Chapter 9
TREATMENT FOR ALCOHOL AND DRUG ABUSE

INTRODUCTION

Prior to the 1960s, most mental health professionals considered alcohol and drug abuse a form of mental pathology. Consequently, they were often treated in the same facilities and with the same techniques used for mental illness. But the past decade has witnessed a major transition. Most drug and alcohol treatment is now administered in separate facilities by a specially trained staff, and this trend appears likely to continue. The reasons for this transition are varied and complex, but we can identify several here.

First, there has been a growing conviction that while the onset of excessive drinking or drug use may ensue from a psychological crisis of some sort, the addiction process once set in motion has its own mechanisms that go beyond the earlier psychodynamics. The release from addiction therefore may require treatment processes relatively independent of those necessary for the earlier psychological problems, and in fact they may take place long after the psychological crisis has subsided.

Second, many alcoholics and drug addicts have strongly resisted being classified as mentally ill, and will avoid treatment in a setting that allows such identification to take place, whether or not that treatment is effective. This resistance is best embodied in the Alcoholics Anonymous (AA) philosophy that the illness is the alcohol dependence itself, and total abstinence is the only remedy. This philosophy may be based in part on moral and religious precepts, but the fact is that AA has probably helped more alcoholics to recover than has any other treatment modality, and any theory of remedy that depends exclusively on psychotherapeutic treatment must contend with AA’s success.

Finally, perhaps as a result of these scientific and social developments, the Federal Government has now officially sanctioned a separation of alcohol and drug abuse research and treatment activities from mental health, and has established separate but equal institutes to promote them: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). This separation has caused similar reorganization within many states and local communities. While these trends do not mandate separation of all local treatment, education, and prevention activities, as a practical matter the separate funding channels will not discourage differentiation at the local level. Our discussion in this chapter will make a distinction between alcohol and drug abuse treatment programs.

In Chap. 3, on the population needing service, we brought together existing information to assess the magnitude of the alcohol and drug abuse problem in Nevada. This was a necessary first step in a comprehensive planning study of Nevada’s service programs. In Chap. 5 we briefly discussed prevention of alcohol and drug abuse. In the remainder of this chapter we first describe existing alcohol and drug abuse treatment service systems throughout the state as a whole, as well as specific characteristics of major treatment programs. This sets the stage for the last two
sections: an analysis of some of the major problems and shortcomings in the existing system, and a set of recommended first steps toward solving these problems. Finally, Chap. 11 discusses the Vocational Rehabilitation program's services for alcohol and drug abusers.

The Nevada Bureau of Alcohol and Drug Abuse estimates that 28,215 cases of drug or alcohol abuse were treated in various kinds of drug and alcohol abuse programs in Nevada in 1974.1 As will be seen from the program descriptions in this chapter, which covers all the major treatment programs we are aware of in the state, that figure of 28,215 significantly exceeds the number of alcoholics and drug addicts receiving substantial treatment services for their addiction.

The alcohol and drug abuse treatment programs discussed in this chapter expended about $2.6 million last year, including over $1.1 million for alcohol abuse and over $1.4 million for drug abuse. At least 700 alcoholics and 300 drug addicts received substantial service last year from these treatment programs; in addition, more than 700 persons participated in Alcoholics Anonymous in Nevada. Alcohol and drug abuse education programs reached many more.

EXISTING SERVICE DELIVERY SYSTEM

Treatment services for Nevadans suffering from alcoholism and drug abuse are currently supported and dispensed by a number of agencies at the state, county, and community levels. When we add to these levels the variety of purposes, sponsorship, and funding sources represented by those agencies, the resulting service system is a complex one indeed. Furthermore, to speak of an "existing" system is somewhat hazardous, because the system is experiencing considerable flux as state and local organizations grow and as they respond to the newly created NIAAA and NIDA.

The complexity is eased to some extent by the fact that most services are provided within the two regions of Nevada that comprise about three-quarters of its population: the Reno area (Washoe County) and the Las Vegas area (Clark County). Before turning to the regional service agency descriptions for Clark, Washoe, and rural counties, however, it may be helpful to describe the Nevada Bureau for Alcohol and Drug Abuse, which has overall planning and coordination responsibilities. By seeing the relationship between the Bureau and other state and local agencies, such as the Bureau of Vocational Rehabilitation, the Nevada Division of Mental Hygiene and Mental Retardation, and the local umbrella coordinating organizations, the reader will get an overview of the treatment delivery system as a whole.

Nevada Bureau of Alcohol and Drug Abuse

The Nevada Bureau of Alcohol and Drug Abuse was created in 1973 by an amendment to Sec. 458 of the Nevada Revised Statutes. The amendment appears to have been motivated in part by federal legislation requiring a single state agency to receive and dispense federal monies for alcohol and drug abuse programs. Another motivating factor may have been a desire to centralize formerly fragmented units dealing with various aspects of alcohol and drug abuse prevention and treat-

ment, in particular by combining the separate and relatively small alcohol and drug programs within a single state agency.

