reno, Nevada 89502
(702) 356-7334

CTH—APW
2000 Del Monte Lane
Reno, Nevada 89511
(702) 688-0425

CTH—Desert Hills
480 Galletti Way
Sparks, Nevada 89431-5574
(702) 688-1638

MEMORANDUM

TO: Wilford W. Beck, Ph.D., Director, NNCAS

FROM: E. P. Galantowicz, Ph.D., Director (EPG)
Program Evaluation and Training

DATE: October 26, 1989

SUBJECT: ACR 52 REQUEST FOR INFORMATION (LAHREN MEMO: SEPTEMBER 18, 1989)

(The following information has been shared by telephone with Sharon Guidera)

I have reviewed the quarterly data accompanying the above-referenced memo. Beginning with FY88, NNCAS shows a reduction in the number of cases presenting with alcohol or drug abuse as primary complaints. I suggest there being two reasons for this trend.

First in FY88 several new clinical status categories were added to the Quarterly data report. For our agency's younger clients, the new "depression" and "school involvement" categories often characterize more accurately clients' immediate presenting complaints at time of intake. The two top ranked problem areas for each client are reported to Division. While noted in the client chart, secondary or family-related substance abuse problems may thus go unreported in the Quarterly data system.

Secondly over the past few years our community has seen an increase in private-sector substance abuse programming. there are several such programs expressly for the young abuser. NNCAS is likely to receive fewer clients with alcohol/other drug problems as long as such problem-specific programs continue in operation.

WORKLOAD INDICATORS

I have two comments regarding Item 2 of the above-mentioned Lahren memo. AVAILABLE FTE-per-unit-of-direct service provides a more accurate/meaningful measure of program production than does AUTHORIZED FTE-per-unit-of-direct service. Too, outpatient clinicians typically provide more client services than are reported for the Division standard.

Such additional services can include correspondence and/or reports on behalf of/relative to clients; preparation time for court testimony; court appearances; other agency contacts/meetings on clients' behalf. We would like to see these additional "non-direct" client services included in any overall clinical productivity measures.

Regarding clinician caseload information, such information is available to us through the agency computer database. This resource provides agency with ongoing information relative to clinical staff productivity, direct service our, available FTE, program admission/termination data, etc. Division-generated reports are useful to us as a cross-check on the accuracy of agency report data and as a gauge of agency contribution toward overall Division clinical productivity.

EPG:lc

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE AND MENTAL RETARDATION

NORTHERN NEVADA
CHILD AND ADOLESCENT SERVICES
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BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director
Department of Human Resources

Children's Behavioral Services
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Adolescent Treatment Center
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CTH—Reagan
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2000 Del Monte Lane
Reno, Nevada 89511
(702) 688-0425

CTH—Desert Hills
480 Galletti Way
Sparks, Nevada 89431-5574
(702) 688-1638

MEMORANDUM

TO: Sharon Guidera, Chief Program Evaluation
Division MH/MR

FROM: Wilford W. Beck, Ph.D., Director
NNCAS

DATE: November 2, 1989

SUBJECT: ACR 52

Attached is a memo from Dr. Galantowicz in response to a September 18, 1989 memo regarding ACR 52.

I want to especially emphasize my agreement with Dr. Galantowicz regarding item two, available versus authorized FTE. As you are well aware, clinical staff in the outpatient program are frequently involved in activities which directly benefit the community and/or other agencies while detracting from the available time to provide face-to-face outpatient services. The community based activities are as important to the operation of a mental health program for children and their families as our direct services. Using authorized FTE per unit of direct service penalizes staff as well as the agency.

WWB:lc

cc: Brian Lahren, Ph.D.
Pete Galantowicz, Ph.D.

APPENDIX N
CASE MANAGEMENT STUDY

STATE OF NEVADA
DIVISION OF MENTAL HYGIENE
AND MENTAL RETARDATION
Kinkead Building, Room 403
505 E. King Street
Carson City, Nevada 89710
(702) 885-5943

BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director

BRIAN LAHREN, Ph.D.
Administrator

May 16, 1990

MEMORANDUM

To: Bob Guernsey, Principal Deputy Fiscal Analyst
Legislative Counsel Bureau

From: Brian Lahren, Ph.D., Administrator, BL
Division Mental Health Mental Retardation

Re: Case Management Study

As requested, attached is a copy of the case management study recently completed by our two mental retardation agencies. I believe the study is self-explanatory, but if you have any questions please give me a call.

Attachment

cc: Jerry Zadny

STUDY OF
COMM[illegible] CASEMANAGEMENT FOR PERSONS W[illegible] M.R.

Nevada Casemangement studies - 1990 (see attached detail)

Casemanagment type	hours/yr	Service hours available per casemanager	Caseload
Level I - home-based	14.11	1300	1 : 92
Level II - purchased placements	72.1	1300	1 : 18
Level III - state administered placements	91.6	1300	1 : 14

Comparative data resulting from litigation

North Dakota - For persons in alternatives to institutional care. Community services provided as part of Class Action Suite.

External casemanagement: purchasing and monitor individualized service plans.	1 : 60
Internal casemanagement - manage day-to-day activities and services consistent with treatment.	1 : 24
Total casemanagement (internal and external combined) for every 60 clients 1 external and 2.5 internal casemanagers for a total of 3.5.	1 : 17

Oklahoma - Hissom Center consent decree ragarding residents and former residents of the Hissom Center. (1/12/90)

Casemanagement for first year after placement	1 : 10
Ongoing casemanagement after the first year	1 : 20

SUMMARY

A study of the caseload services provided by the Northern Nevada Mental Retardation Services community casemanagement staff examined activities needed for each type of case. Based on the results, 3 levels of service were defined (see A, Casemanagement Levels). Referrals and intakes were also studied; they require 1.5 and 27.5 hours respectively (see B, Referrals and Intakes). Other duties relevant to selected cases, administration and supervision were also analyzed.

Comparison of Nevada Caseload service needs were consistent with litigation settlements in other states.

4/19/90

A. Casemanagement Activity	CASEMANAGEMENT LEVELS (NUMBER OF CASES STUDIED) 255 TOTAL CASES						
	LEVEL I HOME-BASED (139)		LEVEL II PURCHASED PLACEMENTS (70)			LEVEL III STATE ADMINISTERED PLACEMENTS (46)	
	Follow-Along & Nursing Home (127)	Family Pres. Program (12)	Waiver/ RMS/DH Cases (37)	RMS Sup. Apt. Program (6)	Non-Waiver Dev. Homes RPF Ind. (27)	Non-Waiver & Private Grp. Home (24)	Sup. Apt. Program (22)
	NEEDED TIME PER CASE PER YEAR						
1- Correspondence/Letters	2 hrs.	—	1 hr.	3 hrs.	3 hrs.	3 hrs.	3 hrs.
2- C.S.P. Adaptive test given yearly & pre-waiver enrollment	—	—	2.5 hr	--	2.5 hr	2.5 hr	2.5 hr
3- Documentation/Charting of case-work activities (excl. I.T.'s)	1 hr.	.5 hr	15 hrs.	15 hrs.	15 hrs.	15 hrs.	15 hrs.
4- Weekly Staffings at Group Homes & Apartments	—	—	15 hrs.	10 hrs.	10 hrs.	20 hrs.	26 hrs.
5- Annual Planning Conf./Qtrly Reviews/Core Team Mtgs.	1 hr.	4 hrs.	12 hrs.	12 hrs.	12 hrs.	12 hrs.	8 hrs.
6- Signing and Updating Legal Papers (Admission/Releases)	--	--	1 hr.	1 hr.	1 hr.	1 hr.	1 hr.
7- CTC Certifications and Recertifications	1.5 hr	.75hr	1.5 hr	1.5 hr	1.5 hr	1.5 hr	1 hr.
8- Client Observations (in homes, at CTC's)	1.5 hr	1 hr.	12 hrs.	6 hrs.	12 hrs.	12 hrs.	4 hrs.
9- Social Worker Evaluation & Update (Yearly Evaluations)	1 hr.	1.5 hr	2 hrs.	1 hr.	2 hrs.	2 hrs.	2 hrs.
10-Transportation Time to Meetings & Client Related Activities	1 hr.	1 hr.	1 hr.	1 hr.	1.5 hr	1.5 hr	1 hr.
11-Writing Program Plans & Goals	2 hrs.	1 hr.	4 hrs.	--	18 hrs.	18 hrs.	18 hrs.
12-FPP Applications (Completing Paperwork/Formulating FPP Care Plan/Yearly Redeterminations	--	3 hrs.	--	--	--	--	--
13-Client Counseling/Problem Solving	1 hr.	2 hrs.	1 hr.	--	2 hrs.	4 hrs.	5 hrs.
14-Obtaining and Maintaining Benefits	2 hrs.	.5 hr	--	--	2 hrs.	2 hrs.	2 hrs.
15- HOURS PER YEAR PER CLIENT:	14.00	15.25	68.00	50.50	82.50	94.50	88.50
16- TOTAL CASEWORK HOURS:	1778	183.0	2516	303	2227.50	2268.00	1947.00
17- **AVERAGE HOURS/YEAR/CLIENT**	**14.11**		**72.1**			**91.6**	

Effective 4/11/90
LG:cjc (LG-LOAD/2)

B. Referrals - Intakes

Initial/Ongoing Casework Provided to All Cases Regardless of Service or Placement Designation

	FY 87/88 55 Cases Needed Time	FY 88/89 64 Cases Needed Time	FY 89/90 (To 4/16/90) 68 Cases Needed Time
1 - REFERRALS			
1.1 Initial Referral - Includes phone contact; returning calls; information sharing with person making referral; mailing out applications and agency information; making referrals to other agencies; completing referral paperwork; receiving and assigning cases.	1.5 hr	1.5 hr	1.5 hr
AVERAGE HOURS/CASE	**1.5 hr**	**1.5 hr**	**1.5 hr**

	FY 87/88 27 Cases	FY 88/89 25 Cases	FY 89/90 (To date) 42 Cases
2 - INTAKE/I.P.C.			
2.1 Intake Interview - Includes scheduling; obtaining releases; gathering/reviewing information; meeting with family; consulting other agencies; writing and editing Intake report; consulting with Clinical Services Team; presentation to Admissions Committee.	9 hr	9 hr	9 hr
2.2 Initial Planning Conference - Includes inviting pertinent participants; coordinating meeting dates; chairing meeting; dictating, reviewing and mailing of meeting minutes.	3 hr	3 hr	3 hr
2.3 Interface with other agencies and professionals to coordinate service delivery.	12 hr	12 hr	12 hr
2.4 Placement History - Compile history of all placements and services provided to a particular client. Time indicated is an average of time required to review information used in compiling the history.	3 hr	3 hr	3 hr
2.5 Placement History Update - Done as service and placement changes dictate and at least yearly.	.5 hr	.5 hr	.5 hr
AVERAGE HOURS PER CASE	**27.5**	**27.5**	**27.5**

LG-GEN/2
LG:cjc

C. Other Duties - Selected Cases Only Additional Case Management Activities Provided to a Small Number of Already Open Cases *		Total Casework Time Needed Time
3.1 Behavior Management Committee - Includes gathering data in reference to program plans; presenting data to Behavior Management Committee; revising and circulating program plans.	24 Cases	96 hrs
3.2 Individualized Educational Plans - Attend IEP's to represent clients' Interdisciplinary Team and advocate for client educational services.	13 Cases	26 hrs
3.3 Arranging client visits for transfers to other programs, for orientation to group home living, and for orientation to respite care situations.	20 Cases	60 hrs
3.4 Respite Care - Receiving the request, identifying a resource, providing training and orientation to the provider and arranging, chairing and documenting the Temporary Care Planning Conference.	35 Cases	290 hrs
TOTAL CASEWORK HOURS		472 hrs
AVERAGE HOURS/CASE		5.1 hrs

* Only needed by 36.1% of cases (92÷255)

