Chapter 6
IDENTIFICATION

INTRODUCTION

Identification, in the context of this study, is the recognition and correct assessment of a person's disabilities and abilities. Nationwide, it has long been one of the most serious gaps in recognizing and serving handicapped people. Both in the literature on the subject and in actual practice, there is no well-developed continuity of concern from earliest awareness of potential disability, to diagnosis, and on through post-identification service and follow-up after service. Nevada's experience with identification and subsequent services in the mental health and mental retardation service systems is no exception to this general point.

There are clear and meaningful connections and relationships between identification and several of the other services discussed in other chapters in this report, e.g., between direction, prevention, and actual treatment. Identification is distinguished from these other services, however, by virtue of the fact that it is mainly a recognition process and activity. To understand better what we mean when we talk about identification, we offer the following questions that need to be answered in establishing an effective identification program:

- By what mechanisms can a mental impairment be recognized and errors of identification minimized?
- What treatable pathological condition, if any, underlies the disability?
- Are secondary mental disabilities likely to be "caused" by the basic condition? For example, is the mental retardation or mental health problem of one family member likely to induce emotional disturbances elsewhere in the family or even precipitate a breakdown of the family unit?
- Can the condition be corrected, reduced, or prevented through timely intervention? At what age or point in time is such intervention most likely to be appropriate and hence identification needed?

At the total service system level, inadequate identification prevents one from accurately knowing the size and condition of the overall population in need of mental health, mental retardation, and alcohol and drug services. (Recall the discussion in Chap. 3 of prevalence rates for various disorders.) If a clear picture is lacking of the overall population's needs, including the names of people needing service, it is unlikely that sufficient service system capacity and a range of adequate services to meet these needs will be provided; that situation currently prevails in Nevada.

In the absence of organized information connections between specialists who provide mental health and mental retardation services (a problem treated in Chap. 4 and recurrently mentioned in this report), client follow-up and direction to the appropriate mix of needed services often are not done. Follow-up and adjustment of the supply and composition of services, taken from the perspective of the overall system, are consequently not done well either.

Aggregating all Nevada efforts to screen for potential mental handicaps prior
to full diagnosis, and to reach out to find potential clients for mental health and mental retardation service programs, we found that the total of all such efforts in FY 1974 cost perhaps $200,000 to $250,000. These cost figures do not include the cost of diagnosis following screening, nor do they include the cost of personnel who notice a possible mental disorder while they are primarily involved in providing some other service (e.g., education, medical, or social welfare services). The primary screening and outreach efforts we found were the early screening program for Medicaid-eligible children; a school screening program for all children in one rural county (the two counties with large populations do not screen all schoolchildren for mental handicaps); an outreach program of the Nevada Special Children’s Clinics; and small, still rudimentary outreach programs at the Reno and Las Vegas Mental Health Centers.

There are several plausible reasons for the current weakness of identification as a service. In noting what appears to be the main reason in Nevada, our intent is not to excuse the current situation but to lay out the underlying rationales that must be understood in order to effect remedial courses. In interviews with service providers, we were repeatedly told that service capacity is insufficient to meet the current need and that the paucity of available services discourages referral initiatives; if the service system is already overburdened, it is logical to ask why one should bother hunting for still more clients. There are three answers to that question:

- Not all of those with the most need or the greatest ability to benefit from services are among those known to the service system.
- Were more of those in actual need identified, then the service system might eventually respond with a more adequate level of services.
- People in need can benefit from knowledge of the nature of their conditions, even if we assume that the public sector cannot serve them or chooses not to. With accurate and reliable information about the basic condition and services required, a person is somewhat better prepared to seek out private sources for care.

Finally, although the difficulties and possible ill effects of identifying and classifying people to be served have been well publicized, classification is useful in obtaining appropriate services for people in need, for planning and seeking support for programs, and for evaluation. The salient question is not whether people’s needs should be categorized, but how that can best be done to minimize the sometimes negative effects of labels while retaining the positive effects resulting from categorization of needs.¹

The remainder of this chapter discusses the identification process, treats general problems with identification as a service, and discusses identification services that now exist in Nevada; the chapter ends with recommendations for action to improve the current situation.

IDENTIFICATION AS A PROCESS

Identification is a service, but it is also useful to characterize it as a process in the interests of understanding better what it is and why it is not well executed in Nevada and most other places. We have described the process in detail in our earlier work on handicapped children. The constructive conceptualization of the process in Fig. 6.1 has been advanced by the Illinois Commission on Children; it is a good place to begin in figuring out where to go with identification.

Fig. 6.1—Identification process (adapted from Illinois Commission on Children, Report of a Committee on Early Location and Care of Children with Handicapping Conditions, State of Illinois, Springfield, Illinois, January 1972, pp. 13-14)

At the preawareness stage no one has any suspicion of actual or potential disablement in the person concerned. That stage may be brief in the case of a severely retarded child, or last for months and even years in the case of a hard-to-diagnose emotional or behavioral disorder. One objective of identification is to reduce the time between preawareness and the delivery of needed services, and to minimize the chance that those services will never be delivered.

Sensitizing occurs when one or more people—parents, neighbors, friends, physicians, relatives, social workers, teachers, or the afflicted person—begin to sense that the person is somehow "different." Sensitizing is enhanced if people are knowledgeable about the signals to look for; it would be particularly helpful if people who deal with children, such as teachers, were better informed about the symptoms of potential disorders.

Awareness is the partially confirmed realization that the person’s behavior or performance is not normal, with respect either to the person’s age or to certain more or less understood and widely accepted norms for behavior, as is the case for people with mental health disorders. Intelligence testing and other mass screening pro-

grams for certain disorders concentrate on this phase of the identification process. The aim of such screening is commonly to identify those who are not behaving or performing up to normal levels expected for persons like themselves (for children of similar demographic characteristics and socioeconomic status, for example). Awareness is not diagnosis; it is a necessary precursor to competent and thorough diagnosis.

Seeking is a critical link between awareness and diagnosis. As awareness is not diagnosis, neither is it confirmation of a disorder; screening programs and other methods create awareness merely of potential disorders. A thorough individual examination by service professionals is still needed to confirm the presence of the disorder and to diagnose it. A child’s falling below “normal” levels on a school intelligence test, for instance, may or may not indicate mental retardation. The test results may be erroneous or, more important, the child may not be functioning at a retarded level. Before sounding the alarm and disturbing both the parents and the child, it is terribly important to examine the child’s functional abilities and determine why performance on the screening test was less than “normal.” The child may simply have “had a bad day,” for whatever reason; the testing situation may have been less than ideal; the tester may not have been well trained to administer the test; the test may have been inappropriate for children of the individual’s age and socioeconomic or cultural characteristics; the child may have been taking medication (antihistamines have been implicated in slightly depressed performance on intelligence tests); or any of a host of other factors, both known and suspected, may have accounted for the child’s below-normal performance.

Diagnosis is the thorough evaluation of the disability. Thoroughness in this sense comprises a full and forthright assessment of the disability, the services required, and the most likely and desirable futures for the individual, e.g., an individualized “plan” for services and treatment. The necessity for a full assessment of needs and services cannot be overstressed. Nonetheless, that assessment is denied to many of Nevada’s citizens who need services because of disorders of mental health or mental retardation. The need for what we have termed the direction service is obvious during and following this phase of the identification process. Also, as obvious as it appears, once said, a thorough medical examination would assist in making a valid diagnosis; however, we find that in Nevada, and elsewhere, many people in the mental health and mental retardation service system have not had such an examination as part of the diagnostic process—or at least no indication of such an examination carried on their active records (this was especially so for the mental health centers in both northern and southern Nevada).

Recording and referral, a “direction” aspect of the overall service process that follows identification (and is frequently missing), pertains to the follow-up carried out once diagnostic insights have been attained. If no one follows through with services, the most elegant diagnostic work-up in the world is wasted. Uneasy questions therefore arise. If the client needs medical attention, does he receive it? If periodic reevaluation of the disorder is called for, is it carried out? For example, if an alcoholic or drug abuser is found to require detoxification and economic assistance, as well as psychological services, are the needed elements of a plan for services worked out and then pursued, or not? Failure to do so, or the neglect of even one element of the overall service plan for the client, may degrade efforts to fulfill other elements of treatment and service.
Service is the actual delivery of the needed services, in accordance with the client’s diagnosed condition and needs. An obvious and critical but often neglected element of service is to keep track of the person who has an identified mental disorder until all necessary services have been completed. In Nevada, someone should verify that needed follow-up service has been provided to the client following, for example, discharge from the Nevada Mental Health Institute. Someone in the service system should check out the delivery of services to see that they are in fact being received and are achieving what was intended. A regional direction center would do this. We found follow-up services to be especially weak in Nevada, particularly in the mental health service (see Chaps. 8 and 10).

COMMON PROBLEMS WITH IDENTIFICATION

The problems that may be encountered in an identification program include failure to identify a large fraction of mentally handicapped people in need of service, misidentification, and inadequate follow-up. Each is discussed in turn below.

Failure to Identify

Failure in identification owes partly to society’s not making the effort to find and serve all mentally handicapped people, and partly to the difficulty of identification. With respect to society’s making the effort, Fig. 6.2 diagrams several strategic options. As shown, society can couple any level of identification effort with any level of service treatment and follow-up.

Under option "a," existing levels of identification effort would be reduced or, at the extreme, eliminated altogether. The resulting reduction in service demand would be translated into a reduced bill for all types of services. That particular option is not really open to Nevada, however, where the level of identification efforts is already very low.

Reducing identification efforts while maintaining the current level of service expenditures (option "b") could have several outcomes: it could mean at least the same or better service to clients already in the system or fortunate enough to find their way in, or it could enable the concentration of services on those who are more severely impaired. Such a strategy would be plausible in the case of runaway inflation of medical costs, for example.

A decrease in identification resources with an increase in other system resources (option "c") might improve services for those fortunate enough to receive them, or enable an expanded variety of services. This strategy fosters the half-truth that "excellent" services are provided, at the expense of some number of the population in need who are unidentified and unserved.

Society could also maintain the status quo in identification and decrease, maintain, or increase other service provision. When the total capacity of the service system is reduced (option "d"), we arrive at a fair representation of the problem that

---

2 The discussion in the following section draws from our earlier work on handicapped children, Brewer, Kakalik, et al., op. cit. We believe it necessary and useful to repeat here some of the points made in that study; although they are general in nature, they are related specifically to many pressing needs of the Nevada service system.
currently besets some programs in Nevada, faced as they are with rapidly expanding and inflating service costs that result in a net real loss in total buying power of the dollar. The status quo is represented in option "e." Option "f" is to increase the system's other-service capacity while maintaining the present level of identification; the line of thought behind this option can be roughly expressed as, "We already have more clients than we can take care of adequately now, so let's improve things for them and not spread our resources any thinner."

Options "g" and "h" call for increased identification efforts, but with either the same or reduced levels of total service provision. In these cases, society would find as many handicapped people as possible, serve those assigned highest priority, and give the rest information on what services to seek privately.

Finally, society could increase both identification and total service provision (option "i"). This option would help realize the stated objectives of those responsible for the service system, and it is certainly the most beneficial option for mentally handicapped people in need.

This brief exercise summarizes a number of extremely difficult choices confronting responsible officials who face the problems of insufficient identification and other related services. The choices bristle with thorny moral, economic, and ultimately political considerations. On the one hand, it is in the clearest interest of mentally handicapped people to be made aware of their problems and to be diagnosed (the earlier the better, if remedial services are to have greatest effect). On the other hand, more and better identification may impose costs—of itself, and because there would be an undeniable obligation to do something for the additional people discovered. The tacit recognition of those costs may underlie many poor identification programs or explain the total absence of programs in some cases. Policymakers therefore must decide which course is the more prudent: minimal identification and "acceptable" services to those identified; or maximal identification and either visibly inadequate or more costly services.

In Nevada, total identification of those in need of mental health and mental retardation services clearly will mean significantly increased and expanded services, either publicly or privately financed, since the number of people in need is significantly larger than the mentally handicapped population currently served (see
Chap. 3 for a description of that population in Nevada). The question is a tough one, but it calls for honest resolution: If efforts are made to find those in need, will Nevada make an equal effort to serve those identified and provide the necessary resources? Or will those unserved now remain unidentified, making it easier, perhaps, to ignore their needs?

Even under a vigorous program of identification, however, some mentally handicapped people will go undetected as they do today, and for similar reasons. Some people are hard to identify because they do not routinely make contact with any part of the public or private service system (for example, babies, some preschool children, and physically healthy working adults). Some newborns with a known high risk of handicaps are not examined later to see if the handicaps materialized. Sparsely populated rural areas may require different types of identification programs from those in urban areas. And many mentally handicapped people may deliberately avoid being identified, or be kept from society's view and hence sometimes denied needed services because of fear, guilt-feelings, or ignorance on their own or their relatives' part. All of these reasons lessen the chances for complete identification, but an effective program can deal with several of them and partially reduce their unwanted and harmful effects.

**Misidentification**

Misidentification is represented by a classical problem of error types in the field of statistics. In this setting, Type I errors occur when those who are not mentally handicapped are screened and erroneously labeled handicapped. For example, a person may be identified as mentally retarded solely on the basis of an IQ test, when in fact no functional disability exists. Type II errors occur when screening fails to detect those who are in fact handicapped. A bright and clever adult who is severely emotionally disturbed, for example, may behave unobtrusively on the day of an examination and come up with enough "right" answers to escape detection. A combination of Type I and Type II errors also is possible. Screening may miss a child's deafness, for example, but mistakenly identify the child as mentally retarded. The results of error are usually distressing. Impaired people may be treated as "normal" and thus be denied the services they need, or, what is potentially worse, may be given the wrong services (and wrong impressions), as when a deaf child of normal intelligence is placed in a residential institution for mentally retarded people.

Excessive Type I, or "false positive," errors could indicate that screening criteria are too conservative in whom they permit to pass as "non-handicapped," or they could indicate the screening procedures are unreliable. Too many "false positives," if referred for specialized diagnostic procedures, may overload scarce and expensive diagnostic resources and gradually erode diagnosticians' trust in the seriousness or worthiness of the identification screening program. Nor should the injurious effects of misidentification on individuals and their families be discounted. It is shocking to be told that you or one of your family has a mental problem; it is tragic to labor under that impression when it is untrue. Some Type I errors are to be expected, however, when test subjects are very young and hence uncooperative, when the screening procedure or instrument is known to have a significant margin of error, when the disorder being searched out is not well understood and its present-
ing signs and symptoms are obscure or inconsistent, or when the testing personnel are inexperienced and make judgmental and procedural mistakes. Should any or all of these conditions hold in the actual test situation, several alternatives should be considered to reduce the impact of Type I error, since one “cries wolf” only so often until the cry is ignored:

- Personnel may be better trained, certified, supervised, and exposed to more screenings to gain experience.
- The screening instrument may be evaluated and improved.
- One may raise the age at which children are screened.
- Or, a second and third retesting may be performed on all positives initially screened, to confirm the first identification and to minimize false positives before they are referred to a diagnostician.

Excessive Type II errors, in which mentally impaired people pass undetected, indicate that the identification procedures are not discriminating enough. Too many “false negatives” can damage people by denying them needed services. Type II errors of identification can be expected when handicaps are slight, latent, subtle, or overshadowed by other more obvious problems, when the test instrument is faulty or too “coarse-grained” to discriminate the condition, when testing personnel are not properly trained and supervised, or when the actual causative etiology can be confused with some other handicap, as when a deaf child is incorrectly thought to be mentally retarded. One should think about the following remedial actions if excessive Type II errors are encountered in a given identification program:

- Train the personnel better, certify them, and alert them to the often subtle, subjective clues that may signal the presence of a handicap.
- Improve the test procedure or instrument, especially to increase the level of resolution to pick up more handicaps.
- Or, give repeated tests, both immediately and over time, with the same or similar, complementary procedures or instruments to give the disability every opportunity to demonstrate its presence. Such a procedure is particularly suitable for progressive or degenerative disabilities and for “high-risk” populations.

The special problems attendant to screening multiple handicapped and other hard-to-test people deserve special mention as a persistent source of misidentification. In the case of the mentally retarded child, for instance, there is no reason to believe that a “normal” intelligence screening test will reliably indicate either the presence or the absence of some other handicapping condition. Perhaps the mere presence of a mental disorder, whatever it may be, should entitle the person to a full medical diagnostic evaluation. Statistically, there is reason to believe that people with one handicap have a greater than average probability of being handicapped in other ways as well.

Inadequate Follow-Up

Significant breakdowns occur in the identification process between both the

---

"Awareness" and "Diagnosis," and the "Diagnosis" and "Service" phases depicted in Fig. 6.1 above.

Breakdown in the first instance occurs when a person has been screened and is thought to be impaired, but nothing is done to secure competent diagnosis. Breakdown in the second instance is thought to be less frequent, but is still notable; it occurs when a full diagnostic work-up is carried out and the person is "identified," but nothing is done to provide the services indicated by the nature and extent of the disability and recommended by the diagnostican.

A screening program is nearly worthless without follow-up. The problem might be attacked simultaneously from several angles. General publicity about the nature and importance of detection of potential problems might help, for instance. Parents who are so informed, either through the media or by various types of service personnel, might give the general problems more attention, being alert to recognize gross signals of disorders in the individual and to search out competent care. The critical importance of the general medical practitioner has not received the attention warranted.

Formal procedures to help ensure follow-up could be instituted by every service program in which follow-up is appropriate. Creation of Regional Direction Centers would solve much of the follow-up problem (see Chap. 4).

Another and more difficult aspect of the breakdown phenomenon deserves more investigation: Why do individuals and their families either seek or not seek mental health and mental retardation services? What incentives operate in this matter? When we have more complete answers to these "simple" questions, we will begin to know how to provide not only better screening follow-up but better services generally. Follow-up in Nevada today, once a tentative finding of impairment or possible impairment has been made, is often left to the mentally handicapped person or to his or her close relatives. Some percentage of these people, for whatever reason, will not proceed to a competent diagnostican for clarification, confirmation, or rejection of the initial finding. Others will go, but only after some encouragement.

Follow-up is too important to be left to chance, and responsibility for it must be carefully and clearly defined early and maintained throughout the mentally impaired person's life. It is time-consuming, frustrating, and demanding work, but doing it correctly has been demonstrated to have considerable positive benefits in other health and mental health service areas.

IDENTIFICATION IN NEVADA

The general points made in foregoing sections highlight many unmet needs in Nevada's mental health and mental retardation service system. While we endeavor throughout this report to stress the positive and improving aspects of the service system, where they exist and warrant such treatment, remedial recommendations for improvement require full disclosure and confrontation of deficiencies. The following summary observations and evaluative comments are advanced in this constructive, rather than accusatory or destructive, spirit.

General Observations

In general terms, people who have a mental health problem, mental retarda-
tion, or an alcohol or drug abuse problem, become identified to the service system primarily through either of two mechanisms: (1) personnel in some segment of the service system (e.g., police, private physicians, or teachers) have "trouble" with an individual, or notice symptoms of a disorder, or (2) the individual or his or her family seeks assistance. Identification for certain disorders—mental retardation in school-age people, for example—could be done by a testing and screening program, but such screening programs do not exist in most of Nevada's counties, including the two large ones that account for about three-fourths of the state's population. Also, even if a mentally handicapped person is identified by one part of the service system, the mechanism of making referrals to all other appropriate service programs is often not used; therefore the person is often unidentified to and unserved by some or all of those other programs.

Since service needs exceed service capacity in most areas, each program could set priorities and use its limited resources accordingly. While it is true that most service programs in Nevada are already operating at full capacity, they are not serving all high-priority clients (or even as many of the high-priority clients as they might serve, since not all those high-priority clients have been individually identified).

Professional service personnel such as physicians, teachers, and social workers often fail to refer mentally handicapped people to other services for various reasons: because they are unaware of the existence of some particular service program (an understandable eventuality in a system where so much new activity exists); because they in fact know that no service currently exists or that there is an excessive wait; or because they are very busy, and it takes time to keep informed about where to refer people (and even to refer them). Breakdown at this juncture also occurs sometimes because the identifying agent lacks confidence in the existing service or program to which the client might be referred, a factor we noted in several of our interviews with private physicians.

Follow-up, a critical feature of the identification process, often does not exist in Nevada's service programs except in instances when an individual service program or provider has made a special effort to provide it or when the families or the impaired individuals do their own follow-up. (The Special Children's Clinics are a notable exception to this criticism.)

One psychiatrist we interviewed alleges that the "token service coverage" provided by private non-psychiatric physicians to people with mental health problems, in the absence of sufficient service capacity in the mental health service system, has sometimes resulted in poor diagnosis and a breakdown of the identification and treatment process. This factor was similarly noted, especially with respect to timely intervention for children and adolescents, by two of the medical consultants employed in support of this research effort.

An administrative tendency in Nevada that may impede full and accurate identification was noted by one physician in terms of the lessened use of individual diagnostic categories, especially for people with mental health problems. There are understandable reasons for not wanting to categorize and label a person unnes-

---

6 Interview with Dr. Donald Molde, private psychiatrist, Reno, Nevada, May 9, 1974.
6 Noted following interviews in Nevada by Rand consultants Dr. Robert Rubenstein, July 17, 1974, and Dr. Arnold Milstein, August 24, 1974.
7 Interview with Dr. William O'Gorman, Las Vegas, Nevada, October 31, 1974.
sarily, but the lack of meaningful diagnosis can impede timely and accurate treatment.

Identification in Education Programs

Schools could provide an essential component in screening for possible mental retardation and serious emotional disturbance in children, but they do not do so in either of the two largest counties with three-quarters of the Nevada population, and they do not do so in most rural counties. The identification programs in the Reno and Las Vegas areas, plus a commendable program in rural Churchill County, are summarized below.

**Washoe County School District.** In the Reno area, identification of mentally handicapped children in need of special educational services is accomplished by referral from parents, medical and public health personnel, teachers, and other school personnel. There is no screening program for all children to detect possible mental disorders. The school district has six psychologists (i.e., only about one for every 5000 schoolchildren in the county) to test referred children; and there is a waiting list for testing. About 25 to 35 percent of those referred are accepted for special education services.⁸

**Clark County School District.** The Las Vegas area also lacks a school screening program to identify children with mental health problems or mental retardation. Not all children in the school district receive an IQ or other screening test, and a child receives special education services only if the regular teacher notices a problem and refers the child to a school psychometrist for testing.⁹

**Churchill County School District.** While the two urban school districts do not screen all children for mental handicaps, the Churchill County School District (serving a rural county with a population of about 12,000 centered on Fallon) has a commendable identification program for screening all children at least once for special service needs.¹⁰ It is probably the best such program in any Nevada county. The district operates a preschool clinic in which about 99 percent of the children participate. This school-readiness clinic provides screening by both medical and school district personnel for hearing, vision, social development, emotional development, functional ability but not IQ, and any detailed evaluation the screening indicates as needed. So that children are not missed in the screening, every new admission to schools in the district must first go through a comprehensive screening similar to the preschool clinic screening, and any suspected disability is followed up with a more intensive evaluation. Coupled with the provision of services after identification, this comprehensive screening for mental and physical handicaps and incipient handicapping conditions, makes a good "prevention" program. The Churchill County School District provides identification services to Mineral, Nye, and Pershing Counties in the form of psychological testing services, while also using specialists from Washoe County (Reno) when needed for specialized medical testing of Churchill County children. It was noted that the screening clinic has been ap-

---

⁸ Interview with Gerald Myers, Coordinator, Special Education Services, Washoe County School District, Reno, Nevada, August 19, 1974.

⁹ Interviews with D. Seigle, Special Student Services, Clark County School District, Las Vegas, Nevada, March 5, 1974, and October 24-25, 1974.

proved for reimbursement from Medicaid under the early and periodic screening portion of that program, but the Churchill County School District does not request funding from Medicaid because "it is too much paperwork to ask for reimbursement."\footnote{11}

Identification by Mental Retardation Service Programs

Like the mental health service programs to be described in the next subsection, most of the mental retardation service programs do not go out looking for potential clients to identify. For the most part, the Nevada Mental Health Institute, the two mental retardation centers, and the associated Interdisciplinary Committees screen potential clients who come or are referred to them (see Chap. 10 for a description of those programs). There are attempts by the several Associations for Retarded Citizens and Community Training Centers, and by the Mental Retardation Staff of the Nevada Division of Mental Hygiene and Mental Retardation, to make people in the community aware of the availability of services, but no specific screening programs have been established, even in the schools in most counties.

The Division of Health operates a program that is especially interesting because one of its prime objectives is to identify retarded preschoolers. Two Special Children's Clinics for mentally retarded and other developmentally disabled children aged 0 to 6 years primarily (although youth up to age 21 years are served) provide a variety of services. We have already discussed their direction services (in Chap. 4). The clinics place a heavy emphasis on identification and diagnosis, which we summarize here. Each also provides counseling (see Chap. 8) and operates a preschool (see Chap. 7).\footnote{12}

To carry out these tasks, each center has a full-time staff including a clinical psychologist, a psychiatric social worker, one (north) or two (south) child development specialists, one (south) or two (north) speech pathologists, and two secretaries. Complementing the full-time staff in each clinic is a pediatrician who works part-time diagnosing children, and a part time nutritionist and audiologist.

Two points must be noted in understanding services delivered by the clinics. Since their founding in 1957, the clinic staffs have expanded only minimally while Nevada's population has more than doubled; and the population in the catchment area and expenditures per person served differ considerably between the clinics. Basic funding for the clinics comes from the state legislature and federal Maternal and Child Health Services dollars, which are equally divided between the clinics. Other funds obtained are the result of the proposal-writing initiative of the two clinic administrators. In FY 1975 the northern and southern centers' budgets were about $119,000 and $87,000, respectively.\footnote{13} Although the state divides the basic budget between the two centers equally, the southern center had about 60 percent more young children in its catchment area than did the northern center (based on 1970 Census data). However, over 95 percent of the southern center's population to

\footnote{11} Ibid.

\footnote{12} Information on the Special Children's Clinics was obtained through interviews with Drs. J. Ashbaugh and J. Edwards, Directors of the Southern and Northern Nevada Clinics, respectively, 1974; a letter from J. Edwards to The Rand Corporation, February 26, 1976; and a letter from J. Owen, Director of The Southern Nevada Special Children's Clinic, to The Rand Corporation, February 27, 1976.

\footnote{13} Data from M. Herman, Bureau Chief, Bureau of Maternal, Child, and School Health, Nevada Division of Health, June 1974.
be served was located in Clark County, whereas only 60 percent of children eligible for services from the Northern Nevada Clinic came from Washoe County. Thus, a major problem for the Reno clinic is the delivery of services over long distances to the 11 rural northern Nevada counties it serves.

During FY 1973, the Las Vegas clinic had 428 children on its active caseload, of whom 285 were under 5 years old. The Reno clinic had 297 children on its active caseload, of whom 128 were under 5 years old. Most of these clients had been diagnosed in previous years, however; new diagnoses per year number about 100 and 150 at the northern and southern centers, respectively.

If we divide the total clinic budget by the total number served, for FY 1973, the northern clinic spent approximately $255 for each child served; the southern clinic, $177.

For both clinics, referrals come from a myriad of sources—parents, private physicians, public health nurses, and the schools. A major difference between the two centers in 1974 was that the northern one had an outreach program to locate potential clients. With a developmental disabilities grant of $35,000 for FY 1974, the Northern Nevada Special Children’s Clinic began a training program for public health nurses in the identification of both high-risk mothers and developmentally disabled children. For FY 1975, another grant of $24,000 has enabled the northern center to mobilize a traveling clinic, to provide services that year to only two rural counties. The traveling diagnostic team consists of a pediatrician, psychologist, speech pathologist, and social worker. This traveling diagnostic clinic has continued to function; between October 1974 and February 1976, a total of 15 clinics were held in rural areas. Beginning in late 1975, the Southern Nevada Special Children’s Clinic also had a traveling diagnostic team.

An effective outreach program, particularly one involving distances of hundreds of miles, must provide a means for clients to reach its services. Otherwise, it becomes a contradiction in terms, a public service only for those who can afford to go to it or who live near it. Recognizing this situation, the northern clinic arranged through its 1974 developmental disabilities grant for some families to be reimbursed for traveling expenses to Reno for specialist diagnosis. The outreach programs in both clinics are a fine beginning, but continued development is hampered both by lack of necessary funds and by funding uncertainties. Strong outreach programs must be developed if these clinics are to fulfill their function effectively.

Both clinics have pediatricians who conduct half-day or full-day screening clinics once a week. Also on file, in addition to the medical work-ups, are reports of the clinic psychologist on test results and the social worker on family interviews, and the results of hearing, vision, and physical therapy examinations. The pediatrician at the Northern Nevada Clinic makes referrals to such specialists as neurologists and ophthalmologists when needed. The pediatrician at the Southern Nevada Special Children’s Clinic typically conducts all physical examinations and neurological work-ups himself. For both clinics, inadequate funding and hence inadequate staffing have meant waiting lists for diagnosis, with sometimes up to several months delay.

The Special Children’s Clinics are the logical units for providing genetic testing and counseling, and this is done at both clinics. (See Chap. 5 on prevention.)
Identification by Mental Health Service Programs

The various programs providing diagnosis, treatment, and follow-up for mental health disorders are described in detail in Chaps. 8 and 10; we summarize here the pretreatment identification services provided in some of the programs. In most programs for mental health treatment in Nevada, prediagnosis identification services are virtually nonexistent, e.g., outreach to locate potential clients who are not referred by others and who do not come at their own initiative.

**Las Vegas Mental Health Center.** There is little outreach to identify clients for the Las Vegas Mental Health Center—a breakdown of the identification process at its "Seeking" and "Awareness" phases. The situation is clearly a matter of priorities, as the Las Vegas Mental Health Center is in a period of rapid expansion to meet treatment service needs. In our view, this type of operation corresponds best to what we have called "option f" in Fig. 6.2; that is, to devote available resources to the clients at hand, who already number more than can be taken care of adequately.

The Las Vegas Mental Health Center does have a satellite center apart from the main facility. However, the indistinct delineation between outreach, intake, and treatment units of the satellite makes it difficult to determine what identification is taking place, if any. Outreach may be in operation, but from the records kept it is impossible to figure out what its impact might be.

Even if a client finds her or his own way to the Las Vegas Mental Health Center, there are still operational identification-related problems to contend with (see Chap. 8 for details on each of the following problems). The general deficient state of client recordkeeping found throughout Nevada’s mental health service system also exists at the Las Vegas Mental Health Center. This can deprive key direct-service personnel of essential elements of information about a patient, even if the patient’s problem was well diagnosed by some other service professional; it can also result in patients recycling through various phases of the identification process when they meet different service personnel, or if they return to the center at some time in the future. Another signal of a possible problem with the identification and intake process is the significant drop-out rate in the outpatient department; as of the summer of 1974, in excess of 35 percent of the clients dropped out between the time of the intake interview and the next appointment. In addition, we noted problems in 1974 of sometimes less than fully adequate diagnostics, and inadequate follow-up in the time period following inpatient care. We stress that these problems are not unique to this one mental health center, but occur in some others in Nevada.