In 1973 Senate Bill 590 gave the Bureau five primary responsibilities as the sole agency for administering the alcohol and drug programs (Sec. 38):

- To formulate and operate a state plan for the development and distribution of prevention and treatment programs, including a survey of needs in this area;
- To formulate and operate a state plan for educating the public about alcohol and other drugs, including a needs survey;
- To formulate and operate a state plan for training teachers and health professionals needed by education, prevention, and treatment programs, including a needs survey;
- To coordinate all state and federal funding of alcohol and drug abuse programs, including dispensing state funds to local facilities (Sec. 50) as well as approval of all applications for state and federal money;
- To develop and publish standards of certification for facilities and exercise authority to certify or deny certification of facilities, noncertified facilities being ineligible to receive state and federal funds.

In 1975 Senate Bill 379 extended the certification powers of the state Bureau to include not only facilities but also programs and personnel. While the Bureau's planning and coordination functions resemble those of many other states' programs for alcohol and drug abuse, the real teeth of the legislation and the potential power of the Bureau lie in the provisions for dispensing funds to local treatment or education facilities and for certifying the eligibility of those facilities and their programs and personnel to receive state and federal funds. Since the legislation creating NIAAA and NIDA also requires approval from the responsible state agency for any federal grant to a local agency, at least on paper the Bureau has tight control of all federal and state governmental financing of drug and alcohol programs throughout Nevada. As we shall see, however, there are other state and county agencies with some funds and authority in the alcohol and drug program areas.

**Internal Structure of the Bureau.** The Bureau's main offices are in Carson City. They house a director and six major staff members, not counting secretarial and clerical support staff. The internal organization appears to be differentiated to some extent between alcohol program coordination and drug program coordination, although this is not reflected in their official organization chart.

In addition to the central Bureau staff in Carson City, there is an area coordinator in Las Vegas. Local service agencies in the Reno area receive assistance directly from the central staff; Las Vegas agencies receive assistance first through the area coordinator.

The legislation creating the Bureau did not limit its responsibilities to the five major ones already listed, and the Bureau has already made some operating decisions about how it is going to carry out its mission. Several are worth noting. First, the Bureau has prepared and published two state plans, one for drugs and one for

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2 Interview with B. Rose, Nevada Division of Rehabilitation, Carson City, Nevada. June 10, 1975.
alcohol. These plans embody some but not all of the planning and survey requirements of the enabling legislation. For example, the state plans do not include comprehensive incidence and prevalence data for alcohol and drug abuse (see Chap. 3 of this report for a discussion of the limited available data). Also, the plans contain relatively little discussion or information about specific needs in either treatment or training programs, particularly those for alcohol. At the present time the plans primarily amount to a broad statement of goals and a description of existing treatment agencies throughout the state.

The Bureau has also decided to implement data collection systems for evaluation and monitoring of alcohol and drug abuse programs. The first of these to be implemented is named IDARP, a reporting system for drug abuse programs; the state has received an NIDA grant for this purpose. No action has been taken as yet on an alcohol program monitoring system.

Finally, the Bureau has elected not to engage in providing treatment services, leaving that to local community agencies. Its role will be confined to coordination, education, certification, and training; in the realm of treatment services, its only role will be to make grants to local service agencies from state funds or help them find other funding sources.

**Relations Between the Bureau and Other Agencies.** Although Sec. 458 of the Nevada Revised Statutes appears to give the Bureau virtually total control of alcohol and drug programs throughout the state, a number of other agencies still maintain substantial responsibilities in that field, either directly or indirectly. Together with the Bureau's own "umbrella" organizations for coordinating programs in the Reno and Las Vegas areas, they form a network of crisscrossing direct and indirect relationships, some of which are portrayed in Fig. 9.1. The solid lines represent direct administrative authority or direct service provisions; the dotted lines indicate influence but not direct control. Most influence is in the form of financial assistance and certification of programs; another form of indirect influence is the facility approval function of the Comprehensive Health Planning (CHP) agencies. We note that most direct service for alcohol and drug abusers is not provided by government agency programs.

**Umbrella Organizations.** The state Bureau has recognized two umbrella organizations for local alcohol and drug abuse treatment programs: NASAC (Northern Area Substance Abuse Council) for the Reno area, and SNDAC (Southern Nevada Drug Abuse Council) for the Las Vegas area. To some extent the umbrella organizations represent a partial decentralization of the Bureau's coordination functions. Their primary responsibilities are to develop master plans for the local area, to build good working relations with community leaders and local funding sources, and to help local programs that are seeking state and federal funds. They are private nonprofit organizations that receive most of their operating funds from local and state grants (as in the case of NASAC) or federal grants (as in the case of SNDAC). Like the Bureau, the umbrellas are officially clearing and coordinating houses whose primary function is not the provision of direct services. SNDAC has a large grant from NIDA, however, and does operate some treatment service programs.

Although local agencies are encouraged to affiliate with the umbrella organizations, such affiliations are not required by the state Bureau and in fact there are a number of local agencies receiving state funds that are not so affiliated. A local agency may apply for state funds directly to the Bureau in the north or through the
Area Coordinator in the south; however, copies of all such applications are sent to the appropriate umbrella organization for review prior to final disposition.