LG-ADDL/2
LG:cjc

D. Other Duties Case Management Administrative and/or Supervision Activities	Total Needed Case Manager Time
4.1 Quarterly Home Observations - Includes scheduling, time spent in the home, write-up of the visit, and presentation to the home staff. (3 hours/quarter x 3 homes each) 4.5 Case Managers	162 hrs
4.2 Social Effectiveness Training Group Leaders/Confederates - Includes leading group role plays and evaluating students. (20 hours/class x 3 classes/year) 3 Case Managers	240 hrs
4.3 Orientation - Present Normalization segment to new agency hires. (1 hour/class x 6/year) 2 Case Managers	12 hrs
4.4 Community Education - Presenting agency and program information to agencies, professionals, parents' groups, educational agencies. 4.5 Case Managers	108 hrs
4.5 Training/Workshops/Classes - 40 hours of training to be provided each year by the state; 15 hours per year of training required per year for relicensure. 4.5 Case Managers	180 hrs
4.6 Additional Transportation - Work-related; non-client related. 4.5 Case Managers	54 hrs
4.7 Code 100s/Fire Drills 4.5 Case Managers	9 hrs
4.8 Update/Discuss Placement List. (1/4 hour/week x 52 weeks) 4.5 Case Managers	54 hrs
4.9 Supervision of group and developmental home staff - Includes non-client related consultations, i.e., staffing, finances, physical plant. (Average .5 hours/month/developmental home x 15 homes plus 2 hours/month/group home x 8 homes.)	1092 hrs
4.10 Administration - Respite program - Includes receiving new referrals, recruiting providers, education/information to families regarding the program, coordinates general training programs for providers, coordinates financial aspects of programs, distributes provider packets (This is a full-time position through SNMRS.) 1 Case Manager	450 hrs
4.11 Recruitment/Interviews for group and developmental home staff - Includes placing ads, taking initial phone inquiries, scheduling interviews, reviewing resumes, conducting interviews and home studies.	
Initial Contacts x 1 Case Manager	20 hrs
Follow-up Contacts x 2 Case Managers	64 hrs
TOTAL HOURS PER YEAR	2445
Hours/year/case (255 cases)	9.5
Hours/Case Manager (4.5)	**543.33**
E. Supervision of Case Management Services	
5.1 Staff Supervision/Evaluations - Includes case consultations, support, checking on timelines, problem solving, actualizing new programs (CTCs, etc.), representing case management staff in administrative decision-making process. (2 hours/Work Performance Evaluations x 4 staff per year; spot checks and staff support 16 hours/week) .5 CSW-III	840 hrs

STATE OF NEVADA
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(702) 885-5943

BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director

BRIAN LAHREN, Ph.D.
Administrator

December 15, 1989

MEMORANDUM

TO: BRIAN LAHREN, Ph.D.
ADMINISTRATOR

FROM: JERRY ZADNY, Ph.D.
DEPUTY ADMINISTRATOR, NORTH

RE: ACR-52 QUESTION 14 of 11/13/89:
CASE MANAGEMENT STAFFING STANDARD

The case management staffing standard of 1:35 was developed in 1986, based on a survey of expert informants identified by staff at the National Institute of Mental Health. Respondents included Ron Manderscheid of NMHI (paper attached), Charles Rapp at the University of Texas, Penelope Carazonne who had conducted considerable research on case management, and representatives of the Wisconsin and Texas state mental health agencies.

Recommended staffing ratios ranged as low as 1:4 (for a time limited intensive program). The consesus was that the most cases a case manager could carry and still effectively deliver direct services to clients was 35. Beyond that level, the experts felt there would only be time for paper management of cases. The 1:35 ratio also assumes a balanced caseload so that extremely difficult and demanding cases are evenly distributed among case managers and so that there are enough minimally time consuming follow along cases to compensate for the assignment of recent inpatient discharges who require considerable help to get settled.

As of December 1, 1989, the case management caseload for Southern Nevada Adult Mental Health Services (SNAMHS) was 593 clients. SNAMHS has 14 authorized case managers. This yields 1:42 staffing. The Nevada Mental Health Institute's (NMHI) December 1, 1989 case management caseload was 154 clients. NMHI has 5.5 authorized case managers, which yields 1:28 staffing. NMHI is in the process of assigning Galletti medication clinic clients to case management to reach an average staffing ratio of 1:35.

JZ/ls

cc: Jerry Griepentrog

Attach.

Community Mental Health Journal, Vol. 19 No. 1, Spring 1983

A Descriptive Analysis of Community Support Program Case Managers Serving the Chronically Mentally Ill

Ingrid D. Goldstrom
Ronald W. Manderscheid

ABSTRACT: This article presents a description of case managers who serve community-based chronically mentally ill (CMI) persons through the Community Support Program (CSP). Information is presented on case managers' demographic characteristics, education, job training, job history, current job activities, and locus of employment. Data were generated through the Case Manager Background Questionnaire, a 23-item self-administered instrument developed in conjunction with the CSP, a pilot Federal-State collaboration project designed to explore strategies for improving the delivery of community-based mental health and related services to the CMI. Results of the study suggest that a typical CSP case manager is white, female and in the mid-thirties. Case managers are a highly educated group; nearly one-half have graduate degrees and about two-thirds have participated in an in-service or continuing education program. Currently, two out of three CSP case managers are employed at Community Mental Health Centers and about one-third of their time is spent in direct service provision. While CSP case managers have been working at their present location for about one and one-half years, they have been in the community-based mental health system for about four years, and with the mentally disabled an average of seven years. A critical issue emerging from this analysis is the need for future research on the relationships among job training, education, job functions, and service delivery.

An estimated 1.7 to 2.4 million adults in the United States suffer the disabling consequences of severe psychiatric illness that has persisted or is likely to persist over a prolonged period of time (U.S. Department of Health and Human Services, 1980). Historically, these chronically mentally ill persons were cared for in their homes; over time, however, state and county psychiatric hospitals, often located in remote areas, became the locus of care. More recently, due to an increased awareness of human and economic costs, improved treatment techniques, and concern for the civil liberties of this special population, states

The authors are affiliated with the National Institute of Mental Health, Rockville, Maryland. These data derive from Contract No. 278-79-0031(OP), Division of Biometry and Epidemiology, NIMH. The authors appreciate the insightful comments provided by three *CMHJ* reviewers, as well as background information offered by Judith Turner and Janet Meleney of the NIMH Community Support Program.

0010-3853/83/1300-0000$02.75

have increasingly emptied these public institutions and discharged the chronically mentally ill, among others, back into their communities (U.S. Department of Health and Human Services, 1980).

In response, local communities, with the assistance of state and federal governments, have made attempts to care for the chronically mentally ill in the least restrictive and most beneficial manner possible. The practice of case management techniques has emerged as an important means of dealing with the unique problems faced by the chronically mentally ill in the community.

Case management is based on a belief that chronically mentally ill (CMI) persons can be successfully maintained in noninstitutional community settings when needed services are both available and accessible. At the root of this service approach is the case manager, whose activities are primarily aimed at enhancing the quality of life of the client in the community and, from a clinical perspective, reducing the rate of hospitalization of clients, or the length of stay should hospitalization become unavoidable (Curry, 1981).

While there is no uniform definition of case management across states, a few broad conceptions are informative. Graham (1980) sees case management as the process of coordinating the delivery of rehabilitative and support services to individual clients and helping clients to solve problems that prevent or inhibit their continued access to services. The objective of continuity of care and service is emphasized in the Balanced Service System, the conceptual model that forms the basis for accreditation of community mental health service programs by the Joint Commission of Accreditation of Hospitals (JCAH) (1979). The JCAH (1979) defines case management as essentially a coordinating and problem-solving function designed to assure continuity of care and service and to overcome system rigidity, fragmentation, misutilization, and inaccessibility. Young and Bigelow (1981) conceive of case management as a somewhat more intensive activity, designed to fill service gaps and eliminate barriers within the service system, ensure an integrated and comprehensive service package for clients that leaves no critical need unmet, and entails the practice of vigorous outreach to compensate for the client's lack of assertiveness.

Irrespective of the definition of case management, three common elements are generally involved—linking, monitoring, and advocacy. Graham (1980) defines these as follows: Linking is work activity aimed at helping clients identify and gain access to agencies, programs, and people that offer services; monitoring is activity aimed at learning about problems clients face in adjusting to the community; advocacy is activity to solve problems clients are having with service providers and members of the community. The JCAH (1979) adds the elements of assessment, which they see as an ongoing process, and planning, which entails the development of a specific service plan for each client, with provisions for linkages to needed services.

Because of the pivotal role of the case manager in the process of service delivery, it is worthwhile to examine the types of individuals who perform this

function and to look at exactly what they do. The purpose of the present article is to offer a national description of case managers who are working in the Community Support Program (CSP), which is specifically based on the case manager model of service coordination, and according to Robinson (1981), where the concept of case management has been actualized.

The CSP was initiated by the National Institute of Mental Health (NIMH) in 1977, and designed as a national pilot project in Federal-State partnership to explore strategies for improving the delivery of community-based mental health and related support services to chronically mentally ill adults. Eighteen demonstration sites throughout the country were funded. (For a more detailed description of the CSP, see Turner and TenHoor, 1978).

Case management is one of ten essential key service components of the program. While states and local agencies have flexibility in how they define case management and interpret the role of case managers within the context of their own unique program needs, specific guiding principles were suggested by NIMH.

> At the client level, there should be a single person (or team) responsible for remaining in touch with the client on a continuing basis, whether the client is in the hospital or in the community, regardless of the number of agencies involved. The number of clients assigned to this person or team should be small enough so that each client is known well, treated uniquely, and so that a supportive caring relationship is possible.... (NIMH, 1980).

Furthermore, case managers should

> Facilitate effective use by clients of formal and informal helping systems, by... helping the client make informed choices about opportunities and services, assuring timely access to needed assistance, providing opportunities and encouragement for self-help activities, and coordinating all services to meet the client's goals. (NIMH, 1980)

The CSP case manager, then, either guides the clients in locating services or directly provides services in the following areas specifically designated as essential components of the CSP: identification and outreach; assistance in applying for income, medical and other entitlements; twenty-four hour quick response assistance; psychosocial rehabilitative and support services; medical, dental and mental health care; backup support to families, friends, and community members; grievance proceedings and mechanisms to protect client's rights; transportation services; and, as mentioned, case management. The CSP case manager performs considerably more encompassing tasks than would a traditional therapist, for example, for while the CSP case manager might be a mental health professional, the provision of clinical services is only one of his or her responsibilities. (Lamb (1980) provides a good description of the "therapist-case manager.") Alternatively, it is possible that the CSP case manager is a social worker, assisting the client to obtain mental health care from another source yet directly providing social services assistance. The CSP

case manager could also be a paraprofessional whose function is that of a broker of services—not providing any direct services but securing them for clients.

In the above examples, or others adopted by states or agencies, the case manager monitors and facilitates the client's movement through community-based services. At each of 18 CSP sites, a core service agency assumes responsibility for coordinating the ten key service components. Core service agencies can be located in many different types of facilities including community mental health centers (CMHCs), private or public social service agencies, hospitals, or some combination of these facilities.

By defining itself as a pilot project, the CSP also assumed responsibility for critical and timely self-examination. As part of this evaluation process, the CSP began to systematically collect basic information in 1980 about the 4,287 clients being served across the country in 18 demonstration sites. (For a descriptive analysis of the client population, see Goldstrom and Manderscheid, 1982.) Since the ability of the case manager to perform his or her central function in the program may depend to a large extent on the case manager's background, education and training, and work history, another objective of the evaluation was to determine the characteristics of case managers. The purpose of the present article is to provide a description of CSP case managers generated from data collected in a questionnaire administered to CSP case managers.