**Henderson Mental Health Center.** In the summer of 1974 when we conducted interviews there, the very small Henderson Mental Health Center provided very minimal identification service. Outreach was negligible at the center, and no physician was in attendance during the period of our field inquiry. Owing to the lack of multidisciplinary professional support staff, most intake and diagnostic work was done by psychological clinicians and mental health technicians with relatively modest levels of training, considering the basic diagnostic skill requirements. In the

---

14 Interview with Dr. Larry Miller, Director of the Las Vegas Mental Health Center, Las Vegas, Nevada, July 17, 1974. Dr. Miller acknowledges that this is one of the known weaknesses of his operation.

15 Interviews at the Las Vegas Mental Health Center, August 8, 1974.

16 Interview with Mr. G. Eversaul, Henderson Mental Health Center, August 6, 1974.
opinion of one of Rand's psychiatrist-consultants, staff at the time of our interviews did not appear to have sufficient multidisciplinary skills to make adequate judgments regarding diagnosis and treatment. Since that time, however, the center has hired a new clinic administrator and has acquired a larger multidisciplinary staff; by the time this report is published, the center may be providing fully adequate diagnostic services as part of the identification process.

Children's Behavioral Services. The Children's Behavioral Services program in Las Vegas for preteenage children had no significant prediagnosis identification program in 1974.\(^7\)

**Reno Mental Health Center.** In 1974 the Reno Mental Health Center had a small program, staffed by two people and called the "public consultation and community education unit." Among other services, it provided some outreach and prediagnostic identification services. In mid-1974 staff members operated a branch office at Lake Tahoe a half day a week, and said they regularly visited the police, parole agency, child detention center, Head Start program, and schools. They provided some consultation during those visits, and referred potential clients to the main center facility for diagnosis and possible treatment. Press releases also informed potential clients of the center's services. Since 1974, this unit has been phased out and its professional staff reassigned to strengthen other Reno MHC units. The adult and adolescent/family units now carry the community education and consultation responsibilities.\(^8\) (See Chap. 8 for details.)

**Nevada Mental Health Institute.** For all intents and purposes, there is no prediagnosis identification service at the Nevada Mental Health Institute; service begins with diagnosis of patients who arrive there. (Chapter 10 contains a complete description.)

**Rural Clinics.** The Rural Clinics program places mental health personnel in several rural communities, but prediagnostic identification service is minimal. The people served are mostly self-referred "walk-ins from the street," to cite the program's director.\(^9\) Furthermore, the overall lack of coordination in the entire mental health service system has resulted in haphazard notification (sometimes late and sometimes none at all) of Rural Clinics personnel when patients have been released from the Nevada Mental Health Institute and returned to their homes in rural areas.\(^10\) In identification terms, patients known to one part of the service system (the Institute) sometimes are not identified to Rural Clinics, which are to provide follow-up services. Cooperation among general practitioner physicians and Rural Clinics personnel, a necessity in a program with insufficient staff, also is sometimes minimal according to one Rural Clinics office head and others interviewed.\(^11\)

---

\(^7\) Dr. A. Milstein, following interviews at the Henderson Mental Health Center, August 6, 1974.


\(^9\) Interview with Dr. T. Weyl, Reno Mental Health Center, July 3, 1974; letter from Mr. R. Keiffer, Reno Mental Health Center, to Dr. J. Kakalik, The Rand Corporation, February 27, 1976.

\(^10\) Interview with Roger Glover, Rural Clinics program, Reno, Nevada, April 23, 1974.

\(^11\) Ibid.

\(^12\) Interview with Bruce Bilbrey, Director of the Rural Clinic in Elko, May 10, 1974. He states that many potential patients prefer to use their local physicians instead of the Rural Clinics, which operate, in his view, under a stigma of being welfare-oriented.
Identification by the Medicaid Program

Although the Medicaid program emphasizes treatment (see Chap. 12 for a more complete description), since 1967 there have been federal provisions for mandatory early and periodic screening, diagnosis, and treatment of Medicaid-eligible children and youth under the age of 21. The purpose is to detect physical and mental problems and provide health care, treatment, and other measures to correct or ameliorate the problem conditions discovered.

In Nevada, screening is provided by the Economic Opportunity Board Clinic in Reno, by two screening centers in Las Vegas, and by public health nurses and private doctors. In addition, the Northern Nevada Special Children’s Clinic provides diagnosis for developmental disabilities. Fees for screening run between $15 and $33. If a public provider screens, lab fees are included in the basic payment; if a private provider screens, lab fees are paid in addition to the basic screening fee. The program calls for screening to take place on a periodic basis, with a child screened on first becoming eligible for Medicaid and every three years thereafter.

Within the Division of Welfare, results of the Medicaid screening of children and youth are coded on a Health Screening Record, copies of which go to the screening agency, the district welfare office, and two to the child’s parent (one for the referral physician). These collected data could be used to make sure all Medicaid-eligible children are screened, to establish a registry, and to keep track of the current status of patients to see they are receiving needed treatment, and to signal the time of periodic review. This, however, is not done. When we interviewed at the Division of Welfare, the raw data forms were simply piled in a desk file drawer, and according to the person whose desk it was, they were unused. The staff members we interviewed indicated that no one checks to see that all eligible children receive the mandatory screening, and no one checks to see how many mental problems are discovered or whether the children are referred and given treatment services. If the data were computerized, it would be easier to provide the follow-up needed. Currently, central office follow-up primarily concerns utilization of Medicaid money billed. It deals with matters such as whether a bill received was acceptable, and whether the client actually got the treatment the office was billed for. According to the central staff in Carson City, information (if available at all) on whether or not a child ever gets treatment for a condition discovered by the screening may consist only of a notation made by a district worker in the mother’s file.

Outreach consists of the central office’s notifying all welfare recipients at least once a year of their eligibility. The district office is responsible for notifying all new eligibles. Frequency and method depend upon the philosophy of the district office. In addition, some public screening clinic providers send out notices. On the other hand, we observed a surprising omission: the pamphlet describing Medicaid services published by the Nevada State Welfare Division does not mention, let alone describe, the early and periodic screening program.24

One problem may be that the screening payment schedule appears to be significantly lower than private rates. This deterrent, coupled with the paperwork and

23 Information obtained during interviews with Minor Kelso, who heads the Medicaid program within the Nevada Division of Welfare, and several of his program’s staff members, Carson City, Nevada, August 15, 1974.
24 Pamphlet Number 2-256 (Rev. May 1972).
sometimes delayed payments, may be limiting the number of private providers of this service, and may be significantly affecting the quality of the screening.

RECOMMENDATIONS

The two primary problems with identification in Nevada are: (1) many mentally handicapped people are not identified because of the lack of identification services, and (2) referral and follow-up for those who are identified are often lacking. The following recommendations are aimed at these two main problems.

Certain of the ideas developed in Chap. 5 on prevention are also relevant to identification. To reiterate, we recommend implementation of monitoring and enforcement mechanisms to help ensure that all newborn children are screened for phenylketonuria (PKU), and we recommend creation of a registry and follow-up of children born abnormal or at high risk of being mentally retarded or having some other handicap. Reporting to the registry by medical personnel could be mandatory. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services (tertiary prevention) could begin at as early an age as is desirable.

There is no formal mechanism to screen and identify children, a key target population for any physical health, mental health, or mental retardation service system, after they leave the newborn nursery and until they enter elementary school. In this case we are speaking of a medical examination designed to detect a range of potentially debilitating mental and physical conditions so that services may be offered at as early an age as is desirable to help alleviate the effects of the mental or physical disorders. Because comprehensive identification programs designed to reach all children simply do not exist in Nevada, we are particularly excited about the prospects of the recently mandated Child Health and Disability Prevention (CHDP) program in California. It is ambitious yet relatively simple in concept. (A description of the CHDP program is contained in Appendix C.) Its careful adaptation and adoption of some of its major tenets in Nevada would go a long way, in our view, to improving the early identification of handicapped children. The program is not flawless; no program is, and we have reservations about the way California is implementing what otherwise appears to be an excellent program. (For example, the proposed Medicaid fee for a "developmental assessment" is a rather low $3.30.) Rather, it is a long-overdue, first step toward improved identification that Nevada's

---

21 The number of children who never see a physician in the period from 0 to 5 years of age may be as high as 25 to 30 percent of the total population of that age cohort. Interview with Dr. Frederick A. Frye, Department of Pediatrics, University of California Medical School, La Jolla, California, February 1972.

22 The specific case of screening for mental retardation is carefully and thoroughly detailed in John Meier, Screening and Assessment of Young Children at Developmental Risk: The President's Committee on Mental Retardation, DHEW Publication (OS) 73-90, Washington, D.C., March 1973; this source contains the most extensive survey and review of screening and identification programs for the mentally retarded child that we have encountered. The general case is spelled out in K. Aileen Allen et al., "Early Warning: Observation as a Tool for Recognizing Potential Handicaps in Young Children," Educational Horizons, Winter 1971-1972, pp. 43-55, where Head Start, day care, and preschool nursery contacts are thought to be an underexploited and possibly important source of identification referrals. Each of these ancillary activities needs to be explicitly considered and evaluated by Nevada officials to determine the extent to which identification opportunities are being realized or not.
responsible officials should seriously consider emulating. The following are some of the most desirable features of the California program that we recommend for Nevada.

We recommend that parents of children beginning their first year of school, or entering a Nevada school for the first time from out of state, be required as a condition of admission of the child to present to the school either (1) the results of an approved health and developmental screening by an approved professional, or (2) a statement that the parents have decided not to have their child receive the screening services. This screening is valuable but not infallible for two primary reasons: parents may choose not to have their children screened for various reasons; and screening methods for the detection of mental disorders at the age of 4 or 5 years are not as valid and reliable as we would like them to be. Nonetheless, most of the more severely disordered children can be detected with existing screening methods. Care must be taken, however, not to label children for whom the results of the screening and later diagnosis are not clear-cut. Before implementing this recommendation, the screening methods to be used would have to be carefully considered. If these recommendations were adopted, the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program would pay for the screening for Medicaid-eligible children. The results of the screening would be forwarded to the state (to a Regional Direction Center, ideally), where they could be used to follow up to see that the various appropriate mental health and mental retardation programs provide needed service at as early an age as is desirable, and to aid in planning future service programs. Implementation of privacy safeguards for people identified will be essential. Churchill County already has a related and commendable screening program provided by both medical and school district personnel for every child entering the school system.

The Federal Government has had difficulty getting some states to implement the required Medicaid Early and Periodic Screening, Diagnosis, and Treatment program.27 Nevada has implemented this well-intentioned program but, as we indicated earlier in this chapter, the program as implemented has certain problems such as lack of checking to see that all Medicaid-eligible children are screened, and lack of adequate follow-up on the results of the screening. Consequently, to facilitate the provision of needed services, we recommend that procedures be adopted (1) to help ensure that all Medicaid-eligible children and youth up to age 21 years receive early and periodic screening, unless such screening is formally refused, and (2) to help ensure that follow-up steps are taken to obtain diagnosis and treatment for those who need them. The Regional Direction Centers (if created) would be useful in making referrals and coordinating needed services and follow-up. We note that implementation of this Medicaid screening recommendation would facilitate transfer of eligible clients from the Aid to Dependent Children program to the more desirable Supplemental Security Income program (see Chap. 14 of this report for details).

Regarding the two very small Special Children's Clinics that provide diagnostic

---

services for mentally retarded youth, we recommend increased funding for these two centers, distributed between them more equitably on a per capita basis than it is now, with provision for stable funding of a traveling multidisciplinary team to perform diagnoses in rural areas for people of any age thought to be potentially mentally retarded on the basis of the results of screening programs. We note that some rural counties do not even have a school psychologist who could help with diagnoses.

The schools are an ideal setting for identification of mental handicaps in young people of school age, since nearly all children are assembled, observed, and compared on a routine basis. Since screening of schoolchildren is feasible and not excessively costly, and the human and social costs can be great if young handicapped people do not receive timely special services, all children should be entitled to at least one behavioral and psychological screening to detect possible mental retardation or serious emotional disturbance. Nevada lacks such a program. School psychologists in most counties do not screen all children; and since there are many unidentified mentally handicapped children in school, the mechanism of relying on teacher referrals has not been very effective. We recommend that a screening program be established in every county school district to identify all mentally retarded and seriously emotionally disturbed children who need special education and other services. A school district cannot adequately serve children with mental handicaps and refer them for other services if it does not know who they are. We earlier suggested that a medical and developmental screening program reach children before they first enter school. Here we are recommending that the schools conduct a different behavioral and psychological screening of all children when they reach a specified age (perhaps 7 or 8 or 9 years old) to identify any who were missed in the preschool medical and developmental screening or whose mental health or mental retardation problems developed or became identifiable in the years since the preschool screening.

It may also be desirable to train regular teachers and other service professionals (e.g., public health nurses and social workers) to recognize the symptoms of incipient emotional handicaps and mental retardation.26

In the mental health area specifically, we have one additional recommendation. We recommend screening of high-risk populations to identify people who might be offered immediate mental health and other needed services to help alleviate existing mental health disorders before the persons become more seriously ill or dysfunctional. While a mechanism does not exist to readily reach everyone in high-risk populations, many can be reached through the mechanism of screening people who are in contact with public service systems for other reasons. For example, likely candidates for screening would be abused children and their abusers who come to the attention of health, welfare, and criminal justice personnel; juvenile and adult offenders; residents in the two Nevada Children’s Homes; emotionally disturbed schoolchildren; children of a psychotic parent who is in contact with the mental health service system; and some callers to Crisis call and Suicide Prevention lines.

Once a person has been identified as potentially having a mental problem, the next steps are to obtain a professional diagnosis, develop a service plan, and implement services. Unfortunately, as we pointed out in Chap. 4 on direction and coordination services, the agency that identifies people may give them one service but

neglect to refer them for all other needed services, as when a seriously emotionally disturbed schoolchild gets special education but not psychological treatment. An agency is understandably most concerned with the services it provides, but this lack of global responsibility for seeing that all the needs of an individual are met can be detrimental. Consequently, we reiterate our recommendation for the creation of Regional Direction Centers. (See Chap. 4 for details). As soon as any service program or service provider in the state identifies a person as possibly mentally handicapped, those regional direction and coordination centers should be notified as soon as possible, to help ensure the provision of appropriate diagnosis, planning, referral, needed services, and follow-up. We cannot say strongly enough how important we believe it is to coordinate the present fragmented service system so that the full range of needs of each mentally handicapped person are considered and met. We urge that all previous recommendations made in Chap. 4 with respect to the direction service be implemented as soon as possible and that the information generated in the process be analyzed from the perspective of identification. Nevada needs to know who are the people in need; where they are located; how they enter the system and what entrance channels are underutilized; what are the main and subsidiary paths through the service system; what services have been effective; what groups of people located where seem to be under-identified (i.e., the number identified seems to be significantly less than the number thought to exist). Not only would this information begin to provide those responsible with some picture of the current compositional features of the population served, but it also would enable them to determine more accurately what facilities are needed and which service programs should be expanded.

A program requiring service professionals to report all mental handicapping conditions to the Regional Direction Centers (or, in their absence, to the Division of Mental Hygiene and Mental Retardation or the Bureau of Alcohol and Drug Abuse) should be carefully designed and implemented. We recognize the real possibility, in this case, of a clash between the right to privacy and the social desirability of service, but we believe that careful design of procedures that will ensure legal and moral safeguards is possible and desirable.
Chapter 7
SPECIAL EDUCATION AND TRAINING SERVICES

OVERVIEW OF CURRENT SERVICES

This chapter discusses special education and training services for mentally handicapped Nevadans, estimates the need for those services, makes projections to 1985, and presents recommendations for improvements. We are primarily concerned here with special education services for seriously emotionally disturbed children and youth to age 18 years, and special education and developmental training of mentally retarded people. Chapter 11 discusses prevocational and vocational training services; Chap. 8 discusses psychological services for seriously emotionally disturbed children. While highly important, the special needs of "learning disabled" children are not within the central scope of this report, if they are not primarily mentally retarded or seriously emotionally disturbed. However, we present data on the special education programs serving "educationally handicapped" children, since children who are primarily emotionally disturbed, mentally retarded, or learning disabled are sometimes served together in Nevada under the label of "educationally handicapped," and since many children can be classed as either or both emotionally disturbed and learning disabled under the rather vague definitions of those terms (see the next section on county school district programs for details of those definitions as used in Nevada).

A handicapped youth’s need for and right to education is generally accepted in the United States. While there is agreement that handicapped youth need special educational assistance, there is disagreement over what constitutes a severe enough impairment to handicap the child in obtaining an education, and what special assistance should be provided. We stress that there is a continuum of degree of need for special education; placing children in special classes for handicapped children or in special schools are only two of the many different ways of helping youth that are used by Nevada’s special educators and discussed in this chapter. Many of these youth need special assistance but can still be educated primarily in regular classrooms. (It is beyond the scope of this study, however, to offer recommendations concerning the specific type of special education placement, curriculum, and teaching methods thought to be most appropriate for each specific type of child.)

We conservatively estimate that at least 2 percent of the school-age population in Nevada are mentally retarded and need some type of special education, and another 2 percent are seriously emotionally disturbed (see Chap. 3 for sources of these prevalence estimates). If so, at least 2650 emotionally disturbed children and another 2650 mentally retarded children aged 5 through 17 in Nevada needed some special educational assistance in FY 1974. If one assumes that mentally retarded children and youth need and can benefit more fully if education and training ser-

1 See Chap. 3 for definitions and prevalence of handicapping conditions. The connotation of the term "seriously emotionally disturbed children" is that the emotional disorders of those children are severe enough that they have a substantial need for special education services.
services are extended over a longer span of their lives, say from ages 3 through 17, then at least 3030 were in need in FY 1974.

The major special education and training programs serving mentally handicapped Nevadans, as shown in Fig. 7.1, are operated in two state departments, in county school districts, and in the private sector: the county school district special education (SE) programs operate under standards of the Nevada Department of Education and with partial state funding; the Community Training Centers (CTC) program consists of six very small private centers operating under guidelines and partial funding from the Nevada Division of Mental Hygiene and Mental Retardation; the Special Children's Clinics operated by the Nevada Division of Health have two small preschools and infant stimulation programs; and the Washoe County School District operates a special education and training program at the Nevada Mental Health Institute for retarded youth. In addition, a small federally funded program, P.L. 89-313, pays for special education personnel at some state facilities, and is described in Chap. 10.

Fig. 7.1—Organization of major special education and training programs for mentally handicapped Nevadans

Table 7.1 gives an overview for each program of the number of mentally handicapped children served, teaching staff, and estimated expenditures in education and training programs in FY 1974 by type of mental handicap. Of the more than 3700 mentally or educationally impaired children receiving special education, only about 100 emotionally disturbed children are identified as being served in Clark, Churchill, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education services in any of the other
### Table 7.1
**Summary of Special Education and Training Services for Mentally Handicapped Nevadans, FY 1974**

<table>
<thead>
<tr>
<th>Number Served, Staff, and Expenditures</th>
<th>County School Districts</th>
<th>Community Training Centers</th>
<th>Special Children’s Clinics</th>
<th>Nevada Mental Health Institute</th>
<th>All Programs Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number served</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>190</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>1502</td>
<td>70</td>
<td>40</td>
<td>32</td>
<td>1644</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>3589</td>
<td>70</td>
<td>40</td>
<td>32</td>
<td>1987</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3731</td>
</tr>
<tr>
<td>Estimated teaching staff (full-time equivalent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>160</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>182</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>162</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>162</td>
</tr>
<tr>
<td>Total</td>
<td>331</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>353</td>
</tr>
<tr>
<td>Estimated expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>$225,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$225,000</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>3,750,000</td>
<td>$168,000</td>
<td>$53,000</td>
<td>$100,000</td>
<td>4,071,000</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>5,050,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5,050,000</td>
</tr>
<tr>
<td>Total</td>
<td>$9,025,000</td>
<td>$168,000</td>
<td>$53,000</td>
<td>$100,000</td>
<td>$9,346,000</td>
</tr>
</tbody>
</table>

**NOTE:** See text of this chapter for sources of data.

...counties in Nevada. Of the more than $9 million expended in FY 1974 on special education of mentally handicapped Nevadans, only about $225,000 was for identified seriously emotionally disturbed children. And of the 353 special education teachers serving mentally handicapped children and youth in Nevada, only 9 full-time-equivalent teachers worked with identified seriously emotionally disturbed children. The remainder worked with mentally retarded and educationally handicapped children and youth.

About 1644 mentally retarded children and youth received special education from 182 full-time-equivalent teachers with FY 1974 expenditures of approximately $4 million. Mentally retarded individuals are the only ones receiving special education services from sources other than the school district, i.e., at the Community Training Centers, the Special Children’s Clinics, and the Nevada Mental Health Institute. However, in terms of the number of people served, the county school districts provide the vast majority of all special education and training services for mentally retarded young people. The tertiary prevention of mental retardation (and mental health disorders) through the provision of special education services to help alleviate or eliminate the handicap is significant (see Chap. 5 for a discussion of prevention services). An economic benefit/cost analysis conducted by Conley, using national data, showed that "educational services provided to the mildly retarded can be justified on the basis of earnings alone. . . . It is, in fact, self-defeating not to provide these services, since this would sacrifice a large long-run gain for a small
short-run gain. He was unable to support the same conclusion for moderately and more severely retarded youth, but he did not consider the major economic benefits of averting institutionalization of these people, nor did he consider the important quality-of-life benefits.

Over half of the possibly mentally impaired children served are not identified as either mentally retarded or as seriously emotionally disturbed. Nearly 2000 "educationally handicapped" children received special education from 162 full-time-equivalent teachers, with expenditures of over $5 million in FY 1974. The characteristic most often possessed in common by educationally handicapped children is low academic achievement, and some of these children undoubtedly are mentally retarded or seriously emotionally disturbed, or both. Even so, the total number of children served with all types of mental and "educational" handicaps combined is far below the minimum estimate of the total number of seriously emotionally disturbed and mentally retarded children needing those services.

While the numbers of staff and children shown in Table 7.1 are known fairly accurately, the estimates of special education expenditures depend heavily on what proportion of certain expenditures are attributed to special education. The expenditure data in Table 7.1 are operating expenses for FY 1974, including special education teacher salaries and materials plus an allocation of a portion of the joint expenses that benefit both handicapped and nonhandicapped children (e.g., administrative and cafeteria costs). The expenditures shown generally do not include major capital expenditures for buildings. Specific expenditure data are presented later in this chapter for Clark, Churchill, and Washoe Counties, which contain more than three-fourths of Nevada's students; owing to the lack of better data, the special education expenditures for the remaining counties were assumed to be the same per special teacher as the average for the three counties on which we did have data. The higher expenditures per teacher for Clark County (Las Vegas area) in contrast to Washoe County (Reno area) are due primarily to allocation of more school expenditures to special education rather than being due to higher direct salaries or special education materials costs. Of the $9.3 million shown in Table 7.1, about $5 million came from state government for special education, less than $1 million came from federal sources, and the remainder (about 40 percent of the total) were from regular county school district funds.

Table 7.2 shows the number of mentally handicapped people provided with special education and training services in the three major areas of the state. In terms of the total fraction of the school-age population provided special education and training services because of mental retardation, the rural counties (with an average of 1.50 retarded children served per 100 school enrollees) do slightly better than Washoe County (1.38 per 100), and Clark County is even lower (an average of 1.02 retarded children served per 100 school enrollees). Comparison of the three geographic areas based on the number of seriously emotionally disturbed children served in relation to need is not as important as the major point that special educational services for seriously emotionally disturbed children are extremely low in relation to need in all three areas. Special educational services specifically for

---


3 The average salary for the 399 special education teachers in Nevada was $11,240 in October 1973, ranging from a low of $5,000 in Eureka County to a high of $11,775 in Churchill County. Clark (Las Vegas area) and Washoe (Reno area) Counties averaged $11,770 and $10,883, respectively.
### Table 7.2

**Special Education and Training Services for Mentally Handicapped Nevadans by Geographic Area, FY 1974**

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Estimated Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>County School Districts</td>
</tr>
<tr>
<td>Clark County</td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>29</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>731</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>1133</td>
</tr>
<tr>
<td>Total</td>
<td>1893</td>
</tr>
<tr>
<td>Total per 100 school enrollees</td>
<td>2.43</td>
</tr>
<tr>
<td>Washoe County</td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>50</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>398</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>375</td>
</tr>
<tr>
<td>Total</td>
<td>823</td>
</tr>
<tr>
<td>Total per 100 school enrollees</td>
<td>2.72</td>
</tr>
<tr>
<td>All other counties combined</td>
<td></td>
</tr>
<tr>
<td>Emotionally disturbed</td>
<td>21</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>373</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>479</td>
</tr>
<tr>
<td>Total</td>
<td>873</td>
</tr>
<tr>
<td>Total per 100 school enrollees</td>
<td>3.22</td>
</tr>
</tbody>
</table>

**NOTE:** See text of this chapter for sources of data.

<sup>a</sup>Except for 32 residents from throughout the state served at the Nevada Mental Health Institute, for whom we do not have the original county of residence.

Seriously emotionally disturbed children are nonexistent in most Nevada counties, and the rest serve only a token number of children. Most of those children who do not receive needed special services attend school in regular classrooms, but what is probably a minority of them have been expelled or have "dropped out" so they are not in school at all.

Nationwide in 1970, an average of 1.6 mentally retarded children per 100 enrollment received special instruction or assistance; the comparable figure for emotionally disturbed pupils was 0.54 per 100.<sup>4</sup> Nevada is below the national average in special education service to mentally handicapped children, and the national average leaves much to be desired.

Despite the state law requiring special education of all handicapped minors, we estimate that in relation to the minimum number of Nevadans needing special education and training services, only about 4 percent of seriously emotionally dis-

---

turbid children are identified as such and served, and only about 54 percent of mentally retarded children and youth are served. Even if one assumes that every educationally handicapped child served is either mentally retarded or seriously emotionally disturbed (which is certainly not true), only about 63 percent of those in need are being served. The true number of mentally handicapped children in need is not accurately known, but we have used what we consider to be low estimates of need; and if we used, say, the 3 percent prevalence figure most commonly used by Nevada's Associations for Retarded Citizens, then estimates of the fraction in need who receive special education would be even lower (e.g., 36 percent of retarded children served).

The next several sections of this chapter provide a more detailed description of special education and training programs for mentally handicapped Nevadans. We suggest that the reader who is uninterested in descriptive details turn directly to the last section of this chapter, which discusses problems and recommendations for improvement.

COUNTY SCHOOL DISTRICT PROGRAMS

The county school districts provide the great majority of the special education services in Nevada, but do so under state regulations and guidelines and with the state paying more than half the expenses of special education. Accordingly, we first describe the special education regulations and guidelines set at the state level.

The 1973 session of the Nevada Legislature ordered that a school district "shall make such special provisions as may be necessary for the education of handicapped minors." A handicapped minor is defined in the statutes as "any person under the age of 18 years who deviates either educationally, academically, physically, socially or emotionally so markedly from normal growth and development patterns that he cannot progress effectively in a regular school program and therefore needs special instruction or special services." The age range to be served is 5 up to 18 years for educationally handicapped (including emotionally disturbed and learning disabled) children, and 3 up to 18 years for mentally retarded children. A handicapped minor is not required to take advantage of the special education program if the parent or guardian files a statement "showing that the minor is receiving adequate educational advantages." The Nevada Department of Education, by law, prescribes minimum standards for the special education of handicapped minors, and state funds can be withheld from a county failing to meet those standards. The state budget provides $16,000 per year to the counties per special education unit (basically, a certificated special education professional), with a total of 506 units for all types of mentally and physically handicapped children being funded over the entire state in the FY 1976 school year (up from $14,500 for each of 434 units in FY 1975).

The following are highlights of the state-prescribed minimum standards. A special education program unit must be operated during at least nine months of a school year (with a school day of 330 minutes). A unit must have the full-time

---

Nevada Revised Statutes (NRS) 388.440-388.520, inclusive.

NRS 388.490, as amended, 1975.

Interview with L. Davis, Nevada Department of Education, Carson City, Nevada, July 9, 1975.
services of a certificated employee with an endorsement in the area of his or her major type of exceptional pupil teaching responsibility (see the certification standards below). Before admission to a program, a child must be examined individually with written permission from the parent or guardian to determine if he or she is a handicapped minor according to the state definition. Standards on the maximum number of enrollees for instruction at any one time must be met.8

The state defines two types of mental handicaps: "mentally handicapped" (basically, mentally retarded), and "educationally handicapped" (including emotionally disturbed and learning disabled children, as well as those in detention homes or correctional institutions).

Specifically, mentally handicapped (retarded) children are those

... who, as a result of ineffective intellectual functioning, are unable to profit educationally from a typical classroom situation.

Educable Mentally Handicapped. The performance on an individual psychoeducational evaluation shall fall within the I. Q. range of 50 to 75 in order for a student to be eligible for this program. (The psychologist may make a recommendation for placement of children falling outside the above parameters.)

Trainable Mentally Handicapped. The performance on an individual psychoeducational evaluation shall fall between the I. Q. range of 30 and 50 in order for the student to be eligible for this program.

Severely and Profoundly Handicapped. The performance on an individual psychoeducational evaluation shall fall below an I. Q. of 30 in order for a student to be eligible for this program.9

Educationally handicapped are those

... who, as a result of emotional disturbances and/or learning disabilities, require a differentiated educational program in order to make constructive use of their school experience. Children detained in detention homes or correctional institutions are educationally handicapped. ...10

Emotionally Disturbed. The performance on an individual psychoeducational evaluation shall determine that the emotionally disturbed are those students with persistent maladjustive behavior.

Learning Disabled. Children with learning disabilities exhibit a disorder in one or more of the basic psychological processes of central-motor, central-perceptual, central-cognitive, and/or spoken or written language. These disorders may be manifested in the areas of listening, thinking, talking, reading, writing, spelling, or arithmetic. The performance on an individual psychoeducational evaluation shall determine involvement in one or more of the following areas:

1. Marked discrepancies between intellectual achievement potential and achievement level
2. Perceptual motor impairment (auditory, visual, haptic)

8 Nevada Department of Education, Standards and Instructions for Administration of Exceptional Pupil Education Programs, November 15, 1973.
9 Ibid.
10 All children in detention homes or correctional institutions are by definition classed as "educationally handicapped" so that they can receive special educational assistance.
3. General orientation defects (space, time, body image)
4. Disorders of speech and language
5. Developmental disparity in processes related to education
   (auditory, visual, haptic)

The maximum number of students to be instructed at any one time by a special education teacher ranges from 5 to 14 depending on the type of mental handicap and the age of the children; details are shown in Table 7.3.

An individual educational assessment is supposed to be made annually with goals and objectives written in measurable terms,\textsuperscript{11} but we were unable to obtain any quantitative summary information from county or state personnel we interviewed on the effectiveness of the special education services.