**Expenditures of the Bureau of Alcohol and Drug Abuse.** The state Bureau of Alcohol and Drug Abuse receives its major funding from several sources and passes some of it on to local education, training, and treatment programs in the form of state grants. Table 9.1 is a summary of estimated income and grant expenditures.

The total funds for grants amount to about $330,000, or about 50 percent of the total uncommitted income (i.e., the state allocation and federal formula grants). The bulk of these grants go to treatment agencies for the provision of direct services. Most of the remaining funds support the personnel and overhead costs of the Bureau and its Las Vegas office. Of course, since some of the Bureau’s staff time is spent giving lectures and in public education projects, some of these funds might properly be listed under education.

**Division of Mental Hygiene and Mental Retardation**

The Division of Mental Hygiene and Mental Retardation has several major subagencies that provide direct service to alcohol and drug abusers. The most important is the Nevada Mental Health Institute (NMHI), whose “Ward 10” is the only comprehensive inpatient treatment facility for alcohol and drug abusers in the state of Nevada (see Chap. 10 for a description of the Nevada Mental Health Institute).
Table 9.1
FINANCIAL RESOURCES AND SELECTED EXPENDITURES OF THE NEVADA BUREAU OF ALCOHOL AND DRUG ABUSE, 1975

<table>
<thead>
<tr>
<th>Source or Receiver</th>
<th>Approximate Amounts</th>
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<tbody>
<tr>
<td>Income</td>
<td></td>
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<tr>
<td>State budget</td>
<td>$384,000</td>
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<tr>
<td>Federal formula grant: alcohol</td>
<td>200,000</td>
</tr>
<tr>
<td>Federal formula grant: drugs</td>
<td>100,000</td>
</tr>
<tr>
<td>Drug monitoring system (IDARP)</td>
<td>128,000</td>
</tr>
<tr>
<td>OEO occupational program grant</td>
<td>51,000</td>
</tr>
<tr>
<td>Total income</td>
<td>$863,000</td>
</tr>
<tr>
<td>Grant obligations(^a)</td>
<td>Alcohol  Drugs</td>
</tr>
<tr>
<td>Umbrella organizations(^b)</td>
<td>$12,500  $12,500</td>
</tr>
<tr>
<td>NASAC</td>
<td>27,280</td>
</tr>
<tr>
<td>Education</td>
<td>102,978</td>
</tr>
<tr>
<td>Training</td>
<td>9,000</td>
</tr>
<tr>
<td>Treatment programs</td>
<td>94,400</td>
</tr>
<tr>
<td></td>
<td>143,180</td>
</tr>
<tr>
<td></td>
<td>185,678</td>
</tr>
<tr>
<td>Total grant obligations</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Interview with Paul Cohen, Nevada Bureau of Alcohol and Drug Abuse, November 1974.

\(^a\)Includes both actual and potential commitments.

\(^b\)Some of these funds are used for treatment, and some for administrative purposes.

Ward 10 is not affiliated with the NASAC umbrella at the present time; it receives all its funding from the Division of Mental Hygiene and Mental Retardation without involvement of the state Bureau of Alcohol and Drug Abuse. While NMHI primarily serves alcohol abusers of the northern areas, a client can be admitted from any part of the state. NMHI is the only facility that can receive court-committed cases of alcohol and drug abuse that are processed under existing mental health statutes.

The Division of Mental Hygiene and Mental Retardation also operates three Mental Health Centers (MHCs) serving the Henderson, Las Vegas, and Reno areas. These Centers handle some alcoholism cases on an outpatient basis, but at the present time none is a major service delivery agency for alcohol and drug abuse clients, and only the Las Vegas Mental Health Center has a specific alcohol program (outpatient group therapy).

Finally, the Division of Mental Hygiene and Mental Retardation has a Rural Clinics program for providing mental health services to outlying regions (see Chap. 8 for a description of the program). Although these clinics do not appear to provide direct services to many alcohol and drug abusers, they are supposed to act as screening agencies for clients admitted to NMHI.

**County Comprehensive Health Planning Agencies**

The County Comprehensive Health Planning agency performs various functions for the State Comprehensive Health Planning Advisory Council. Among other things, this council and its county counterparts advise the Nevada Bureau of Health
Facilities regarding licenses to operate health care facilities. The Clark County CHP is quite active and, for example, is the recommending authority for facility licensure of the Las Vegas Mental Health Center.

The Clark County CHP also has a Substance Abuse section, responsible for preparing recommendations for alcohol and drug abuse facilities. Alcohol and drug treatment program facilities currently come under the definition of "health care facilities" and are therefore required to have licenses from the Bureau of Health Facilities with proper approval from the CHP. One may conclude that the facility certification function of the Bureau of Alcohol and Drug Abuse and the facility licensing function of the Bureau of Health Facilities overlap and could conflict.

**Nevada Bureau of Vocational Rehabilitation**

The major function of the program operated by the Bureau of Vocational Rehabilitation is not to treat the alcohol or drug abuser, but to provide vocational services. VR expenditures for alcohol and drug abuse were approximately $150,000 in FY 1974 (of which about 56 percent was for drug abusers). VR service was completed for 140 alcohol and drug abuse clients in FY 1974 (of whom about 46 percent were drug abusers). The program is fully described in Chap. 11, with breakdowns of data specifically for people who have had alcohol and drug abuse problems.