METHODOLOGY

The Case Manager Background Questionnaire is a 23-item, self-administered instrument that includes questions on demographic characteristics, education, training, job history, current job activities, and the types of facilities where case managers work. The overall purpose of this instrument is to provide a basic profile of who case managers are and what they do in their jobs.

All staff (248 persons) at the CSP demonstration sites who had direct responsibility for CSP clients were asked to complete the questionnaire. Two-hundred eleven (85%) responded. Reasons for less than 100% participation include: retirement or leaving the job during the course of the study; short job tenure and resulting unfamiliarity with clients; volunteer status as case managers; and, refusal to complete the questionnaire. No known bias exists in the sample of 211 case managers.

FINDINGS

General Demographic Characteristics

The mean age of the CSP case managers is 36 years, similar to the mean of 33 years found in a study conducted in New York State (Baker, Intagliata & Kirshstein, 1980). Almost two-thirds (62%) are female. The ethnic distribution is as follows: white (86%); black (12%); Asian or Pacific Islanders (1%); and American Indian or Alaskan Native (1%). Overall, 5% of the case managers are Hispanic. Of those specifically identifying themselves, one is Cuban; two, Puerto Rican; and three, Mexican.

Education and In-Service and Continuing Education Programs

The educational level of case managers is quite high. Nearly one-half (48%) have completed graduate or professional school. Only 2%, or 4 of the 211 case managers, did not attend college at all.

The highest academic degree case managers have received are as follows: one-third (33%) have earned a bachelor's degree in arts or science; 27%, a master's degree in social work; and 15%, a master's degree in arts, science, or education. Of the remainder, 9% have a high school diploma, 4% have a Ph.D. or doctoral degree in education, 3% have a nursing degree, and 3% have an Associate of Arts degree.

Case managers also specified their major field as undergraduate and graduate students. As undergraduates, the most frequently mentioned majors were: psychology (31%); sociology (17%); social work (13%); nursing (12%); counseling/therapy/community health (6%); English (5%); and, education (4%). As graduate students, the most frequently mentioned majors were: social work (44%); psychology (23%); nursing (8%); counseling/therapy/community health (7%); and education (7%).

Since on-the-job training and continuing education are frequently essential components of careers in the mental health professions, several questions were asked of case managers about their supplementary training and education. First, case managers were asked whether or not they were currently enrolled in a degree-seeking program. About one in five case managers (19%) indicated that they were currently enrolled in such a program. Of these, about one-fourth were seeking a bachelor's degree; about one-fourth, a doctorate degree; and the remaining half, a master's degree.

Case managers were asked about the continuing education or in-service programs that prepared them for their jobs as case managers. Nearly two-thirds (62%) have participated in some sort of continuing education or in-service training program at some time during their career. Of those who have participated in one of these programs, the following questions were addressed: What type of curriculum or training was involved? Why was the program meaningful? Case managers had the option of citing three programs in which they had participated. In summary, across the three in-service or continuing education programs chosen, the most frequently mentioned curricula or training topics were: CSP case management (30%); therapy (22%); and, general knowledge, excluding therapy (23%). To a lesser degree, learning about CSP quick response emergency needs, CSP legal problems, the future of mental health service delivery, and personal skills training were cited. Case managers found this training meaningful because they felt it assisted them in performing their case management activities, provided general knowledge, or helped them to serve particular types of people more effectively. The responses to this question imply that case managers are interested in obtaining additional specific information about functioning as a case manager, but that they also find it valuable to acquire general knowledge about mental health service delivery.

Job Activities of Case Managers

This section reports on several aspects of the job performed by CSP case managers. The topics discussed include: job title; full-time versus part-time employment; team versus individual approaches to case management; caseload; use of foreign languages; and, percent of time spent on various job functions.

Case managers were asked, in an open-ended question, their job title. Only about 2%, or 5 out 211, wrote "case manager." Although on first reflection this finding may appear surprising, it should be remembered that the CSP sites exist within broader organizational frameworks that usually assign job titles by discipline. For the purpose of analysis, generic professional categories typically found at mental health facilities were developed. The categories, and the frequencies with which they were mentioned, include: Social Worker/Psychologist (36%); Therapist/Counselor (23%); Supervisor/Coordinator (13%); Nurse (10%); Advisor/Technician (8%); and, Director/Administrator (6%). Although experience in the field has demonstrated that both professionals and paraprofessionals can function effectively as case managers (Benjamin & Ben-Dashan, 1981), it appears that the majority of CSP case managers are mental health professionals.

Most case managers work full-time at their jobs; only 11% indicated that they were employed on a part-time basis. For the part-time employees, the mean number of hours per week was 24.4.

Clients may receive services from one person designated as "the" case manger, or from a case mangement team. Each approach has its advantages and disadvantages. As Benjamin and Ben-Dashan (1981) note, there may be more accountability for a client and greater continuity of care delivered by a single case manager, but a team may find it easier to overcome the multiple boundaries of service delivery. Individual case managers may be more susceptible to "burnout" and frustration in their jobs, whereas case management teams may be able to provide interpersonal support for their members. In the CSP, about two-thirds (62%) of the case managers work as part of a team when performing their jobs.

The average overall caseload of case managers is 34 clients. Of these, 29 clients are in the CSP. Graham considers 30 or fewer clients to be a small caseload (Steindorff, Lannon & Soldano, 1981). It is evident that, by and large, the guiding principle that a caseload should be small enough to accomplish the multiple tasks assigned is generally adhered to by the sites.

Case managers were asked to indicate whether or not they use any foreign languages when they perform their jobs. Since some of the clients may not speak fluent English, having case managers who are bilingual might be preferable in some locations. The results indicated that only about 10% of the case managers use a language other than English in performing their jobs. Of the 20 case managers who use a foreign language, seven indicated that they use Spanish and five use sign language. The remaining eight case managers did not specify the language they use.

Case managers were asked to designate the percentage of time they spend on each of nine case management job functions. Other studies have addressed time allocation (Graham, 1980; Haring, 1979); however, as Curry (1981) notes, comparisons are impossible because there is no uniform categorization of job functions adopted across studies. In the present study, the mean percentage of time for each job function was calculated. The results, in descending order of performance, were: direct services (32%); assessment (10%); service coordination (9%); planning (8%); monitoring (8%); client advocacy (7%); follow-up (6%); service evaluation (6%); and, information/referral (6%). Therefore, case managers spend about one-third of their time in direct service activities.

Facilities Where Employed and Duration of Employment

Current—Table 1 presents data on the types of facilities where case managers currently work, where they have worked in the past, and the duration of their previous employment in particular kinds of settings.

Table 1: Work History of CSP Case Managers

Type of Facility	Current Work Setting (Percentage)	Past Work Setting (Percentage)	Past Duration of Employment in Months (Mean)
Community Mental Health Center.....	62	69	41
Outpatient Mental Health Facility.....	19	34	37
Psychosocial Rehabilitation Agency.....	15	20	36
Social Service Agency (Educational or Vocational).....	5	26	39
Psychiatric Hospital.....	4	37	38
Community Residential Program.....	4	21	29
General Hospital Psychiatric Unit.....	3	18	29
Primary Care Physician or General Health Clinic.....	0	12	33

Several case managers indicated that they currently work at more than one facility and as a result, multiple responses were coded. Consequently, percentages do not sum to 100. Furthermore, it should be kept in mind that many of the CSP sites have as their core service agency a Community Mental

Health Center (CMHC), a psychosocial rehabilitation agency, or an outpatient mental health facility.

The results show that about two-thirds (62%) of the case managers are in fact employed at CMHCs. Responses also indicate that outpatient mental health facilities employ 19% of the case managers, and that 15% work at psychosocial rehabilitation agencies. Social service agencies account for 5%; community residential programs, 4%; psychiatric hospitals, 4%; and, general hospital psychiatric units, 3%. Clearly the majority of case managers are associated with CMHCs.

Case managers were asked to indicate the number of months they had worked at the local CSP demonstration project. The results showed that the average duration of employment was 19.3 months or about one and one-half years.

Past—In order to explore case managers past work history, several questions were posed. The first asked the case manager how many total years he/she had worked with the mentally disabled in a community based system of mental health service delivery or elsewhere. The results indicated that case managers had been working an average of 7.1 years. Case managers were also asked to indicate the total amount of time they worked in a community-based system of mental health delivery. The results showed that the average duration of employment was about four years. Therefore, while the case managers had been working at the local CSP demonstration projects for about one and one-half years, they had worked in a community-based system for four years and with the mentally disabled considerably longer.

Case managers were also asked to indicate the types of mental health facilities at which they had worked and to specify the total duration of their employment in that type of facility. (Again, they could check more than one facility.) As Table 1 shows, about 69% of the case managers worked at CMHCs for an average of 3.4 years; 37% worked at psychiatric hospitals for about 3.2 years; 34% worked in an outpatient mental health facility for an average of 3.1 years; 26% worked at social service agencies for about 3.5 years; 21% worked at a community residential program for about 2.5 years; about 20% worked at psychosocial rehabilitations agencies for an average of 3.2 years; 18% worked at a general hospital psychiatric unit for about 2.5 years; and about 12% worked for primary care physicians or in general health clinics for an average of 2.8 years.

These results show that many of the case managers have in the past been employed most frequently at CMHCs, psychiatric hospitals, and outpatient mental health facilities. When comparing this with current place of employment, it appears that while the majority (almost 70%) have at one time been employed at CMHCs, a substantial portion may have moved from the more traditional settings of mental health service delivery such as psychiatric hospitals into CSP core agencies. Clearly, they bring to the CSP a wide variety of experiences in providing mental health services.

SUMMARY AND CONCLUSIONS

The 23-item case manager background questionnaire portrays the typical CSP case manager as a white female in the mid-thirties. Although few have earned doctoral degrees, case managers are a highly educated group of mental health service workers; about one-half (48%) have obtained at least a master's degree. Their undergraduate work has generally been in psychology and sociology; their graduate work, in social work and psychology. Nearly two-thirds of the case managers have participated in an in-service or continuing education program. Currently, two out of three CSP case managers are employed at CMHCs and almost three-quarters have worked in a CMHC at some time. Case managers have been working at the CSP cite for about one and one-half years, in the community-based service system for about four years, and with the mentally disabled an average of seven years. Most case managers work full-time, and about two-thirds work in a case management team. On the average, case managers have 29 CSP clients and five non-CSP clients in their caseload and spend about one-third of their time in direct service delivery.

Stimulated by the CSP, the practice of case management in the care of chronically mentally ill persons in the community has been widely adopted by states and local areas. Therefore, future research on how to improve its application vis-a-vis client functioning is of vital importance. While many studies have been conducted, some questions remain to be answered.

For example, are there any particular demographic and/or educational characteristics of case managers that are more clearly associated with successful client adjustment in the community? Bernstein (1981), in her study comparing CSP case manager and client characteristics, found that there are, in fact, some background characteristics important in service delivery, such as education and training variables. How can this background be altered to result in more positive client outcomes? Some clear indication of the relationships among job training, education, job functioning, and service delivery is needed.

Another area of interest is whether case managers should be spending the bulk of their time in direct service delivery or in brokering services. This decision, a local one, is obviously affected not only by a given philosophy of case management but also any number of conditions present in local agencies, such as the number of persons available to perform case management functions, their professional skills, caseload size, and other resource issues that are specific to the local areas. In today's economic climate, the rational allocation of scarce resources and staff may dictate the philosophy adopted rather than the reverse.

What is an optimal client caseload size for effective service delivery? What is the most appropriate mix of job functions? Complex analyses would be required to answer these questions, necessitating first the adoption by researchers of a uniform classification of job functions to facilitate comparisons and conclusions. Once these job functions were articulated and measures

developed to assess how well case managers are performing them, it would be possible to evaluate their effectiveness in achieving the stated goals.

However, much of the continued research in the area of case management depends ultimately on agreed-upon measures of client outcome, or measures of successful adjustment of clients in the community, a field still in its infancy. Once such measures become more refined, relationships between case manager characteristics, and their success in effecting client adjustment can be more clearly established and progress in the community care of the chronically mentally ill enhanced.