As we indicated, to be eligible for state financial support for a special education unit, the unit's teacher must be certificated. The requirements for certification for special teaching of mentally handicapped (mentally retarded) children are basically either:

- A bachelor's degree and completion of an approved program of preparation for teaching the mentally handicapped

or

- A bachelor's degree, valid teaching certificate and completion of the following:

  Completion of a program for teaching the mentally handicapped consisting of no fewer than 24 semester hours course work distributed to include preparation in each of the following areas, or their equivalent:
  - A minimum of six semester credits in student teaching with the mentally handicapped
  - Survey of the exceptional child and/or introduction to special education
  - Curriculum development and/or methods of teaching the mentally handicapped
  - Diagnosis and remediation of learning disorders
  - Counseling and guidance for exceptional children
  - Career education\textsuperscript{12}

A certificate endorsed for teaching educationally handicapped children is required for special teaching of emotionally disturbed and learning disabled children. The requirements for the certificate for educational handicaps are basically either:

- A bachelor's degree and completion of an approved program of preparation for teaching the educationally handicapped, emotionally disturbed or learning disabled

or

- A bachelor's degree and a valid certificate endorsed for teaching in the elementary or secondary grades, and completion of the following:

  A program for teaching the educationally handicapped, consisting of no fewer than 24 semester hours course work distributed to include preparation in each of the following areas or their equivalent:

\textsuperscript{11} Nevada Department of Education, Standards and Instructions.
\textsuperscript{12} Idem, Nevada Teacher Certification Requirements, Carson City, Nevada, September 1, 1974.
Table 7.3

**Maximum Number of Special Education Students to be Instructed at Any One Time by a Teacher**

<table>
<thead>
<tr>
<th>Type of Handicap</th>
<th>Educable Mentally Retarded</th>
<th>Trainable Mentally Retarded</th>
<th>Severely and Profoundly Retarded</th>
<th>Emotionally Disturbed</th>
<th>Learning Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preschool</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Primary</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Elementary</td>
<td>12</td>
<td>10</td>
<td>6</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Junior high</td>
<td>14</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Senior high</td>
<td>14</td>
<td>12</td>
<td>8</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
</table>

NOTE: Except for the severely and profoundly retarded, the numbers shown can be increased by no more than four if a teacher's aide is present. Nevada Department of Education, *Standards and Instructions for Administration of Exceptional Pupil Education Programs*, Carson City, Nevada, November 15, 1973.

---

Introduction to the psychology and education of the exceptional child
- The learning disabled child
- The emotionally disturbed child
- Counseling and guidance for exceptional children
- Measurement and evaluative techniques
- Curriculum development and methods for teaching learning disabled and/or emotionally disturbed children
- A minimum of six semester hours credit in student teaching of the educationally handicapped

Endorsement as a school psychologist requires:

- A master's or doctor's degree and completion of an approved program of preparation consisting of at least 50 semester hours credit, 36 of which are at the graduate level, distributed to include course work in each of the following areas and sub-areas:
  - Characteristics of school populations (normal and exceptional) ...
  - Characteristics of school systems ...
  - Psychological assessment ...
  - Intervention techniques ...
  - Experimental design ...
  - Internship

- 480 clock hours in supervised field work in school psychology of which at least 240 hours will have been in elementary and secondary school settings

The University of Nevada at Reno has three professors of special education and annually graduates 40 to 45 people with bachelor's degrees and about 20 people with master's degrees in special education. Teachers are prepared for certification in the

---

13 Ibid.
14 Ibid.
areas of educable mental retardation, trainable mental retardation, and educational handicaps. About 90 percent are placed in jobs within the state or on the nearby eastern slope of California's Sierra Nevada. Many of the master's degree graduates are teachers who come for retraining in special education, but of the dozen or so rural teachers that come into the master's program each year from rural areas, only about half return there.¹⁵

The special education program at the University of Nevada in Las Vegas, with seven professors, is about twice the size of the Reno program. The Las Vegas program prepares bachelor's degree level graduates for certification in the areas of educable and trainable mental retardation, severe and profound retardation, and educational handicaps (combining learning disabled and emotionally disturbed).¹⁶ The university does not offer a separate program for training teachers in special education of emotionally disturbed children and youth.

In the remaining subsections on the county school districts' programs, we briefly describe special education programs in the three largest county school districts with over three-fourths of Nevada's school-age population (Carson City, Clark, and Washoe Counties). We also briefly describe the special education programs in two rural counties (Churchill and Douglas). The numbers of special education students and teachers, which we summarized earlier, are presented in detail for each county by type of mental handicap in Table 7.4.

Carson City School District¹⁷

The Carson City School District has the third largest number of certificated special education professionals in Nevada—2 speech therapists, 2 teachers for trainable or more severely mentally retarded children, and 11 teachers for “learning disability” units who were said actually to be serving many mentally retarded children. In Carson City, the one school psychologist tests children (about 300 were tested in the 1973-74 school year), writes an individual plan for each child, works with the teacher in implementing the plan, and provides direction and referral to other service providers. A Reno physician helps in the evaluation of some children.

Children placed in special education are followed up by the school psychologist in six weeks, three months, and nine months. In Carson City there is no psychological counseling by the school psychologist, although some emotionally handicapped children are referred to the Rural Clinics mental health personnel.

Data reported by the Nevada Department of Education indicated that 41 mentally retarded and 77 educationally handicapped children were being served in special education in Carson City at the start of the FY 1974 school year.¹⁸ If the teachers are assigned in about the same ratio as types of special education students, there were about 5 full-time-equivalent teachers serving retarded children and 8 serving educationally handicapped children.

¹⁵ Interviews with Professors J. Campbell and T. Tower, University of Nevada, Reno, November 21, 1974.
¹⁶ Interview with Prof. W. Wagoner, University of Nevada, Las Vegas, October 24, 1974.
¹⁷ Interview with Muriel Keehn, Psychologist, Carson City School District, May 9, 1974.
Table 7.4
SPECIAL EDUCATION IN NEVADA COUNTIES, 1973-74 SCHOOL YEAR

<table>
<thead>
<tr>
<th>County</th>
<th>School Districts</th>
<th>Total School Enrollment, First Month of School</th>
<th>Total Mental</th>
<th>Mental Retardation</th>
<th>Emotional Disturbance</th>
<th>Educational Handicap</th>
<th>Total Mental</th>
<th>Mental Retardation</th>
<th>Emotional Disturbance</th>
<th>Educational Handicap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carson City</td>
<td>5,381</td>
<td>118</td>
<td>41</td>
<td>0</td>
<td>77</td>
<td>13</td>
<td>5</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Churchill</td>
<td>2,890</td>
<td>200</td>
<td>80</td>
<td>20</td>
<td>100</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Clark</td>
<td>77,862</td>
<td>1,893</td>
<td>731</td>
<td>29</td>
<td>1,133</td>
<td>175</td>
<td>68</td>
<td>3</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>Douglas</td>
<td>2,438</td>
<td>43</td>
<td>43</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Elko</td>
<td>4,062</td>
<td>71</td>
<td>53</td>
<td>0</td>
<td>18</td>
<td>10</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Esmerala</td>
<td>97</td>
<td>18</td>
<td>4</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>&lt;1</td>
<td>0</td>
<td>&lt;2</td>
<td></td>
</tr>
<tr>
<td>Eureka</td>
<td>203</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Humboldt</td>
<td>1,717</td>
<td>43</td>
<td>22</td>
<td>1</td>
<td>20</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Lander</td>
<td>765</td>
<td>35</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Lincoln</td>
<td>736</td>
<td>25</td>
<td>7</td>
<td>0</td>
<td>18</td>
<td>3.5</td>
<td>&lt;2</td>
<td>0</td>
<td>&lt;2</td>
<td></td>
</tr>
<tr>
<td>Lyon</td>
<td>2,617</td>
<td>132</td>
<td>27</td>
<td>0</td>
<td>105</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Mineral</td>
<td>1,752</td>
<td>37</td>
<td>10</td>
<td>0</td>
<td>27</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Nye</td>
<td>1,270</td>
<td>53</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Pershing</td>
<td>647</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>27</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Storey</td>
<td>107</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Washoe (except NMHI)</td>
<td>30,374</td>
<td>823</td>
<td>398</td>
<td>50</td>
<td>375</td>
<td>76</td>
<td>36</td>
<td>4</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>White Pine</td>
<td>2,388</td>
<td>60</td>
<td>51</td>
<td>0</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Total, except Clark and Washoe 27,170 873 373 21 479 80 36 2 42
Total, all counties 135,406 3,589 1,592 100 1,987 331 160 9 162


For Eureka, Humboldt, Lander, Pershing, and White Pine: the same sources plus interview with W. Green, Special Education consultant for rural counties, University of Nevada, Reno, November 21, 1974.

For Carson City, Churchill, Clark, Douglas, and Washoe: see text discussions of individual county programs for variation from the foregoing data sources.
Churchill County School District\textsuperscript{19}

The Churchill County School District is discussed in more detail than other rural Nevada districts because of its reputation as having one of the better rural county special education programs. Churchill County has about 12,000 people. Over 98 percent of its school children live within 15 miles of the town of Fallon, where all special education services are provided; no handicapped children are sent to other counties for service.

Churchill County has six schools, all in Fallon. Sixty-eight percent of the children in the school district are bussed. The longest commute by school bus is 70 miles (taking 1 hour and 20 minutes) each way. Three children make the 70-mile commute, and the district is considering using a private plane to fly the children in each day. Since so many of the children are within a 15-mile radius of Fallon, the commuting problem is not as difficult as it might seem to be at first.

The six Churchill County schools include one for kindergarteners only, one that is ungraded and serves only children in the first and second years of their schooling, one that is ungraded and serves only children in the third and fourth years of their schooling, one that serves fourth, fifth, and sixth graders, one graded junior high school, and one graded senior high school, which was said to be very vocational in its curriculum.

In 1974 there were about 3000 children in school in Churchill County, of whom 10 to 11 percent were said to need some form of compensatory education. W. Hammer, who is in charge of special education in Churchill County, avoids the term "special education," however, because he believes it usually entails labeling. He prefers to provide compensation for specific deficits in the individual child’s abilities, rather than label groups of children under a common classification and provide the same special education services across whole groups.

The county is reimbursed for nine special education units by the state, but operates a total of 13 units. Thus, Churchill County goes well beyond what the state provides in terms of units, contrary to the practice in the much larger Clark and Washoe Counties. However, Hammer indicated that they are still not serving all the known handicapped children, and if they served all the learning disabled children who have been identified, they would need 12 or 13 more special education units.

The current 13 units are located in regular schools. There are four self-contained classes serving a total of 62 children, most of them educable mentally retarded but a few with different types of handicaps. The children are divided into primary, elementary, junior high, and senior high age groups. The district also runs two self-contained classes serving 18 emotionally disturbed children of elementary school age, and four self-contained classrooms for 75 to 80 learning disabled children. Two units provide a "flow-through resource type class" where some 60 to 70 children are seen for one-half hour each in a one-teacher-to-three-student setting. One unit of speech therapy is also provided in the district. All children work on a "diagnostic prescriptive program" prepared for each individual child by the school psychologist and two reading specialists. If a child has a severe emotional disturbance that cannot be handled through a day-care program in the schools, a psychiatrist from Reno provides consultative services in the short run; in the long run, W.

\textsuperscript{19} Interview with W. Hammer, Churchill County School District, Fallon, Nevada, November 21, 1974.
Hammer indicated that the child must leave the county to receive adequate service. He also indicated his feeling that the mental health personnel of the Rural Clinics program in Fallon in late 1974 could not deal effectively with severe emotional disturbance. In total, the district in late 1974 was providing special educational services to about 80 to 90 retarded children, about 20 emotionally disturbed children, and about 100 children with learning disorders.

The special education and related staff consists of the director and one secretary, the 13 professionals associated with the 13 special education units (11 of the 13 were primarily serving children with mental problems), and 18 aides at the elementary grade level providing one-to-one education based on prescriptions written by professionals. In addition, the district employs two psychologists and five school nurses, and has one counselor for each school. Churchill County recruits in several states, apparently has little difficulty obtaining qualified teachers, and typically pays about $12,000 per school year for special education teachers. In-service training workshops for the special education teachers are conducted by the county special education director and by other staff members.

The 1974-75 budget for education of all children in Churchill County was about $4 million. In special education, the direct personnel and material cost (exclusive of facility and overhead) came to $245,000, of which only about $130,000 came from the state, and about $60,000 was a federal grant (under Title I of the Elementary and Secondary Education Act) to pay for the 18 special aide personnel. In a breakdown of 1970-71 special education costs, which Hammer said was as accurate as any he could prepare in 1974, the direct costs were shown to be about 70 percent of total operating costs. Thus the total 1974-75 special education operation costs in Churchill County would be about $350,000, of which slightly under $300,000 was for children with some type of mental impairment (if costs are assumed to be in proportion to the number of children of each type served).

Churchill County has a commendable program for screening all children, at the time they begin school or transfer into the school system, for the presence of functional mental retardation and impaired emotional development (see Chap. 6 on the identification service for details).

Clark County School District

The Clark County School District is the largest in Nevada. It serves more than half of Nevada’s school-age population: approximately 76,500 students in the 1973-74 school year at 96 schools. The great majority of the people in the county live in the Las Vegas area, where all special education services are provided, with the following exceptions. Henderson has three special education units (teachers) and Boulder City has one. All mentally handicapped children in those two cities spend most of their time in the “mainstream” in class with nonhandicapped students, with the exception of a few trainable or more severely retarded or multiply handicapped students who are bussed to two special schools in nearby Las Vegas. In the rural

---

21 Information in this section, unless otherwise noted, is based on interviews with Dorothy M. Seigle, Special Student Services, Clark County School District, Las Vegas, Nevada, March 5, 1974 and October 24-25, 1974.
areas of Clark County, special education is provided in Overton, Indian Springs, and Virgin Valley; each has one special education teacher who serves both educationally handicapped and educable mentally retarded children of several ages. Private special education is virtually nonexistent in Clark County. There is one special education teacher in a parochial school.

In the Las Vegas area, the program specifically for emotionally disturbed children consists of one teacher serving adolescents in temporary residence at the Las Vegas Mental Health Center, and two teachers serving elementary school-age children in what is called the MOD Center, run jointly by the Clark County School District and the Children's Behavioral Services branch of the Nevada Division of Mental Hygiene and Mental Retardation in 1974. (See Chap. 8 of this report on psychological services for descriptions of these two programs, which are more for treatment of emotional disturbance and behavior problems than for special education). Other emotionally disturbed children are served within the school district in the program for educationally handicapped children, where the common characteristic of all students is academic performance at least 50 percent below the average for that age of child. Other than initial testing and teacher-provided therapy, psychological services are virtually nonexistent.

The difference between programs for the educable mentally retarded (EMR) and the educationally handicapped children is that the EMR children are more often in self-contained classes, and the educationally handicapped children are more often in remedial education programs designed to get them back into the mainstream. In practice, a principal can place a child in special education when the only problem is low reading achievement. An educationally handicapped child must meet normal graduation requirements, whereas a mentally retarded youth does not. Educable mentally retarded children who have severe behavioral problems are not served by the present school system in Clark County, although the MOD Center program may attempt to get some of them back into special education in the future.

Most handicapped children in special education in Clark County do some schoolwork with nonhandicapped children, e.g., physical education. Those that spend much of their time with nonhandicapped children are in what has become known nationally as the "mainstream." In Clark County there are two basic types of special education called mainstreaming: in one the child is primarily assigned to a special class but is sent to regular classes for physical education and one or two other subjects; in the other the child is primarily assigned to a regular class but the child's education is supplemented by a special education resource teacher. The district receives no special education funding from the state for the regular mainstream class teacher, but does receive state funding for the resource teacher. Mainstreaming is being tried in Clark County, with some apprehension over whether the reduction of special classes will result in more children being placed in special schools, and over whether principals will use special education resource teachers as remedial teachers for children who are not substantially handicapped.

The Medical Consultant Program operated by the Clark County School District in cooperation with the County Health Department was developed mainly to diagnose and treat students with symptoms of hyperkinesis, although children with serious learning problems for whom there is no other medical resource will also be seen. In the 1973-74 school year, 87 children were referred to this program, of whom 80 were placed on medication and 7 were referred elsewhere for medical help.
The county does not supervise the special education staff at the local school. The local principal is in control and there is no regular consultant help to the local special education teacher, although coordination and consultative assistance from the district are available. Consequently, the local teacher has much independence. Funds were said to be needed for consultant help to the teachers, but they are not provided under the present state formula. Thus the local teacher has little help in curriculum and other types of education program development unless he or she is part of a federal project. For example, the district is using the federal dollars to employ two staff members to teach the teachers in the mainstream program in 18 schools.

In-service training of special education teachers is provided only if the special education teacher asks for it. The teacher then might be allowed to go to a workshop, for example, or attend a course at the university.

A total of 731 mentally handicapped students were enrolled in special education in the Clark County School District in the first month of the 1974-75 school year: 215 educable mentally retarded children at the elementary school-age level; 275 educable mentally retarded youth at the secondary school-age level; 142 trainable and more severely retarded children at the special Helen J. Stewart school; and 99 multiply handicapped children (mentally retarded plus some other handicap) at the special Variety School. Some special educational services were provided to 9 adolescents with mental health problems who were in residence at the Las Vegas Mental Health Center; and to about 20 emotionally disturbed elementary school-age children in the MOD Center program operated jointly with the Children's Behavioral Service branch of the Nevada Division of Mental Hygiene and Mental Retardation. Special educational services also were provided to 1133 "educationally handicapped" children. These numbers of enrollees are approximately the same as those at the end of the FY 1974 school year.

In 1974, the school district was serving no children less than five years old, with the exception of three severely and profoundly retarded four-year-olds at the special Helen J. Stewart School. The State Division of Health's Southern Nevada Special Children's Clinic, however, was serving about 20 three- and four-year-old mentally retarded children of Clark County in a nursery school program.

In Clark County there is no screening program to identify children with mental health or mental retardation handicaps. Not all children receive an IQ test, and a child receives special education services only if the regular teacher notices a problem and refers the child for special education.

In the spring of 1974 Clark County had what was termed a "huge waiting list" for special education (66 educationally handicapped and 14 educable mentally retarded children). All but one of the children on the waiting list were in regular school classes. By the fall of 1974 the children on the spring waiting list had been placed into special education and the fall waiting list was very small (exact number unknown). However, there were said to be many referred children who had not been tested, because of a shortage of psychologists. However, every identified trainable mentally retarded person of school age in Clark County was said to be receiving special education.

In the 1973-74 school year, Clark County had about 233 special education units (certified professional special education personnel units), of whom 59 served educable mentally retarded children, 14 served trainable or more severely retarded chil-
dren, 6 were special education vocational counselors primarily for mentally retarded youth, 9 served multiply handicapped retarded children, and 87 served educationally handicapped children (including one at the Las Vegas Mental Health Center and two at the MOD Center for emotionally disturbed children). In addition, there were 18.5 full-time-equivalent psychologists, 11.5 full-time-equivalent social workers, and 16.5 full-time-equivalent school nurses serving all types of nonhandicapped and handicapped students.

Psychologists are paid by county school districts and are not reimbursed by the state as special education units. Psychologists mostly do psychometric testing and "don't do individual case work or therapy with individual students." Psychologists sometimes try to counsel teachers on how to handle the children (but are able to spend only a small percentage of their time on this) and thus seek leverage by training other service personnel. The Clark County rule is that one social worker or psychologist is provided for about every 3000 students. 22

The salary range for teachers begins at about $8000 per year and extends to above $16,000; special education teachers receive an additional $200 per year. The district does not actively recruit since it has sufficient numbers of high-quality applicants for special education teaching jobs.

The annual operating expenditures for special education in Clark County are not precisely known, and the use of the $14,500 per unit provided by the state in FY 1974 is not accounted for separately in the expenditure records. 23 However, using the following two alternative methods of estimating the total annual special education operating expenditures, we estimate the total for FY 1974 for mentally handicapped students was approximately $5.2 million. The first method of estimating special education expenditures was to use estimates of $3500 per year per pupil for the expenditures on children in the two special schools in the district, 24 $2683 per year per educationally handicapped pupil, 25 and $2500 per year per educable mentally retarded student. 26 This results in an estimate of $5,187,000 for FY 1974 special education expenditures for mentally handicapped students in Clark County. The second method we used to estimate those expenditures was based on an estimate by the Clark County special education administrative staff that in FY 1974 the county provided at least half of the total special education expenditures. Given the state funding of $14,500 per unit and the number of units, and assuming that county funding was at least half the total, leads to an estimate of at least $5,075,000 for FY 1974 special education expenditures for mentally handicapped students in Clark County. This is very close to the estimate obtained by the first method, which is probably the more accurate of the two. By type of mental handicap, using the first method of estimation, the FY 1974 expenditures for special education in Clark

---

22 Interview with Clair McKee, Chief of Psychology and Social Work Services, Clark County School District, Las Vegas, Nevada, October 24, 1974.
23 The unit figure was raised to $16,000 by the 1975 session of the Nevada Legislature.
24 Per pupil expenditure data at the Helen J. Stewart and Variety Schools, obtained from the principals of those two schools, October 24-25, 1974.
25 Based on the most recent available data on special education expenditures per educationally handicapped pupil in Clark County ("Clark County School District Special Education [Expenditures]—1971-72," mimeograph, undated), with an adjustment upward of 5 percent per year for inflation. This 5 percent inflation is thought to be a low estimate of the unknown inflation rate in the cost of special education from FY 1972 to FY 1974.
26 Based on adjusted FY 1972 special education expenditures per educable mentally retarded student in Clark County. See footnote 25 for source of data and adjustment factor.
County were: $2.1 million for mentally retarded students, and $3.1 million for educationally handicapped (including emotionally disturbed) students.

Helen J. Stewart School.\textsuperscript{27} The Helen J. Stewart School, a separate day school, has a high-quality facility, staff, and program for special education of trainable and more severely retarded children in Clark County. It is the best special education program for such children in Nevada, and in our view compares favorably with the better programs for trainable and more severely retarded children nationally. Approximately 142 children aged 4 to 18 are served, of whom half are over the age of 12. Sixteen are severely or profoundly retarded. Dr. Robert Foster, the principal, indicated he knew of very few trainable or more severely mentally retarded children of school age in Clark County who are not being served. The modern facility was designed specifically for service to those types of youth after visits to several exemplary facilities nationwide. The school provides physical therapy and physical education, vocational training, and training in activities of daily living, and possesses a one-acre farm, greenhouse, and several classroom-type areas. The professional staff includes 15 teachers, 2 social workers, a clinical psychologist (2 days a week), a speech therapist, a vocational specialist, and a physical therapist. There are several teachers' aides, and between 100 and 200 volunteers provide some assistance each week. (These volunteers also raised about $40,000 in funding during the 1973-74 school year.)

The program for severely and profoundly retarded children at the Helen J. Stewart School is behavior modification oriented, with one teacher and one teacher's aide for every four such children. Both parents and teachers of these children sign a "contract" specifying what each is to do, and parents spend one evening each month at the school for consultation and for training in how to help their children.

The school's basic objective is to help each child develop as much self-sufficiency as possible. The program for trainable retarded children includes significant amounts of physical-motor development, language development, socialization, activities of daily living, recreation, and vocational training (see Chap. 11 for description of the latter program). Most graduates are placed either in jobs or sheltered workshops following graduation; the transition from school to adult life is facilitated as much as possible. The annual operating expenditures for this school are about $3500 per child.

Variety School.\textsuperscript{28} The Variety School, also a separate day school, is for special education of physically and multiply handicapped children who are too severely handicapped to be served in a special education classroom in a regular school. The school began as a charitable project of the Variety Club. About 99 of the 156 students are mentally retarded. The school has seven classes for educable mentally retarded children who also have some additional handicap, two classes for trainable or more severely retarded children who are in wheelchairs, four classes for physically handicapped children only, and two special kindergarten classes. The school's operating budget is about $3500 per child per year. The staff of 58 includes 15 classroom teachers, 2 full-time physical therapists, a speech therapist, an occupational ther-

\textsuperscript{27} Information based on an interview with Dr. Robert Foster, Principal of the Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.

\textsuperscript{28} Information in this subsection is based on an interview with Principal Howard Marr, Variety School, Las Vegas, Nevada, October 25, 1974 and a letter from Dorothy Seigle, Clark County School District, to James Kakalek, The Rand Corporation, March 9, 1976.
pist, and a social worker, plus a psychologist, a nurse, and a vocational counselor part-time. A school bus provides transportation for students as far away as Boulder City and Henderson (a total of 60 children are bussed to the Helen J. Stewart and Variety Schools from those two cities), but no one from the remote rural areas of Clark County is served. In response to the 1975 state legislature's lowering of the age of special education for mentally retarded children to 3 years old, the Variety School served 36 mentally retarded children aged 3 or 4 years old as of March 1976. With due praise to the high dedication and effort of the staff of the Nevada Mental Health Institute, we note that the overall level of professional preparation of the staff, the quality of the facility, and the comprehensiveness and depth of the service programs for retarded children and youth at the Helen J. Stewart and Variety Schools in Clark County are better than those for retarded residents of the Nevada Mental Health Institute (see Chap. 10 for a description of the Institute).

Douglas County School District

The Douglas County School District has four special education teachers, who serve about 43 mentally retarded children. One of these teachers works outside the county, at the facility of the Ormsby Association for Retarded Citizens in Carson City; Douglas County sends four of the more retarded children there, and provides a budget of $24,000. Although more than four children per teacher are allowed by state regulation, Douglas County reportedly does not have a means of identifying additional retarded children to fill the class it funds at the Ormsby ARC facility.

Washoe County School District

The Washoe County School District is the second largest in Nevada in terms of population, serving a county with a total population of about 142,000. The great majority live in the urbanized Reno-Sparks area where, with the exception of two teachers at Lake Tahoe, all special education services available in the county are provided. No children are bussed in for special education service from rural areas of Washoe County, and no assistance is provided to other counties. The district provides a comprehensive program of services to educable and trainable mentally retarded children, but admits providing only partial services for emotionally disturbed children. Mentally handicapped children are admitted into the special education program by a certified psychologist or, in the case of retarded children, perhaps by a person serving under the direction of such a psychologist. The specific criteria for an emotionally disturbed child in Washoe County are:

1. The child must be incapable of being educated effectively through regular classroom instruction.
2. A reasonable assumption that the child can benefit from the special facilities available.

31 Interview with S. Landis, Ormsby ARC, Carson City, Nevada, November 15, 1974.
32 Information in this section is based on interviews with Roy Berry, Director, and Gerald Myers, Coordinator, Special Education Services, plus several special education teachers, Washoe County School District, Reno, Nevada, August 19, 1974, and November 20-21, 1974.
33 Special Education Programs, Washoe County School District, Reno, Nevada, 1974.
3. While the child may be functioning as if retarded, there shall be no
diagnosis of mental deficiency.
4. The child's behavior must not constitute a threat to the physical
welfare of other students.\textsuperscript{24}

The criterion for a learning disabled child is exhibition of "a disorder in one or
more of the basic psychological processes of central-motor, central-perceptual, cen-
tral cognitive, and/or spoken or written language. These disorders may be manifest-
ed in the areas of listening, thinking, talking, reading, writing, spelling or arithmetic." A common element among learning disabled children in Washoe County was
said to be a two-year deficit in academic skills.

The criteria for an educable mentally retarded child are:

1. An Intelligence Quotient (I.Q.) score between 55 and 80 on an indi-
   videntally administered, nationally standardized test of intelligence.

2. A Social Maturity Quotient (S.Q.) score between 60 and 80 or a rating
   by the examiner indicating sufficient social competency to partici-
   pate in and benefit from a semi-integrated school program.

3. Academic performance at least one standard deviation below that
   which would be expected of a typical child of comparable age.

For a trainable mentally retarded child the criteria are:

1. An Intelligence Quotient (I.Q.) score between 25 and 55 on a nation-
   ally standardized, individually administered test of intelligence.

2. A Social Maturity Quotient (S.Q.) score between 25 and 60 or a rating
   by the examiner indicating social competency to the extent that the
   child is capable of cooperating with his teacher and his peers.

3. The child should be ambulatory and toilet trained.

4. The child should have sufficient communication skills to make his
   needs known.

The maximum number of educable mentally retarded enrollees for instruction
at any one time by a certificated teacher varies from 8 children of preschool age to
14 children of high school age. With a teacher's aide, the number of enrollees per
teacher can be increased by up to four children. The above numbers also hold for
emotionally disturbed and learning disabled enrollees. The maximum number of
trainable mentally retarded enrollees for instruction at any one time by a certificat-
ed teacher is two less than the maximum for educable mentally retarded children.

The special education program for educable mentally retarded children in
Washoe County is typically conducted by "mainstreaming," with the EMR children
integrated into regular classes at regular county schools whenever feasible. The
EMR children are generally outside the regular classroom at most half of the time,
and time for each child (typically, one-fourth of the time) is scheduled in special
resource rooms. At the high school age, the program becomes quite vocationally
oriented, with many going into a cooperative work-study program (see Chap. 11 for
details). Trainable and more severely retarded children who the school district
administrators feel do not require "custodial type care" are served at a special

\textsuperscript{24} Ibid., pp. 6-8, for these and subsequent criteria in this section.
school. A new special school for these retarded children, containing about 10 classrooms with a capacity of 105 children, is being constructed at a cost of approximately $1.1 million and is scheduled to open in 1975. The county also has a cooperative agreement whereby it receives extra state funding and provides four special education teachers for retarded children from throughout the state who reside at the Nevada Mental Health Institute (see the next section below, "Special Education at the Nevada Mental Health Institute.")

When we asked about special education for emotionally disturbed children in Washoe County, the county's Director of Special Education responded, "We don't have any in this county," which technically is true. The special education program in Washoe County for emotionally disturbed and learning disabled children, who are grouped together for service and called "educationally handicapped," is almost exclusively "mainstreaming," with the children spending most of their time in regular classrooms and a small portion of their time in special resource rooms. The special education coordinator estimated that there are approximately 50 seriously emotionally disturbed children labelled and served as "educationally handicapped." In 1974 the county did not have a teacher certified in the area of special education of emotionally disturbed children. With 50 served, the full-time-equivalent teaching staff would be about four. The special education coordinator also cautioned that care must be taken with "mainstream" programs to see that they are not a "ruse to get more money for doing the same thing they were doing before." In brief, the Washoe County schools provide only about 50 seriously emotionally disturbed children with special educational service, which may or may not be appropriate to their needs. In addition, less than 50 of the most severely emotionally disturbed children were referred to the Reno Mental Health Center for psychological services in 1974.

Interviews with special education teachers for learning disabled children in Reno illustrate how these programs sometimes function.45 One school we visited had a staff of two teachers plus one aide serving 24 learning disabled children on a one-to-one basis. They did so for a maximum of 2½ hours per week per child in a resource room to which the children are sent from the regular classroom where they spend the great majority of their time in the "mainstream" with nonhandicapped children. The special education teachers said most of these learning disabled children were "really just not performing up to snuff." The school has no remedial reading teachers, however; consequently, a child two years behind his or her peers in reading achievement may be labeled "learning disabled" and placed in this program for special tutoring. As one might expect, there is considerable turnover during the year (about 50 percent) among students in the program at this particular school. The children in a learning disability class can range from those with identifiable neurological handicaps to those who are behind in academic skills and need remedial tutoring.

Two of the Washoe County special education units are demonstration classes at the University of Nevada at Reno, serving 8 learning disabled and 7 trainable retarded children.