We now proceed to an overview of local treatment programs for alcohol and drug abuse in the Reno, Las Vegas, and rural areas.

**Treatment Programs in the Reno Area**

Most of the treatment specifically for drug and alcohol abuse in the Reno area is provided through the seven programs listed in Table 9.2. Since most of these programs are or have been affiliated with the NASAC umbrella, it would be appropriate to start with the role of that organization in the service delivery system.

**The NASAC Umbrella.** The Northern Area Substance Abuse Council has evolved through several stages and councils since 1964. In 1964 it was called the Washoe County Council on Alcoholism, at which time it was an umbrella organization for alcohol treatment programs. In March 1974, apparently in response to requirements of the state Bureau of Alcohol and Drug Abuse for umbrella organizations, the council name was changed to the Washoe County Council on Alcohol and Drug Abuse. This was accompanied by some conflict with an organization called DETRAP, which had viewed itself as the unofficial umbrella organization for drug treatment programs prior to the creation of the Bureau. This conflict resulted in another name-change by the council to the current "NASAC" in September 1974. DETRAP was originally funded by the City of Reno and by a federal grant from the National Institute of Mental Health (NIMH). At one time it had its own treatment programs; Omega House was initially a part of DETRAP, but it has pulled away recently. At the present time the state Bureau has named NASAC as the official umbrella organization for both drugs and alcohol, and it appears that DETRAP may be relatively inactive.

NASAC had an operating budget of about $57,000 in 1974, of which $17,500 came from the state Bureau, $18,500 from the City of Reno, $9,500 from the City of Sparks, and $11,500 from Washoe County. This supports a director, an assistant director, and a secretary, all of whom are full-time, and a suite of two offices.
Table 9.2

MAJOR ALCOHOL AND DRUG ABUSE TREATMENT AGENCIES IN THE RENO AREA

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>1974 Umbrella Affiliation</th>
<th>Public or Private</th>
<th>Treatment Setting</th>
<th>Estimated 1974 Client Capacity</th>
<th>Average Length of Stay</th>
<th>Estimated Annual Budget</th>
<th>Major Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic Rehabilitation Association (ARA)</td>
<td>Active</td>
<td>Private</td>
<td>Live-in, work and therapy</td>
<td>22</td>
<td>3-4 mo</td>
<td>$96,000&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Client fees</td>
</tr>
<tr>
<td>Beacon House (women only)</td>
<td>Active</td>
<td>Private</td>
<td>Live-in, therapy</td>
<td>9</td>
<td>1-2 mo</td>
<td>$7,200&lt;sup&gt;b&lt;/sup&gt;</td>
<td>State grant; facilities fully owned</td>
</tr>
<tr>
<td>Nevada Mental Health Institute (NMHI, Ward 10)</td>
<td>None</td>
<td>Public</td>
<td>Inpatient work and therapy</td>
<td>28</td>
<td>2-3 mo</td>
<td>$415,000</td>
<td>State</td>
</tr>
<tr>
<td>Washoe State Rehabilitation (men only)</td>
<td>Inactive&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Private</td>
<td>Live-in, work</td>
<td>15</td>
<td>3 mo</td>
<td>$35,000</td>
<td>Client fees</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>None</td>
<td>Private</td>
<td>Outpatient meetings</td>
<td>200</td>
<td>—</td>
<td>—</td>
<td>None</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Omega House</td>
<td>Active</td>
<td>Private</td>
<td>Outpatient counseling</td>
<td>100/yr</td>
<td>—</td>
<td>$115,000</td>
<td>State grant</td>
</tr>
<tr>
<td>Entitas Foundation</td>
<td>Inactive</td>
<td>Private</td>
<td>Live-in, work and therapy</td>
<td>30&lt;sup&gt;d&lt;/sup&gt; (62/yr)</td>
<td>1 yr&lt;sup&gt;e&lt;/sup&gt;</td>
<td>$56,000</td>
<td>Operationally self-supporting&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>“Public” means that agency authority stems directly from the state and local government.
<sup>b</sup>Excludes funds for counseling personnel, which are administered directly by NASAC. In 1975 the state grant affiliation with NASAC ended.
<sup>c</sup>“Inactive” means that the agency is receiving no funds or direct assistance from NASAC.
<sup>d</sup>Includes non-drug-addict clients.
<sup>e</sup>Varies from 1 week to 6 years.
<sup>f</sup>For example, a hog ranch, health spa, and hay business are operated.
In addition to these funds NASAC also has a special grant of $37,000 to support a counseling program for ARA and Beacon House, two live-in treatment organizations, as well as a counselor training program that is conducted mainly at ARA. Interestingly, it appears that in the future NASAC may not act as a funding “conduit” to local treatment programs. It is reported that because of red tape and administrative procedures, it is easier for the local treatment agency to apply directly to the state, with assistance and advice from NASAC. This means that NASAC will be neither a direct provider of treatment facilities nor a provider of financial assistance to local treatment facilities.