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APPENDIX O
BUREAU OF VOCATIONAL REHABILITATION

BUREAU OF VOCATIONAL REHABILITATION
SERVICES TO PERSONS WITH MENTAL DISABILITIES
STATEWIDE

Level of Service

The Bureau rehabilitated the following during State Fiscal Year 1989:

Psychotic Disorders	27	Northern	10.8%
Psychoneurotic Disorders	57	Southern	5.0%
Personality Disorders	34	Rural	4.2%
Mental Retardation, Mild	28		20.0%
Mental Retardation, Moderate	24		
Mental Retardation, Severe	1		
Total	171		

These disabling conditions constituted 20% of the total cases (845) rehabilitated from 7/1/88 to 6/30/89. These figures include primary disabling conditions only.

Case Service Funds

18.5% of case service funds expended for total rehabilitations were expended for disabling conditions described above.

Relationships with Mental Health Service Providers

Bureau offices are co-located with Mental Health agencies at the following locations:

Southern Nevada Mental Health Center, Las Vegas
North Las Vegas
Truckee Meadows Hospital, Reno
Elko
Fallon
Henderson

Itinerant co-locations include:

Fernley
Yerington
Gardnerville
Tonopah

APPENDIX P
DRUG AND ALCOHOL DETOXIFICATION SERVICES

BOB MILLER
Acting Governor

JERRY GRIEPENTROG
Director

STATE OF NEVADA

STEPHEN A. SHAW
Administrator

DEPARTMENT OF HUMAN RESOURCES

REHABILITATION DIVISION
505 E. King Street, Room 500
Carson City, Nevada 89710
(702) 687-4790

May 11, 1990

MEMORANDUM

TO: Bob Guernsey, Principal Deputy fiscal Analyst
Fiscal Analysis Division

FROM: Liz Breshears, Chief
Bureau of Alcohol and Drug Abuse

SUBJECT: Information Request for ACR 52:
Drug and Alcohol Detoxification Services

Attached please find the following information items which may be of assistance in the ACR 52 Subcommittee consideration of detoxification services:

1. A short explanation of BADA's capacity to participate in a medical detox program;

2. A history of detox services in Northern Nevada; and

3. An explanation of the difference between detoxification and Civil Protective Custody (CPC).

EMB:ca

pc: Steve Shaw, Administrator
Carl Dahlen, Senior Management Analyst

DRUG AND ALCOHOL DETOXIFICATION SERVICES
BUREAU OF ALCOHOL AND DRUG ABUSE

The largest portion of BADA funding for treatment is through the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) of the Department of Health and Human Services. As per the statutes which govern these funds,**"A state may not use amounts paid to it to...provide inpatient hospital services in the case of amounts provided for alcohol or drug abuse programs."** The intent of the legislation is that drug and alcohol monies are to be used for non-medical programs; the distinction is made that BADA can fund "residential social-model" treatment, but cannot fund "inpatient", i.e. medical, treatment.

In response to this statutory restriction, all BADA grantees, including detoxification services, are social model programs. The Bureau would participate in a medical detoxification project, however the issues of liability, as well as JCAHO or other appropriate accreditation must be considered. BADA program certification, which is required by NRS 458.025 for all programs which receive BADA funding, utilizes standards, which are appropriate only for social model programs. The protocol is inadequate for medical services.

BADA is not in a position to accredit or effectively monitor a medical detoxification unit. In addition, the agency must be careful to avoid actions which might jeopardize the major source of treatment funding. Therefore, the two options which appear most suitable are:

1. BADA participate in a medical detoxification program, with another agency or political entity assuming the lead; or

2. A medical detoxification project be established with the goal of stabilization of patients. Patients would then be transferred to the more cost effective social detox unit, which BADA currently funds in northern Nevada via Northern Area Substance Abuse Council.

As stated at the previous hearing, over 90% of patients are immediate candidates for a social model program and need no medical intervention. However, for the roughly 10% who do need medical services, BADA will assist as appropriate in program development and implementation.

BUREAU OF ALCOHOL AND DRUG ABUSE
CIVIL PROTECTIVE CUSTODY/DETOXIFICATION SERVICES
WASHOE COUNTY

The largest chemical dependency program in Washoe County is the Northern Area Substance Abuse Council (NASAC). This organization, which was founded in the 1960's, provided outpatient treatment and referral services prior to CPC and social model detoxification development in Reno. In 1978, NASAC received a three (3) year National Institute on Alcoholism and Alcohol Abuse (NIAAA) grant to provide detoxification services.

Since the time of initial BADA participation in this project, the funding from BADA and local funding agencies has increased except for Washoe County. BADA receives monies from liquor taxes authorized by 1981 legislation. These liquor taxes are specifically earmarked for alcohol rehabilitation services including CPC. BADA has approximately $600,000 available annually from the dedicated alcohol tax. NASAC consistently receives a significant portion of this funding. It should be noted, however, that the alcohol tax generated has shown a small but consistent decrease over the last eight years, despite the state's population growth.

NASAC has 16 beds which are designated as CPC beds, and an additional 18 beds which are designated as social model detoxification beds.

Individuals who are admitted to CPC facility must be brought to the facility by the police. Clients must be non-violent, not in need of acute medical treatment, conscious during the admission process, and express a willingness to stay. The average length of stay in CPC is approximately 8 hours and the average number of admissions is approximately 5 per individual.

Since the CPC facility opened in February, 1983, there have been 26,758 admissions. As mentioned above, many of these are multiple admissions, and some cases in excess of 50 separate admissions per individual.

CPC admissions tend to fluctuate from month to month depending upon a number of external factors. Cold weather has a tendency to drive individuals into CPC, as well as increased volume during peak tourist seasons. However, the fact which has the most impact on the utilization of CPC services is the cooperation of local law enforcement entities. Often officers find it more convenient to take the CPC clients to the consolidated jail rather than to the CPC facility at the Nevada Mental Health Institute. This perceived inconvenience by police officers frequently results in inappropriate admissions to the jail, and contributes to over crowding.

Social model detoxification services tend to be somewhat more stable in regard to admissions. The length of stay fluctuates somewhat, particularly when individuals are held pending admission to the chemical dependency unit.

In an effort to have appropriate CPC referrals sent to NASAC rather than jail, and to develop some additional detox beds, representatives from the Washoe County Sheriff's Office, NASAC, and BADA, have been meeting regularly for two years to discuss procedures and alternatives related to CPC and social model detoxification.

It was suggested that nursing staff be added to the existing NASAC staff to provide 24 hour nursing coverage. This was initiated at the request of the emergency rooms in Reno to relieve some of the problems related to alcohol related emergency room admissions. This concept is currently being researched in and additional funding may be forthcoming from local governmental entities.

Another issue concerns clients who are both chemically dependent and psychologically impaired. This situation is particularly troublesome when the client is acutely intoxicated. Recently, Washoe Medical Center has significantly reduced the availability of psychiatrists for indigent clients, thus compounding this problem. It has been suggested that a triage unit be developed for the assessment of dual diagnosis clients and individuals who are simply intoxicated. The CPC and social model detoxification issue being viewed within this broader context to include a full spectrum of services. BADA and NASAC are continuing to meet with representatives from Washoe County, Reno P.D., Washoe Medical Center, St. Mary's Hospital, and the Division of Mental Hygiene and Mental Retardation.

NORTHERN AREA SUBSTANCE ABUSE COUNCIL
320 FLINT STREET, RENO, NV 89501
786-6563

April 19, 1990

Elizabeth M. Breshears, Chief
Bureau of Alcohol and Drug Abuse
505 East King Street, Room 500
Carson City, Nevada 89710

RE: Distinction CPC - Detox

Dear Liz:

There is confusion between the roles of the social detoxification unit and Civil Protective Custody Unit. Often people refer to one when they mean the other.

Social Detoxification

This unit accepts clients who are intoxicated and who voluntarily come to our program. Clients may be brought in by their family, friends, AA members, etc. or may simply walk in on their own. The stay ranges from 3 - 7 days with clients attending AA meetings, watchin_ films on substance abuse and are evaluated. A majority accept an ongoing program, either to outpatient, CDU or New Frontier Treatment Center.

The goal is to encourage clients to continue their treatment. We cannot accept individuals with serious mental health or physical health problems. We have 18 beds in this unit.

Civil Protective Custody (CPC)

Clients entering this facility must be intoxicated, pose an immediate danger to themselves and be brought in by the police. We have no restraints so they must be willing to stay 4 - 12 hours. Their time is spent in bed. Upon leaving, they are encouraged to go into the social detox unit, but only about 5 - 10% per month agree to do that. Often clients are brought in several times during the month. We have 16 CPC beds.

Summary

Social Detox is a voluntary 3 - 7 day program, designed to sober clients up and get them into ongoing treatment.

CPC is a 4 - 12 hour sobering-up program accepting only clients who are brought in by law enforcement for public drunkeness.

If you have questions, please contact me.

Sincerely,

Bill Wollitz, Dr. P.H.
President/Executive Director

BW:cb

APPENDIX Q
PLACEMENT OF THE PROTECTION AND ADVOCACY SYSTEM

STATE OF NEVADA

OFFICE OF PROTECTION AND ADVOCACY

2105 Capurro Way
Suite B—First Floor
Sparks, Nevada 89431
(702) 789-0233
Toll Free: 1-800-992-5715

April 26, 1990

MEMORANDUM

TO: Bob Guernsey, Principal Deputy Fiscal Analyst
Legislative Counsel Bureau

FROM: Holli Elder, Director
Office of Protection and Advocacy

RE: Placement of the Protection and Advocacy System

Thank you for your memo of April 12, 1990 regarding suitable placement of the Office of Protection and Advocacy - or, more specifically, the suitable placement and organizational structure of the agency in Nevada best able to perform the mandated functions of protection and advocacy systems.

Protection and advocacy systems are required pursuant to Part C of the "Developmental Disabilities Assistance and Bill of Rights Act" (42 USC 6041 et seq.) and by the "Protection and Advocacy for Mentally Ill Individuals Act" (42 USC 10801 et seq.). Part C, Section 142 of the "Developmental Disabilities Assistance and Bill of Rights Act" states:

> "the State must provide assurances satisfactory to the Secretary [of the Department of Health and Human Services] that the agency implementing the system will not be redesignated unless there is good cause for the redesignation and unless notice has been given of the intention to make such redesignation to persons with developmental disabilities or their representatives."

These "assurances" are submitted once every three (3) years and are signed by the Governor as the chief executive officer within the State. I have attached a copy of the most recent "assurances" submitted by Nevada, signed by then Governor Richard Bryan.

The "Protection and Advocacy for Mentally Ill Individuals Act", Section 102, paragraph 2, defines the term "eligible system" as the "system established in a State to protect and advocate the rights of persons with developmental disabilities under Part C of the 'Developmental Disabilities Assistance and Bill of Rights Act'."

The Office of Protection and Advocacy in the Department of Commerce has been designated by the Governor as the official protection and advocacy system in Nevada. Given the limited financial resources available, the placement of the protection and advocacy system in an executive branch agency has given the system additional support that it would not have had if placed totally outside any state government agency. More importantly, placement of the Office in the Department of Commerce has facilitated the establishment of a statewide advocacy system - which is probably the greatest accomplishment of the program over the last seven (7) years.

Please be advised that I have no plans, on behalf of the Office or as an individual, to submit a proposal to change the placement of the Office.

I am not aware of any specific examples of problems in representing clients that we have encountered, which we were unable to appropriately resolve due to the administrative status of the Office.

I have no information concerning the reasons which may have caused the Northern Nevada Alliance for the Mentally Ill or the Washoe Association for Retarded Citizens to suggest that the agency be redesignated as a non profit entity.

Presently, I understand the Governor is pleased with the placement of the program in the Department of Commerce and has no plans to redesignate the protection and advocacy system to a different location.