The certified special education teachers in Washoe County number 104, of whom 99 are funded by the state and 5 by federal money. The district personnel

indicated that a "buyer's market" prevails for teachers and they have no trouble obtaining good special education teachers. Current teachers have an average of about six years experience. There are also about 10 full-time-equivalent special teaching assistants. The school district employs six psychologists at $20,000 each to perform testing almost exclusively. With 31,000 students, there is one psychologist for approximately every 5,000 enrolled students. The average special education teaching salary in FY 1974 was $13,306; district personnel averred that the $14,500 per unit received in FY 1974 from the state about covered direct salary plus materials. Numerical data on fringe benefits, transportation, guidance, school operation, and all facility costs are not included in the $13,306 and were not available since they are part of the general education budget and not accounted for separately for special education teachers. Direct salaries of special education teaching personnel in the 1974-75 school year were thus about $1.5 million, including about $100,000 for the special teaching assistants.

Assuming that salaries are about 57 percent of total special education expenses as shown in the best available data—a 1971 study that prorated all Washoe County education expenses in an attempt to estimate special education expenses—we estimate 1974-75 special education expenditures in Washoe County to be approximately $2.6 million. That figure would include about $100,000 for the four units at the Nevada Mental Health Institute. The state provides $1,435,500 (99 units x $14,500 per unit), Title VI of the federal Education of the Handicapped Act provides about $40,000, Title III of the federal Elementary and Secondary Education Act provides about $26,000, and local funds make up nearly all the rest of the approximately $2.6 million expended annually.

In September 1974, exclusive of the Nevada Mental Health Institute, about 100 trainable and 300 educable mentally retarded children received special educational services from a staff of about 36 full-time-equivalent people. About 375 learning disabled children were served by a full-time-equivalent staff of about 36, exclusive of the 50 seriously emotionally disturbed children mentioned earlier. Prorating the total special education budget in proportion to the certified teaching staff yields a 1974-75 school year estimate of $1,725,000 for Washoe County's special education budget for mentally handicapped children; $825,000 for retarded children, $800,000 for learning disabled children, and $100,000 for seriously emotionally disturbed children.

Washoe County has no overall screening program to detect possible mental disorders in schoolchildren; the only identification is by testing children referred by the regular classroom teachers to special education for service. (See Chap. 6). The waiting list of handicapped children for special education in Washoe County is approximately 100, but according to the special education director that number is inordinately small because the word gets out that there are no vacancies and children cease to be added to the list.

In Washoe County, the county-level staff hires the special education teachers, rather than the local school principal. The county staff also supervises those teachers, unlike the practice in Clark County. However, we learned from professors at the

---

36 The salary range in FY 1974 was $8,200 to $17,250; there is no extra pay for teaching in the special education program.

University of Nevada at Reno, and from some local teachers, that the supervision is sometimes minimal. The Washoe County central special education office consists of 2.5 full-time-equivalent personnel, one of whom goes into the field to counsel and supervise the teachers. The philosophy is to let the local special education teachers develop their own programs “unless they get too far out of line.”

As far as teacher retraining is concerned, there is voluntary participation in in-service training classes, with one class running at all times. It is a one-hour-a-week, eight-week program that provides teachers with one credit toward salary merit increases. In addition, all special education teachers get together for a meeting one day a year.

SPECIAL EDUCATION AT THE NEVADA MENTAL HEALTH INSTITUTE

In 1974, four certified teachers and one aide provided special education services to 32 trainable, severely, and profoundly retarded people aged 5 up to 18 from throughout the state who were residents at the Nevada Mental Health Institute. The annual cost was about $100,000. The special education program is not operated by the Institute, but is under control of the Washoe County School District. No such services are provided in the summer. Retarded residents of other ages at the Institute need similar education and training services, but because they were not of the legal school age they were not served by the education system.

As of June 30, 1974, there were 23 other residents aged 5 up to 18 years who did not receive the services given to their 32 peers. In other words, though all 55 needed special education and training and such service is mandatory by Nevada state law, less than 60 percent were served, because the state did not provide funds for more than four teachers and because Nevada Department of Education regulations limit the number of children each special education teacher can serve.

The special education and training program at the Institute began only in FY 1974. For several years prior to that time no such services were provided to residents, so considerable progress is being made in program improvement at the Institute.

Teachers set up their own program for each resident served and work with each of them on both a one-to-one and a small-group basis. Instruction covers such items as social skills, physical activity, coordination, feeding and toilet training, language development, and some academic skills for some of the less severely retarded residents. The teachers indicated they feel there is no one they can turn to for guidance on program content, and that their professional training was geared almost exclusively to less severely retarded people than they are presently serving. They were not familiar with the program, and had not met with the staff, of the Helen J. Stewart School in Las Vegas, which also serves more severely retarded children.

The teachers would like to take the residents off the institution’s grounds more,
to broaden their experiences and aid in training for "normalization" of their lives, but do not have the transportation to do so.

Teachers report considerable progress now that residents are receiving services they need, although objective evaluation data are not yet available. In the fall of 1974, however, they gave a Social Maturity test to each student and intend to do so each fall and spring in the future.

The teachers indicated very strong feelings that the ward staff level is inadequate, and that ward staff do not follow through on treatment programs and do not fully implement individual treatment plans. It was suggested that ward staff levels be increased and that one person be responsible for running the ward staff meetings on each child, for developing a service plan, and for seeing that it is implemented and enforced.

A primary problem is that the wards do not have enough staff to do all the things the teachers believe they should be doing. The ward staff is supposed to be responsible for feeding training and toilet training, for example, but because they have not adequately handled those functions, the special education teachers were helping them learn the techniques. For about 30 to 60 minutes each afternoon, two teachers worked with ward staff members to get them to follow up on and reinforce the teachers' work.

In early 1976, all residents between 3 and 18 years of age are enrolled in an education program. Only 7 of the 38 residents of those ages attend classes in the Reno community; the remaining children are served on the Institute grounds. These are 5 special education units which are served by 5 special education teachers and 1 teaching assistant. One half-time mental health technician also assists with transporting the nonambulatory clients to school and helps in the school program. Some minimal adult educational services are available for some of the higher functioning clients who are over 18 years of age. There are approximately 20 clients between 18-21 years that are unserved in early 1976. Efforts are now being made to obtain federal educational dollars for this population in cooperation with the state Department of Education and the Washoe County School District.

PRIVATE COMMUNITY TRAINING CENTERS

Several private community training centers in Nevada aid mentally retarded or functionally retarded persons who are not served by other programs; hence most services in these centers are for preschool children and adults. The centers are partially funded by the Community Training Center program within the Nevada Division of Mental Hygiene and Mental Retardation. They may provide a variety of services, including day-care activities, education, developmental training, individual and family counseling, supervised residential living, and sheltered work. (Education services are described in this chapter; other services by the centers are described in this report's chapters on vocational services and residential living.) The state-provided funding is a minimum of $300 per enrollee per quarter, the actual

---

40 Defined as a person who "functions like an individual meeting the [AAMD definition of mental retardation] requirements. See Nevada Division of Mental Hygiene and Mental Retardation, Operating Regulations for Approved Community Training Center Grantees, Reno, Nevada, 1974.

amount depending on funds available. Each center receives a minimum of $14,000 per year, provided staff expenses are equal to that amount and they have a minimum of five certified enrollees per quarter. The state has paid a maximum of $350 per enrollee per quarter in large centers and a maximum of $15,000 per annum in small centers. In addition to the centers described below, a new satellite center recently opened in Gerlach-Empire and serves 8 preschoolers.\(^4\) To be eligible for funding, the centers also must have a minimum staff of one person for each group of five retarded persons or major fraction thereof. Centers must certify why each enrollee is not in a local school program (e.g., "not of school age"). The centers must provide service a minimum of six hours a day, five days a week, 240 days a year, excluding holidays and one day a month for staff development.\(^4\)

Currently, about 70 preschool and school-age mentally or functionally retarded children are provided education and training services in six community training centers. The full-time-equivalent staff for these children is approximately 14. Assuming an annual operating cost of at least $2400 per enrollee, the annual expenditures for these retarded children are at least $168,000. The Community Training Centers program is collecting about $75,000 per annum in federal Title XX social services funds.\(^4\)

The numbers of people served in programs of the various community training centers are described below.

The *Elko Developmental School* serves 11 people. It is primarily a preschool directed by a certified special education teacher, but it also operates a small sheltered workshop.\(^4\)

The *Mineral County Sheltered Workshop* serves approximately 13 people. It is primarily a preschool, and secondarily a prevocational and vocational program for retarded adolescents and adults. The program is directed by a special education teacher, assisted by two half-time teaching aides and volunteers.\(^4\)

In the past, the *Opportunity Village Association for Retarded Citizens* operated a school for severely retarded children who were not served by the public school system. As special education services expanded in Clark County public schools, the Opportunity Village school program was phased out. In historical sequence, there was a need filled by the private sector followed by application of pressure on the public school sector to recognize the right of handicapped children to have an education, and finally, gradual inclusion of the services in the public school sector.\(^4\)

The *Ormsby Association for Retarded Citizens* served 12 children and 8 adults in November 1974 with a staff of 18, including a social worker, a half-time speech therapist, a part-time physical therapist, two teachers, one teacher’s aide, and volun-

\(^4\) NRS 435.240 and 435.290 as amended by SB374 and SB298, respectively, 1975, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 10, 1976.

\(^4\) Nevada Division of Mental Hygiene and Mental Retardation, *Operating Regulations* ... "

\(^4\) The $2400 figure is obtained assuming an average salary of $10,000 a year divided by the five children maximum per staff member, plus $400 for other direct operating expenses. This excludes all facility costs and hence is a low estimate. Information on the Title XX Funds was provided by J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, February 10, 1976.

\(^4\) Interview with M. Carroll, Community Training Center Coordinator, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, October 7, 1974.

\(^4\) Ibid.

\(^4\) Interview with Dr. T. Johnson, Executive Director, Opportunity Village Association for Retarded Citizens, Las Vegas, Nevada, July 17, 1974.
teers. Although the center is in Carson City, which is in Ormsby County, adjoining Douglas County provides $24,000 annually and one special education teacher for the center, and sends four retarded children of school age. In addition to serving school-age children, the Ormsby center operates a preschool program for children who are too young for attendance in public school or who are functioning at a developmental level inappropriate to a classroom situation. The center provides transportation.

The Panaca Community Training Center is primarily a sheltered workshop and training facility for retarded people beyond school age, although one preschool-age child was being served in late 1974. At the time we obtained this information, an attempt was being made to have the child served in a more appropriate school setting.

In 1973 the Washoe Association for Retarded Citizens phased out the child development center for mentally retarded children it formerly operated, as the local school district accepted the responsibility for serving those children.

The White Pine County Rehabilitation Center is a daily living and prevocational skills training center for developmentally disabled adults, although in late 1974 one 14-year-old was attending. The child was not in public school because of a conflict between the child’s family and the school. According to the state Community Training Center Coordinator, there is no appropriate service program in Ely for that child.

The Zion Methodist Day Nursery, a preschool program in Las Vegas, integrates functionally retarded and some mentally retarded children with nonhandicapped children, and also supplements the retarded children’s preschool program with some small-group work. The day nursery serves approximately 150 children (handicapped and nonhandicapped) with a staff of 14 teachers and 10 foster grandparents. Most of the teachers have no formal training in education. Of the 150 children, 38 are diagnosed as “functionally mentally retarded.” Rediagnosis takes place once a year.

Child’s World, a private day-care and training program for both preschool-age handicapped and nonhandicapped children sponsored by the Economic Opportunity Board of Washoe County, served 9 mentally retarded children in 1974. It did not receive funding from the state Community Training Centers program in 1974, and was closed in July 1975.

SPECIAL CHILDREN’S CLINICS: PRESCHOOL EDUCATION

The two Nevada Division of Health Special Children’s Clinics for young men-

---

46 Interview with S. Landis, Ormsby Association for Retarded Citizens, Carson City, Nevada, November 15, 1974.
49 Description of Community Training Center Program, Ormsby Association for Retarded Citizens Developmental Center, submitted to the Nevada Division of Mental Hygiene and Mental Retardation, 1974.
50 Interview with M. Carroll.
52 Interview with M. Carroll.
53 Interview with M. Bennett, Zion Methodist Day Nursery, Las Vegas, Nevada, October 26, 1974.
tally retarded children provide diagnosis, counseling, and direction services, and each also operates a nursery school and an infant stimulation program.55

Each clinic runs a part-day nursery school to which children diagnosed as needing its services are referred. The nursery schools served about 20 children each in 1974, 10 in the morning and 10 in the afternoon, for about two-hour sessions. As can easily be imagined, the waiting lists were long in 1974, since the public schools did not serve preschoolers prior to the fall of 1975 (except for a few at the Helen J. Stewart School in Las Vegas). In March 1976, the Washoe County School District was supplying one additional teacher for a cooperative preschool program located at the Northern Nevada Special Children's Clinic, and the Southern Nevada Special Children's Clinic was phasing its 3 and 4 years old preschoolers into the Clark County school system. The 1976 Northern Nevada Special Children's Clinic nursery school, and both the Northern and Southern clinics' infant stimulation programs use their personnel not only to help the child, but also to train the child's parents. Thus, parents learn how best to help their retarded child, while the clinic makes the maximum use of its limited teaching resources.

As currently established, with the exception of the traveling diagnostic team (described in Chap. 6) both clinics' preschool programs effectively are limited to Reno and Las Vegas residents. The operating expenditures for the clinics' preschools are not itemized separately in their budgetary material, but assuming they are approximately the same per unit (professional) as the average of the Clark and Washoe County school district expenditures, the two clinics expended approximately $53,000 on the preschool program in FY 1974.

NEEDED IMPROVEMENTS IN SPECIAL EDUCATION AND TRAINING PROGRAMS

Problems

Although Nevada's special education and training programs are improving, several problems with those services for mentally handicapped children and youth can be identified from inspection of the program descriptions presented earlier in this chapter. They include insufficient funding and service (less than half of those conservatively estimated to be in need are served); inequities in service by type of mental handicap (services specifically for seriously emotionally disturbed children are nonexistent in most Nevada counties and are provided to a token number in a very few other counties); a questionable allocation of about half of the limited available special education resources for services to mentally handicapped people to people with the generally less severe "educational handicaps"; differential service by sex (boys outnumber girls in special education in Nevada two to one, and we seriously question whether there are twice as many handicapped boys as handicapped girls in the general Nevada population); and inequities in service by geogra-

55 Information in this section is based on interviews with Drs. J. Ashbaugh and J. Edwards, Directors of the Southern and Northern Nevada Special Children's Clinics, respectively, 1974, on a letter from J. Edwards to The Rand Corporation, Santa Monica, California, February 26, 1976, and on a letter from J. Owen, Director, Southern Nevada Special Children's Clinic, Las Vegas, Nevada, to The Rand Corporation, Santa Monica, California, February 27, 1976.
phy (for all handicapped children in the remoter rural areas of every county, and for trainable and more severely mentally retarded children in the entirety of all but a few counties). Those problems also include insufficient attention to the transition from school to adult services (e.g., to the Vocational Rehabilitation program if those services are needed); lack of programs in schools for identification of all mentally handicapped children needing services (none of the three largest school districts, which contain three-quarters of the state's school-age population, has a screening program reaching all children); lack of direction to other service providers (see Chap. 4); and lack of information (at the state level, even the number of mentally handicapped children in special education is not accurately known, and quantitative data on the effectiveness of Nevada's special education are virtually nonexistent). Finally, there is a problem of an inadequate number of professional staff to manage the special education program at the state level (only two consultants), and of tripliation of preschool education responsibility at the state level (among the Department of Education, the Division of Health, and the Division of Mental Hygiene and Mental Retardation). Of all the problems listed, the greatest by far is the large fraction of seriously emotionally disturbed and mentally retarded children who receive no special education at all.

Special Education and Training Recommendations

The primary concern, then, is to expand special education services and make them available to all seriously emotionally disturbed and all mentally retarded children and youth who need them, as is required by law. It may clarify the following discussion if we mention two factors that will not impede that expansion.

First, the major current factors limiting expansion of services do not include the inability to hire qualified special education teachers. Although the problem is more difficult in rural counties, administrators we interviewed in the larger counties (with over three-quarters of the population) and in rural Churchill County said they had no difficulty in hiring special educators.

Second, the major factors limiting service do not include insufficient dollars per special education unit supplied by the state; the financial incentive was strong enough to induce the counties to use all available units when $14,500 was supplied per unit, and the amount was raised to $16,000 in 1975. The average annual operating expenses shown in Table 7.1 are approximately $27,000 per special education unit (professional). Since the $11,000 difference between $16,000 and $27,000 is about $1000 per handicapped child served by the unit, or about the same as the $1000 for a special education child above the expense of regular education for a mentally handicapped child above the expense of regular education.

---

56 Washoe County officials we interviewed claim their county does not establish additional special education units using county funds exclusively because of strong budget pressures in other areas. A situation that we suspect exists in most Nevada school districts. One pressure mentioned was the demand by the strong Washoe County teachers' organization for salary increases.

57 The average number of special education students per unit is about 11. See Table 7.1.

for a nonhandicapped child. Consequently, we do not recommend increasing the $16,000 per unit state support level, except as future inflation may require.56

In our view, the two factors most responsible for restricting the number of mentally handicapped children receiving special education are: (1) the limited number of units for which the state will provide financial support, and (2) the lack of identification programs for mentally handicapped children in the county school districts.

We reiterate our Chap. 6 recommendation that a comprehensive screening program be established in every county school district to identify all mentally retarded and seriously emotionally disturbed children in need of special education services. Obviously, a school district cannot serve mentally handicapped children if it does not know who they are. Churchill County already has a commendable screening program for every child entering the school system (both kindergarteners and transferees). We suggest that the identification program reach all children first entering the school, and provide for a one-time review of all children when they reach a selected elementary school age (perhaps 7 or 8 or 9 years old) to identify any who were missed earlier or whose mental problems developed in the intervening years. See Chap. 6 for details. The tertiary prevention of mental handicaps by providing early special education is discussed in Chap. 5.

In FY 1974, the enrollment by sex in special education was 2271 males and 1152 females.60 The total school population in the state is split about evenly between boys and girls; we seriously question whether the 2 to 1 ratio of boys to girls in special education reflects the actual prevalence of handicapping conditions in children. Perhaps handicapped boys are more likely to be "trouble makers" in class than handicapped girls are, and hence the regular teacher is more likely to refer them for special education. The improved identification program we recommend should enable school officials to halt any sex discrimination that may be afoot.

We recommend that the state finance an additional 230 special education units above FY 1974 levels specifically for seriously emotionally disturbed children, and an additional 163 units specifically for mentally retarded children. This would furnish special education to a total of 2650 seriously emotionally disturbed children and 3030 mentally retarded children, with the same average teacher-to-student ratio shown in Table 7.1. If more or less than those numbers of handicapped children are identified by the screening program we have recommended, the number of special education units can be adjusted accordingly. While it is desirable to place a ceiling on the number of units to prevent unnecessary labeling of children who do not have substantial handicaps, and to control costs, the Nevada Legislature has been ambivalent in mandating special education for all handicapped children but failing to allocate funds to cover the expense. The legislature did significantly increase the number of units in 1975, however, and thus continued the growth of the special education system. Since special education of all handicapped children is legally required in Nevada, we suggest a state goal of having every handicapped youth in special education by 1980. While spreading the action over a five-year period does

56 The alternative mechanism of having the state pay the exact amount of added costs of special education above the cost of regular education is not endorsed because of the expense and red tape of the separate accounting system that would be required, and because it is felt that some counties might load the special education budget with overhead.

not solve the problem of unmet needs immediately, it will allow time to identify the children in need, to modify facilities and retrain personnel, to hire high-quality new special education teachers, and to develop transportation. (A lawsuit also has been filed in Nevada to force the provision of special education to all handicapped children; this is essentially the same lawsuit that has been won in other states on constitutional grounds.)

Inequities in service by type of handicap may be only partially resolved by increasing the number of units funded. Under current definitions used in Nevada education, children with significantly different service needs are lumped together under the term "educationally handicapped." The term is so broad that large numbers of children could find themselves labeled unnecessarily, and many children who do not have substantial handicaps (e.g., children who need only remedial reading) might be placed in special education, while those with substantial handicaps might go unidentified and unserved if funds are not earmarked for them. We recommend that the definitions of handicapping conditions issued by the Nevada Department of Education be made more specific, that limits be placed on the number of units by type of handicap, including seriously emotionally disturbed children as a separate category, and that all special education standards be enforced.

We recommend that the special education staff of the Nevada Department of Education be significantly increased to at least 10 full-time-equivalent professional staff members so that they can adequately provide guidance and consultative technical assistance to rural county school districts, and so that they can adequately manage their major responsibilities in the area of special education. The two consultants who currently make up the state special education professional staff are to be commended for the fine job they are performing, but they are only human; a much larger staff is needed.

Since it is not reasonable to expect the rural school districts to have, on their full-time county staffs, all of the specialized and expensive special education expertise they may need, the Nevada Department of Education should provide for consultation and technical assistance to rural special educators.

Specifically, we recommend three teams be created with Department of Education funding to provide consultative technical assistance to special education personnel in rural Nevada. Two of the teams would be based in Reno and Las Vegas so as to tap the professional talent available at the university and elsewhere in those two cities; they would serve rural areas in northwestern and southern Nevada. The third team would provide consultative assistance to rural eastern Nevada counties; it might be based at a Special Education Center in, say, Elko or Ely; one center with a well-trained and specialized staff in rural Nevada would be preferable to several poorly staffed ones. Staff at these centers could provide consultation upon request by rural county school districts regarding such matters as diagnostics and planning for individual children, and special education methods and materials. They could also provide in-service training for local special educators.

Some of this consultation service is already provided, but not on a long-term basis with stable funding. For example, University of Nevada professors report

---

enthusiastic response to three- or four-day short courses followed by assignments and a return visit in about a month. Summer traineeships and workshops are also available. On a more regular basis, the University of Nevada at Reno has a full-time "circuit-rider" who provides special education consultation services to teachers in several rural northern Nevada counties. He works with the teachers, only on referrals through school principals, in setting up programs for individual children; he also provides some special education materials. Although federally funded, he is really doing work that the Nevada Department of Education could provide on a long-term basis for all rural Nevada counties. He assists not only special education teachers, but also some regular education teachers. For example, one school he assists consists of a regular teacher, seven nonhandicapped students, and one handicapped student attending in a house trailer that also serves as the teacher's residence. The "circuit-rider" returns regularly to do follow-up with the teachers he assists, and sees a teacher one to three times every two months. Regarding areas of deficiency in rural special education, he noted the problems of serving severely handicapped children, and the fact that there is essentially no service for emotionally disturbed children.

For the most severely handicapped children, the highly specialized programs and personnel needed generally are not now available in rural Nevada. Since only a small number of such children are to be found in any given rural area, and specialized personnel to serve them are scarce, it would be expensive to provide a high-quality program for all types of severely handicapped children in each rural county. In practical terms, the family that wants high-quality specialized services for their severely handicapped child may be better off moving to Reno or Las Vegas if it is feasible for them to do so; or if the family lives in a county near Reno or Las Vegas, perhaps the child could go to one of those cities for schooling and return home each weekend.

In-service training and advice to rural special education teachers can also be given by means of telephone and television (regular TV, two-way videotelephone, or video tape). The exemplary Helen J. Stewart special school in Las Vegas, for example, has videotape equipment and taped materials for use in the special education training of teachers of trainable severely and profoundly retarded children. Copies could be made at relatively low cost for use in staff and parent training in rural areas, which thereby could capitalize on the specialized knowledge available in the larger Clark County school system. The Nevada Department of Education could provide funds and staff to disseminate these materials and to prepare additional ones. After an in-service training class has viewed a videotaped lesson, a professor at the University of Nevada or some other special education specialist could answer their questions by telephone.

For education and training of mentally retarded persons at the Nevada Mental Health Institute, we recommend that (1) nearly all mentally retarded residents be provided special education and training services appropriate to their level of development; (2) those special education and training services be provided away from the institutional setting for nearly all residents; and (3) a teaching aide and adequate equipment and materials be provided for each special teacher. The present numbers

---

62 Interview with Prof. W. Wagoner, University of Nevada, Las Vegas, October 24, 1974.
63 Interview with W. Green, University of Nevada, Reno, November 21, 1974.
64 Ibid.
of teachers, aides, equipment, and materials are inadequate in relation to the clear
need. Service away from the institutional setting would enhance the education,
training, and quality of life of residents by giving them wider exposure to the normal
situations and experiences of everyday life.

The Community Training Center program as presently operated is a dichoto-
moid entity that provides two basically different kinds of service to mentally re-
tarded people: a preschool program, and a day care, activities of daily living, prevoc.
tional, and vocational (including sheltered work) program for the more severely
mentally retarded people about age 18 or above.

Since the age range for mandatory special education of mentally retarded chil-
dren by the public school system was lowered to age 3 in 1975 by the Nevada
Legislature, we recommend that the preschool portion of the CTC program in rural
areas focus on developmental stimulation and training for the more severely retarded
children below age 3 only. In the Las Vegas and Reno areas, we recommend that the
Community Training Centers serve only adults, leaving developmental stimulation
and training for the more severely retarded children below age 3 to the Special
Children’s Clinics. These changes in focus will decrease the present fragmentation
and triplication of responsibility for preschool special education and training pro-
grams.

For the CTC program, we estimate the cost per enrollee per year to provide
minimum quality services is currently two to four times as high as the minimum
level of funding per client the CTC program provides.65 However, primary funding
for some clients at these centers is provided by a county school district or by the
Vocational Rehabilitation program. We recommend that the Community Training
Center minimum funding level per enrollee be at least doubled for those clients not
primarily funded by some other agency.

The Nevada Division of Health’s Special Children’s Clinic program presently
operates two small nursery schools and infant stimulation programs, primarily for
mentally retarded preschool children who were not served by the county school
districts in FY 1974. Since the Nevada Department of Education, as a result of 1975
legislation, requires the special education by public schools of 3- and 4-year-old
mentally retarded children, we recommend that the Special Children’s Clinic pro-
gram transfer their nursery school children of those ages to the county school districts
and concentrate their very limited resources on identification of preschool-age re-
tarded children, direction of their families to other service providers, counseling of
families with retarded children, and developmental stimulation and training for the
more severely mentally retarded children below age 3.

The parents of retarded preschool children are a potential source of develop-
mental training assistance. To make the maximum use of limited teaching re-
sources, and to help the parents learn how best to help their retarded children
develop, each preschool special education and training program for retarded chil-
dren might also offer training for parents. The northern Nevada Special Children’s
Clinic is already doing this with apparent high success; it could be extended, and
parents could be a source of assistance in the classroom during their training.

65 Funding is a minimum of $1200 per enrollee per year ($300 per quarter), while the staff-to-enrollee
ratio must be 1 to 5 or better. If the average staff salary is only $10,000 per year, the salary cost alone
per enrollee is $2000 per year. The Nevada Association for Retarded Citizens estimates that the present
CTC funding covers only 19 percent of the cost (as reported in “Retarded Patients to Attend Hearing,”
Regarding interaction of education with other service programs, we recommend improved referral from special education to other programs serving mentally handicapped children and youth. In particular, we recommend increasing the number of referrals to Vocational Rehabilitation of mentally handicapped youth well before they leave school, and increasing the number of referrals of seriously emotionally disturbed children and youth (whether or not they are in special education) to the local mental health center, rural mental health clinic, or Children's Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other programs exist to provide those services. These referrals could all be made and followed up by Direction Centers, if they existed. In the event that other programs do not have adequate resources to serve all those in need of service, then priorities should be established and all referred youth should be screened so that high priority needs are met first.

Because available information on special education and training in Nevada is inadequate for effective program management, accountability, evaluation, and planning (recall that we are not even sure exactly how many mentally handicapped children are in special education), we recommend that improved program management and effectiveness information be obtained for each Nevada special education and training program. With available data, it is not possible to say precisely how much different children benefit from special education, or what the returns per dollar expended are for different types of mentally handicapped youth in Nevada.

Looking at the four basic options displayed in Table 7.5, note that if Nevada does no more than maintain, until 1985, the status quo level and quality of special

Table 7.5
ALTERNATIVE SPECIAL EDUCATION SERVICE LEVELS FOR MENTALLY HANDICAPPED NEVADANS, 1974 AND 1985

<table>
<thead>
<tr>
<th>Number Served and Expenditures</th>
<th>Status Quo</th>
<th>Reallocation of Resources</th>
<th>Geographic Equity</th>
<th>Minimal Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain 1974 level of services per capita</td>
<td>Shift status quo level of resources among and within programs</td>
<td>Raise level of services per capita in each of three regions to level of best-served region</td>
<td>Provide current quality services in each program to meet conservatively estimated need per capita</td>
<td></td>
</tr>
<tr>
<td>Mental health (emotionally disturbed)</td>
<td>100</td>
<td>133</td>
<td>100</td>
<td>133</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>1644</td>
<td>2186</td>
<td>1644</td>
<td>2186</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other mental (educationally handicapped)</td>
<td>1987</td>
<td>2640</td>
<td>1987</td>
<td>2640</td>
</tr>
<tr>
<td>Total</td>
<td>3731</td>
<td>4959</td>
<td>3731</td>
<td>4959</td>
</tr>
<tr>
<td>Expenditures (in $ million)</td>
<td>$9,346</td>
<td>$12,43</td>
<td>$9,346</td>
<td>$12,43</td>
</tr>
</tbody>
</table>

*These are total expenditures for regular and special education and training of mentally handicapped children; they are not solely expenditures above those that would be made for regular education of these children if they were not mentally handicapped.
education and training services per capita and the same programs, the expenditures will rise from $9.3 million to $12.4 million per year (see Table 7.5). There are several ways to implement the option of reallocating resources within and among the special education and training programs without increasing total annual expenditures beyond the status quo. The example shown in the table indicates no major change in the number of each type of children served; this would allow implementation of several of our relatively inexpensive recommendations. Another example, not shown in the table, might result from state or local decisions to shift some existing special education funding from, perhaps, educationally handicapped to seriously emotionally disturbed or mentally retarded children. The geographic equity option of raising the level of service per capita of emotionally disturbed and mentally retarded children in each program in each of the three major regions (Clark, Washoe, and all other counties combined) to the level prevailing in the region with the best service would result in about an 11 percent increase in expenditures. The minimal need option assumes implementation of all our recommendations; and gross expenditures for all regular and special education and training services for these mentally handicapped youth roughly double in that option (from $9.3 million to $19.7 million\textsuperscript{44}), primarily because so many mentally handicapped children in need of special education and training are not being provided any special services now. Thus, the estimated gross annual increase in education and training expenses for these children would be $10.4 million. The estimated net increase in total expenditures for educating these mentally handicapped children would be an estimated $6.6 million per year above FY 1974 expenditures, after deducting regular education expenditures that would no longer be required for these children. The annual total education expenditures to meet the minimal need would rise with population growth to about $26 million in 1985 (in 1974-value dollars).

\textsuperscript{44} The cost of implementing the identification recommendation is counted in the identification chapter, and is not included in the total here.
Chapter 8
NONRESIDENTIAL MENTAL HEALTH SERVICES

INTRODUCTION

Nonresidential mental health services discussed in this chapter include outpatient, emergency care, and day-treatment psychological services. They are delivered in Nevada primarily through mental health centers, Children's Behavioral Services programs, Rural Clinics, Suicide Prevention and Crisis Call lines, by psychological counselors in schools, by the Air Force and Veterans Administration, and by psychiatrists and psychologists in private practice. Residential treatment services for mental health disorders are discussed in Chap. 10. Some people receive nonresidential mental health services following 24-hour inpatient treatment at the Nevada Mental Health Institute (NMHI); not a major program in 1974, it is described in the section of Chap. 10 on mental health services at the Institute.