Alcohol Programs in the Reno Area. There are more programs for alcohol abusers than drug abusers in the Reno area. The two programs that appear to be the most stable and the most illustrative of professional treatment standards are NMHI’s Ward 10 and the ARA. Both have full programs emphasizing a combination of work and treatment; the ARA provides about two hours of group and one hour of individual therapy or counseling each week, while NMHI provides about nine hours of group therapy. Both stress regular work as well, with NMHI clients working inside the Institute and about half the ARA clients working in outside jobs. They also have a greater number of treatment staff with professional training (in relation to the number of clients) than does the average treatment program in the state.

Ward 10 has a director with an M.S.W. and long experience in the alcoholism field and a psychiatric L.P.N. with certification for psychiatric services; they provide most of the group therapy, with the director conducting confrontation group counseling and the L.P.N. conducting ego or supportive group counseling. ARA has the services of five counselors, two of whom are part-time and hold higher degrees (master’s and Ph.D.) and two of whom are full-time recovered alcoholics who have received inservice training.

The main differences between Ward 10 and ARA are in the treatment setting and financing. Ward 10 is a full inpatient program within a state-funded mental institute. At ARA, of course, entry is voluntary and most clients work on the outside, so in this sense ARA is more like a halfway or recovery house. Since most of its financial support comes from client fees, ARA tries to avoid the skid row alcoholic or other types of clients who are unable or unwilling to work. On the other hand, NMHI is supported entirely by the state, so there is no self-selection on the basis of employability.

The other alcohol programs are less comprehensive from a treatment point of view. Beacon House is a relatively small program for women only; until the arrangement terminated in 1975, it offered some counseling service from a Ph.D. psychologist provided by NASAC, with each client receiving two hours of group counseling per week. Washoe State Rehabilitation is strictly a work program with no psychotherapeutic counseling. Finally, there are several chapters of Alcoholics Anonymous including chapters at ARA, Beacon House, and Washoe State. As in most parts of the country, the AA in the Reno area accounts for the great bulk of alcoholics who seek help for their problem.

Drug Programs in the Reno Area. There are only two major programs for drug abuse treatment in Reno, and one of these accepts non-drug-abusers as well. The Entitas Foundation is a live-in therapeutic community that accepts persons with any type of “problem,” but most of the problems are drug-related. Entitas is staffed by former clients who have completed its therapeutic program. The forms of
treatment include work, a relatively stable social community, and group sessions of residents. Entitas operates a hog ranch, a mineral bath and spa, a haying business, and a trailer court which render it operationally self-supporting, and the residents work in these businesses. Interviews with its director, Wes Brown, reveal plans for expanding Entitas to accommodate 250 residents if funding can be secured.

The Omega House is the major outpatient drug treatment facility in the Reno area. It offers counseling on an outpatient basis only, but apparently has future plans for some type of live-in facility as well. The program employs five counselors; four are paraprofessionals, but the director has a master's degree and considerable experience in the field. All types of counseling are offered, including individual, group, and family. The mode is once per week for most clients. Most of the clients are youths with pre-addiction problems involving soft drugs.

In addition, a small fraction of NMHI Ward 10 patients are drug abusers but the program is designed for alcohol abusers. There are no detoxification facilities for hard-core heroin addicts, even though the figures in Chap. 3 suggest that opiate addiction may be a serious problem in the Reno area.

Treatment Programs in the Las Vegas Area

The treatment situation in Clark County is in some ways opposite from that in the Reno area (see Table 9.3). While Reno has more facilities for alcohol abusers, Las Vegas has far more facilities and expenditures for drug abuse, even though our incidence analysis shows alcoholism rates to be higher in the area than drug abuse rates. The reason may be tied to the particular history of the Southern Nevada Drug Abuse Council (SNDAC), the umbrella agency for the Las Vegas area.

The SNDAC Umbrella. Until November 1973 SNDAC was the umbrella agency for drug programs, after which time it was recognized as the umbrella for both alcohol and drug programs.

There are other differences between SNDAC and NASAC. While NASAC serves mainly as a coordinating agency and tries to stay out of direct service delivery, SNDAC has taken a different service path by initiating several in-house treatment programs. The major basis of this thrust is a large grant SNDAC has received from NIDA; current funding is at the level of about $500,000 a year. Apparently, the terms of this grant require that the umbrella provide some in-house facilities, although the bulk of these funds is channeled out through subcontracts to local affiliates that provide direct treatment services. SNDAC also receives some funds from the state—$50,000 for drugs and $40,000 for alcohol—as well as about $225,000 from other sources in the form of goods, services, and cash donations. In sum, SNDAC is funded at a level of over three-quarters of a million dollars a year.

The central staff includes a director, an assistant for programs who is responsible for monitoring SNDAC's subcontracted drug treatment agencies, an alcoholism program coordinator, and some clerical and business management personnel. There are also some treatment staff for their in-house direct service programs (described later in this chapter). SNDAC has an extremely large board of directors—about 150 members—who meet periodically to guide SNDAC's overall policies.