Please do not hesitate to contact me directly for additional information or clarification.

cc: Larry Struve, Director
Department of Commerce

Cecilia Colling, Executive Assistant
Governor's Office

Members, ACR 52 Committee

APPENDIX R
BOARD ELIGIBLE VERSUS BOARD CERTIFIED PSYCHIATRISTS

Requested information for A.C.R. 52 Study Committee

Question 4.

The A.C.R. 59 Study Subcommittee examined in detail psychiatrists' salaries and requirements for employment. The 1989 Session of the Legislature extended the time period in which a board-eligible psychiatrist could be employed prior to receiving board certification up to five years. Could you please review this issue and provide the subcommittee with your thoughts concerning the need for board-certified psychiatrists versus board-eligible. As you are aware, the Department of Prisons has the option to recruit either board-eligible or board-certified psychiatrists with no requirement placed upon those individuals to be board certified after five years.

Response to Question 4.

It is axiomatic in industrial and organizational psychology that the "selection ratio," or the number of people to be hired vs. the number of people available to be hired, is a significant determinant of the caliber of those who are finally hired (Schultz, 1978).* Obviously, if there are policies which restrict the number of available candidates then management is less able to hire desirable individuals and may have to lower their standards to fill positions. For this reason, it is considered by MH/MR staff to be more appropriate to broaden the number of potential candidates for psychiatrist positions at this time, not restrict the number of candidates from whom we can select our psychiatric staff. In the case of our recent hiring of psychiatrists, we have not lowered our standards, but neither have we been able to fill all our positions.

Only one-third of all U.S. psychiatrists are Board Certified. Requiring Board Certification, even with a five year grace period in which to become certified, imposes a barrier to many of the remaining two-thirds who might be interested in coming to Nevada. In essence, we are asking an uncertified psychiatrist to commit to us, carry a full workload while studying for an arduous series of written and oral tests, with no assurance that we will employ them if they fail--regardless of how exemplary their services to our citizens. All this based on passing an examination that is not necessarily related to the quality of care a psychiatrist actually delivers.

It must be remembered that Board Certification is no guarantee that a psychiatrist is good at his/her craft. Certainly, it would be preferable to hire a certified individual over a non-certified individual, all other things being equal. In practice, and facing the situation of vacant positions and not enough interested applicants, we are currently better served by carefully screening all applicants, regardless of certification status,

*Schultz, Duane P. Psychology and Industry Today. 2nd ed. Macmillan Publishing Co., Inc. 1976, p. 71.

and paying more attention to their letters of recommendation, their previous professional experience and demonstrated interest in working with our system in Nevada. It does not seem appropriate to deny Nevada citizens access to psychiatric care because we are holding out for individuals with credentials held only by one-third of the relevant professional class.

At a future time when salareis are more competitive, and we have multiple candidates for vacant positions, we can afford to hold out for a criterion that effectively limits the available candidates to the best of those with certification. I just do not believe that care by those not possessing Board Certification is discriminably less effective than the alternative, which may in fact be no care or care from an extremely over-worked Board Certified psychiatrist.

1/90

APPENDIX S
RESPITE PROGRAM

13. Request for information regarding the Respite Program that was implemented in July, 1989.

Attached is information thus far regarding the new programs, including policy and procedures for southern Nevada.

The new respite program got underway late in August of 1989. Fifty-eight applicants were processed for that first quarter. During the second quarter there were eighty-nine applicants, an increase of 31.

The program is set up to provide day care services, twenty-four hour care services, and in-home sitter care services. Allotments are determined on a quarterly basis and given to families in the way of stipend voucher. The amount of this voucher is also affected by a sliding fee scale based on income and the size of the family.

A preferred provider list has been developed through screening for police background checks, abuse records, minimum training requirements, and appropriate licensure. Families are provided with this list and allowed to go to the provider of choice. Providers establish their own daily rates up to a maximum of $32.00 per day. New vouchers are issued each quarter based on annual projections.

Families appear to be quite pleased with the new system, although a few families who had utilized the services prior to this new program are dissatisfied because of the reduction in service to them. It was felt at that time that a few families received great amounts of services when most families were unable to receive services at all. We believe that parody has been provided through this new program.

The primary problems with the program are still lack of qualified providers for families to access services. In addition, certification and licensure of sitters still are in question.

DRAFT

SOUTHERN NEVADA MENTAL
MENTAL RETARDATION SERVICES

SECTION NO: 330

PAGE 1 of 10

REFERENCE:

SUBJECT: RESPITE

DATE ISSUED:	REVISED:PAGE(S)1 thru 10	APPROVED BY:
07/31/85	EFFECTIVE:	
	DISTRIBUTION:	REGIONAL DIRECTOR

RESPITE/SITTER SERVICE POLICY AND PROCEDURES

PROGRAM

Respite service is appropriate, short-term, temporary care provided in a variety of settings for the care of the mentally retarded on a regular or intermittent basis to meet planned or emergency needs of the family and to restore or maintain harmony within the family unit.

Respite Care can be defined as either temporary care or in/out of the home.

I. RESPITE CARE DEFINITION

Respite provides intermittent short-term, overnight care. Respite Care is provided by specifically certified/licensed individuals in a variety of settings, including the family's home, the provider's home, vendor programs, and DDC's residential setting.

For the purpose of calculating family's time-used and family co-payments, service is defined as:

A. Any period of care of at least 12 hours duration and including an overnight stay.

B. Overnight stays of less than 12 hours duration are defined as sitter services.

Sitter Service Definition

Sitter service is intermittent short-term care and supervision provided to a developmentally disabled individual by a certified provider. Sitter services may take place in the family's home, or in a licensed child care facility.

For the purpose of calculating a family's time-used and co-payment, sitter services is defined as:

A. One full hour = one hour paid sitter service.

B. Fraction of hour is to be rounded to the nearest one-half (½) hour.

4. Care greater than ten hours duration, but not involving an overnight stay will be counted and co-paid as sitter service. Co-payment and time-used on actual number of hours of care provided. In addition, overnight care of less than 12 hours duration will be counted as sitter service.

Calculations will be based on

II. ELIGIBILITY FOR SERVICES

Families with members who are determined eligible for SNMRS Services are also eligible for Respite/Sitter services.

III. SERVICE CEILINGS

Based on available funds, appropriate service settings, and service needs, the Division will establish service settings. This service ceiling will limit the amount of Respite/Sitter Services a family can receive in an one year period.

Extentions are available under certain conditions, over and beyond the established service ceiling.

Where there is no financial participation by the Division, there are no limitations on the amount of services the family may receive from Certified Providers.

IV. FINANCIAL ASSISTANCE

Financial subsidies are available to those families who apply. Application for financial assistance must be requested from the Respite Coordinator. Respite Allocations are established on a sliding fee scale and are distributed on a quarterly basis.

Application for financial assistance is updated annually.

Co-payments by families may be established.

V. FEES FOR SERVICES

Fees for Respite/Sitter services will be established by the Respite providers.

VI. CO-PAYMENT PROCEDURES

A. It shall be the responsibility of the family to pay their co-payment at the time service is rendered. ↑ to the provider

B. The DDC co-payment will be made directly to the provider upon receipt of required documentation.

VI. C. Any disputes between the family and provider regarding payment must be resolved between the family and provider.

D. A family's failure to provide co-payment to a provider on a timely basis for services rendered may result in denial of future respite/sitter services.

VII. RESPITE SERVICE PROCEDURE

Upon completing the application process through the Respite Coordinator, the family will receive a respite allocation in the form of a voucher and a list of qualified, certified Respite Providers. It is the family's responsibility to contact a provider(s) directly and coordinate provision of services.

If the family is in a crisis or is for any reason unable to make arrangements directly, the Respite Coordinator will provide assistance to the extent necessary to ensure that adequate services are provided.

Requests for Emergency Care will receive priority ~~of~~ over vacation care.

VIII. MEDICAL CARE WHILE IN RESPITE

Respite care providers will be responsible for administering medication (established medication regimens) ~~to~~ children and adults who do not self medicate maintaining the same schedule as in the home or foster home setting.

Respite care providers are responsible for providing the necessary services in an emergency situation. Paramedics will be called or the child will receive services at an Emergency Room at a hospital. At the first opportunity the Administrative Beeper will be called for:

Dale Warby, or
Nancy Knox,
Barbara Fidelman,
Charlotte Crawford

evenings and weekends. Should this problem arise during normal weekday working hours, the Social Worker shall be notified or supervisor if social worker is unavailable.

Should a sudden illness occur, contact the emergency contact number that is on the form in the respite packet you received when the child arrived in your home on the pre-visit.

SAMI cards will accompany the child to Respite.

IX. BEHAVIOR MANAGEMENT WHILE IN RESPITE

Respite Providers will implement Behavior Management techniques as outlined in training. The use of corporal punishment and restraints of any type are not acceptable.

X. LICENSING AND CERTIFICATION OF RESPITE PROVIDERS

A. Overview

1. General Process and Requirement

Any individual desiring to provide services through the Respite/Sitter Program, and for whose services families wish to receive DDC/SNMRS co-payment, must be 18 years of age or older and be licensed or certified by the appropriate licensing agency or by Division staff. Certification includes screening and background checks, orientation and training and health and safety inspections of the prospective provider's home. The specific requirements for the various levels of certification are described in Section B.

2. Provisional Licensing and Certification

Under some circumstances, and at the family's request, the Division may issue a provisional certification prior to completion of the entire certification process. Such Certification will be issued with the understanding that the provider must complete all appropriate certification as speedy as possible.

3. Suspension of Revocation of License and Certification

Should the Division receive information of alleged misconduct on the part of the provider while the provider is rendering Respite/Sitter services, or if the home conditions warrant such action, an investigation will be conducted, by proper authorities, to address any or all allegations or conditions. If said allegations or conditions are substantiated, the Division shall suspend and/or revoke that provider's certification, agreement and/or license.

X. 4. PHILOSOPHY AND INTENT OF LICENSING AND CERTIFICATION

The Division's philosophy, policies and practices acknowledge and support the primary role of the family, not only in identifying services needed by the disabled family member, but in ensuring that services are tailored to individual's needs and are delivered in a manner compatible with the family's wishes and expectations. While the licensing and certification process is designed and intended to screen out those applicants whose backgrounds, attitudes, and experiences are inappropriate or undesirable and to ensure that certified providers demonstrate the basic knowledge and skills needed to care adequately for a developmentally disabled individual, it does not and can not guarantee that every provider will be able to meet the unique needs of every disabled individual and his/her family without additional training and preparation.

The family has the responsibility, and the right, to provide such additional specialized training as may be required to ensure that the Respite/Sitter experience is safe, comfortable, and constructive for the Provider, the family, and handicapped individual.

B. Certification Requirements

1. Level I Certification

~~There~~ This is a limited certification for individuals recruited by the family of the handicapped child or adult and who wish to provide services for that family only. The requirements for certification are as follows:

a. Screening/background checks

1. Must submit completed Respite/Sitter application.
2. Must have fingerprints taken.
3. Must obtain three positive references (written or oral).

b. Training

1. Overview of Respite/Sitter Program requirements and expectations.
2. Completion of Respite/Sitter documentation.
3. Depending upon the needs of the client, other training such as Basic First Aid, Cardio Pulmonary Resuscitation, and Seizure Management may be required.

X. c. If the provider intends to provide care in his/her own home, that provider must meet the licensing requirements as outlined by Nevada State Welfare or the Bureau of Health Facilities.

NOTE: At the request of the Respite Coordinator and depending on the needs of the individual(s) served, additional background information and training may be required.