In this chapter, we first present an overview of nonresidential mental health services in Nevada, and then present details of each of those Nevada programs and their problems. Following that, we discuss Nevada’s programs in relation to desirable features of a mental health service system. Basically, we take the eclectic position that people experience a variety of kinds of mental health problems which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency. We conclude this chapter with recommendations for improvement.

We have estimated that, in 1975, at least 11,000 Nevadans had significant mental health disorders that result in a substantial need for psychological or psychiatric services. That figure is a conservative minimum estimate; the true figure may be as much as five times that, or 55,000 people. (See Chap. 3 for definitions and prevalence data.) The major nonresidential mental health service programs intended to meet those needs, as shown in Fig. 8.1, are operated by professionals in the private sector, by the Nevada Division of Mental Hygiene and Mental Retardation, by the Nevada Health Division, by Nevada education agencies, and by the Federal Government. Some of the programs shown in the figure are small components of larger agencies whose primary concern is not mental health services, such as those serving Indians and mentally retarded people. The two predominant segments of the nonresidential mental health service system intended to meet those needs are the private psychiatrists and psychologists, and the Nevada Division of Mental Hygiene and Mental Retardation.

Table 8.1 is a summary of the FY 1974 estimated caseload, staff, and expenditures for these nonresidential mental health service programs. A total staff of about 171 people provided services in person to a maximum caseload of about 10,500; another approximately 6800 callers to Suicide Prevention and Crisis Call Centers
Fig. 8.1—Organization of major nonresidential mental health service programs in Nevada
### Table 8.1
**Summary of Major Nonresidential Mental Health Services in Nevada, FY 1974**

<table>
<thead>
<tr>
<th>Program</th>
<th>Estimated Caseload</th>
<th>Estimated Total Staff (full-time equivalent)</th>
<th>Estimated Annual Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Las Vegas Mental Health Center</td>
<td>2,184</td>
<td>44</td>
<td>$582,000</td>
</tr>
<tr>
<td>Henderson Mental Health Center</td>
<td>570</td>
<td>6.5</td>
<td>$128,000</td>
</tr>
<tr>
<td>Reno Mental Health Center</td>
<td>900</td>
<td>23.5</td>
<td>$375,000</td>
</tr>
<tr>
<td>Rural Clinics</td>
<td>1,200</td>
<td>23</td>
<td>$443,000</td>
</tr>
<tr>
<td>Children’s Behavioral Services</td>
<td>600</td>
<td>17</td>
<td>$168,000</td>
</tr>
<tr>
<td>MH service programs in education agencies</td>
<td>700</td>
<td>&lt;9</td>
<td>&lt;$150,000</td>
</tr>
<tr>
<td>Private psychiatrists and psychologists</td>
<td>4,200</td>
<td>26&lt;sup&gt;a&lt;/sup&gt;</td>
<td>$1,400,000</td>
</tr>
<tr>
<td>Suicide Prevention and Crisis Call Centers</td>
<td>6,780&lt;sup&gt;b&lt;/sup&gt;</td>
<td>20</td>
<td>$12,000</td>
</tr>
<tr>
<td>Federally operated programs for Indians and the military</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MH service programs for mentally retarded people</td>
<td>≤100</td>
<td>&lt;2</td>
<td>≤$50,000</td>
</tr>
<tr>
<td>Total in person&lt;sup&gt;c&lt;/sup&gt; served</td>
<td>&lt;10,454</td>
<td>171</td>
<td>$3,308,000</td>
</tr>
</tbody>
</table>

**NOTES:** See text of chapter for sources of data and methods of estimation.

<sup>a</sup>Professionals only.

<sup>b</sup>Includes all people served, some fraction of whom do not have substantial mental health disorders.

<sup>c</sup>Includes an unknown amount of double-counting due to people admitted to a program more than one or admitted to more than one program in a year.

were served by telephone. To some degree, however, these numbers represent apparent rather than actual achievement for the mental health service system. For reasons given immediately below, the number of different people with mental health disorders served in person in FY 1974 is significantly less than 10,500; one cannot conclude that nearly all 11,000 people needing substantial psychological or psychiatric services (our minimum estimate) are being served. The 10,500 figure is a count of the number of cases served by the various agencies, and includes: double-counting if people were served by more than one agency in a year or were admitted to the same agency’s program more than once; counting of people served who do not have substantial mental health disorders (e.g., some parent-effectiveness trainees in the Children’s Behavioral Services program, some consciousness-raising group participants at the University of Nevada, some mildly neurotic people served by private professionals, and various types of people served by Rural Clinics, such as those receiving premarital counseling); and counting of people who are not really served (e.g., those who are counted as cases but who do not return after an initial intake interview—33 percent of outpatient cases at the Las Vegas Mental Health Center are of this type). Finally, cases reported by the agencies may represent people served who have substantial mental health disorders, but who were inappropriately served...
due to nonexistence of a service they needed such as day treatment, or inadequately served by a relatively unskilled and untrained mental health technician.

We could not accurately determine what fraction of the 10,500 cases reported as served by the programs represented different people with substantial mental health disorders who were adequately served, so we have reported the maximum 10,500 figure and caution the reader as to its meaning.

Table 8.2 presents the estimated caseloads for nonresidential mental health services in the three major areas of the state. There is a major difference in the total amount of nonresidential mental health service delivery per capita by geographic region; rural counties have a combined public and private caseload of about 11 per 1000 population, Clark County has about 17 per 1000, and Washoe County has about 26 per 1000. The relatively underserved rural areas of the state receive almost no service from private psychiatrists and psychologists; most of the service that is provided comes from the state Rural Clinics mental health program, which has a seriously deficient staff. Clark County is better served on a cases-per-capita basis, and Washoe County is best of the three by far on that same measure. However, that measure does not reveal the fact that in Washoe County the mental health center provides only a limited range of services that are not appropriate for all persons’ needs; it does not provide a needed day treatment program or 24-hours-a-day emergency care, for example. This major difference in the level of service per capita in

<table>
<thead>
<tr>
<th>Program</th>
<th>Clark County</th>
<th>Washoe County</th>
<th>All Other Counties Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Per 1000 Population</td>
<td>Total</td>
</tr>
<tr>
<td>Las Vegas MHC</td>
<td>2184</td>
<td>6.9</td>
<td>0</td>
</tr>
<tr>
<td>Henderson MHC</td>
<td>570</td>
<td>1.8</td>
<td>0</td>
</tr>
<tr>
<td>Reno MHC</td>
<td>0</td>
<td>0</td>
<td>900</td>
</tr>
<tr>
<td>Rural Clinics</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Children’s Behavioral Services</td>
<td>600</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>MH service programs in education agencies</td>
<td>380</td>
<td>1.2</td>
<td>300</td>
</tr>
<tr>
<td>Private psychiatrists and psychologists</td>
<td>1800</td>
<td>5.7</td>
<td>2400</td>
</tr>
<tr>
<td>Suicide Prevention and Crisis Call Centers</td>
<td>2190</td>
<td>6.9</td>
<td>4590</td>
</tr>
<tr>
<td>Federally operated programs for Indians and the military</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MH services for mentally retarded people</td>
<td>&lt;50</td>
<td>&lt;1</td>
<td>&lt;50</td>
</tr>
<tr>
<td>Total in-person caseload^a</td>
<td>&lt;3580</td>
<td>&lt;17.5</td>
<td>&lt;3650</td>
</tr>
</tbody>
</table>

NOTES: See text of chapter for sources of data. NA = not available.

^aIncludes an unknown amount of double-counting due to people admitted to a program more than once or admitted to more than one program in a year.
different geographic regions also exists in the public service system considered by itself, despite the fact that the public service system is state operated.

We now consider each of Nevada's nonresidential mental health service programs and their problems.

LAS VEGAS MENTAL HEALTH CENTER

A major advance in mental health services delivery in the last decade has been the community mental health center (CMHC) movement. Here, as in many other service areas, the intentions of many of those involved in the CMHC movement have been well enough articulated in principle; however, the actual implementation of many of the CMHCs nationwide has differed from the basic principles upon which the movement was based. In principle, a CMHC is to accomplish the following:

- Create local community-based, complementary service alternatives to state mental hospitals.
- Serve all citizens in need in the community, especially poor people for whom private mental health services have been nonexistent or out of reach financially.
- Provide a full range of treatment services, e.g., emergency care available 24 hours a day, inpatient care, day care, partial hospitalization, and outpatient care.
- Create and implement preventive and indirect services, e.g., public education and consultation to other social service providers.
- Integration of mental health servers and services with the other elements of the social service system.

Of these programs called mental health centers in Nevada, only the Las Vegas MHC comes close to being a full-fledged CMHC; the Henderson and Reno MHCs do not even provide a full range of treatment services.

The Las Vegas MHC does provide the full range, including inpatient services to adults and to adolescents over age 12. That residential service is discussed in Chap. 10 in the context of other residential mental health services in Nevada. Las Vegas MHC outpatient, emergency, day-treatment ("partial hospitalization"), and consultation and education services are discussed in this chapter.1

The catchment area "officially" served by the Las Vegas MHC is the western portion of Clark County including the west census tracts of Las Vegas, as well as the towns of Indian Springs, Arden, Goodsprings, and Mesquite. The population in the Las Vegas MHC catchment area is about 105,000, less than half that of the Henderson MHC catchment area. Since the Henderson MHC is very small, it does not offer the complete range of services that the Las Vegas MHC does; in fact, approximately 70 percent of the people served by the Las Vegas MHC actually live in the Henderson MHC catchment area.

The FY 1974 actual expenditures by the Las Vegas MHC were $1,132,000. The

1 Unless otherwise noted, information in this section was obtained during interviews with Dr. L. Miller, T. Burke, and various other staff members and patients of the Las Vegas MHC, Las Vegas, Nevada, in March, July, and August 1974, and from a letter from L. Miller to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.
FY 1975 working budget was about $1.9 million, with a staff of 115. Most of the difference in expenditures between the two years was due to the fact that the center’s staff was not complete in FY 1974; even at the end of FY 1974 the staff actually numbered 90, i.e., only about 80 percent of the authorized staff positions were filled. No new positions were authorized by the 1975 session of the Nevada Legislature. The February 1976 actual staff size was 110.

Of the total staff and budget for the Las Vegas MHC, we estimate in Chap. 10 that about 46 staff members and $550,000 were devoted to residential treatment in FY 1974. Total FY 1974 inpatient admissions were approximately 50 adolescents and 600 adults.

Approximately $900,000 of the FY 1975 Las Vegas MHC funds came from the Federal Government. The funds were part of an 8-year federal CMHC grant that began in October 1973. As time progresses, the grant pays a decreasing percentage of salary costs of most of the center’s employees (dropping from 75 percent in the first two years of the grant to 30 percent in the last four years).

The 31.5 authorized professional service staff positions at the Las Vegas MHC include 4 psychiatrists (2 positions were vacant in mid-1974), 10 psychologists (4 positions were vacant), 7 psychiatric nurses (1 position was vacant), 8.5 psychiatric social workers (1.5 positions were vacant in mid-1974), an occupational therapist, and a recreational therapist. Overall, only three-fourths of the authorized professional positions were filled in mid-1974. The professionals were assisted by numerous paraprofessionals, including 6 psychiatric LPNs, 44 mental health technicians, an occupational therapy technician, and a recreational therapy technician.

The Las Vegas MHC outpatient program had an average monthly census of 106 people in FY 1974, of whom about half were primarily receiving psychotherapy and half were primarily receiving chemotherapy. Of those in the center’s total active registry of clients, over 90 percent were outpatients; the percentage served per month varied from 33 to 42 percent and averaged about 38. There were 13,940 outpatient treatments in FY 1974. New admissions to the outpatient program averaged 151 per month in FY 1974; total new intakes (new admissions plus readmissions) averaged 172. In the first quarter of FY 1975, the average monthly census rose to 1251, and as more professional staff positions were filled the patients primarily receiving psychotherapy rose from about half to 60 percent. New admissions averaged 177 per month in the first quarter of 1975; total new intakes averaged 226. This outpatient program is responsible for follow-up of patients released from the Nevada Mental Health Institute (NMHI) who are Clark County residents.

The outpatient program at the main Las Vegas MHC facility had 8.5 full-time-equivalent staff members in mid-1974: 1.5 psychiatrists, 4 psychologists, and 3 social workers.

As of the summer of 1974, the outpatient program was experiencing a significant drop-out rate in excess of 33 percent between the time of the intake interview and the next appointment, signaling possible difficulties with the intake process. One possible difficulty is that patients are assigned at intake to whoever has the duty at the moment. Normally, at intake, a patient would be expected to spend at least an

---


3 Ibid.

4 Ibid.
hour in consultation with a professional to determine who should be treating him or her on an outpatient basis. This is not done; assignment is best characterized as random. It is desirable to have patients assigned to the staff member whose training and treatment methods seem best suited to the client’s needs. The “luck of the draw” assignment method employed by the Las Vegas MHC outpatient program not only results in inefficient use of the available variety of staff resources, but also deprives the patient of the therapeutic belief that rationality has determined the choice of his or her therapist. Whatever the reason for the drop-outs, at the least one would expect there to be follow-up procedures for those who do not reappear for outpatient services. Such follow-up was not pursued during the period of our observation.

The Las Vegas MHC also operates a satellite office in the westside area of Las Vegas, to increase accessibility of residents in that area to services. In mid-1974 it was staffed by one Psychologist III (a middle-level position requiring a master’s degree), a social worker, 5 mental health technicians, and a public service intern; still unfilled were the only senior professional position at the satellite (for a psychiatrist) and 2 psychiatric nurse positions. The area served has a concentration of black residents, and the satellite office is staffed primarily by blacks. The satellite office eventually will have three units: intake, treatment, and outreach. The treatment unit was still in the “planning stage” at the time of our interviews in mid-1974, although some group therapy was to begin soon. Reportedly, none of the people were receiving individual psychotherapy or chemotherapy at the satellite office. If people were to receive treatment, they somehow had to get to the main Las Vegas MHC facility five miles away; the satellite office usually did not provide transportation to that facility. Problems with the satellite facility included lack of space and lack of a soundproof room for therapy sessions. The activities of the satellite office included consulting with other community agencies, making referrals of clients to other agencies and to the main Las Vegas MHC facility for service, and helping cut juvenile arrests in the neighborhood by assisting in a “community court” where police could send juveniles rather than arrest them. One staffer organized a karate club and another was thinking of starting a Boy Scout troop. Regarding the lack of direct treatment, we note that the staff of the satellite office in mid-1974 really was not fully skilled or trained to provide direct mental health treatment services of the nature of those provided by the outpatient program at the main facility. Also, the office had no senior professional to guide and supervise on a daily basis those staff members who were there.

The average number of patients seen monthly on an emergency basis rose from 23 in FY 1974 to 35 in the first quarter of FY 1975. Emergency mental health services are available on a 24-hours-a-day basis. On weekdays, they are provided by the outpatient program’s professional staff. Nights and weekends, the inpatient staff provides emergency services; senior professionals are on call if needed. If necessary, inpatient services lasting one day or longer can be provided at the same location in Las Vegas.

Day treatment is provided for people who need more intensive treatment or structure than they could receive as outpatients, but who are not so emotionally disturbed as to require inpatient care. The Las Vegas MHC day-treatment program for adults had a half-time senior psychologist position unfilled in mid-1974, but was

---

* Ibid.
functioning quite well. Clients were well known by the staff, and vice versa. Supervision of the technician staff by a psychiatrist and a social worker was adequate. Follow-up procedures were well developed and most of the clients had jobs and/or received follow-up services at time of discharge from the day-treatment program. The recidivism rate was a low 5 percent. The adolescent residential treatment program at the Las Vegas MHC also accepted up to 16 youth at a time (over age 12 years) for day treatment (see Chap. 10 for a program description). The adolescent program also includes the services of a special education teacher provided by the Clark County School District. As detailed in Chap. 10, the adolescent program was not functioning well at the time of our interviews, probably because both key senior professional staff positions were vacant.

Average daily attendance at the Las Vegas MHC for day treatment rose from 10.2 people in FY 1974 to 16.3 people in the first quarter of FY 1975; average new admissions to this program rose from 8.0 to 10.3 for the same time periods.6

The community consultation and education program at the Las Vegas MHC was staffed at a low level by two people in mid-1974: an "education and public information" specialist and one clerical-secretarial support employee. In FY 1974 this program averaged 72 "units of service" per month (a unit of service can be one consultation with one other agency, for example). As described in the Staffing Grant Proposal for the Las Vegas Mental Health Center:

Consultation will serve to provide specific agencies with assistance in maximizing its effectiveness in providing services to individual clients. The effort is a cooperative one with input from the consultant in terms of his unique skills and training. Program consultation will also be provided to aid in program planning and development within an agency seeking such assistance.

Education will provide first for training of personnel in agencies in early identification of mental health problems so as to facilitate early treatment. Secondly, its aim is to increase public awareness of available services, sources, ways of obtaining service, and purpose.

An advocacy program mentioned in the Las Vegas MHC's 1972 proposal for a federal staffing grant did not been staffed in 1974, but has since been developed as an "Advocacy/Aftercare Program" with the major function of providing follow-up services to former inpatients of the Las Vegas MHC and the NMHI, and generally to monitor and implement continuity of care. The program performs some of the same functions as the Regional Direction Centers we propose in Chap. 4.

HENDERSON MENTAL HEALTH CENTER

The area served by the Henderson Mental Health Center was created to conform to the definition of a "catchment area" in federal guidelines. Much of the recent

---

6 Ibid.
7 L. Miller, Las Vegas Mental Health Center, Las Vegas, Nevada, August 30, 1972.
8 L. Miller, Staffing Grant Proposal for Las Vegas Mental Health Center, Las Vegas, Nevada, August 30, 1972.
population growth in Clark County has been in the Henderson MHC catchment area. In FY 1974, the Henderson MHC was serving a catchment area of about 226,000 people with a staff of 6-1/2 (professionals plus support staff) and an annual budget of $128,422. Though 90 percent of the Henderson MHC services are to residents of the catchment area, it is clearly impossible to serve the entire need. In reality, many of those in need were being served at the Las Vegas MHC or by private mental health providers, or received no services at all. Although the Henderson MHC contains some elements of a community mental health center, it would be a misnomer to call the current Henderson MHC a community mental health center; it is not. Without additional staff it is impossible for the current Henderson MHC to provide a full range of services. In contrast, the Las Vegas MHC with federal assistance has a staff of 110 and its catchment area has a population of 105,000, less than half that of the Henderson MHC. As a result, the great majority (approximately 70 percent) of the services at the Las Vegas MHC are provided to clients who reside in the Henderson MHC’s catchment area.

The operations of the Henderson MHC fall short of what one would expect in a mental health center providing a continuum of care. They fall into only three classes: outpatient services to an average monthly client census of about 250 people, half from the Boulder City-Henderson area and half from the Las Vegas area; limited emergency services for walk-in clients or phone calls during the agency’s hours of operation; and consultation and educational services to about 25 Clark County social service agencies in FY 1974. The center averaged about 35 new clients per month in 1974. The total number of people served in FY 1974 was about 570.

A recent addition to the services has been a satellite center in North Las Vegas. The North Las Vegas Counseling Center has a staff of two. After two months of operation, the client load was 29 with nine new clients in January 1976.

Of the clients receiving service at the center in the last six months of 1975, approximately 22 percent were adolescents. Of the adults served, 39 percent came from disrupted families, 20 percent had less than a high school diploma, 24 percent had incomes below $3000 and 4 percent were aged 60 or above.

When we interviewed in mid-1974, behavior modification was the predominant treatment modality used at the Henderson MHC; the center did not employ a full range of modalities. No physician or psychiatrist was associated with the Henderson MHC at the time of our interviews, even as a consultant.

In the 1975 Nevada legislative session, four new staff additions were approved: a psychiatrist, a psychiatric social worker, and two clerical staff members. As of December 1975, services were provided by persons trained in a wide range of disci-

11 The Executive Budget, p. 322.
13 The Executive Budget, p. 323.
14 "Community Mental Health Center, East Clark County."
15 Information provided by H. Clemens, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.
plines. Psychological services were provided by a doctoral level clinical psychologist and a master's level person trained in behavior modification. Psychiatric services, including chemotherapy, were provided by a board-eligible psychiatrist. A master's level social worker and another bachelor's level staff member round out the clinical staff. Other staff qualifications included training in nursing and

In an overall sense, the biggest problem with the Henderson MHC was its very small size in relation to the majority of the Clark County population it is supposed to be serving.

RENO MENTAL HEALTH CENTER

The Reno Mental Health Center in theory is responsible for mental health services for some 140,000 people who live in Washoe County. However, it does not offer a complete range of services and is not a full-fledged community mental health center in the sense that the Las Vegas MHC is, which has a staff nearly five times as large as that of the Reno MHC.

The Reno MHC has an authorized staff level of 23.5 positions, including 1 administrator, 10 other professional positions, 9 mental health technicians, and 3.5 clerical and secretarial positions. Although the staff is insufficient in size to meet service needs and 9.5 new staff members were requested, no new positions were approved during the 1975 legislative session. The FY 1974 budget was $375,252. The center charges for its services on a sliding scale, with those unable to pay not being charged.

The Reno MHC provides adult outpatient services to Washoe County residents at a small downtown Reno facility (staffed by three professionals in mid-1974), day treatment services to children and adolescents at another facility on the outskirts of Reno (staffed by 3 Reno MHC professionals, the mental health technicians, and 2 teachers paid with federal P.L. 89-313 education funds), and limited preadmission screening and postdischarge outpatient follow-up services to Washoe County residents by a Reno MHC "Transition Unit" at the NMHI (staffed by 2 professionals in mid-1974). The center also had a small "Community Education Consultation Unit," staffed by 2 professionals. By early 1976, as detailed below, significant changes in staffing had occurred by means of reclassification of existing paraprofessional positions as vacancies occurred and by staff reassignments and transfers. No overnight or longer residential services are provided by the Reno MHC.

The new Children's Behavioral Services staff provided by the 1975 legislature will work in conjunction with the Reno MHC staff while the new CBS facilities are being constructed.

The Reno MHC active caseload at one point in time in late 1974 included over 650 people, of whom about 150 were children, adolescents, and their families. In FY 1974, 1200 different people applied for services. Since the FY 1974 turnover of

---

19 The Executive Budget, p. 312.
19 Ibid.
18 Information in this section was provided by R. Keiffer, Clinic Administrator, and by various other staff members of the Reno Mental Health Center, in interviews conducted between April 22 and November 22, 1974, and in a letter from R. Keiffer to J. Kakalik, The Rand Corporation, February 27, 1976.
20 The Executive Budget.
patients typically was 60 to 90 a month, the total number of people served annually is on the order of 900.

The Reno MHC Adult Outpatient Unit was staffed by a psychiatrist, a clinical psychologist, and a psychiatric social worker in mid-1974. It served primarily people with urgent needs, in the opinion of the center's administrator, who cited acute hospital-prone and suicidal cases as examples. Those with lesser needs were usually not accepted for service; they accounted for about one-third of those who applied for service. The social worker provided screening and initial intake interviews of applicants for mental health services, as well as therapy for a very few people. The psychiatrist served an active caseload of about 160 clients, the majority of whom were said to be schizophrenic (about three-fourths of the people on his active caseload were primarily receiving chemotherapy). The psychologist had an active caseload of about 33 (all primarily receiving psychotherapy). In mid-1974, no one answered the Reno MHC telephone at times other than 8 a.m. to 5 p.m. on weekdays. At other times, callers were automatically referred by a recorded message to the Nevada Mental Health Institute and to the Suicide Prevention and Crisis Call Center in Reno. The Reno MHC telephone is now answered 24 hours a day, but even emergency services are not provided other than on weekdays from 8 a.m. to 5 p.m. In early 1976, the Adult Unit professional staff consisted of 3 master's level psychiatric social workers, 1 master's level psychologist, 1 Ph.D. level psychologist, and a full-time psychiatrist.

The Reno MHC Family Unit consists of an outpatient section, which serves youth and their families, and the Crossroads School, which is a day treatment program for about 25 severely emotionally disturbed children and adolescents who cannot be served adequately by the existing special education program in the Washoe County schools, but who do not need full residential treatment services. Recall that the Washoe County schools offer almost no special educational services for emotionally disturbed children (see Chap. 7); those emotionally disturbed children are not served in the public schools with an appropriately trained teacher. The Reno MHC thus provides outpatient mental health services to students able to function in existing regular or special education programs in a regular school, and provides a special school with mental health services for those who are not. Demand for services from the Family Unit far exceeds the supply; although 60 percent of the applicants in early 1974 were not accepted, there was a waiting list of about 50 accepted applicants in mid-1974. A chemotherapy program serving about 55 children monthly had to be terminated temporarily because of a lack of psychiatric staff. In July 1974 the Family Unit served about 200 children and 50 parents (the annual total is about 300 children and youth), with a professional staff of 1 psychiatric nurse, 1 social worker, and 3 teachers. Problems with the Family Unit included its small size, the assignment of all outpatient work to only one employee (the psychiatric nurse), the use of 9 relatively unskilled and untrained mental health technicians in the day treatment program, the lack of professional input to the program by psychologists and psychiatrists (at most a total of about a half-day per week was available to the Family Unit from people with those professional backgrounds), the lack of service to children who did not have private transportation to the facility and to children whose parents would not come in for therapy sessions, and operation in an office building that was not really designed to be a service facility. Major staffing changes have occurred during the past year in this adoles-
cent/family unit. As of early 1976, the staff included a full time psychiatrist and a full time Ph.D. clinical psychologist; two master's level psychiatric social worker positions had been authorized.

The Reno Service League operates a Behavioral Treatment Center for 40 pre-school children per week in the same facility used by the Reno MHC Family Unit's day treatment program for older children and adolescents. A psychologist from the Reno MHC consults with the Behavioral Treatment Center and helps train the Service League women who work there.

The Reno MHC Transition Unit at NMHI, with only a psychiatrist and a social worker plus a half-time secretary for staff, was unable to fulfill its assigned responsibilities adequately (see Chap. 10 for details). Screening of people by the Reno MHC before admission to NMHI was rudimentary at best, supplied the NMHI staff only with the name, age, and sex plus a recommendation regarding admission of the applicant, resulted in nonadmission of only about 10 percent of those screened, and duplicated a later NMHI screening that probably would not have passed most of that 10 percent anyway. Reno MHC predischarge planning and interaction with NMHI patients was minimal; follow-up after discharge was not provided to all Washoe County residents; and 75 percent of those followed up primarily received chemotherapy. In July 1974, the active caseload of the Transition Unit was about 140. The average number of new patients seen by the unit per month was about 30 in early 1974. In 1975, NMHI's dissatisfaction with the follow-up of released patients by the Reno MHC led to the development of plans for the NMHI to provide its own follow-up for Washoe County residents (see Chap. 10 for a description of Reno MHC Transition Unit operations in 1974 and the NMHI plans for 1975). The Reno MHC Transition Unit was phased out in November 1975 and the staff transferred to the 560 Mill Street office.

The Reno MHC Community Education and Consultation Unit, with a clinical psychologist and a half-time teacher for staff in late 1974, operated a branch office at Lake Tahoe a half-day a week, and regularly visited community agencies such as the police, the parole agency, the child detention center, Head Start programs, and the schools, to provide consultation and to refer potential clients back to the Reno MHC facility for diagnosis and possible treatment. Staff members of the unit conducted in-service training classes of 4 to 16 hours total duration for teachers, school counselors and nurses, police, probation officers, and public health nurses on how to handle behavior problems in youngsters. Press releases also informed potential clients of the center's services. Since 1974, this Community Education and Consultation Unit has been phased out and its staff reassigned to strengthen other units of the Reno MHC. The Adult and Adolescent/Family Units now carry the community education and consultation responsibilities.

**RURAL CLINICS**

Service delivery in sparsely populated rural areas is a nationwide problem of consequence, and delivering mental health services in rural Nevada is no exception. Delivery is difficult even for services needed by the majority of the population, such

---

21 Interview with R. Keiffer, Reno Mental Health Center, Reno, Nevada, April 22, 1974.
as general medical care. It is far more difficult for specialized services needed by only a small fraction of the rural population, such as those with substantial mental health disorders. The problem is one not only of economics, but of most mental health professionals' preferring to work and live in the larger population centers. The Rural Clinics program is an attempt to overcome those problems and provide mental health services needed in rural areas of Nevada outside of Clark County and Washoe County. Rural citizens living in those two counties outside the Reno and Las Vegas metropolitan areas are supposed to be served by the Henderson, Las Vegas, and Reno MHCs—and they are, if they are willing and able to travel to the centers, which have no outreach services to rural areas.

Before 1972, the Rural Clinics program operated under a different overall concept. That previous concept involved sending a team of well-trained professionals, usually by airplane, to rural areas periodically to provide mental health services. Since about the end of 1972, the modus operandi has been to use several small field offices located throughout the state and permanently staffed by less well-trained personnel.

Operating with an FY 1975 budget of $443,203, the Rural Clinics program has field offices in Carson City, Elko, Ely, Fallon, Hawthorne, and Winnemucca. The average total number of clients seen per month by Rural Clinics personnel in the first nine months of 1974 was 449 (109 in Carson City, 83 in Elko, 30 in Ely, 28 in Fallon, 140 in Hawthorne, and 59 in Winnemucca). With a client turnover of about 15 percent per month (the actual average for the first half of FY 1974), we estimate the program had about 1200 to 1300 clients in 1974 (including some unknown number of repeat clients). Each local office also has responsibility for smaller towns and communities located nearby, e.g., the Elko center is supposed to serve Wells and Owyhee; Winnemucca serves Battle Mountain; Fallon covers Lovelock; and so forth. Services theoretically are also available to state facilities such as the Northern Nevada Children's Home in Carson City and the Nevada Youth Training Center in Elko. It is the stated objective of the administrator of the Rural Clinics program to make the six community programs independent and, in time, autonomous mental health centers.

In principle, Rural Clinics is serving a rural population of some 94,000 people, of whom about 34,000 are children, spread over rural Nevada's vast 96,000 square miles. Under the best of circumstances, delivering good-quality mental health services to such an area would be a remarkable accomplishment; consequently, we were not surprised to find that the reality in Nevada falls far short of the desirable. Our recital of some of the major problems with the program will suggest ways to improve service delivery.

The first two problems we noted in 1974 were the small number of staff members in the Rural Clinics program, and the relatively low skill-levels of many of those staff.


24 The Executive Budget, p. 315.

25 Interview with Roger Glover, Administrator, Rural Clinics program, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, April 23, 1974.
members. In early 1976, the skills of the Rural Clinics staff had been upgraded somewhat by filling previously unfilled professional staff positions, and by "overfilling" some of the mental health technician positions with master's degree level professionals. However, the problem of the small number of staff members remains, and we question whether the low-paid MHT positions can continue to be overfilled by professionals when the job market ceases to be tight.