SNDAC sees its role as somewhat broader than that of NASAC; it feels it should monitor and advise on specific grant applications to state and federal agencies from local programs, do communitywide planning, and be responsible in a general way for fund raising for all local programs affiliated with the agency. In this connection
### Table 9.3
**MAJOR ALCOHOL AND DRUG ABUSE TREATMENT AGENCIES IN THE LAS VEGAS AREA**

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>1974 Umbrella Affiliation</th>
<th>Public or Private</th>
<th>Treatment Setting</th>
<th>Estimated 1974 Client Capacity</th>
<th>Average Length of Stay</th>
<th>Estimated Annual Budget</th>
<th>Major Funding Source</th>
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<tr>
<td><strong>Alcohol</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Alcoholism Recovery Services (EOB)</td>
<td>Inactive</td>
<td>Private</td>
<td>Live-in, work and therapy</td>
<td>20</td>
<td>2-3 mo</td>
<td>$100,000</td>
<td>Federal grant (NIAAA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Information and referral, some outpatient counseling</td>
<td>40/mo</td>
<td>(b)</td>
<td>$42,000</td>
<td></td>
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<tr>
<td>Community Alcoholism Centers (2) (EOB)</td>
<td>Inactive</td>
<td>Private</td>
<td>Inpatient</td>
<td>20</td>
<td>(b)</td>
<td>(b)</td>
<td>Client fees</td>
</tr>
<tr>
<td>North Las Vegas Hospital</td>
<td>None</td>
<td>Private</td>
<td>Outpatient counseling</td>
<td>42</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
<tr>
<td>SNDAC</td>
<td>Active</td>
<td>Private</td>
<td>Detox plus outpatient treatment</td>
<td>10 + 60;</td>
<td>527 detox per year</td>
<td>$68,000</td>
<td>State grant</td>
</tr>
<tr>
<td>Sunrise Hospital</td>
<td>None</td>
<td>Private</td>
<td>Outpatient group meetings</td>
<td>500</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
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<tr>
<td>Alcoholics Anonymous</td>
<td>None</td>
<td>Private</td>
<td>Outpatient group therapy</td>
<td>126/yr</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
<tr>
<td>Las Vegas Mental Health Center</td>
<td>None</td>
<td>Public (state)</td>
<td>Outpatient group therapy</td>
<td>126/yr</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction Treatment Clinic</td>
<td>None</td>
<td>Public (county)</td>
<td>Outpatient methadone</td>
<td>90</td>
<td>Indef.</td>
<td>$60,000</td>
<td>Client fees (NIDA)</td>
</tr>
<tr>
<td>Family, Inc.</td>
<td>Active</td>
<td>Private</td>
<td>Live-in</td>
<td>14 (30/yr)</td>
<td>1 yr</td>
<td>$195,000</td>
<td>Federal grant (NIDA)</td>
</tr>
<tr>
<td>Fitzsimmons Halfway House</td>
<td>Active</td>
<td>Private</td>
<td>Live-in</td>
<td>6</td>
<td>2-6 mo</td>
<td>$62,000</td>
<td>Federal grant (NIDA)</td>
</tr>
<tr>
<td>Latino Project</td>
<td>Active</td>
<td>Private</td>
<td>Outpatient counseling</td>
<td>5</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
<tr>
<td>NIKE House</td>
<td>Active</td>
<td>Private</td>
<td>Live-in, teen-age girls</td>
<td>5</td>
<td>3 mo</td>
<td>$52,000</td>
<td>Federal grant (NIDA)</td>
</tr>
<tr>
<td>Operation Bridge</td>
<td>Active</td>
<td>Private</td>
<td>Outpatient counseling</td>
<td>49</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
<tr>
<td>SNDAC Clinic</td>
<td>Active</td>
<td>Private</td>
<td>Outpatient counseling</td>
<td>44</td>
<td>(b)</td>
<td>(b)</td>
<td>(b)</td>
</tr>
</tbody>
</table>

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*aEconomic Opportunity Board is the grantee; this is a new program that started January 1, 1975.

*bThis is a new program that started in December 1975.

*cActual expenditures are not reliably known, and are part of the overall LVMHC budget.
some questions might be raised about potential overlap between the jurisdiction and duties of SNDAC and the local coordinator in the state Bureau’s Las Vegas branch office. Further, at the present time there is apparently no formal or informal relationship between SNDAC and the relatively active Substance Abuse section of the Clark County Health Department.

**Alcohol Programs in the Las Vegas Area.** In contrast to the Reno area, there are relatively few major alcoholism treatment programs in the Las Vegas area other than the traditional AA chapters, even though the Las Vegas area probably has more than three times as many alcoholics as the Reno area. One program, Comprehensive Alcoholism Recovery Services, is just getting under way with a new grant from NIAAA. It will be a halfway house or recovery home emphasizing both detoxification and relatively long-term care; work and psychotherapeutic counseling will be provided. It will have a director with considerable experience in alcoholism counseling (currently working in one of the EOB Community Alcoholism Centers), a full-time counselor, and a half-time nurse for the nonmedical detoxification unit. In spite of this relatively comprehensive program, the service will be able to handle only 16 live-in and 4 detoxification clients.