2. Level II Certification

This is a general certification which allows the Provider to care for individuals having minimal to severe needs for supervision, assistance, and training. A Level II Certified Provider may be referred to any family.

a. Screening/background checks

1. Must submit completed Respite/Sitter application.
2. Must have fingerprints taken. (If services are to be provided in the applicant's home, all person residing in the home who are 18 years or over must also be fingerprinted.
3. Must obtain five positive references (written or oral).
4. Must complete an assessment interview or home study.

b. Training

1. Overview of Respite/Sitter Program requirements and expectations.
2. Completion of Respite/Sitter documentation.
3. Basic First Aid Training.
4. Cardio Pulmonary Resuscitation (CPR).
5. Introduction to Developmental Disabilities.
6. Overview of the DDC principles and practices.
7. Working with parents.
8. Behavior Management.
9. Seizure Management.

c. If the provider intends to provide care in his/her own home, that provider must meet the licensing requirements as outlined by Nevada State Welfare or the Bureau of Health Facilities.

X. NOTE: At the request of the Respite Coordinator and depending on the needs of the individual(s) served, additional background information and training may be required.

3. Level III Certification

Level three certification is issued to those facilities or individuals who are providing Day Care Services. The requirements for certifications are as follows:

a. Screening/background checks

1. Must submit completed Respite/Sitter application.
2. Must submit proof of appropriate Day Care licensure.

b. Training

1. Overview of Respite/Sitter Program requirements and expectations.
2. Introduction to Developmental Disabilities.
3. Depending upon the needs of the individual(s) to be serviced, other training such as Basic First Aid, Cardio Pulmonary Resuscitation, and Seizure Management may be required.

4. Level IV Certification

This is a certification which allows the provider to serve individuals who require specialized care, assistance, supervision, or training because of severe medical impairments. Following are the requirements for the Level IV Certification.

a. Screening/background checks

1. Must submit completed Respite/Sitter application.
2. Must have fingerprints taken.
3. Must obtain three positive references (written or oral).
4. Must complete an Assessment Interview.
5. Must submit proof of appropriate documentation of Licensed Practical Nurse or Registered Nurse Licensure.

X.

b. Training
   1. Overview of Respite/Sitter Program requirements and expectations.
   2. Completion of Respite/Sitter documentation.
   3. Additional specialized client - specific training provided by the handicapped individual's family.

c. If the provider intends to provide care in his/her own home, the provider must meet the licensing requirements as outlined by Nevada State Welfare or the Bureau of Health Facilities.

XI. RESPONSIBILITIES OF ALL PARTIES

A. Parental Responsibilities

Parent or guardian is required to:

1. Participate in a preservice visit, if possible.
2. Provide written information on the needs of the developmentally disabled individual and how, when, and in what amounts medication is to be administered.
3. Insure that all drugs and medicines are properly labeled and that there is sufficient quantity to last the length of service.
4. Leave the certified provider all health and insurance cards and other relevant information needed to obtain emergency medical and dental services. This must include the name, address, and telephone number of the principal physician.
5. Sign a consent agreement authorizing the certified provider to obtain emergency treatment, DDC-C-145.
6. Complete/sign the Respite Packet, providing the needed information and give to provider.
7. Furnish enough appropriate clothing, diapers, food for special diets, and any other required specialized items.
8. Provide sufficient food if the service occurs in the parent's home.
9. Furnish any special blenders or equipment needed for the care of the developmentally disabled person.
10. Provide money for outings if the service includes an approved outing.
11. Transport the developmentally disabled person to and from the service site unless other arrangements have been made.
12. Pay co-payment at the time of service.
13. Notify the certified provider of any cancellations of service.
14. Be responsible for damage to other persons or property while in a respite/sitter provider's care.

XI. B. Provider Responsibilities

The respite/sitter provider is required to:

1. Complete the training and certification procedures required by DDC.
2. Comply with the respite/sitter agreement.
3. Become acquainted with the developmentally disabled person prior to the scheduled service, if possible.
4. Accept the developmentally disabled person for service assuring that the parents have provided the medical and social information and clothing and other items needed during the service.
5. Sign the Emergency Medical and Release of Liability form (DDC-C-145).
6. Provide supervision of the developmentally disabled person for the period of time designated.
7. Provide for the physical and psychological needs of the developmentally disabled person during the respite/sitter service.
8. Provide for the total physical needs of the developmentally disabled person, including administering of medication as prescribed and obtaining medical treatment, if necessary.
9. Provide social recreational activity during the respite stay, per the agreement with the family.
10. Maintain a valid driver's license and up-to-date insurance, if transportation is to be provided.
11. Provide for the maintenance of the developmentally disabled person's programming, if requested by the parent.
12. Submit reporting documents as required by DDC following delivery of services.
13. Notify the parent and/or DDC of any emergencies or cancellations.
14. Follow the Agency emergency, confidentiality, and abuse procedures discussed at training.

C. Respite Coordinator Responsibilities

The Respite Coordinator is required to:

1. Recruit, screen, train, and certify respite/sitter providers.
2. Maintain an up-to-date listing of certified providers.
3. Match the needs of the developmentally disabled person with the abilities of the certified provider.

XI.

4. Provide the parents or guardians with a certified provider capable of meeting the needs of the developmentally disabled person, if requested.
5. Upon receipt of service delivery information from the parents and providers, assure that the certified provider is paid for services delivered.
6. Maintain up-to-date documentation of services delivered including the numbers of persons served who have specific disabilities and reasons for denial of services.
7. Provide services based on preestablished priorities for service.

SUMMARY--Makes appropriation to state public works board for facility for treatment of adolescent offenders. (BDR S-361)

FISCAL NOTE: Effect on Local Government: No.

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

AN ACT making an appropriation to the state public works board for the planning and construction of a facility in Clark County to be used for the evaluation, classification and treatment of adolescent sexual offenders and mentally disturbed adolescent offenders; and providing other matters properly relating thereto.

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

Section 1. There is hereby appropriated from the state general fund to the state public works board the sum of $8,500,000 for the planning and construction of a facility in Clark County to be used for the evaluation, classification and treatment of:

1. At least 12 adolescent sexual offenders; and
2. Not more than 50 mentally disturbed adolescent offenders.

Sec. 2. The state public works board shall carry out this project as provided in chapter 341 of NRS. The board shall ensure that qualified persons are employed to accomplish the authorized work. Every contract pertaining to the work must be approved by the attorney general.

Sec. 3. The state public works board may accept bids on the whole or any part of the construction of the building and the equipment and furnishings for it, and may let separate contracts for different and separate portions of the authorized work or a combined contract, if savings will result, to the lowest responsible bidder, but any and all bids may be rejected for any good reason.

Sec. 4. Any money from the appropriation made by section 1 of this act remaining after the completion of this project reverts to the state general fund.

Sec. 5. This act becomes effective on July 1, 1991.

SUMMARY--Requires facilities and programs operated or administered by mental hygiene and mental retardation division of department of human resources to be licensed by appropriate agencies of state. (BDR 39-365)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; requiring the facilities and programs operated or administered by the mental hygiene and mental retardation division of the department of human resources to be licensed by an appropriate agency of the state; and providing other matters properly relating thereto.

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

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

1. Except as otherwise provided in this section, the division shall not operate a facility or administer a program for the care, treatment or training of clients of the division without first obtaining a license therefor from the state board of health.

2. The state board of health shall adopt:

(a) Licensing standards for each facility or program operated or administered by the division;

(b) Regulations governing the licensing of such facilities and programs; and

(c) Regulations governing the operation of such facilities and programs.

3. The state board of health shall adopt separate regulations governing the licensing and operation of facilities and programs which are administered for the division by an independent contractor. The regulations must require the independent contractor to obtain from appropriate law enforcement agencies information on the background and personal and criminal history of any employee or prospective employee who will be providing services to the clients of the division.

4. The provisions of this section do not apply to:

(a) Facilities and programs of the division that are required to be licensed pursuant to NRS 449.001 to 449.240, inclusive; and

(b) Any services provided by the division that are related to the placement of children in foster homes and governed by the provisions of chapter 424 of NRS and any regulations adopted pursuant thereto.

Sec. 2. NRS 424.020 is hereby amended to read as follows:

424.020 1. The welfare division of the department of human resources, in cooperation with the state board of health and the state fire marshal, shall:

(a) Establish reasonable minimum standards for family foster homes and group foster homes.

(b) Prescribe rules for the regulation of family foster homes and group foster homes.

2. *The welfare division shall adopt separate regulations prescribing standards for any services provided by the mental hygiene and mental retardation division of the department of human resources which are related to the placement of children in foster homes.*

3. All licensed family foster homes and group foster homes must conform to the standards established and the rules prescribed in subsection 1.

SUMMARY--Establishes ratio of pupils to counselors in public schools in kindergarten through grade 12. (BDR 34-408)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public education; establishing the ratio of pupils to counselors in kindergarten through grade 12; and providing other matters properly relating thereto.

WHEREAS, It is in the best interests of all residents of this state to ensure that a successful educational system is provided so that children in Nevada can develop the skills, knowledge and attitudes necessary to become healthy, productive adults; and

WHEREAS, It is clear that the ratio of pupils to counselors is one of the most important factors in providing a quality education and in serving the developmental needs of pupils in this state; and

WHEREAS, Pupils must be provided with a systematic program of counseling and guidance to handle the academic and personal demands placed upon them by a society which is constantly changing; and

WHEREAS, Comprehensive counseling is important in helping pupils achieve their greatest potential and in preventing problems before they interfere with a pupil's ability to learn and develop in a healthy manner; and

WHEREAS, Achieving an appropriate ratio of pupils to counselors throughout the state is one of our most critical priorities; now, therefore,

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

Section 1. Chapter 388 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *1. Except as otherwise provided in this section, after the last day of the first month of the school year, each school district shall maintain a ratio of at least one counselor for every 600 pupils in that district enrolled in kindergarten to grade 12, inclusive.*

2. Each school district shall employ at least one counselor for pupils in that district enrolled in kindergarten to grade 12, inclusive.

3. The state board may grant to a school district a variance from the required ratio set forth in subsection 1 if:

(a) Sufficient financial support is not available to maintain the required ratio; or

(b) A sufficient number of qualified counselors are not available for employment.

4. The state board shall, before February 1 of each odd-numbered year, report to the legislature each variance granted by it during the preceding biennium and the specific justification for the variance.

Sec. 3. *1. Except as otherwise provided in this section, after the last day of the first month of the school year, each school district shall maintain a ratio of at least one counselor for every 350 pupils in that district enrolled in kindergarten to grade 12, inclusive.*

2. Each school district shall employ at least one counselor for pupils in that district enrolled in kindergarten to grade 12, inclusive.

3. The state board may grant to a school district a variance from the required ratio set forth in subsection 1 if:

(a) Sufficient financial support is not available to maintain the required ratio; or

(b) A sufficient number of qualified counselors are not available for employment.

4. The state board shall, before February 1 of each odd-numbered year, report to the legislature each variance granted by it during the preceding biennium and the specific justification for the variance.

Sec. 4. Each school district shall:

1. Develop a detailed plan for reducing the ratio of pupils to counselors within that district, if required, to enable it to comply with the required ratios of pupils to counselors set forth in sections 2 and 3 of this act. The school district shall submit the plan to the state board of education on or before January 1, 1992.

2. On or before January 1 of 1993, 1995 and 1997, report to the state board of education the progress made in complying with the required ratios of pupils to counselors set forth in sections 2 and 3 of this act.

Sec. 5. The state board of education shall report to the 1993, 1995 and 1997 sessions of the Nevada legislature the progress made by the school districts in complying with the required ratios of pupils to counselors set forth in sections 2 and 3 of this act.

Sec. 6. With this act, the legislature hereby intends to:

1. Establish a ratio of at least one counselor for every 600 pupils enrolled in public schools in kindergarten to grade 12, inclusive, by the beginning of the 1992-93 school year.

2. Reduce gradually that ratio to a ratio of at least one counselor for every 350 pupils in kindergarten to grade 12, inclusive, by the beginning of the 1998-99 school year.

3. Allow the local school districts the necessary discretion to effectuate this reduction in the manner appropriate in their respective districts.