The program had 24 authorized staff positions in mid-1974: 1 administrator, 1.5 psychiatrists, 4 psychologists, 4.5 psychiatric social workers, 1 psychiatric nurse, 1 child development specialist, 6.5 mental health technicians, and 4.5 clerical and secretarial support staff. At the time of our interviews in mid-1974, some professional positions were unfilled; for example, there were no psychiatrists on the staff or acting as consultants to the program. Later in the year, however, a part-time consultant psychiatrist was hired for at least two hours a week. The mid-1974 professional staffing in each of the Rural Clinics offices consisted of a psychologist and a social worker in Carson City; a psychologist in Elko; a half-time psychologist in Ely; a social worker in Fallon; a psychiatric nurse and a social worker in Hawthorne; and a half-time psychiatric nurse in Winnemucca. A child development specialist traveled a circuit to serve each office. Thus, of the 12 authorized professional service personnel, a very small number for all of rural Nevada to begin with, 8 were working in the field delivering mental health services. Each office also has one or two "Mental Health Technicians III," who need only a high school education (as noted below, some of these positions were "overfilled" in March 1976). While those technicians' official job requirements also specify a certain amount of "paid work experience" and training (300 to 900 hours, depending on the person's education and experience), in practice they receive much less formal training (some state programs provide none at all). In the Rural Clinics program in mid-1974, we were told a training program was being developed but was not yet in operation. In our view, the technicians were responsible for mental health services they were not fully qualified to perform, either by their prior training or the low level of their training by Rural Clinics. And not having a physician affiliated with this staff-starved program more than a few hours a week severely limited the use of chemotherapy to treat certain mental disorders, with the result that people with those disorders usually had to be served by other more staff-consuming therapies, or not served at all.

The program's administrator expressed his hopes of securing the services of physicians in the rural areas to prescribe medication, but at the time of our interviews in 1974 such services were provided only on an ad hoc basis and by nonpsychiatrists.

The 1975 session of the Nevada Legislature did little to resolve the staff problem: it authorized only 4.5 new staff positions for the Rural Clinics program: 3.5 clerks and typists plus one master's-degree-level psychologist.

By early 1976, with the filling of previously unfilled staff positions and by limited

---

26 The Executive Budget.
27 Interview with Roger Glover.
28 See Chap. 10 for the detailed mental health technician job requirements, which were provided by O. Wahrenbrock, Department of Human Resources, Carson City, Nevada, May 13, 1974.
29 Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.
hiring made possible by five grants, the Rural Clinics staff had been upgraded somewhat. However, the Clinical Director of the program, Roger Glover, acknowledged in a February 27, 1976 letter to Rand that “there is no doubt that the Rural Clinics program has inadequate numbers of staff to meet the needs of the communities served.” The Rural Clinics program in early 1976 employed two psychiatrists, one-half time each, who provided consultation services to each Rural Clinics center on a biweekly basis. In early 1976 the clinical staffing at each center was: Carson, one psychologist, one person with a master’s degree in counseling and guidance, and one psychiatric social worker; Elko, one Ph.D. psychologist and one psychiatric social worker; Ely, two master’s level psychologists and one substance abuse counselor; Fallon, one master’s level psychologist and one person with a master’s degree in counseling and guidance; Hawthorne, one psychiatric nurse and one psychiatric social worker; Winnemucca, one master’s level psychologist and one substance abuse counselor; and Yerington, one bachelor’s level social worker and one master’s level psychologist. The six filled mental health technician positions had been effectively upgraded by “overfilling” three of the positions with master’s degree level professionals (one each of the counseling and guidance, social worker, and psychologist staff members noted above are actually mental health technicians). The administrator of the Rural Clinic program in March 1976 indicated he had been able to “overfill” these MHT positions because the job market was tight and better people were willing to work for a lower MHT salary; we question what will happen when the job market ceases to be so tight. The other three MHT positions in March 1976 were filled by people with: 1½ years of college education; a B.A., and two half-time predoctoral students.

Direct services such as individual, group, family, premarital, and marital counseling are provided by Rural Clinics staff; some parent effectiveness training is offered; some parents are being assisted to develop a cooperative preschool; some work is being done to curb child abuse; many young children are screened for mental retardation; indirect services such as mental health consultation and behavior modification training to teachers, clergy, and police are also provided.30 In our view, the Rural Clinics program is trying to provide too many different services with too few people.

According to the Rural Clinics Program Description, “Rural Clinics’ philosophy has never been to provide all of the direct services a community may require, but to strengthen the community’s natural service systems by offering consultation, training, and education. . . .” About half the staff time is spent on direct mental health services.31

The assessment of the Rural Clinics’ administrator was that his mid-1974 staff typically could handle neuroses but not psychoses.32 By his own admission, that is, the program could not furnish adequate outpatient treatment, or adequate outpatient follow-up to inpatient treatment at NMHI, to those rural Nevadans who needed it most sorely. In February 1976, however, the same administrator indicated that “the upgrading of the Rural Clinics professional staff, as indicated earlier, has made

30 Interview with Roger Glover; interview with B. Bilbrey, Rural Clinics program, Elko, Nevada, May 10, 1974.
31 Nevada’s Rural Clinics: Program Description, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.
it possible to provide services to increasing numbers of people experiencing 'severe mental disorders' in the local community."

The NMHI serves some rural people on an inpatient basis (see Chap. 10), but the Rural Clinics program is responsible for outpatient services to help prevent the need for residential services at the Institute, and for follow-up after treatment at the Institute. However, for Nevadans released from the NMHI to rural areas, there is often no meaningful transition or follow-up by the public mental health service system. In the past, the Rural Clinics mental health program staff used to meet with all Institute patients from rural areas prior to discharge; in 1974, they reportedly saw almost none. Even if they had regularly performed follow-up, the use of certain treatment modalities, such as chemotherapy, would have been restricted because the Rural Clinics program had only a part-time psychiatrist at the time of our interviews in 1974. Because the program also did not have enough skilled clinical psychologists, it is doubtful that the existing staff could have provided effective follow-up mental health services for all rural Nevadans released from the Institute.

The NMHI, in turn, seemingly did not facilitate follow-up in 1974. Cooperation between the Institute and the Rural Clinics program existed on paper, but joint prerelease planning for individual patients seldom occurred; reportedly, the Institute generally did not notify the Rural Clinics program of a person's release until several days afterward. Allegedly, rural residents sometimes entered and left the Institute without the Rural Clinics program's knowledge. When notification was received from the Institute, it was said to consist of the released person's name and county of residence only, with no specific address or mental health information.33

In a February 26, 1976 letter to Rand, the Administrator of the Rural Clinics program indicated: "The problems of provision of adequate services to rural Nevadans requiring inpatient services continue. One problem was that oftentimes people move into and out of the Institute without the awareness on the part of the Rural Clinics Staff.... Inpatient services have been established on a limited basis in three communities in conjunction with local general hospitals through activities of consulting psychiatrists. These services are minimal, but functional. Additional psychiatric services are needed and would allow more intensive follow through."

Rural Clinics service was not sufficient for people living in state facilities in rural areas who needed mental health services. For example, the Nevada Youth Training Center in Elko for adjudicated delinquent males reported having received no services from the Rural Clinics program (in mid-1974) although services had been requested.34 The state-run Northern Nevada Children's Home in Carson City does not have the budget, staff, or service program to provide mental health treatment to residents who need it. At one time, the Carson City Rural Clinics office provided a master's-level psychologist 1½ to 2 days a week. From a waiting list of children, he individually counseled those he had time to see. Since mid-1974, however, because of increased community demand for services, the Carson City Rural Clinics office has no longer provided that service.35

33 Interview with Roger Glover.
34 Ibid.
35 Interview with J. Aberasturi, Superintendent, Northern Nevada Children's Home, Carson City, Nevada, May 9, 1974.
The basic, overriding problem with the Rural Clinics mental health program is that too few people are trying to accomplish far more than their meager numbers would allow under even ideal conditions. It is an excellent example of a small embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans with mental health disorders are concerned, especially those with the more severe disorders.

CHILDREN'S BEHAVIORAL SERVICES

The Children's Behavioral Services (CBS) program in Las Vegas, operated by the Nevada Division of Mental Hygiene and Mental Retardation, is intended to serve only Clark County children under 13 years of age who need mental health services.\footnote{36}\footnote{Unless otherwise indicated, information in this section was provided in CBS interviews in Las Vegas, Nevada, with J. Burnett, Clinic Administrator, March 6, July 10, and October 25, 1974; C. Hahn, H. Flatt, D. Johnson, and R. Salsbury, August 5, 1974; and S. Kruger, October 24, 1974, CBS, Las Vegas, Nevada; in an interview with C. McKee, Chief of Psychology and Social Work Services and project manager for the MOD Center, Clark County School District, Las Vegas, Nevada, October 24, 1974; and in a letter from J. Burnett, CBS, Las Vegas, Nevada to J. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.}
The 1975 session of the Nevada Legislature approved a CBS program for Washoe County patterned after the Clark County program. No comparable program exists for children and youth of any age in rural Nevada counties. For youth aged 13 years and over in Clark County, the Las Vegas MHC provides a range of both residential and nonresidential services. In Reno, Washoe County youth over age 12 presently receive only nonresidential service at the Reno MHC. Even with the new CBS program, then, gaps still prevail in the mental health service system for Nevada children and youth.

The CBS program, according to one descriptive brochure, includes "treatment, education, prevention and research. The goals of the program are to eliminate current difficulties and to prevent the development of future problems."\footnote{37}\footnote{Clark County Children's Behavioral Services, Children's Behavioral Services, descriptive brochure, Las Vegas, Nevada, September 1, 1973.} Positive behavior modification is the treatment modality predominantly employed; as the brochure describes it:

Although we often classify children's difficulties as mental, emotional, social, or behavioral, it is always what the child does (his/her behavior) that causes our concern. In this sense, the problems are almost always behavioral. For this reason, our services are based on the science of human behavior. This science informs us that most of the things children do can be changed by changing the consequences for what they do. Positive consequences for a behavior make that behavior more likely to occur again. On the other hand, negative consequences make a behavior less likely to occur again. Treatment by Children's Behavioral Services is based on the law of positive consequences for desired behavior. In treatment, the children learn to increase doing what they should. In the process, these desired behaviors substitute for the undesired behaviors which decrease or cease altogether.\footnote{38}\footnote{Ibid.}
Reno. It will be identical to that already under construction for emotionally disturbed children in Las Vegas. It includes residential units for short-term intensive inpatient treatment of a maximum of 16 highly mentally disturbed youth, plus a classroom and outpatient service building. However, for programmatic reasons and because of financial limitations, the Las Vegas CBS program currently has a full-time residential capacity of only 12 children and 1 family in treatment. Both parents and children will be involved in services, which in Reno will include family counseling, group therapy for parents and children, classes for parents in effective management techniques, individual therapy for children, and an evaluation service. The evaluation service will include a medical and a behavioral assessment of the child and an evaluation of the strengths in his or her social environment. The levels of services to be offered include relatively short-term residential intensive inpatient service, transitional residential placement with specially trained professional parents outside the facility, conventional foster home care services during the full day, and outpatient services. Services as they existed in February 1976 at the CBS program in Las Vegas are described below. Residential intensive services, day care, and outpatient services at each facility are expected to reach about 40, 74, and 500 emotionally disturbed children per year, respectively. The active caseload in the Clark County program in mid-1974 was approximately 250 children and their families receiving outpatient service, and 20 receiving day-treatment in a special class. About 600 children received services from the Clark County CBS program in FY 1974.

Regarding the need for CBS services, we conservatively estimated in Chap. 3 that at least 2 percent of Nevada's children have emotional disturbances of sufficient severity to require substantial special services in any given year. Since there are about 195,000 children and youth aged 0 to 18 in Nevada, this means at least about 4000 need substantial services for emotional disturbances. About 2500 children are 0 to 12 years old. In February 1974, a Nevada Division of Mental Hygiene and Mental Retardation survey of Washoe County and surrounding northern Nevada agencies asked how many children aged 0 to 12 they knew of who were emotionally disturbed. The agencies reported 57 very severely emotionally disturbed, 147 severely emotionally disturbed, and 1461 moderately disturbed. These results exceed the 2-percent figure we use in this report, but our figure is a conservative minimum estimate.

The Clark County CBS program began operation in FY 1974 with a budget of $168,000. In FY 1975 its operating budget was about $438,000, a new facility was

---

39 The Executive Budget, and February 27, 1976 letter to The Rand Corporation from J. Burnett, CBS, Las Vegas, Nevada.
40 Nevada Division of Mental Hygiene and Mental Retardation, Children's Behavioral Services—Washoe County, Department of Human Resources, Reno, Nevada, February 1975.
41 Interviews with J. Burnett and B. Salsbury, CBS, Las Vegas, Nevada, March 6 and August 5, 1974, respectively.

---

40 Division of Mental Hygiene and Mental Retardation, A Proposed Treatment Program for Emotionally Disturbed Children in Washoe County, Nevada Department of Human Resources, Reno, Nevada, August 1974. The definitions used in that report are: Very Severely Emotionally Disturbed (typically called psychotic, autistic, etc. Examples of very severely disturbed behavior might include: bizarre thinking; hallucinations, non-speaking and non-communicative, severe self-mutilation, etc.); Severely Emotionally Disturbed (examples of severely disturbed behavior: two or more problems of a serious nature such as extreme and unreasoning fears, unusual sexual preoccupations or perversions, cruelty to animals or children, severe shyness and social withdrawal, habitual firesetting, etc.); Moderately Disturbed (examples of moderately disturbed behavior: habitual lying, truancy, theft, emotional dependency, lack of friendships, continual feelings of worthlessness and unhappiness, etc.).
under construction,\textsuperscript{43} and the program had an authorized staff of 17. The staff included 1 administrator, 1 receptionist, 1 account clerk, 2 secretaries, 1 business manager, 1 supervisor of volunteer services, 4 mental health technicians and 5 professionals (a psychologist, 2 social workers, and 2 teachers).

The CBS facility in Washoe County not yet being complete, the 1975 session of the legislature approved only about $47,000 in salaries for four staff positions to start up the new program in FY 1976.

With the CBS facility in Clark County near completion, the 1975 legislature approved $161,000 a year in salaries for new staff positions for it, and above the 17 FY 1974 staff positions: a pediatrician or psychiatrist, 2 child development specialists, 3 sets of "professional parents," one relief parent, and a custodial worker. Seven additional positions were authorized, conditional on receipt of sufficient federal Social Services funds which have now been received.\textsuperscript{44} We have two comments about the Clark County staffing. First, a physician with specialty training in psychiatry should be hired since some of the children to be served undoubtedly will need psychiatric services (see the discussion earlier in this chapter on the desirability of offering an expanded range of treatment modalities to meet the range of children's needs). CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. Second, the staff conditionally authorized can be put to effective use—services would have suffered markedly if the federal funds had not been there to hire them.

Next, this section describes the two major elements of the CBS programs as they existed in 1974 in Clark County: the MOD Center program and the Community Learning Consultants program.

The Model Orthogenic Development (MOD) Center program in 1974 was a day-treatment program confined to about 20 clients at any one time on the campus of the Sunrise Acres Elementary School. Its treatment modality was based on behavior modification. The program was designed for disruptive elementary schoolchildren with "social, behavioral, or emotional problems" who had been expelled or would soon have been expelled from the regular school program.\textsuperscript{45} It was jointly operated by CBS and the Clark County School District in 1974, but is now operated by the school district with consultative assistance from CBS. A "contract" was written whereby the principal of the child's original school agreed to take the child back when the frequency of offensive behavior was lowered to some acceptable level. The MOD Center staff also consulted with regular classroom teachers on how to handle disruptive children when they returned. Mandatory attendance sessions with the parents also were held by the MOD Center teacher an average of twice per month to help them learn to work with the child at home in modifying her or his behavior.

The small size of the MOD program was determined by available funds and staff. According to the CBS administrator, the program would be swamped if it undertook direct consultation with all the school district's problem children.\textsuperscript{46} The MOD Cen-

\textsuperscript{43} The Executive Budget, p. 325.

\textsuperscript{44} Information provided by H. Clemens, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.

\textsuperscript{45} Children's Behavioral Services, \textit{MOD Center}, undated descriptive brochure (used in 1974).

\textsuperscript{46} Interview with Joe Burnett, CBS, Las Vegas, Nevada, March 6, 1974.
The teacher said he received two or three referrals each week, virtually all of whom needed the program but could not be admitted because of its small size.

The MOD Center was officially staffed by a psychologist, a social worker, two teachers, and a mental health technician, but the building housing the MOD program did not have facilities for support personnel offices. On the day we visited the center, the teaching staff were present plus an unpaid observer from the university who was counting the number of times different behaviors occurred. A psychologist had not been hired, and the work-study observers from the University of Nevada at Las Vegas (UNLV), according to the teacher, were not qualified to do more than observe and count behaviors. One UNLV special education professor consulted with the teacher and tested the children for six hours a week. In addition, the school district psychologist, social worker, and school principal and nurse could be consulted. The MOD center was also serviced by the CBS pediatrician for physical exams.

The teacher said he does academic work with the children as well as behavior modification. Otherwise, he believes the children would slip so far behind academically that their behavior would regress when they returned to their regular schools.

Of the 35 children who received service from the Sunrise Acres MOD program during the 1974-75 school year, only 35 percent returned for the start of the 75-76 school year. Most of the children who returned had attended in the 1974-75 school year for an average of only 3½ months. Eleven of the children returned to regular class or were referred for phasing into regular class. Seven children met criteria in the cooperative programs that had been established in other Clark County Schools and were phased into appropriate classroom settings and 5 of the children moved out of the Clark County School District.

According to the teacher, great unmet needs prevailed in Henderson, Boulder City, and Las Vegas. The most severely emotionally disturbed children were not admitted to the center, and similar services did not exist in southern Nevada's rural areas.

CBS called its 1974 behavior-modification-based outpatient work with children and their parents the Community Learning Consultants program. "This program educates families in effective child management and assists families in evaluating their children's behavioral problems, treating the problems, and ensuring that once treated, the problems do not return." The program primarily worked directly with the parents, in groups and individually. Parent training groups typically met once a week for eight weeks. In October 1974, about 250 families were involved in this program, up from 150 as recently as March 1974. Mildly and moderately disturbed children were served, but the CBS director said in 1974 that very few severely disturbed children were served. Information provided by the CBS director in February 1976 indicates that more severely disturbed children are now being served, however.

The CBS staff recently analyzed 211 active cases (those currently receiving continuing services from CBS clinical staff) to ascertain the degree of emotional disturbance in CBS clients. According to a February 27, 1976 letter to Rand from the CBS Director, the categories they used were:

- "Very Severely Emotionally Disturbed (typically called psychotic, autistic,
etc. Such behavior might include: bizarre thinking, hallucinations, non-
speaking and noncommunication, severe self mutilation, and the like.”

• “Severely Emotionally Disturbed. Such children may have two or more
problems of a serious nature, such as extreme or unreasoning fears, unusu-
al sexual preoccupations or perversions, cruelty to animals or children,
severe shyness and social withdrawal, habitual firesetting, etc.”

• “Moderately Disturbed. Such behavior may be marked by habitual lying,
truancy, theft, emotional dependency, lack of friendships, continual feel-
ings of worthlessness and unhappiness, etc.”

• “Mildly Disturbed. Such children may have non-compliant, non-attentive
or back-talk behaviors. This service is basically preventive in nature.”

The CBS staff, using the above definitions, reported in February 1976 that only 6
percent of the clients were very severely disturbed, while 26 percent were severely
disturbed, 41 percent were moderately disturbed, and 26 percent were mildly dis-
turbed.

Regarding program effectiveness, the CBS Director reports that “in a random
survey 100 percent of the parents responding to the survey indicated that they were
more able to cope with their children after completing the agency’s parent consult-
ation program.” Thus, this program, which uses behavior modification techniques
almost exclusively in treating children’s mental health problems, appears to be
producing some behavior improvement. We know from the available data presented
later in this section that parents report better behavior from their children, but we
do not know from the data how emotionally disturbed the children are—i.e., we do
not know the children’s levels of psychological functioning.

We queried staff members on diagnostic evaluation procedures, treatment
modalities, and the types of clients served. We learned that in 1974 behavior modifi-
cation techniques were used almost exclusively (even though different treatment
approaches may be appropriate for, say, a severely depressed child who has at-
tempts suicide). It also appeared that a substantial portion of the CBS outpatient
caseload consisted of children who were only mildly emotionally disturbed; but given
the apparent lack of in-depth contact with and diagnosis of the children’s problems
this CBS program had in 1974, neither we nor the CBS staff could tell how many
children were only mildly disturbed. The question is: given limited staff, who should
be served? There is no doubt that the outpatient portion of the FY 1974 Clark County
CBS program lacked in-depth intake screening and diagnosis of the children’s prob-
lems in 1974. One staff member said he had had cases in which he had never seen
the child during the entire course of treatment. He was proud that he was treating
the child by teaching the parents, and said that typical procedure in the program
was to try to make at least one home visit to see the child during the program; he
added, however, that “not everyone does this all of the time.” In the absence of initial
contact with the identified patient, it is very difficult to diagnose the disorder, and
hence ascertain the most appropriate intervention strategy. Lack of subsequent
follow-up contact makes it hard to learn of any undesired consequences of the
treatment (e.g., “symptom substitution” or worse). For example, a child may respond

---

49 Attachment to letter from J. Burnett, CBS Director, Las Vegas, Nevada, to J. Kakalik, The Rand
Corporation, February 27, 1976, providing a correction to a letter from J. Burnett to J. Kakalik dated
March 12, 1974.
to behavior modification techniques by abandoning objectionable behavior, only to become very depressed. In such a case the CBS program would rate the treatment as "successful," although the mental health problem may not have been resolved at all—only submerged in depression. The point here is not to suggest that behavioral treatment has little value, or that it is frequently accompanied by symptom substitution; rather, it is that the complex outpatient mental health needs of children require a thorough and systematic pre- and post-treatment evaluation in order to ensure the potentially beneficial effects of a behavior treatment program as one component of a comprehensive range of services. (See the "Range of Treatment Modalities" section later in this chapter.)

The Las Vegas CBS director, Joe Burnett, provided significant new information on how the program is currently functioning with a February 27, 1976 letter to Rand.

In the area of "clinical assessment," the material Burnett provided describes a situation that appears markedly different from what we observed in practice in 1974. He indicates:

When a child is referred to Children's Behavioral Services, an effort is made to accumulate complete information in order to assess the physical, psychosocial and intellectual-academic functioning of the child. The components of this assessment are:

Physical. The intake procedure at Children's Behavioral Services includes a comprehensive physical workup.

In an effort to broaden health care services, various working arrangements have been developed with outside individuals, agencies or health care facilities. CBS currently has working arrangements for optometric services, dermatological services, specialty laboratory services, audiological services and consultative developmental diagnostic services. The agency has a written working agreement with the Henderson Mental Health Center for psychiatric consultation and is developing a similar agreement with Las Vegas Mental Health Center.

Psychosocial. In assessing the history and current circumstances of a child, several components are investigated. Permission is obtained from the parents or guardian to allow records from other professionals and agencies to be procured. These records include documentation from the school district, juvenile court, welfare, family physician and any other resources utilized by the child.

Intellectual-Academic. CBS staff includes educational and psychological specialists who perform testing services which provide a measure of the child's intellectual functioning and academic performance.

In the areas of "Individual and Group Parent Consultation, Home Visits, and Families in Residence," the material Burnett provided states:

In the individual, and group, parent consultation programs, clinical staff teach parents skills in improving the interaction between family members. The objective of these improved interactional skills is to support the child's behavioral adjustment.

A clinician may conduct some or all sessions in the client's home. Home based services assist in making assessment, developing objectives or implementing portions of the treatment program. Home visits may be made when
the family has a serious transportation problem or when the problems are such that they can be more adequately dealt with in the home setting. In the latter case, the families in residence program may also be considered.

Families in residence may be appropriate when the child's behavior is severely and dangerously disruptive or in other situations in which an intensive degree of closely supervised treatment is necessary. For example in cases of severe child abuse [sic] . . .

This situation, in which the parents live in an apartment complex that is part of the CBS facility, can be used during acute periods, allowing the clinician to observe problems first hand and provide the family with ongoing consultation and support designed to remediate the situation.

The apartment facility is also used in conjunction with the residential program so that the teaching parents can spend weekends working more intensively with the parents of children in the residential program.

Although CBS programs are described as separate service areas, the more frequent situation is one in which the child and his family are receiving more than one type of service. With the exception of parent education (to be discussed later), all children receiving services are seen by members of the clinical staff . . .

Data reported in the Fall 1974/Winter 1975 of People Magazine reports a parent evaluation of treatment programs as follows:

1. One hundred percent of the parents completing consultation programs said they were more able to cope with their child.
2. Seventy-five percent of the parents indicated that all treatment goals were reached and the remaining 25% believed partial success had been obtained.
3. Ninety-six percent of the behaviors disapproved by parents had shown some improvement following treatment.
4. Eighty-two percent of the parents said they felt they could handle new behavior problems arising in the home environment.
5. Eighty percent of the parents surveyed said they had recommended CBS to other families.

In the area of "child counseling," the material Burnett provided states:

As with the parent consultation program, child counseling procedures include individualized treatment objectives, measurements of effectiveness and treatment plan revisions as needed. Child counseling services are provided on an individual basis or in a group setting depending on the child's specific behavior or developmental problem . . .

Some of the techniques used by staff members include assertive training, relaxation training/anxiety management, systematic desensitization, role playing, behavioral rehearsal, contingency contracting, problem solving and discrimination training . . .

Child counseling services are frequently provided along with other available services based on assessments of the individual case. And, child counseling services may include both individual and group counseling . . .

In the area of "social skills groups," the material Burnett provided states:
In cases where a group setting appears to offer the child a more viable method for learning and practicing new appropriate skills, the child is enrolled in one of the social skills groups.

The program for relationship development (Social Skills Groups) is directed toward children between the ages of 6 and 12 who are experiencing difficulty getting along with others.

The groups meet for approximately one hour each week for ten weeks. The maximum group size is four children and two adult leaders.

In the area of the "Develomental Center and Learning Center Preschools," the material Burnett provided in February 1976 states:

The Children's Behavioral Services Developmental Center and Learning Center preschools are model programs for dealing with preschool children lagging in behavioral and learning development.

The Developmental Center is co-sponsored by the Nevada Division of Welfare, Children's Behavioral Services and the University of Nevada, Las Vegas, College of Education, and Department of Special Education. The children are referred through the Division of Welfare, the C.B.S. staff provides the programming, and the University provides the facilities.

The Learning Center is sponsored solely by Children's Behavioral Services. The children in the Learning Center are referred by their parents for similar kinds of problems.

The children, ages 3 to 5, are referred to these Preschool Programs on the basis of learning and behavioral developmental lags. The enrollment is limited to ten children in each session.

With respect to the "Model Orthogenic Development Center," there are now two MOD Centers in Las Vegas: the Center at the Sunrise Acres which existed in 1974 and was described above, and a new MOD Center at the CBS facilities. The material Burnett provided states:

The Model Orthogenic Development classrooms at Children's Behavioral Services opened October 20, 1975. There are two MOD classrooms which are staffed by teachers with training in special education. These classrooms are jointly sponsored by Children's Behavioral Services and the Clark County School District.

There have been seventeen children enrolled in the classrooms. Six of those children have successfully completed the MOD Program and have been transitioned to the regular classroom in their respective home schools.

All twelve of the children in the OASIS Residential Treatment Program (described below) attend the MOD classroom until the social and academic success of each child indicates that he is ready to be transitioned to a regular classroom. In addition, four community children who are not residents of OASIS attend MOD. Children whose behavior has made it impossible for them to function in a regular classroom are referred to the program. A child who exhibits the following behaviors may be referred:

1. Excessive fighting
2. Aggressive behavior to adults
3. Consistent refusal to participate in the classroom work
4. Stealing
5. Destruction of property
6. Disruption of classroom and school activities.

With respect to the "OASIS Residential Treatment Program," the material provided states:

The OASIS Residential Treatment Program is based on a group home model developed and researched by the Achievement Place Research Project at the University of Kansas.

Achievement Place is a community based, family style, residential treatment program for delinquent youth.

The OASIS Residential Treatment Program opened for residential placement October 1, 1975. Since opening, fourteen children have been admitted to the program. One of the children has graduated and is now doing very well with foster parents. A second child is on the homeward bound system and is spending a majority of his time in his natural home.

Children in need of residential treatment for behavioral or emotional problems may be referred to the OASIS Residential Treatment Program of Children’s Behavioral Services by the family of the child, the school, the Division of Welfare, or other concerned agencies and individuals.

Children who meet the following criteria are acceptable referrals for placement in the OASIS Residential Treatment Program.

1. They have not yet entered the 7th grade and are under the age of 13.
2. They have families who: (1) will accept them back in their home at the end of the residential treatment period; and (2) will work closely with the residential staff during the treatment period.

The family will normally be expected to be in contact with residential staff a minimum of three times a week. The family’s involvement during residential treatment will include parent conferences, observing the child in the residential setting, home visits made by the staff and other indicated training techniques.

During residential treatment the family will be expected to accept the child back in the home for regular visits during which the family and child practice and evaluate the interactional skills they have learned. If a child is referred who has no family, the OASIS staff will work with the Division of Welfare in training a foster family with whom the child can learn.

3. Their behaviors are of such a nature that they would benefit from medium term residential treatment.
4. Their treatment history is represented by one of the following situations:
   (a) has exhausted all other services provided by Children’s Behavioral Services or other community treatment facilities.
   (b) the child’s problems are so serious and/or of such long duration that other community services would not be appropriate.
   (c) the interactions between the child and his family or community have degenerated to the point that residential placement is required.
5. The Wechsler Intelligence Scale for Children or Binet indicates that their intelligence potential is not sub-normal.
6. Their physical condition does not require specialized care or equipment that the agency is unable to provide.

In the area of the "Parent Education Program and Community Consultation," the material Burnett provided in February 1976 states:

The parent education program is designed to assist prospective parents in maximizing their child rearing skills and minimizing the possible incidence of future problems. This program is offered to pre-adoptive, expectant and potential foster parents. It is also available to parents who are not experiencing problems as well as those whose children are currently living outside the home. Basic principles of behavior management are taught along with the educational components of a positive environment. The parent's role in the development of desirable behavior is stressed and specific behavioral techniques are taught. Training is usually conducted in group settings in which actual problems are presented for the parents to "solve" with assisted practice.

Agency staff are available as lecturers for educational institutions, civic groups, and community organizations for the purpose of giving information on clinical concerns, and child development and management techniques. Also, schools, social agencies, and court systems in providing services to children may call on CBS for workshops and/or case consultation.

MENTAL HEALTH SERVICE PROGRAMS IN EDUCATION AGENCIES

County School Districts

Special education services for seriously emotionally disturbed children were discussed in Chap. 7. In summary, a total of only about 100 emotionally disturbed children are identified as receiving special education services in Churchill, Clark, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education services in any of the other counties in Nevada. In relation to the minimum number of Nevada children and youth needing special education, only about 4 percent of the seriously emotionally disturbed children are identified and served in programs designed to meet their needs. Some unknown additional number of those children are grouped with "educationally handicapped" children in special education programs that may or may not be appropriate to their needs.