In December 1975, the North Las Vegas Hospital opened a 20-bed alcohol treatment center that includes a hotline, a detoxification unit, and an inpatient program; the program’s multidisciplinary team utilizes a multiple treatment approach, including self-help, social work with the alcoholic’s family, and individual and group work with a psychologist.3

The only other detoxification service available to Las Vegas area residents is offered by Sunrise Hospital, but this is only on a fee basis at the rate of $150/day (many clients apparently pay this with medical insurance). The alcoholism counselor at Sunrise also has several outpatient counseling groups, most of whose members enroll following detoxification.

It is worth pointing out here that until recently two other agencies offered detoxification and some inpatient care: Southern Nevada Memorial Hospital and Cedarbrook Hospital. Southern Nevada receives support from the county for indigent patients. At present, however, it accepts detoxification cases only in medical emergencies (e.g., severe withdrawal symptoms), and its psychiatric ward—Ward 700—does not accept patients with a primary diagnosis of alcoholism. Cedarbrook formerly handled drug and alcohol detoxification as well as a methadone maintenance program under subcontract from SNDAC, but it has recently terminated that service.4 It seems clear that, given the size of the alcoholic population, the Las Vegas area has insufficient nonmedical detoxification facilities.

SNDAC offers an outpatient counseling service; the counseling is all one-to-one and is handled by a full-time counselor (with a Ph.D. in philosophy) and the alcoholism coordinator (with an M.A. in psychology). Most of the clients have been committed by a court for DWI offenses (Driving While Intoxicated). Some outpatient counseling, as well as information and referral, is provided at two Community Alcoholism Centers under EOB auspices. The area has no other outpatient services for alcoholics with the exception of a single small alcoholic group at the Las Vegas Mental Health Center.

The local Economic Opportunity Board maintains two "Community Alcoholism Centers," but they are primarily information and referral centers that do some informal counseling. The problem these centers have is that there are few places to which they can make referrals.

Not shown in Table 9.3 are two residential facilities—We Care for women and Samaritan House for men. Other than AA, they have no treatment services per se and serve primarily as temporary shelters.

**Drug Programs in the Las Vegas Area.** All but one of the drug programs in the Las Vegas area are affiliated with SNDAC and are at least partially funded by SNDAC's NIDA grant. They represent a fairly wide range of services, but some operate at less than capacity. Operation Bridge is an outpatient counseling program focusing on young pre-addicts involved with soft drugs. It has two full-time counselors, both of whom have master's degrees in counseling; individual, group, and family counseling are offered. Bridge also has a hotline that averages 500 calls per month.

Fitzsimmons and Family, Inc. are live-in facilities. Family, Inc. focuses on a therapeutic community for the hard-core addict, and Fitzsimmons on creating social and vocational stability for the post-addict. Both apparently have had high turnover and some staffing problems. In addition, both have been embroiled in public controversies over alleged availability of drugs.

NIKE House is a live-in facility for adolescent girls, and the Latino Project is a similar facility for Mexican-American drug abusers. Both programs focus on the young pre-addict involved with soft drugs. The Latino Project has also had some staffing problems and may not be funded by SNDAC, at least in the short-term future.

The SNDAC Clinic is the only outpatient facility for drug abusers. It employs a part-time psychiatrist, a full-time psychologist (M.A.), a full-time counselor (B.A.), and two paraprofessionals. Many of the cases come from court assignments, and this unit also does considerable diagnostic evaluations for the court.

The Addiction Treatment Clinic, sponsored by Clark County, is the only methadone maintenance program in the Las Vegas area and in the state. Its headquarters are at the Southern Nevada Memorial Hospital (although it is strictly an outpatient program). The county sponsors the program but does not have to contribute much money to it since it is financed mostly by client fees. This means, of course, that most clients must have relatively stable employment. The Clinic is not currently affiliated with SNDAC and receives no funds from the state.

**Treatment Programs in Rural Areas**

Aside from several AA chapters and some small amount of outpatient counseling in a few of the rural counties, there are few treatment programs outside of Clark and Washoe counties. A major exception is the New Frontier program in Fallon, which offers detoxification (18 beds) and counseling services to clients throughout a large part of central Nevada. Another is the Elko Council on Alcoholism, which recently received funds from the state Bureau for an alcoholism counselor and has a caseload of about 100 clients. Two other programs serve rural substance abusers: the Nevada Mental Health Institute program described above, and the program for Indians noted in the next subsection.
Treatment Programs for Special Populations

Other treatment programs deal with special types of clientele. These include the Veterans’ Administration hospitals or clinics and the Indian programs.

**VA Hospitals in Reno and Las Vegas.** The VA has a clinic in the Las Vegas area and a hospital in the Reno area, but apparently neither has an alcoholism program as such. Some alcoholics (about 6 in late 1974) are handled on an outpatient basis in the Las Vegas clinic, but those requiring inpatient care are referred to VA hospitals in other states—particularly the San Diego VA Hospital in California.

**Indian Program.** There is an Intertribal Council Alcohol and Drug Abuse program for Indians with headquarters in Reno. It is supported in part by an NIAAA grant of $211,000. Currently, only outpatient counseling is offered at 10 satellite sites throughout the state. The program has three counselors, each of whom maintains a load of about 20 clients. There is no inpatient rehabilitation facility, but the program is applying for an NIAAA grant that will provide one if the grant comes through. Some detoxification services are offered at the Schurz Indian Hospital and the Duck Valley Hospital.