Sec. 7. 1. This section and sections 4, 5 and 6 of this act become effective on October 1, 1991.

2. Section 2 of this act becomes effective on July 1, 1992, and expires by limitation on July 1, 1998.

3. Section 3 of this act becomes effective on July 1, 1998.

SUMMARY-- Requires mental hygiene and mental retardation division of department of human resources to adopt standards for projecting number of case managers required to serve needs of its clients. (BDR 39-409)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; requiring the mental hygiene and mental retardation division of the department of human resources to adopt standards to project the number of case managers required to serve the needs of its clients; requiring the division to report to the legislature certain information related to case managers; and providing other matters properly relating thereto.

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

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

1. The division shall adopt by regulation standards for projecting the number of case managers required to serve the needs of the clients of the division. The standards must be based on:

(a) The types of services provided by the division;

(b) The various levels of case management required; and

(c) The needs of the clients of the division.

2. At the beginning of each regular session of the legislature, the division shall submit to the assembly standing committee on ways and means and the senate standing committee on finance a report containing:

(a) The current ratio of case managers to clients, by the type of service provided by the division;

(b) The recommended ratio of case managers to clients and the number of case managers needed to achieve the recommended ratio; and

(c) The cost of achieving the recommended ratio.

SUMMARY--Urges certain state agencies and local governing bodies to cooperate with public and private agencies to establish medical detoxification programs for alcohol and drug abusers. (BDR R-410)

CONCURRENT RESOLUTION--Urging the bureau of alcohol and drug abuse of the rehabilitation division of the department of human resources, the mental hygiene and mental retardation division of the department of human resources and the boards of county commissioners of Washoe and Clark counties to cooperate with public and private agencies to establish medical detoxification programs in those counties for alcohol and drug abusers.

WHEREAS, The bureau of alcohol and drug abuse of the rehabilitation division of the department of human resources is responsible for coordinating efforts to carry out the state plan for the development and distribution of services designed to treat and prevent alcohol and drug abuse and for coordinating all state and federal financial support for alcohol and drug abuse programs in this state; and

WHEREAS, A large part of the federal funding for such programs is received from the Alcohol, Drug Abuse and Mental Health Administration; and

WHEREAS, The bureau of alcohol and drug abuse is prohibited from using this federal money for programs which provide services related to medical detoxification and, therefore, provides financial assistance only to programs providing social services for detoxification; and

WHEREAS, Although approximately 90 percent of the bureau's clients have no medical risk and do not require medical assistance, a substantial portion of the state's population require medical treatment for their alcohol and drug abuse in order to ease the discomfort associated with detoxification; and

WHEREAS, Many of these people also require treatment for mental illness or mental retardation which is best provided by the mental hygiene and mental retardation division of the department of human resources; and

WHEREAS, If programs providing medical detoxification were provided, persons suffering from drug or alcohol abuse could be appropriately screened and receive the medical care they require; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE

CONCURRING, That the Nevada Legislature hereby urges the bureau of alcohol and drug abuse of the rehabilitation division of the department of human resources, the mental hygiene and mental retardation division of the department of human resources and the boards of county commissioners of Washoe and Clark counties to cooperate with appropriate public and private agencies to establish medical detoxification programs in those counties for persons who require medical assistance for their alcohol and drug abuse; and be it further

RESOLVED, That a copy of this resolution be prepared and transmitted forthwith by the to the chief of the bureau of alcohol and drug abuse, the administrator of the mental hygiene and mental retardation division and the chairmen of the boards of county commissioners of Washoe and Clark counties.

SUMMARY--Reestablishes office of protection and advocacy as independent agency within office of governor. (BDR 39-411)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental health; reestablishing the office of protection and advocacy as an independent agency within the office of the governor; continuing the designation of the office as the agency of this state responsible for carrying out a system to protect and advocate the rights of mentally ill persons and persons with developmental disabilities; and providing other matters properly relating thereto.

WHEREAS, The office of protection and advocacy was designated, pursuant to the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. §§ 6041 et seq.) and the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. §§ 10801 et seq.), as the agency of this state responsible for carrying out a system to protect and advocate the rights of mentally ill persons and persons with developmental disabilities; and

WHEREAS, When originally designated, the office of protection and advocacy was established as an independent agency within the office of the governor; and

WHEREAS, The office of protection and advocacy was subsequently moved from the governor's office and now operates as a part of the department of commerce; and

WHEREAS, With this Act, the legislature intends to continue the designation of the office of protection and advocacy as the agency of the state which is responsible for carrying out a system to protect and advocate the rights of mentally ill persons and persons with developmental disabilities, and to reestablish the office as an independent agency within the office of the governor; now, therefore,

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

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

1. For the purposes of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. §§ 6041 et seq.) and the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. §§ 10801 et seq.), the office of protection and advocacy is hereby designated as the agency of the state which is responsible for carrying out a system to protect and advocate the rights of mentally ill persons and persons with developmental disabilities.

2. The office of protection and advocacy is hereby granted the authority and duties set forth in 42 U.S.C. § 6042(a)(1)(A) and 42 U.S.C. § 10805(a).

3. The office of protection and advocacy must be maintained as an independent agency within the office of the governor.

4. As used in this section:

(a) "Developmental disabilities" has the meaning ascribed to it in 42 U.S.C. § 6001.

(b) "Mentally ill person" has the meaning ascribed to "mentally ill individual" in 42 U.S.C. § 10802.

Sec. 2. NRS 433A.360 is hereby amended to read as follows:

433A.360 1. A clinical record for each client must be diligently maintained by any division facility or private institution or facility offering mental health services. The record must include information pertaining to the client's admission, legal status, treatment and individualized plan for habilitation. The clinical record is not a public record and no part of it may be released, except:

(a) The record must be released to physicians, attorneys and social agencies as specifically authorized in writing by the client, his parent, guardian or attorney.

(b) The record must be released to persons authorized by the order of a court of competent jurisdiction.

(c) The record or any part thereof may be disclosed to a qualified member of the staff of a division facility, an employee of the division or a member of the staff of [an agency in Nevada which has been established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. §§

6041 et seq.) or the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. §§ 10801 et seq.)] *the office of protection and advocacy* when the administrator deems it necessary for the proper care of the client.

(d) Information from the clinical records may be used for statistical and evaluative purposes if the information is abstracted in such a way as to protect the identity of individual clients.

(e) 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.

(f) The record must be released without charge to any member of the staff of [an agency in Nevada which has been established pursuant to 42 U.S.C. §§ 6041 et seq. or 42 U.S.C. §§ 10801 et seq.] *the office of protection and advocacy* if:

(1) The client is a client of that office and he or his legal representative or guardian authorizes the release of the record; or

(2) A complaint regarding a client was received by the office or there is probable cause to believe that the client has been abused or neglected and the client:

(I) Is unable to authorize the release of the record because of his mental or physical condition; and

(II) Does not have a guardian or other legal representative or is a ward of the state.

(g) The record must be released as provided in chapter 629 of NRS.

2. As used in this section, "client" includes any person who seeks, on his own or others' initiative, and can benefit from care, treatment and training in a private institution or facility offering mental health services.

Sec. 3. The office of protection and advocacy retains any authority and is responsible for carrying out all of its duties granted to it before the effective date of this act.

Sec. 4. This act becomes effective on July 1, 1991.

SUMMARY--Authorizes mental hygiene and mental retardation division of department of human resources to employ psychiatrists who are not certified by American Board of Psychiatry and Neurology. (BDR 39-412)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to mental health; authorizing the mental hygiene and mental retardation division of the department of human resources to employ psychiatrists who are not certified by the American Board of Psychiatry and Neurology; 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 433.209 is hereby amended to read as follows:

433.209 "Person professionally qualified in the field of psychiatric mental health" means:

1. A psychiatrist licensed to practice medicine in [the State of Nevada certified by the American Board of Psychiatry and Neurology;] *this state;*

2. A psychologist licensed to practice in this state;

3. A social worker who holds a master's degree in social work, is licensed by the state as a clinical social worker and is employed by the division;

4. A registered nurse who:

(a) Is licensed to practice professional nursing in this state;

(b) Holds a master's degree in the field of psychiatric nursing; and

(c) Is employed by the division **[.]** *; and*

5. A marriage and family therapist licensed pursuant to chapter 641A of NRS.

Sec. 2. NRS 433.267 is hereby repealed.

TEXT OF REPEALED SECTION

433.267 Limitation on time for certification of psychiatrist employed by division. Any psychiatrist who is employed by the division must be certified by the American Board of Psychiatry and Neurology within 5 years after his first date of employment with the division. The administrator shall terminate the employment of any psychiatrist who fails to receive such certification.

SUMMARY--Requires facilities which provide intermediate care to persons with mental retardation to be licensed by health division of department of human resources. (BDR 40-413)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to mental health; requiring facilities which provide intermediate care to persons with mental retardation to be licensed by the health division of the department of human resources; expanding the program for the certification of mental health-mental retardation technicians to include certain persons not employed by the mental hygiene and mental retardation division of the department of human resources; and providing other matters properly relating thereto.

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

Section 1. NRS 439A.103 is hereby amended to read as follows:

439A.103 1. The following projects are exempt from the requirements of NRS 439A.100:

(a) Any project to increase the number of beds in a facility for skilled nursing , [or] a facility for intermediate care *or a facility which provides*

intermediate care to persons with mental retardation, or to establish such a facility, if:

(1) The director determines that, at the time the application for an exemption is made, the proposed increase in the number of beds in a service area would not cause the total number of beds to exceed by more than 15 percent the total need for beds in that service area as set forth in the state health plan, and that the increase is otherwise consistent with the requirements of the state health plan; and

(2) The applicant provides evidence satisfactory to the director that:

(I) He has secured financing for the construction of the project;

(II) He owns or has an option to purchase a proposed site that is properly zoned for the project; and

(III) Sufficient money has been committed for the first year of operation of the project.

If the applicant for any reason fails to begin construction of the project within 1 year after the date of the certificate of exemption issued pursuant to subsection 2, the exemption is automatically revoked.

(b) Any project related to a health maintenance organization, if it is subject to review pursuant to 42 U.S.C. § 300m-6.

(c) Any project for the development of a health facility that has received legislative approval and authorization.

2. Upon determining that a project satisfies the requirements for an exemption to NRS 439A.100, the director shall issue a certificate which states that the project is exempt from the requirements of that section.

Sec. 2. Chapter 449 of NRS is hereby amended by adding thereto a new section to read as follows:

"Facility which provides intermediate care to persons with mental retardation" means an establishment which provides active treatment for persons with mental retardation that consists of a program of training, treatment and health services which is designed to prohibit regression and the loss of personal skills and to enable clients of the facility to function independently.

Sec. 3. NRS 449.001 is hereby amended to read as follows:

449.001 As used in this chapter , unless the context otherwise requires, the words and terms defined in NRS 449.0015 to 449.019, inclusive, *and section 2 of this act,* have the meanings ascribed to them in those sections.

Sec. 4. NRS 449.0038 is hereby amended to read as follows:

449.0038 "Facility for intermediate care" means an establishment operated and maintained to provide 24-hour personal and medical supervision, for four or more persons who do not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. *The term does not include a facility which provides intermediate care to persons with mental retardation.*

Sec. 5. NRS 449.0039 is hereby amended to read as follows:

449.0039 1. "Facility for skilled nursing" means an establishment which provides continuous skilled nursing and related care as prescribed by a physician to a patient in the facility who is not in an acute episode of illness and whose primary need is the availability of such care on a continuous basis.