Nevada school psychologists presently function primarily as psychometrists, doing testing of children rather than offering therapeutic treatment of children's mental health disorders. Most of the psychologists would need some retraining to enable them to serve seriously emotionally disturbed children satisfactorily.

In short, mental health services are only slightly developed in the schools, and reach few seriously emotionally disturbed children.

University of Nevada

Some direct mental health services are provided through the University of Nevada at both the Las Vegas and Reno campuses. The FY 1974 Student Services
budget for the University included $41,440 for a staff of 2.88 full-time-equivalent employees in Reno, and $55,648 for a staff of 4.10 full-time-equivalent employees in Las Vegas.\textsuperscript{50} At the Reno campus, ten doctoral students in psychology assist the regular staff.\textsuperscript{51} Any registered student is eligible for therapy for any emotional or personal problem. Therapy programs include individual therapy, group therapy, awareness groups, marriage counseling, and consciousness raising groups. The Las Vegas campus served about 350 people in FY 1974,\textsuperscript{52} but clearly not all of those served had serious mental health disorders. We did not obtain data on the number served in Reno, although it was probably at least as many per staff member as in Las Vegas since graduate students assist the staff in Reno; i.e., the total was at least 250.

PRIVATE NONRESIDENTIAL MENTAL HEALTH SERVICES

Psychiatrists and psychologists in private practice are an important part of the mental health service system. Private residential mental health services are discussed in Chap. 10. Here we are concerned with estimating the amount of private nonresidential mental health services available in Nevada. Their existence is important but is by no means sufficient to meet all of the state's needs.

The Nevada Welfare Division periodically prepares a list of practicing psychiatrists and psychologists approved for Medicaid payments. The August 1974 list contained 26 psychiatrists and 11 psychologists. Of the psychiatrists, 17 practiced in the Reno area (4 primarily at the NMHI, 2 at the Reno MHC, 2 at the University of Nevada, and 9 primarily practicing privately). The Las Vegas area had 9 psychiatrists (1 primarily practicing at the Las Vegas MHC, 1 at Southern Nevada Memorial Hospital, and 7 primarily practicing privately). Of the psychologists, 7 practiced in the Reno area (1 primarily at the Reno MHC and 6 primarily practicing privately), and 4 practiced in the Las Vegas area (all primarily in private practice). In mid-1974 no psychiatrists lived and practiced in any rural Nevada county, although one Utah psychiatrist flew to Elko to practice an average of about one day a week. Since mid-1974, the number of psychiatrists has grown. The Las Vegas MHC has added 2, for example, and in September 1975 the Nevada State Board of Medical Examiners approved 9 psychiatrists for licensure.\textsuperscript{53}

The \textit{Nevada Psychological Association Membership Directory} (revised September 1973) listed 42 full members and 15 associate members, but not all are delivering mental health services; many are working as psychometrists in schools. In mid-1974, there were 32 certified psychologists in Nevada, of whom 11 were in private mental health practice.\textsuperscript{54}

The geographic distribution of these professionals is lopsided in relation to need. Almost twice as many practice in the Reno area as in the Las Vegas area, although the population of the Las Vegas area is about twice as large. And the rural areas,

\textsuperscript{50} The \textit{Executive Budget}.
\textsuperscript{51} Interview with Dr. J. Mikawa, University of Nevada, Reno, Nevada, April 23, 1974.
\textsuperscript{52} Clark County Areawide Comprehensive Health Planning Advisory Council, \textit{Clark County Plan for Health}, Las Vegas, Nevada, December 1974.
\textsuperscript{54} Interview with R. Whitemore, Sparks, Nevada, September 19, 1974.
containing about 20 percent of the Nevada population, have no psychiatrists and psychologists at all in private practice, according to the Medicaid-approved list.

In 1973, there was a national average of one psychiatrist for every 10,200 people.61 If that average prevailed in Nevada, the state would have had 57 psychiatrists in 1974 instead of the actual 26; and the prevalence of mental health disorders in Nevada is probably greater than the national average. The 1974 Clark County Plan for Health62 estimated a need for a total of 33 practicing psychiatrists in Clark County, using a recommended ratio of one psychiatrist per 10,000 general population. By that standard, then, the state as a whole in 1974 had less than half the national average and the recommended ratio of psychiatrists; Washoe County had more than the national average and recommended ratio; Clark County had about one-third of the recommended ratio; and the rural counties had less than one-tenth of the recommended ratio (even after we allocated the NMHI psychiatrists in proportion to the geographic residence of the patients they treated).

Recently, a national survey was conducted of a random sample of psychiatrists who spend 15 or more hours per week in direct patient contact in their private offices.63 The average proved to be 32 patient-visits per week. (The survey did not gather information on private inpatient services, partial hospitalizations, and emergency services.) The survey also estimated a gross income per psychiatrist "in the neighborhood of $67,000 per year" (based on an average hourly fee of just under $40) and a net taxable income of about $47,000. We were unable to get reliable similar information on Nevada's private psychiatrists and psychologists, but, if one assumes the national average of $67,000 for private practicing psychiatrists, and perhaps $30,000 for private practicing psychologists, then the two groups together gross about $1,400,000 per year. That figure does not include fees earned by publicly employed mental health professionals who have part-time private practices, as many of them do in Nevada.

We were unable to obtain data on the total number of people served privately in Nevada in FY 1974, but if we again use the average of 32 patient-visits per week, then there were about an average of 1600 patient-visits per year for each of the 26 primarily private practicing professionals in Nevada, or about 42,000 private outpatient visits. Using the national survey distribution of total number of visits per patient in psychiatric (nonpsychoanalytic) caseloads, we calculate that the national average caseload was about 163 different patients.64 Applying that average to Nevada yields a total of about 4200 different private outpatients in FY 1974.

We caution that these estimates are based on national averages. They may indicate the correct order of magnitude of the expenditures and of people provided

---

63 Marmor, Psychiatrists and Their Patients.
64 Ibid., p. 22. A methodological point is necessary concerning interpretation of data on p. 22 of Marmor's study. By virtue of the way the patients were sampled in the national survey (the last ten patients seen were sampled), patients who came to the office more often were more likely to be selected than were patients who came less often. Hence the average total number of visits by a patient in the caseload is less than the average total number of visits by a patient in the sample. After mathematically adjusting for differences between the average patient sampled and the average patient in the psychiatrists' caseload, we find that the national average number of visits per patient over the entire course of treatment is approximately 10 for psychiatrists who are not psychoanalysts.
outpatient mental health services privately in Nevada, but the actual numbers are unknown.

SUICIDE PREVENTION AND CRISIS CALL CENTERS

Centers are operational in both Las Vegas and Reno to assist people who are suicide prone or have some other crisis by talking with them on the telephone or referring them to other service personnel.

The Reno Suicide Prevention and Crisis Call Center is a joint operation between the University of Nevada and volunteers.\(^5\) Financing of about $7000 per year is provided by United Way. The university provides the building rent-free and provides a semester’s training (40 to 50 hours total) for the volunteers who answer the telephones. There are about 75 to 80 nonprofessional volunteers and about 12 professional back-up staff members, e.g., social workers and psychologists, who volunteer their time. In late 1974, with a $6000 grant from United Way and $5000 in financial assistance from the nonoperating Washoe Community MHC, the Suicide Prevention and Crisis Call Center was able to hire its first full-time paid professional.\(^6\) The Suicide Prevention and Crisis Call Center is operated 24 hours a day, but talks to people only on the telephone—no walk-ins. A total of 4589 initial calls were received in 1973. The number of new calls per day was averaging about 20 in late 1974.

As would be expected, calls are rather lengthy and result in referrals to other community agencies. The center tries to call back later to check on the individuals, but does not always succeed. Professionals do not usually answer the phones, but provide back-up. About 10 to 20 percent of the calls are in fact suicide-related; the remainder are concerned with depression, psychosis, problems with lodging and food, and so forth. Only about 10 percent are not related to mental health. As of April 1974 the center offered the only 24-hour service of its type in northern Nevada (the Reno MHC, however, has since begun answering its telephone on a 24-hour basis). Despite these impressive beginnings, problems remain. Other than 8 a.m. to 5 p.m. on weekdays, in-person services from psychologists or psychiatrists are said to be often unavailable in Reno; and general public knowledge about the center and its program is slight (a recent survey indicated that less than 5 percent of those contacted had even heard of the Reno program).\(^7\)

At the same address as the center is the Washoe Community Mental Health Center—an extremely misleading name, since the organization has no staff and directly provides no mental health services. The name represents a hope rather than an operating service reality. Expenditures by the Washoe Community MHC in the two years through August 1974 had amounted to $62,000 of the $72,000 it had available. Little was accomplished with the funds beyond providing a directory of mental health services in Reno, an information and referral telephone line (answered in late 1974 by the Reno Suicide Prevention and Crisis Call Center), and several workshops. Half the remaining $10,000 was given to the Crisis Call Center in late 1974. Reno does need a functioning full-fledged community mental health

---

\(^5\) Interview with J. Mikawa, Suicide Prevention and Crisis Call Center, Reno, Nevada, April 23, 1974.


\(^7\) Interview with J. Mikawa.
center, but we believe the best way to acquire one is to improve and expand the existing state-operated Reno MHC, not create a new and competing one (see the recommendations section of this chapter).

The Suicide Prevention Center in Las Vegas also provides a 24-hours-a-day telephone service run by volunteers. It is a nonprofit organization supported by contributions. An average of six calls are received per day and are answered by about 40 volunteers, who are psychologically screened and provided with training for about six evenings prior to beginning work.

FEDERALLY OPERATED MENTAL HEALTH PROGRAMS IN NEVADA

The two major Nevada populations receiving mental health services directly from federally operated programs are Indians and the military.

Indian Health Service

The approximately 9000 Indians in Nevada in 1970 represented about 1.6 percent of the state's population. Of these, the Intertribal Council of Nevada estimates that about half live on Indian reservations or in colonies (see Table 8.3). In 1975, there were an estimated 10,000 Indians on reservations and in colonies, and perhaps 4000 in urban areas; the increase in numbers was reportedly due to migration into Nevada from other states. Although eligible for the same mental health services available to other Nevada citizens, geographic location of residence, lack of transportation, and cultural differences probably inhibit full use of these services. For the Indians living on reservations and in colonies in Nevada, the United States Public Health Service's Indian Health Service (IHS) provides one Ph.D. psychologist, who is given a travel budget only, plus one mental health technician and one recreational therapist assigned to work at Owyhee. The psychologist does not provide direct counseling services to Indians. Rather, he provides consultation and inservice training workshops to community health representatives and other professional and paraprofessional personnel who work with Indians. There is no federal allocation of funds, other than salary and travel expenses, for providing mental health services. Obviously, these three staff members can provide only a very small amount of mental health services.

The IHS provides two hospitals for Indians: Owyhee (near Elko) and Schurz (near Yerington and Fallon). At Owyhee, a psychiatrist from Reno flies in one-half day twice a month, and typically sees five or six people in four hours. There are no mental health services at Schurz.

Other programs specifically serving mentally handicapped Indians include the Intertribal Council alcohol abuse program described in Chap. 9 of this report, which has offices in nine locations throughout the state, and the Stewart School, described in Chap. 13.

---

63 Information obtained from Dr. Dean Hoffman, Mental Health Consultant, Indian Health Service, Sparks, Nevada, 1974, and March 1976.
Table 8.3
INDIAN RESERVOIRS AND COLONIES IN NEVADA, 1970

<table>
<thead>
<tr>
<th>Reservation or Colony, and Tribe</th>
<th>Tribal Members</th>
<th>Resident Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duck Valley (Shoshone)</td>
<td>1200</td>
<td>817</td>
</tr>
<tr>
<td>Duckwater (Shoshone)</td>
<td>150</td>
<td>63</td>
</tr>
<tr>
<td>Fallon (Paiute-Shoshone)</td>
<td>1200</td>
<td>127</td>
</tr>
<tr>
<td>Goshute (Shoshone)</td>
<td>200</td>
<td>109</td>
</tr>
<tr>
<td>Fort McDermitt (Paiute-Shoshone)</td>
<td>500</td>
<td>353</td>
</tr>
<tr>
<td>Moapa (Paiute)</td>
<td>350</td>
<td>73</td>
</tr>
<tr>
<td>Pyramid Lake (Paiute)</td>
<td>900</td>
<td>399</td>
</tr>
<tr>
<td>Summit Lake (Paiute)</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>South Fork (Shoshone)</td>
<td>102</td>
<td>102</td>
</tr>
<tr>
<td>Walker River (Paiute)</td>
<td>1000</td>
<td>375</td>
</tr>
<tr>
<td>Yomba (Shoshone)</td>
<td>100</td>
<td>61</td>
</tr>
<tr>
<td>Battle Mountain (Shoshone)</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Ely (Shoshone)</td>
<td>150</td>
<td>31</td>
</tr>
<tr>
<td>Fallon (Paiute-Shoshone)</td>
<td>1500</td>
<td>61</td>
</tr>
<tr>
<td>Las Vegas (Paiute)</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>Lovelock (Paiute)</td>
<td>150</td>
<td>136</td>
</tr>
<tr>
<td>Elko (Shoshone)</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>Carson (Washoe)</td>
<td>129</td>
<td>129</td>
</tr>
<tr>
<td>Dresserville (Washoe)</td>
<td>153</td>
<td>153</td>
</tr>
<tr>
<td>Winnemucca (Paiute)</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Woodfords (Washoe)</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Yerington, Campbell Ranch (Paiute)</td>
<td>400</td>
<td>250</td>
</tr>
<tr>
<td>Reno-Sparks (Washoe-Paiute)</td>
<td>525</td>
<td>499</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9032</strong></td>
<td><strong>4312</strong></td>
</tr>
</tbody>
</table>

SOURCE: Intertribal Council of Nevada, 98 Colony Road, Reno, Nevada 89502.

Military

Mental health services are provided to military employees, their dependents, and veterans through Nellis Air Force Base outside Las Vegas, and the Veterans Administration hospital outside Reno.

Nellis Air Force Base has only an outpatient mental health program staffed by 4 people: a psychiatrist or psychologist, a social worker, and 2 mental health technicians.44 The base is the primary mental health services location for all military installations in Nevada; military employees needing those services are transferred temporarily to Nellis. If the Nellis program is not appropriate for an active duty employee, the program can transfer the employee out of state to a larger Air Force hospital for inpatient care, or can purchase services from civilian mental health professionals and facilities in Nevada. In 1974, active duty personnel averaged 180 patient-hours per month of outpatient mental health service at Nellis, dependents 70, and retirees 5. In addition, as of November 1974 there were 35 mentally retarded and 11 emotionally disturbed children of military employees receiving services in

44 Interview at Nellis Air Force Base, Las Vegas, Nevada, November 1, 1974.
the civilian mental health service system, expenses being paid by the military medical insurance program, CHAMPUS.

The Veterans Administration hospital in Reno has plans for a 24-bed inpatient mental health program and a 12,000 annual outpatient-visit mental health program. A multidisciplinary staff will also provide day treatment, and a night-only treatment program. The staff includes 5 psychologists, 1 social worker and 3 psychiatrists.

MENTAL HEALTH SERVICES FOR MENTALLY RETARDED PEOPLE

Mentally retarded people, like nonretarded people, often have emotional or mental health problems, and their families may require psychological counseling. The Division of Mental Hygiene and Mental Retardation’s brochure Mental Retardation Services in Nevada recognizes those needs and states that mental health center personnel “may provide diagnostic and evaluation services, individual and family counseling—especially where emotional difficulties are found along with retarded mental functioning—and, in some cases, training for parents.” The Division also has a “Director of Psychological Services,” who reports to the Associate Administrator for Mental Retardation. In 1974, however, the mental health centers almost never served mentally retarded people, and the person who held the position of Director of Psychological Services for mentally retarded people said flatly that “there are no psychological services for the mentally retarded.”

He said he provided no direct psychological services himself, supervised no one who did, and had no funds to purchase those services. He also said that the staffs of the Rural Clinics program and mental health centers were not giving direct psychological services to mentally retarded people. In addition, the NMHI almost never provides mental health services to its mentally retarded residents. Our interviews with those other programs confirmed the lack of mental health services for mentally retarded people in Nevada.

The two state Mental Retardation Centers (MRCs) are not really staffed to provide mental health services (see Chap. 10). Yet, according to the administrator of the Northern Nevada MRC, the Reno MHC does not accept mentally retarded people or their families for service. She said the Reno MHC staff argues that the MRC staff knows better how to deal with retarded people and their families. The Southern Nevada MRC is on the same site as the Las Vegas MHC, but little interaction occurs between the two. When we asked the administrator of the Las Vegas MHC about that interaction, he said that only very occasionally did MRC staff come to the mental health center for consultation, and then usually because it was difficult to decide whether a particular client’s problem was primarily a mental health disorder or mental retardation, and hence to decide to which program the person should be admitted. The Las Vegas MHC will accept the client if the mental health disorder is predominant, and then only if the person is only mildly mentally retarded.

* * *

Interview with D. Rockenbeck, Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 19, 1974.
Outside the Division of Mental Hygiene and Mental Retardation, the Special
Children’s Clinics in the Health Division did some counseling of families with re-
tarded children. We described those two Special Children’s Clinics earlier (see
Chaps. 6 and 7) and noted that some excellent counseling is provided there, but each
clinic reaches only families with children under about six years old and has less than
one full-time-equivalent staff member devoted to such counseling.

The various Community Training Centers, usually operated by a local Associa-
tion for Retarded Citizens (see Chap. 11 for details), provide some counseling but are
not professionally staffed to provide mental health services. In 1974, for example,
the Las Vegas Opportunity Village Association for Retarded Citizens did not provide
psychological services to retarded people, but did provide other types of counseling
to persons participating in their sheltered workshop and residential living pro-
gram. The same was true of the Washoe Association for Retarded Citizens in Reno.

SOME DESIRABLE FEATURES OF A PSYCHOLOGICAL
SERVICE SYSTEM

In this section we discuss Nevada’s nonresidential psychological service pro-
grams in general terms, in relation to desirable features of a mental health service
system. This discussion will set the stage for the recommendations given in the last
section of this chapter. While our immediate concern is with nonresidential psychol-
ogical services, the desirable features of a service system discussed here are applica-
table to many other types of service systems. Still other features could be listed, but
the following are some of the major ones to be discussed:

- The system should have sufficient capacity to serve all people whose needs
  the system is intended to meet.
- Available services should be distributed equitably to the population.
- The service system should function in a coordinated manner.
- Services should be of at least minimally acceptable quality.
- A continuum of levels of services should be available to match people’s
  needs, ranging from outpatient to intensive residential treatment.
- A variety of treatment modalities should be available to match the variety
  of people’s mental health disorders.

These features are laden with words requiring value judgments, but they are
nonetheless useful in evaluating existing programs. We believe they encompass the
barest essential standards one should expect in a system.

Sufficiency and Equity of Service Availability

A good psychological service system should be able to reach all of those with a
substantial need on something approximating an equitable basis. That is, if the
public through its elected representatives decides that people with certain types and

** Interview with E. Pillard, Northern Nevada MRC, Sparks, Nevada, August 21, 1974.
** Interview with L. Miller, Las Vegas MHC, Las Vegas, Nevada, July 17, 1974.
** Interview with Dr. Theodore Johnson, Executive Director, OVARC, Las Vegas, Nevada, July 17,
  1974.
degrees of mental health disorder need service, then all such people should be served. No groups should be excluded on the basis of age, income, accident of geographic location, or the like as they are now. In 1974, for example, Nevadans living in Reno or Las Vegas had a far better chance of receiving psychological treatment than did rural citizens, and adults had a better chance of receiving services than did children.

Coordination of the Service System

Fragmented services and fragmented responsibility are generally undesirable, for they may leave gaps in services and lead to inefficient provision of services, and thus to limited availability and quality of care. This issue is so important that we have treated it separately in Chap. 4. Probably no service system is perfectly coordinated, of course, but Nevada’s is very deficient in this regard. The most glaring deficiency with respect to nonresidential psychological services is the lack of coordination between programs as a person is released from a residential treatment program (see Chap. 10 for details).

An important question in a service system should be who is to provide follow-up to monitor the experience of the mentally handicapped client as he or she moves from one service program to another; or even more fundamentally, who is to plan and coordinate an intervention strategy encompassing all services needed by the client with a mental health disorder. In Nevada, sadly, the answer to both questions often is no one.

Quality of Services

One would like the treatment provided to be of high quality, or at least of minimally acceptable quality. In Nevada, some services are not available at all, and some are of low quality because inadequately skilled people try to provide them. The mental health technicians employed in several Nevada programs are a case in point. As mentioned above, and discussed more thoroughly in Chap. 10, the technicians are generally hardworking, concerned, and dedicated people, but in practice usually bring only the barest minimum of qualifications to the job (see Chap. 10 for details). The official state job descriptions prescribe certain amounts of training they are supposed to be provided, but the amount they actually receive usually is much less. The combination of their low skills and their heavy responsibility for providing psychological services, often without close supervision by senior mental health professionals, leads in our opinion to some clients receiving low-quality services. In Chap. 10 we discuss the same type of difficulty in residential treatment programs.

It is easy enough to say that Nevada could solve the problem by hiring the finest professional talent for all staff positions; but that solution appears infeasible because of the cost and the complex problems of recruiting. Not only are high-quality mental health professionals scarce and expensive, but also they often use noneconomic criteria in choosing job locations, e.g., proximity of high-quality colleagues, living amenities, and opportunities for professional development and advancement. Our conclusion being that it is not practical to eliminate the position of mental health technician, we will recommend upgrading technicians’ skills.
Continuum of Levels of Services

Since the types and severity of mental health disorder vary among people, and over time may vary for the same persons, the levels and types of psychological service needed also vary. The individual patient's needs change as the condition being treated changes—as a result of time (e.g., as the patient's environment changes), as a result of positive returns from treatment (e.g., the acute hospitalizing episode gives way to outpatient treatment and in time to no treatment at all), or as a result of lack of treatment (e.g., a deteriorating untreated situation). It is therefore desirable for a mental health system to offer a continuum of care, a continuum of levels of treatment, from which skilled professionals can select the most appropriate for a given person at a given time. That continuum includes emergency services, outpatient services, day treatment, short- and medium-term intensive inpatient treatment, halfway houses, and longer-term intermediate or low levels of residential service for those with chronic disorders.

In that light, the state of affairs in Nevada is far from good. The treatment options in Nevada hardly constitute a "continuum of care," especially in certain geographic areas. Numerous programs have been created in recent years, but some are too small or otherwise inadequate in relation to the need, despite their glowing official descriptions. The well-intentioned Rural Clinics program is largely one such "paper program." Instead of a continuum, most rural Nevadans with mental health disorders have primarily only two options: outpatient treatment by the small Rural Clinics program, or full inpatient residential treatment at the NMH. In the Reno area, day treatment for adults is lacking. There are no halfway houses for people with mental health disorders in the entire state, and there is a statewide shortage of longer-term residential care with intermediate levels of mental health treatment for those who need it (see Chap. 10). The nonresidential mental health programs could, but usually do not, provide intermediate levels of services to people with chronic mental health problems who are now living in group care facilities without special mental health services. We are in favor of serving people in the least restrictive and most normal environment possible, but no service can be worse than "too much" service.

To help avoid misunderstandings, a few words of caution are in order. First, the community mental health center delivery mechanism, as it is usually implemented, does not offer the entire continuum of service levels, and was not designed to do so. The original intention was for the centers to provide levels of service supplementary to those of the more traditional mental hospital with its longer-term service. Nonetheless, one of the more obvious difficulties a community mental health center must face is the pressure put on it to serve as a replacement unit for the mental hospital. Second, this discussion is not immediately concerned with particular psychological treatment modalities, which are considered in the following section, but with the wisdom of having a continuum of levels of care.

We now turn to a brief discussion of the various levels of treatment for mental health disorders. Our aim is to put the nonresidential psychological services discussed in this chapter into perspective with the other levels of treatment discussed in Chap. 10.

We are indebted to Dr. Robert Rubenstein for his thoughtful probings and suggestions on the topics treated in this section.
Access Points. For people who need treatment, the diagnostic phase of their experience with the psychological service system is extremely important. In effect, it is the access or entry point to treatment, at which it is decided what level on the continuum of care is appropriate for their needs. Its importance for everything that follows in the individual’s experience is well known: inadequate or inappropriate diagnosis leads easily to inadequate or inappropriate therapy. Its importance is still operation of the system is not as well appreciated as it should be. Certain classes of disorders and various groups of people are more likely to respond well to certain specific levels of treatment than are others. Treatment resources being scarce, the need is acute to match precisely determined needs as well as possible with available services.

The design of access points merits great attention. The features outlined below make up one desirable design for an access point.

The access point can be thought of as a psychological emergency room. Unlike the traditional medical model, however, it should be equipped to provide emergency care on at least an overnight basis if needed. In the structure we envision here, patients enter the system in a state that could be called the “troubled and troublesome.” They receive immediate and brief treatment, are thoroughly and rigorously assessed and diagnosed by a highly skilled and well-trained mental health professional, and are given positive referral to appropriate service in the continuum of care.

Let us follow a hypothetical patient through the process step by step to understand better the function of the access point and to see how it might relate to other service components.

The patient comes to the access point, perhaps of his own volition, perhaps because his family or friends brought him, because the police or a general physician encouraged him, or for a variety of reasons. A specially trained mental health worker conducts the initial intake interview to size the patient up and begin assembling the fundamental information needed to make a responsible assessment and intervention judgment. If the patient is in an acute episode, he or she receives on-the-spot treatment. A highly skilled mental health professional makes a thorough assessment within 24 hours. This initial judgment is the key to all that follows in the patient’s experience; it should be done by the best possible talent the system can afford. It is not a task for a low-skilled, poorly trained, and poorly supervised mental health technician.

Working in conjunction with those in the access point—probably as operational components of a community mental health center—could be a Family Crisis Unit and a Home Visiting Service. The Family Crisis Unit would determine who in the patient’s personal circle has a strong enough emotional attachment to the patient to serve as a primary contact and support during the treatment period; that person might be a spouse, a parent, a close friend, or even a professional in a related helping field, such as the ministry. The unit would assess the patient’s supporting resources as thoroughly and quickly as possible. Finally, it would provide some information and counseling to the patient’s family and friends in an effort to ease their emotional burdens and to facilitate the patient’s return to his or her normal setting.

The Home Visiting Service, by contrast, could act as the outreach component (now nearly absent from the Nevada system). Its primary responsibilities would be with the home-bound and geriatric populations. Those groups would include many
people who have recently been in institutions, other recently treated patients, and people who for a variety of reasons are reluctant to seek assistance in the first place. The Home Visiting Service also would provide feedback information about recently discharged patients, e.g., how they are faring, and whether their treatment program seems to have been appropriate and effective. The service unit also would work to prevent the need for patients to reenter more service-intensive components of the psychological service system.

A few general observations are needed on two topics: the kinds of patients likely to present themselves at an access point in the public sector, and the need to concentrate highly skilled resources at the "front end" or diagnostic phase of psychological treatment. The topics are intertwined.

Many people in the mental health professions freely admit that they prefer certain classes of patients over others. The reason may be personal predilections or aversions, or simply that the professional is more successful with some types of patients than with others. The mildly neurotic patient may be more desirable than the acutely psychotic to some professionals; others may regard younger patients as more attractive, interesting, and worthwhile than geriatric ones; or patients with average or above-average intelligence as more "suitable" than those who are retarded; those able to pay higher fees may be more welcome than those who are not; and so forth. This natural sorting and selecting process is more prevalent in the private sector where psychiatrists and other therapists have a choice of patients. One notable result is that the more disordered and harder-to-treat segments of the population are the ones most likely to end up in the public sector. Consequently, a full range of high-quality services is needed all the more in the public sector, which should not have the privilege of accepting only the more "desirable" clients.

At the conclusion of intake and initial assessment at the access point, a service option should be selected depending upon the person’s condition. Among those options are direct referral to an outpatient service, to a halfway house, to day treatment, to brief residential treatment in either a general hospital psychiatric unit or in the community mental health center's inpatient unit, and in Nevada, referral to the NMHII. The most likely choice would be outpatient treatment or brief residential treatment.

**Brief Inpatient Evaluation and Treatment.** The purpose of inpatient evaluation or brief treatment is to deal with the patient’s immediate acute difficulty, to the end of returning the patient to as normal a setting as possible as quickly as possible, and to do so with the assistance of a well-considered treatment plan. The emphasis in evaluation, which might extend over a week, would be on resolving the basic question of why residential care was necessary in the first place:

- What elements contributed to the episode? What was the precipitating event?
- What community supports are available to assist the patient’s recovery?
- What personal resources are available?

During the inpatient evaluation period, contacts are made with other helping professionals, the family, and friends, to help in devising an ongoing treatment plan. Patients themselves can be included in the evaluation process to the greatest extent possible, singly and in groups, so as to engage the patient in his or her own plan and
to enable the responsible mental health professionals to see firsthand how the patient handles personal interactions. Some psychological testing could be done to assess mental functioning, and of course a thorough medical examination would be given.

By the end of the 4-to-7-day evaluation period, a plan should have been developed and reviewed with the patient, his or her family or other emotionally supportive people, and the professionals responsible for carrying out the treatment plan. A continuing treatment plan should accompany any and all releases of the patient.

Several possible options exist at this stage:

- Residential care for a short period (up to, say, 30 days).
- Intensive residential treatment for more than a short period.
- Intermediate levels of residential care for chronic cases.
- Day treatment.
- Outpatient care.
- Halfway house.
- Return to family care.
- Return to the community under own recognizance.
- Combinations of the above.

If additional short-term residential treatment is desirable, efforts would be made during this period to engage the person in a therapeutic program that would extend beyond the residential care phase. Efforts would continue to create a “structured life situation,” involving work, family, and friends. Medication, individual or group therapy, and work activities would be coordinated to improve the patient’s chances in the post-residential-treatment period.

**Intensive Residential Treatment For More Than A Short Time Period.**
This service is lacking in Nevada, although it is an important and needed service component. First of all, the idea of intensive residential treatment for more than a short time period is meant to encompass a time-frame of from 3 to 12 months—occasionally more. The facility would concentrate on patients for whom intensive therapy is most likely to have positive returns for the resources invested.

**Intermediate Levels of Residential Mental Health Care.** A chronic weakness in Nevada’s current system, this important service gap needs attention. Some people do not need intensive residential treatment but still are not capable of functioning in the community. They need some intermediate level of mental health services. They may need a halfway-house program that helps them make the transition back to the community or prevents their unnecessary placement in an intensive treatment facility, or they may be chronic cases who need long-term residential care with a nonintensive level of mental health services.

**Day Treatment and Outpatient Care.** These are the two main services provided by the programs described earlier in this chapter. The only remaining point we would like to make about these nonresidential services is that they are not always connected as they should be with the rest of the psychological service system. As far as the client is concerned, the transition from and to nonresidential care should appear to be smooth and care should be continuous. Since changing a patient’s primary therapist is difficult, and can disrupt treatment, it ideally would be preferable to have the same primary therapist during both the inpatient and nonresidential phases of treatment. Professionals such as psychiatrists or Ph.D.-level
psychologists could be used as the single primary therapist in all phases of treatment. However, the new "Master of Mental Health Services" level of personnel we propose later in this chapter could be assigned the role of primary therapist (with appropriate professional supervision and support) and provide substantial meaningful treatment at relatively low cost compared with using only psychiatrists or Ph.D.-level psychologists.

Range of Treatment Modalities

A variety of approaches exist for treating mental health disorders. Drug therapy and behavior modification are only two examples (and not necessarily mutually exclusive ones) of general approaches or classes of treatment modalities. While the choice of modality should depend on the particular client and his or her disorder, the choice is by no means automatic. The state of knowledge is such that mental health professionals do not always agree on which modality is best for a particular disorder. Nearly all would agree, however, that no single modality is the most appropriate one for all individuals and for all mental health disorders. Nonetheless, Nevada in 1974 did not have a range of treatment modalities in some programs in the public sector. In 1974 some programs in Nevada chose to rely almost exclusively on certain types of behavior modification, while others predominantly relied on drug therapy because they lacked sufficient skilled staff.

Basically, we take the eclectic position that people experience a variety of kinds of mental health problems, which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency.

The remainder of this subsection looks at the issue of treatment modalities in more detail, especially the use of behavior modification techniques, which is a subject of public controversy in Nevada.

The last twenty years have seen extraordinary development and growth in mental health professions and services. The growth has resulted from new information and the creation of new, often competing, views of man. Understandably, the profusion of basic knowledge and theory has led as well to a profusion of therapeutic models or treatment modalities.

New information, including empirical evidence and new theoretical formulations, portends well for a better understanding of how humans function. This information has been generated in a variety of disciplines and specialty fields. The following is a brief sample listing of areas of development of new information; while sampling and summarization do injustice to subtle details of specific areas, they have the virtue of brevity and aid the reader in picturing the areas generally.

- Psychology has provided much new information from studies of behavior and of human development, from research in experimental psychology, and from clinical

---

70 We acknowledge the considerate assistance of Drs. Leon Wasserman and Martell Bryant, Mt. Zion Hospital, San Francisco, California, in interviews on June 18, 1975.
research and practice. New concepts, such as certain advances in behavior modification, and improvements on previous theories, such as the broadening of psychodynamics to include stress responses, coping mechanisms, defenses, and ego functions, have improved psychology as a base upon which to ground a treatment system.

- Biological sciences, including many newly created sub-specialty fields, e.g., in neurophysiology, biochemistry, and neuroendocrinology, have led to advances in knowledge about neurochemical bases of anxiety, anger, and depression, for instance. The creation and widespread use of various forms of tranquilizing and energizing drugs, due to rapid advances in the psychopharmacological field, have allowed many formerly unmanageable people to be treated effectively. Psychopharmacological intervention has become increasingly important and useful, but primarily as an adjunct to other kinds of treatment (e.g., psychotherapy), which it may facilitate but does not replace.

- Social science has added somewhat to our understanding of people's interactions and functionings within groups, including contributions related to organizations, group dynamics, and value analyses. The notion of "health" or "normal" development and action within the family, the informal and formal group, the organization, the society, and the culture has been the groundwork of much of the social scientific research and thought in the last generation. Some portion of this new information has a bearing on an improved understanding of the causes, consequences, and cures of mental disorder.

Each of these fields, and their associated professions and disciplines, has in a broad sense added to the aggregate fund of knowledge. However, this knowledge remains incomplete and unintegrated as a total body of learning on mental health disorders; consequently, while effective treatments are known for some mental health disorders, thorough and effective treatment and service models have not been developed for every type of mental health disorder.

New and sometimes conflicting service approaches or treatment modalities have spring up in recent years, to a large extent representing manifestations of the expanding but still incomplete knowledge base. In fact, many of the underlying perceptual and theoretical conflicts existing in different disciplinary areas are drawn out into the open in the applications setting. As practitioners have struggled to lessen human suffering, many relatively new or newly improved approaches have surfaced: psychotropic drug therapy, various types of behavior modification, crisis intervention, family therapy, and transactional analysis are examples. No treatment modality is a "sure-fire bet" for effective treatment of all mental health disorders; all have at one time or another had strong supporters and detractors; and most have been able on occasion to help some number of troubled and troublesome people.

It is beyond the scope of this study to attempt to prescribe which modalities should be used for which mental health disorders. We repeat, however, that no single modality is most appropriate for all cases; a complete mental health service system should offer a range of choices. We belabor this point because certain Nevada advocates of behavior modification have told us they feel that in nearly no other treatment modality is needed, and therefore have severely limited the availability of other major modalities in some Nevada mental health programs.

It is true that behavior modification therapies have demonstrated their success in modifying a wide range of types of maladaptive behaviors in some people, but it is shortsighted to ignore other successful approaches, especially when some other
approach is generally more effective for a particular mental disorder. For example, the role of drugs has expanded greatly and has quietly revolutionized the treatment of some mental health disorders. Research in the past 20 to 30 years has demonstrated the high effectiveness of drugs in treating a number of disorders, including some types of severe depression and schizophrenia.\textsuperscript{71} Hence, if certain types of personnel effectively are excluded from direct service roles in certain Nevada mental health programs, then effective use of some treatment modalities is likewise excluded (such as chemotherapy, which only physicians with psychiatric expertise are both trained and licensed to provide.)

In the past, behavior modification techniques probably were underutilized in Nevada, but the pendulum now appears to have swung to the other extreme in some programs. Most notable for their use of behavior modification in 1974 were the Clark County Children's Behavioral Services program and the Henderson Mental Health Center program. The Rural Clinics program was equally notable in 1974 for its lack of psychiatric personnel for direct service. By February 1976, however, the Henderson Mental Health Center and the Rural Clinics programs had broadened their mix of staff skills to include psychiatrists and to offer a broader range of treatment modalities. The issue is not whether a program should have psychiatrists or psychologists, but why a program does not have both psychologists and psychiatrists, and thus offer a broader range of treatment modalities. The sole reliance on behavior modification techniques has been criticized not only by psychiatrists but also by psychologists, both in Nevada and nationwide.

There are several behavioral schools that have contributed to the body of knowledge related to human behavior, but the work of B. F. Skinner and his followers usually comes to mind when one discusses "behavior modification."\textsuperscript{72} Skinner's approach interprets individual behavior as being primarily determined by the individual's past history of reinforcements; past environments (or "contingencies of reinforcements") shape the person's current behavior. Skinner's work has progressed in stages, including the novel \textit{Walden Two}, and the works \textit{Science and Human Behavior} and \textit{Beyond Freedom and Dignity}.\textsuperscript{73} The last-named met with popular success and acclaim, but also evoked criticism from many scientists and practitioners.\textsuperscript{74} Skinner has responded to his critics in his book \textit{About Behaviorism}.\textsuperscript{75}

Behavior modification, a clinical result of Skinner's and many other people's theorizing, emphasizes learning between the subject and his environment. Behavior modification is not one specific method, but rather a family of techniques. In the


\textsuperscript{72} Earlier works include, for example, Pavlov's deterministic theory of the brain and behavior highlighting of the concepts of reflex and conditioning: Ivan P. Pavlov, \textit{Lectures on Conditioned Reflexes}, trans. and ed. by W. H. Gantt, International Publishing, New York, 1941, 2 vols.


\textsuperscript{75} Knopf, New York, 1974.
mental health area, behavior modification techniques in general have the characteristic that they are concerned primarily with changing maladaptive behaviors and teaching desirable behaviors.

For a summary of the development of the behavioral approach over the years, see *Progress in Behavior Modification*, edited by M. Hersen, R. Eisler, and P. Miller; two summary paragraphs on the historical course of behavior modification are reproduced below:

One of the foundations of what now is labeled as behavior modification can be traced back to the original work conducted by the physiologists Pavlov and Bekhterev in their animal laboratories at the beginning of this century in Russia. For almost three decades, these two reflexologists conducted numerous animal experiments showing that a previously neutral environmental stimulus (e.g., a bell) when temporally preceding a naturally occurring autonomic response (e.g., salivation in the presence of food) could acquire the power to elicit the autonomic reaction after many such pairings. This phenomenon was later described as "classical conditioning," and a number of the current treatment strategies used by behavior modifiers are derived from the principles of classical conditioning.

Not only has there been a tremendous increase in publications relating to behavior modification in the last decade and a half, but the tenor of the writing has changed over the years. That behavior modification is now truly reaching its adult status is underscored by the absence of acrimonious attacks on other schools of thought, so prevalent in the writings of the earlier behaviorists. This, however, does not mean that most behavior modifiers are willing to compromise and merge their views with nonempirical disciplines, although this merger has been suggested. But it does indicate that the scope of behavior modification has increased and that influences from other empirical approaches are being considered. For example, the importance of physiological processes, the use of drugs as adjuncts to behavior therapy and the role of social psychological factors in the treatment process are subjects for both research and clinical application.¹⁸

As noted directly above, some mental health service professionals who take a behavior modification approach will use elements usually associated with other approaches, e.g., drugs, in treating clients. To carry the drug example further, another article in *Progress in Behavior Modification* surveys and summarizes findings from four areas where drug research and applied behavior analysis intersect. These areas include:

... (1) drugs as adjuncts that facilitate behavior therapy; (2) environmental interventions that increase the reliability of drug usage by chronic psychotics; (3) experimental analysis of clinical drug effects using direct behavioral observation; (4) drugs as reinforcers, aversive stimuli, or agents of extinction.¹⁷

The article also states:

Almost 20 years after their introduction, there is no doubt that phenothiazine drugs beneficially alter the deviant behaviors of schizophrenics and that lithium reduces the excessive motor and verbal behaviors of manic patients.

¹⁷ R. Liberman and J. Davis, "Drugs and Behavior Analysis," in *Progress in Behavior Modification*. 
It is the contention of the authors that withholding these psychotropic drugs when clearly indicated by the patient's behavioral disturbance is tantamount to unethical clinical practice.\(^7^8\)

Thus, some advocates of the behavioral approach recently have been expanding the range of specific types of treatment they use. The various policy-makers in Nevada can judge from the evidence we present elsewhere in this report on specific Nevada programs, and from inspection of the current operation of those programs, the extent to which this broader behavioral approach exists [in practice] in Nevada. Still, while the behavioral approach has great value, it is neither a panacea nor an all-embracing theory or method.

In reviewing an earlier draft of this report, a Nevada Division of Mental Hygiene and Mental Retardation administrator sent us the following quotation from the Director of the National Institute of Mental Health:

Considerable evidence suggests that behavior-modification therapy in comparison to traditional therapies has several important advantages in work with children. These include greater effectiveness; greater efficiency; greater specificity of results; greater applicability to a wider segment of the population of children; and greater utilization as a treatment method, i.e., groups other than professional personnel in mental health, including parents and teachers, can carry out the behavior-modification process.\(^7^9\)

Careful reading of the above statement and the rest of the article from which it came shows he does not disagree with the position that behavior modification is not the most appropriate approach for [all] individuals with mental problems. He says in the above quote, "applicability to a wider segment of the population;" he does not say "applicability to [all] the population." Later in the article from which the Nevada Administrator drew the above quotation, we find the following:

... behavior modification is not a method that can be successfully imposed on an unwilling individual. By its very nature, it will succeed only when the individual who is receiving the consequences is responsive and cooperates with the program.\(^8^0\)

Important and useful though behavior modification is, the zeal of some of its champions is uncomfortably reminiscent of that of some enthusiasts of penicillin who claimed near-omnipotence for the medicine as an antibiotic therapy during its early history. As with many another "miracle drug," actual experience proved to be sobering. Basically, four qualitatively different outcomes were observed in the wake of penicillin's wholesale application: (1) some spectacular results, (2) some modest results, (3) no response or reaction at all, and (4) unwanted, often harmful reactions. In time, those types of cases most likely to benefit from penicillin were identified, and penicillin has taken its place as one important mode of health treatment. The analogy appears to hold for behavior modification.

RECOMMENDATIONS

The problems we have noted with respect to nonresidential mental health serv-

\(^7^8\) Ibid.


\(^8^0\) Ibid.
ice include: insufficient service capacity to meet the minimum need in each area of the state, especially in rural counties; mental health technicians inadequately trained and supervised in relation to their mental health treatment responsibilities; lack of a continuum of levels of nonresidential services in each area; excessive reliance on a single treatment modality in some programs in 1974; inadequate follow-up service to people released from the Nevada Mental Health Institute; few services to emotionally disturbed children in the schools; and almost no mental health services for mentally retarded people.

We recommend that all professional staff positions at the Las Vegas Mental Health Center be filled. A number of problems noted in this chapter and in Chap. 10 on the center’s residential services in 1974 (problems with intake assessment, staff supervision, and smooth transition from one level of care to another) could be resolved if the center had all authorized professional staff positions filled. The Administrator of the Las Vegas Mental Health Center indicates that, as of February 1976, the “vast majority” of these professional positions are filled. The one major problem that cannot be resolved by filling those professional positions is the low skill level of mental health technicians and their lack of training; a subsequent recommendation will deal with this problem for mental health technicians in all programs.

We recommend implementation of improved follow-up treatment to provide a continuity of care for mental health patients released from NMHI; mandatory improved follow-up procedures also should be established to help ensure that people released from other state-operated residential mental health treatment programs (Las Vegas MHC and CBS programs) receive adequate follow-up services. This includes both short-term and long-term follow-up, e.g., for people who have a chronic need for some intermediate level of mental health services and are residing in extended care facilities that do not provide those services. See Chap. 10, on residential mental health services, where this recommendation is developed in detail.

We recommend that 24-hours-a-day emergency crisis intervention service be available from every mental health center and from the Rural Clinics mental health program. Although people with mental health disorders obviously require emergency help at times other than weekdays from 8 a.m. to 5 p.m., some of Nevada’s major mental health programs do not have 24-hours-a-day emergency crisis intervention service. This emergency service should include an in-person crisis clinic plus the ability to provide emergency care on an overnight basis if needed, so as to both provide needed service and help avoid unnecessary hospitalization. See the section of this chapter entitled “Some Desirable Features of a Psychological Service System.”

Nonresidential mental health services for rural Nevadans are substantially worse, in both quantity per capita and quality, than those available in Las Vegas and Reno. We recommend that the staff of the Rural Clinics mental health program be substantially increased (at least doubled); that a full range of professional skills be represented on the staff so that a full range of treatment modalities can be used; that the skill levels required of mental health technicians be substantially upgraded as described in a subsequent recommendation; that the present offices in rural areas continue in operation; and that each rural office be visited one day a week by a traveling multidisciplinary team of senior mental health professionals to supplement the lower-skilled rural office staff. Because it is probably not feasible to staff each
rural office with a full team of professionals, we suggest a set of two traveling teams, each on the rural office circuit about half the time. Thus, skills such as those of a psychiatrist, which are needed for chemotherapy and and other modes of treatment but are not needed full time, would be available in each rural area. Local rural office staff would provide outpatient follow-up and emergency services. Traveling teams would complement and supervise the local office staff, assist on difficult cases, and help to follow up discharged residential patients. Residential mental health services needed by rural residents would be provided by the Nevada Mental Health Institute, probably by the same personnel who make up the two half-time traveling teams. Thus, two full-time teams could serve rural residents; each would work half-time with patients from rural areas at the NMHI while the other was visiting Rural Clinic offices. (See Chap. 10.) Also, the current Rural Clinics personnel are spreading themselves thin trying to do many different things. We recommend that the Rural Clinics staff increase the emphasis on what appears to be the greatest need: service to people with substantial mental health disorders. The Rural Clinics program is an excellent example of a small embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans, especially those with the more severe disorders, are concerned.

We recommend that a second community mental health center be established in Clark County. The present Las Vegas Mental Health Center is operating at nearly full capacity and there are still clear unmet needs in the county, e.g., in the areas of follow-up of released residential service patients, service to emotionally disturbed children and adolescents, service to rural residents of Clark County, and service to mentally retarded people with mental health problems. The main problem with the Henderson Mental Health Center is that it is extremely small in relation to the two-thirds of the Clark County population in the geographic catchment area it is supposed to be serving. It does not provide a full range of services and is not located near the center of the population it is supposed to serve. We suggest the present Henderson Mental Health Center be retained as a satellite office of a new community mental health center to be designed on the order of the present Las Vegas Mental Health Center, but located on the opposite side of Las Vegas.

The case for a new community mental health center in Clark County is made in detail in a current proposal by the Division of Mental Hygiene and Mental Retardation.  

Population growth in Clark County that will occur before a new CMHC could be operational (see Chap. 3) adds further weight to the arguments in favor of a new CMHC. No one really knows for sure how many people need mental health services in any of the three major areas of the state, but the existing pressure on the service system in each of the three areas (Clark, Washoe, and rural counties) indicates a need for expanded service capacity. The federal guidelines for community mental health centers recommend that one be established for each 75,000 to 200,000 population. While the reasons for this range are numerous and have been debated from a variety of perspectives, these guidelines are suggestive of what is needed generally to meet the demand for mental health services. Given Las Vegas’s current and projected populations, there appears to be ample evidence to support two full community mental health centers for the metropolitan area. The Clark County Plan for

*1 “Community Mental Health Center, East Clark County.” See footnote 10.
Health estimates a need for 28 new psychiatrists in Clark County, and notes a need for comprehensive mental health services in the Henderson MHC catchment area. When a second CMHC is approved, catchment boundaries in Clark County may need redrawing to reflect the realities of population distribution.

In the Washoe County area, the main problem with nonresidential mental health services is that a full continuum of services is not provided. The Nevada Mental Health Institute functions primarily as an outpatient program for adults, but offers a small day treatment and outpatient program for adolescents. Both programs are operating at full capacity and do not meet the need; people must be turned away. Day treatment for adults is not provided, nor are 24-hours-a-day emergency services or short-term residential care outside the NMHI in Sparks. Rural residents and mentally retarded residents are not now served. Population growth will increase the need for a new community mental health center significantly before it can become operational. We do not believe the Nevada Mental Health Institute should function as a community mental health center for Washoe County; it has enough other functions for which it appears better suited and which will use its staff to full capacity (see Chap. 10). We recommend that the Reno Mental Health Center be expanded to a full community mental health center on the order of the one now operational in Las Vegas. The staff and advisory board of the Reno MHC have prepared a proposal for creation of a community mental health center to provide Washoe County with a wide range of mental health services: intake screening and referral, 24-hour emergency services, adult outpatient treatment, adult inpatient evaluation and short-term treatment, adult day treatment, adult extended care, child and adolescent day-treatment, family consultation and outpatient treatment, 24-hour child and adolescent treatment, outreach services, and community consultation, education, and training.

Under the proposal, the center would contract with the Nevada Mental Health Institute for facilities for a short-term (up to 30 days stay) inpatient unit to be staffed by the center. Longer-term patients would be transferred to the regular NMHI program for residential mental health treatment. The Reno MHC might also contract with a local hospital for inpatient space. The proposed extended care program was prompted by the same concerns we express in Chap. 10 about the lack of longer-term intermediate levels of mental health services for people who need them, especially former chronic patients of NMHI. Approximately 100 Washoe County residents needing long-term mental health care are in group care homes that do not offer such care. The catchment area for the new community mental health center would be all of Washoe County, plus the Lake Tahoe and Carson City areas, since we believe these would be better served by satellite offices linked to a community mental health center in Reno than by the Rural Clinics program, which does not provide a full range of mental health services.

When the northern Nevada Children’s Behavioral Services program is fully implemented, the Reno MHC Family Unit service program and staff for children and adolescents should work in close cooperation with it, to maximize coordination.

---

82 Clark County Area Wide Comprehensive Health Planning Advisory Council, Clark County Plan for Health, Las Vegas, Nevada, December 1974, p. F-5.
85 Interview with R. Keiffer, Reno MHC, Reno, Nevada, April 22, 1974.
of services and continuity of care to children and youth. If the northern Nevada CBS program serves only children under age 13, as the Clark County CBS program now does, there will be a need for services to youths aged 13 to about 18 that the Reno MHC program could concentrate on.

We recommend that the Children’s Behavioral Services program provide more complete initial assessment of the mental health problems and service needs of the children it serves than it did in 1974, concentrate more of its resources on children with the more severe mental health disorders than it did in 1974, and broaden the mix of professional skills on its staff to include specifically both physicians with specialty training in psychiatry and psychologists so that a broader range of treatment modalities can be provided. The program in Clark County in 1974 was dominated by one mental health discipline (psychology) and one mode of treatment (behavior modification) that is not always the most appropriate one for every mental health disorder. CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, the program would also need to provide for pediatric services on at least a part-time consultant basis. In addition, some of the CBS client children whose cases we reviewed may not have had significant mental health disorders. The CBS program justifies serving children with mild behavior disorders by saying serious mental disorders are being prevented; while we fully support the goal of prevention, it is very hard to tell if a serious mental disorder would have occurred in a child with a mild behavior disorder if CBS did not serve the child. See Chap. 5, Prevention, for a discussion of this issue area.

The schools are not presently providing adequate special education for emotionally disturbed children (see Chap. 7), but even if they did, there would still be a need for nonresidential mental health services for the more severely emotionally disturbed children. Rather than try to make the schools into mental health service agencies, we recommend increasing the number of referrals of seriously emotionally disturbed children in school, whether or not they are in special education, to the appropriate mental health center or Children’s Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other service programs exist.

We recommend that mental health services be provided to mentally retarded Nevadans and their families who need them. Such is usually not done now.

We recommend substantially upgrading the skills of mental health technicians involved in treatment of mental health disorders by: (1) eliminating the existing personnel classification and creating three new classifications, one for those employees primarily treating mental health disorders, one for those employees primarily providing mental retardation services, and one for those employees who primarily perform nontreatment support functions such as clerical, housekeeping, and patient escort; (2) upgrading the job requirements for the treatment positions to the master’s degree level, and (3) creating a training program at the University of Nevada at the master’s degree level to provide people skilled in a broad range of mental health services to fill the treatment positions. These recommendations are necessary because, as we have described for certain nonresidential mental health programs in this chapter (and as we will describe in Chap. 10 for residential mental health programs, where the problems are much more prevalent), many mental health technicians currently carry a heavy responsibility for direct treatment of people with mental health disorders although many of them are seriously underqualified
or unqualified to fulfill that responsibility. The job requirements (see Chap. 10) include only a high school education, plus experience and training for higher levels in the "mental health technician" job series. Unfortunately, that training often is clearly substandard; the officially required training levels are low to begin with, and in most cases the Division of Mental Hygiene and Mental Retardation did not appear to have provided even those minimum amounts of training, and certainly had not adhered to the spirit of the training requirements. Each program is supposed to provide that training for its own technicians. At the time of our interviews in 1974, we were told of some very brief training, but saw no high-quality formal training program in existence. In certain cases, such as the Rural Clinics program (where mental health technicians directly treat mental health patients), there was no formal training program at the time of our interviews. A tendency we noted in some nonresidential mental health programs was for the program's administrators to tailor the services provided to fit the skill levels of their personnel, rather than tailoring their personnel to fit the greater service needs (either by revised hiring or revised training policies). Thus, some personnel who do not have the skills to help treat severely mentally ill people are assigned work for which they are more qualified (e.g., parent effectiveness training and premarital counseling) while people with more severe mental disorders go unserved. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's degree level professionals. The NMHI director also told us he is "proceeding to replace mental health technicians with more highly skilled professionals." As of February 1976, the NMHI had converted 2½ such positions. However, as detailed below, the graduates of the proposed university-based work-study program would be skilled in a broad range of disciplines and services needed by people with mental health disorders; they would have significantly broader training than people with master's level preparation in disciplines such as social work or psychology.

Along with upgrading the skills of mental health technicians, certain other changes are necessary. It must be recognized that technicians serving mentally retarded people need different skills from those who serve people with mental health disorders; and much of the technicians' work currently includes escorting people from place to place, housekeeping, and doing other tasks that should not be done by the proposed master's degree level mental health technicians, but should be assigned to people with lower skill levels. The above recommendation clearly will not mean the elimination of all paraprofessionals from mental health service positions, which is neither desirable nor feasible.

The Division of Mental Hygiene and Mental Retardation understandably has been under great pressure, due to the limited number of personnel, to use all available staff to provide services, and it is true that time taken out for training means that both trainers and trainees are not serving patients. However, we believe it is time for a frontal assault on the quality-of-personnel issue. At the very least, it is time to acknowledge through action that psychological services in the public sector are too important to be left to the relatively untrained. The broadest purposes of the proposed University of Nevada master's degree level program are to upgrade the level and quantity of mental health personnel in Nevada and to do so on a continuing basis into the future.

There is a need to train those already active in the service system and to provide a steady source of new talent. In addressing both needs a logical focus is the univer-
sity. In the case of the University of Nevada, coupling the existing psychology program with the nascent medical school program could provide a basis for an improved mental health training program having positive payoffs. At a minimum, the infusion of added professional mental health talent into the university would be a welcome addition. Also, an established training program that offers a university degree should attract desirable trainees who otherwise might not have considered the field.

As we see it, the training program should embody the following features:

- A well-respected teacher-clinician to take responsibility for the overall effort.
- Visiting professionals to provide the best possible instruction and supervision for periods of one month to a full year.
- A work-study schedule devised to make best use of weekends.
- To start, about 12 students entering per year into the 2-year program.
- A program of classroom study and patient contact under supervision that rewards the student-trainee with a professional degree from the University of Nevada, perhaps to be called "Master of Medical Health Services."
- In the interim, until sufficient graduates are produced to staff the service system, provision of more limited training and closer supervision to those already actively working in the service system.

A distinguished professorship could be established at one of the branches of the University of Nevada, perhaps with the title of "Professor of Mental Health Services." It should be well enough funded to attract a truly well-respected person to take the position. It should be awarded for a fixed period of time, not less than about five years, to ensure development and continuity of the program. The professor would be expected to take charge of the mental health services training program and to have the right of access to all other public sector mental health service programs. We are urging a strategy of concentrating resources on one top-notch mental health professional to lead the program, giving him or her an independent base of operations in the university, and mandating training of the current and upcoming generations of mental health servers to levels of excellence well above those now prevailing for mental health technicians. Having a distinguished personage in charge of the program would help to attract other talented people.

San Francisco and Los Angeles have an abundance of highly skilled mental health professionals who could serve as faculty." It should be relatively easy to get two professionals to fly to Nevada on Friday evening and spend all day Saturday providing instruction and trainee supervision; a possible arrangement might be two hour-and-a-half courses and five hours of direct supervision.

The formal program could be divided into four-month trimesters for a year-round schedule. Each trimester would contain two separate courses; i.e., two different instructors would work simultaneously to teach half the class the first period and the other half the following period, to keep class sizes down and individual contact up.

---

**San Francisco has an outstanding Department of Psychiatry at the University of California Medical School, and very strong programs in psychology and special education at U.C. Berkeley and San Francisco State, respectively. Los Angeles has several excellent psychological training programs, most notably at UCLA, and Departments of Psychiatry at both UCLA and USC.**
The students would be on a four-day workweek in service and spend Saturdays with the visiting teaching staff. They also would receive periodic reviews from and contact with the senior professor in charge of the program. They would be officially attached to the university as students and would receive a wage-stipend through the university of from $6000 to $7000 per annum. The students' work experiences would be based on patient contact in public mental health service programs. Additional time would be spent working in other elements of the mental health system, e.g., special education, vocational rehabilitation, and so forth.

At the end of the two-year program, the graduates would be awarded the professional master's degree and provided job opportunities in the Nevada system—perhaps at about $12,000 to $14,000 a year to start. Considering what is currently needed, and all the additional slots that would be created as the programs and population grow, the demand for such talent should be excellent and continuing. As outlined above, the new "Master of Mental Health Services" personnel could be assigned the role of being a client's single primary therapist during both the inpatient and nonresidential phases of treatment. With appropriate professional supervision and assistance, this new type of personnel could provide substantial meaningful treatment, with desirable continuity, and at relatively low cost compared with using only psychiatrists or Ph.D.-level psychologists in that role.

The costs for the program would be modest, but the returns would be significant in improved quality of service personnel and in work performed by the students. The faculty costs would be on the order of $75,000 a year (a distinguished professor at $40,000 to $45,000, two part-time visiting teaching staff members at $10,000 each, plus travel and per diem for the visiting staff of perhaps $12,000 combined). The student wage-stipends would total $144,000 per year (24 times $6000), but they would be earning the wage by working in public mental health service programs.

One major desirable objective of this program is to teach mental health professionals how to create and maintain contact with patients—a nontrivial matter in a situation where there is a usual tendency to avoid making human contact. Another difficulty not to be underestimated is that of maintaining a balance between dependency and patient self-reliance, a balance that obviously shifts in the course of treatment.

Devising every detail of a training program would require more careful thought than is possible here, of course. In any event it should be left to the discretion of the senior professor selected to be responsible for the overall program. Sufficient to say that training first-line practitioners to operate at a level of competence between that of a paraprofessional and a doctoral-level or physician-level professional means that a nontraditional curriculum is going to be needed.

Primary psychological care is person-oriented, generalized, and multidisciplinary—nearly by definition. Thus, there is a need to place such a program within a general-purpose university where the base of educational offerings is large and includes the social, behavioral, biological, and management sciences. The person-oriented aspect of the training is accounted for in the on-the-job component of work; indeed, making a productive tradeoff between work and classroom training will be one of the more challenging tasks.

Specific courses leading to professional responsibility as a crisis therapist, inpatient therapist, and outpatient therapist would be needed and would constitute a core of required knowledge. The basic outline of a two-year training program might look something like the following:
I. PSYCHOLOGICAL THEORY AND TREATMENT
   Theoretical Concepts in Mental Health
   Developmental Concepts in Mental Health
   Concepts of Mental Dysfunction
   Seminar in Psychopathology
   Psychological Testing and Measurement
   Psychological Treatment Methods

II. MEDICAL AND BIOLOGICAL
   Principles of Biochemistry
   Introductory Anatomy and Physiology
   Psychopharmacology
   Basic Pathology: General Survey

III. SOCIAL, CULTURAL, ADMINISTRATIVE
   Psychosocial Problems in Culture
   Mental Health System: A Guide and Overview
   Sociocultural Factors in Prevention, Diagnosis, and Treatment

This program of study is predicated on a supervised and extensive on-the-job work-training experience, and should enable a successful graduate to work as a productive professional. The need to create a "career ladder" for graduates of the program is important, however, both as a means of clarifying advancement potentials and offering professional identification and recognition. It is conceivable that some graduates would, after a period of service, elect to return to school for more intensive training in one of the mental health specialties, and this program would have prepared them in a rigorous and practical way to do just that.

Another outcome is to teach those actually working in the mental health system to be aware as fully as possible of the number and availability of resources, i.e., to know the system in as comprehensive a fashion as possible. This would be a natural by-product of the rotational features designed in originally. It is another way of trying to cope with the scarcity of resources and the currently scattered, even isolated, elements of the system. Professionals need to know about all sections of the service system to improve its overall operation.

We strongly urge responsible officials to take positive steps to coordinate the mental health operations of the various elements of the mental health service system. The need to monitor and coordinate the flow of patients through the mental health service system is clear when one considers the current lack of referrals, and the lack of follow-up that pervades the service system. We reiterate our recommendation for the creation of Regional Direction Centers to provide needed coordination (see Chap. 4).

Finally, because program management information is deficient, we recommend that a comprehensive information system be established for monitoring mental health program operations, as well as the effectiveness of services. Details of information deficiencies were presented earlier in this chapter, and are also discussed in Chaps. 4 and 10.