2. "Facility for skilled nursing" does not include a facility which meets the requirements of a general or any other special hospital [.] *or a facility which provides intermediate care to persons with mental retardation.*

Sec. 6. NRS 449.0151 is hereby amended to read as follows:

449.0151 "Medical facility" includes:

1. A surgical center for ambulatory patients;
2. An obstetric center;
3. An independent center for emergency medical care;
4. An agency to provide nursing in the home;
5. A facility for intermediate care;
6. A facility for skilled nursing;
7. A freestanding facility for hospice care;
8. A hospital;
9. A psychiatric hospital;
10. A facility for the treatment of irreversible renal disease;
11. A rural clinic; [and]
12. A nursing pool [.] *; and*
13. *A facility which provides intermediate care to persons with mental retardation.*

Sec. 7. NRS 449.037 is hereby amended to read as follows:

449.037 1. The board shall adopt:

(a) Licensing standards for each class of medical facility or facility for the dependent covered by NRS 449.001 to 449.240, inclusive, and for programs of hospice care.

(b) Regulations governing the licensing of such facilities and programs.

(c) Any other regulations [as] it deems necessary or convenient to carry out the provisions of NRS 449.001 to 449.240, inclusive.

2. The board shall adopt separate regulations governing the licensing and operation of:

(a) Facilities for the care of adults during the day; and

(b) Residential facilities for groups,

which provide care to persons with Alzheimer's disease.

3. The board shall adopt separate regulations for the licensure of rural hospitals which take into consideration the unique problems of operating such a facility in a rural area.

4. *The board shall adopt, with the approval of the mental hygiene and mental retardation division of the department of human resources, separate regulations governing the licensing and operation of facilities which provide intermediate care to persons with mental retardation. The division may disapprove a regulation proposed by the board only if it finds that the regulation does not comply with applicable federal standards governing the licensing and operation of such facilities.*

5. The board shall require that the practices and policies of each medical facility or facility for the dependent provide adequately for the protection of the health, safety and physical, moral and mental well-being of each person accommodated in the facility.

[5.**]** *6.* As used in this section, "rural hospital" means a hospital with 85 or fewer beds which is:

(a) The sole institutional provider of health care located within a county whose population is less than 100,000;

(b) The sole institutional provider of health care located within a city whose population is less than 20,000; or

(c) Maintained and governed pursuant to NRS 450.550 to 450.700, inclusive.

Sec. 8. NRS 453.038 is hereby amended to read as follows:

453.038 "Chart order" means an order entered on the chart of a patient:

1. In a hospital, facility for intermediate care , **[**or**]** facility for skilled nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department; or

2. Under emergency treatment in a hospital by a physician, dentist or podiatrist, or on the written or oral order of a physician, dentist or podiatrist authorizing the administration of a drug to the patient.

Sec. 9. NRS 453.515 is hereby amended to read as follows:

453.515 1. No pharmacy may deliver a controlled substance requiring a prescription for a specific patient to a hospital, facility for intermediate care ,

[or] facility for skilled nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department *and* which does not have a pharmacy on the premises , except pursuant to a prescription given:

(a) Directly from the prescribing practitioner to a pharmacist;

(b) Indirectly by means of an order signed by the prescribing practitioner; or

(c) By an oral order transmitted by an agent of the prescribing practitioner.

2. If an oral order for entry on a chart is given by a prescribing practitioner the chart order must be signed by the practitioner who authorized the administration of the drug within 48 hours after receipt of the instructions by a licensed nurse.

Sec. 10. NRS 454.0041 is hereby amended to read as follows:

454.0041 "Chart order" means an order entered on the chart of a patient:

1. In a hospital, facility for intermediate care , [or] facility for skilled nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department of human resources; or

2. Under emergency treatment in a hospital by a practitioner or on the written or oral order of a practitioner authorizing the administration of a drug to the patient.

Sec. 11. NRS 454.278 is hereby amended to read as follows:

454.278 1. No pharmacy may deliver a dangerous drug for a specific patient to a hospital, facility for intermediate care , [or] facility for skilled

nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department *and* which does not have a pharmacy on the premises , except pursuant to a prescription given:

(a) Directly from the practitioner to a pharmacist;

(b) Indirectly by means of an order signed by the practitioner; or

(c) By an oral order transmitted by an agent of the practitioner.

2. If an oral order for entry on a chart is given by a practitioner, the chart order must be signed by the practitioner who authorized the administration of the dangerous drug within 48 hours after receipt of the instructions by a licensed nurse.

Sec. 12. Chapter 433 of NRS is hereby amended by adding thereto a new section to read as follows:

The division shall adopt regulations and establish policies and procedures which ensure that all services provided by the division comply with applicable federal standards governing those services.

Sec. 13. NRS 433.279 is hereby amended to read as follows:

433.279 1. The division shall carry out a vocational and educational program for the certification of mental health-mental retardation technicians, including forensic technicians, employed by the division **[**,**]** *or at facilities which are comparable to the division's facilities,* or other employees of the division who perform similar duties, but are classified differently. The program must be carried out in cooperation with the University of Nevada System.

2. A mental health-mental retardation technician is responsible to the director of the service in which his duties are performed. The director of a service may be a licensed physician, dentist, podiatrist, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse or other professionally qualified person. This section does not authorize a mental health-mental retardation technician to perform duties which require the specialized knowledge and skill of a professionally qualified person.

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

4. As used in this section, "mental health-mental retardation technician" means [an employee of the division] *a person* who, for compensation or personal profit, [implements] *carries out* procedures and techniques which involve cause and effect and which are used in the care, treatment and rehabilitation of mentally ill, emotionally disturbed or mentally retarded persons, and who has direct responsibility for:

(a) Administering or [implementing] *carrying out* specific therapeutic procedures, techniques or treatments, excluding medical interventions, to enable clients to make optimal use of their therapeutic regime, their social and personal resources, and their residential care; or

(b) The application of interpersonal and technical skills in the observation and recognition of symptoms and reactions of clients, for the accurate recording of such symptoms and reactions, and for carrying out treatments

authorized by members of the interdisciplinary team that determines the treatment of the clients.

Sec. 14. NRS 639.004 is hereby amended to read as follows:

639.004 "Chart order" means an order entered on the chart of a patient [in] *:*

1. In a hospital, facility for intermediate care , [or] facility for skilled nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department of human resources [or on the chart of a patient under] *; or*

2. Under emergency treatment in a hospital by a practitioner or on the written or oral order of a practitioner authorizing the administration of a drug to the patient.

Sec. 15. NRS 639.2327 is hereby amended to read as follows:

639.2327 A facility for intermediate care , [or] facility for skilled nursing *or facility which provides intermediate care to persons with mental retardation* which is licensed as such by the health division of the department of human resources and is registered with the board pursuant to this chapter may maintain a stock of drugs for emergency treatment of inpatients, subject to the following conditions:

1. The board shall by regulation determine the specific drugs and the quantities thereof which may be maintained.

2. The emergency stock of drugs must be maintained at all times in a solid, sealed container and the seal must remain intact except when the drugs are

needed for emergency treatment of a patient in the facility. The sealed container must be stored at all times in a locked compartment on the premises of the facility.

3. All drugs delivered to a facility must be signed for by the nurse or other person in charge. An inventory of the stock of drugs must be appended to the sealed container. Immediately after the drugs are needed, the physician or registered nurse who breaks the seal shall enter on the inventory sheet the following information:

(a) The date and time the sealed container is opened;

(b) The name of the patient for whom the drugs are to be used;

(c) The name of the patient's physician or the physician who directs the administration of the drugs, if different;

(d) An itemization of the drugs removed; and

(e) The signature of the person who opened the sealed container.

4. When the drugs have been removed and the information required by subsection 3 has been entered on the inventory, the physician or registered nurse shall immediately replace the container in a locked compartment and shall notify the pharmaceutical consultant, as soon as it is practical to do so, that the container has been opened.

5. The sealed container and its contents at all times remain the responsibility of the pharmaceutical consultant. Upon being notified that the sealed container has been opened, or on the next business day if notification is

not received during business hours, but in no event more than 48 hours following receipt of the notification, the pharmaceutical consultant shall:

(a) Examine the inventory sheet;

(b) Replace the drugs removed;

(c) Secure a written prescription for the drugs replaced, if one is required by law;

(d) Enter the name and quantity of the drugs so replaced on the inventory sheet, together with the date and time of replacement;

(e) Reseal the container; and

(f) Sign the inventory sheet.

6. No person other than a licensed physician or registered nurse may open the container or remove any drugs from the container.

7. The board, its agents and inspectors may at all times have access to the premises of the facility to determine compliance with this section.

Sec. 16. NRS 639.267 is hereby amended to read as follows:

639.267 1. As used in this section, "unit dose" means that quantity of a drug which is packaged as a single dose.

2. A pharmacist who provides a regimen of drugs in unit doses to a patient in a facility for skilled nursing , [or] facility for intermediate care *or facility which provides intermediate care to persons with mental retardation* as defined in chapter 449 of NRS may credit the person or agency which paid for the drug for any unused doses. The pharmacist may return the drugs to the issuing pharmacy, which may reissue the drugs to fill other prescriptions.

3. Except Schedule II drugs specified in or pursuant to chapter 453 of NRS, unit doses packaged in ampules or vials which do not require refrigeration may be returned to the pharmacy which dispensed them. The board shall, by regulation, authorize the return of any other type or brand of drug which is packaged in unit doses if the Food and Drug Administration has approved the packaging for that purpose.

Sec. 17. NRS 654.025 is hereby amended to read as follows:

654.025 "Facility for intermediate care" means an establishment operated and maintained for the purpose of providing personal and medical supervision for 24 hours, for four or more persons who do not have illness, disease, injury or other conditions that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. *The term does not include a facility which provides intermediate care to persons with mental retardation as defined in section 2 of this act.*

Sec. 18. 1. The state board of health shall, on or before January 1, 1992, adopt such regulations as are necessary to carry out the provisions of this act. The regulations may not be inconsistent with or exceed the authority granted to the state board of health by chapter 449 of NRS.

2. The health division of the department of human resources shall, on or before January 1, 1992, adopt such regulations as are necessary to carry out the provisions of this act. The regulations may not be inconsistent with or exceed the authority granted to the health division by chapter 449 of NRS.

Sec. 19. 1. This section and sections 12, 13 and 18 of this act become effective on October 1, 1991.

2. Sections 1 to 11, inclusive, and 14 to 17, inclusive, of this act become effective on July 1, 1992.

SUMMARY--Requires mental hygiene and mental retardation division of department of human resources to conduct study to assess needs of older persons for mental health services. (BDR S-414)

FISCAL NOTE: Effect on Local Government: No.

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

AN ACT relating to mental health; requiring the mental hygiene and mental retardation division of the department of human resources to conduct a study to assess the needs of older persons in this state for mental health services; making an appropriation; and providing other matters properly relating thereto.

WHEREAS, The population of older persons in this state continues to grow each year; and

WHEREAS, With advancing age, older persons may have mental limitations that restrict their ability to live independently and carry out activities of normal daily living which can be corrected with proper treatment; and

WHEREAS, Older persons in this state are entitled to receive, and it is the responsibility of state and local governments to provide, within the limits of available resources, the best mental health services available, without regard to economic status; and

WHEREAS, Comprehensive programs are required to ensure the coordinated delivery of essential mental health services to older persons in this state; now, therefore,

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

Section 1. 1. The mental hygiene and mental retardation division of the department of human resources shall conduct a study of the needs of older persons in this state for mental health services.

2. The study must include an assessment of:

(a) The programs and services currently offered by the division for older persons;

(b) How those programs and services will need to be expanded and what additional programs and services will be needed to provide older persons with essential mental health services;

(c) The facilities and personnel which will be required by the division to serve properly the needs of older persons in this state; and

(d) Any other matters properly relating to the needs of older persons for mental health services.

3. The division may contract with consultants to assist in the performance of the study required by this section.

Sec. 2. The mental hygiene and mental retardation division of the department of human resources shall submit the results of the study required by section 1 of this act and any recommended legislation to the 67th session of the Nevada legislature.

Sec. 3. 1. There is hereby appropriated from the state general fund to the mental hygiene and mental retardation division of the department of human resources the sum of $10,000 to conduct the study required by section 1 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1993, and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 4. This act becomes effective on July 1, 1991.