PROBLEMS IN THE CURRENT DELIVERY SYSTEM

Investigation of the service delivery system for alcohol and drug abuse treatment has revealed a number of gaps between people’s needs and services available in current programs. Some of these gaps are readily apparent from the information presented in the preceding sections; other deficiencies became apparent during our interviews with many persons involved in program coordination and direct service delivery. The problems fall into three categories:

- Inadequate information
- Organizational problems
- Facility and service deficiencies

We must stress that our investigation was not so comprehensive as to uncover all the problems that must exist in the growing and complex field of alcohol and drug treatment programs in Nevada, but we are confident that the problems discussed below are the most urgent and pressing.

Inadequate Information

One indication of the information problem in the alcohol and drug abuse field is the fact that we had to develop improved estimates of alcoholism rates in Nevada (see Chap. 3). Just as the analysis and recommendations in this report require information about the magnitude of the alcohol and drug abuse problem in Nevada, so any state or local planning effort must have such data if it is to develop and operate adequate and realistic service programs for those in need.

At a minimum, two types of information are required for proper planning and evaluation of alcohol and drug programs, and are now deficient in Nevada:

- Information about rates of alcohol and drug abuse
- Information about existing treatment programs and their clientele
Chapter 3 summarized the deficiencies in information on rates of alcohol and drug abuse. For alcohol abuse, three separate data sources and methods of estimating the statewide level gave reasonably consistent results; however, estimates of the same quality for different regions of the state were not developed. For drug abuse rates, the data base is of much lower quality; for obvious reasons there is no reliable information on sales, and there is no readily countable physical manifestation of drug abuse comparable to cirrhosis deaths from alcohol. The Nevada state survey just completed by the Gallup polling organization for the Nevada Division of Rehabilitation does not solve the problem of estimating the drug abuse rate, since the population is unlikely to have accurately self-reported illegal hard-core drug addiction.

The second information gap has to do with the current service delivery system. There is inadequate systematic detailed data collection on client loads, staffing, service capacity, funding levels, and the like for treatment programs throughout the state. Intelligent planning under such circumstances becomes very difficult. The information presented in Tables 7.2 and 7.3, and in the previous section, was gathered from numerous time-consuming interviews; while we make no guarantee of its accuracy, it is nonetheless better than any information we could obtain from a single source in mid-1974. In sum, the state has insufficient routine program management information, and little information on program results—clients' conditions following release from treatment—to use in program evaluation.

The state Bureau of Alcohol and Drug Abuse is planning to install IDARP, which will go a long way toward closing both information gaps for drug programs. However, this system is not appropriate for alcohol programs. The Nevada Bureau of Alcohol and Drug Abuse has recognized this lack of information and its 1975 Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse presents plans to begin remedying the situation.

Organizational Problems

Some of the organizational problems in the present service delivery system became apparent in earlier discussions of Fig. 9.1. Even though the state Bureau of Alcohol and Drug Abuse was created to consolidate formerly fragmented units within the state government into a single coordinating state agency, the fact is that there are still several important areas of overlapping or ambiguous jurisdictions, which already have created some conflict and promise to create more.

The first overlap involves the state Bureau and some of its own creations, the local umbrella organizations. Basically, both groups seem to have responsibility for overall coordination of community programs. At first glance one would assume that the umbrellas handle local community coordination and the Bureau handles coordination at the state level. That arrangement would be sensible for a large state like California where there are so many local communities that state and local coordination really are two distinct processes. But Nevada has only two large communities. Consequently, it is not clear why the central office in the Reno area cannot handle Washoe County coordination (particularly if they were located in Reno instead of Carson City) nor why the Las Vegas branch office cannot handle coordination for

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Footnote:

that area; indeed, the branch director's title is "area coordinator." The umbrellas, as they presently are constituted, appear to be an unnecessary bureaucratic layer between the local service delivery agency and the state Bureau. The Bureau has already acknowledged this to some extent by allowing programs to apply directly to the central staff for state funds without going through the umbrella, and the complexity of subcontracting with state monies may accelerate the trend in that direction. SNDAC's subcontracting role is with federal and not state funds. Also, some local treatment programs are not affiliated with the umbrella organizations. We do not mean to imply that there is no need for local advisory councils representing local treatment agencies, but this is not what the umbrellas appear to be, since their boards of directors do not include all heads of local treatment agencies.

A second overlap, legislative in origin, was alluded to in an earlier section. All "health care" facilities must obtain a license from the Bureau of Health Facilities, with issuance contingent on approval by the county health planning people. On the other hand, the state Bureau of Alcohol and Drug Abuse has been given responsibility for certifying alcohol and drug treatment programs, personnel, and facilities. Given the less than full communication and cooperation between the state Bureau and county health people, especially in Clark County, a local treatment agency might well find itself in the midst of interagency bickering to the detriment of its clients—the very persons in whose behalf this whole structure was created. This problem has not fully surfaced yet, but the Bureau has not yet fully exercised its certifying powers.

A third overlap arises out of the continuing responsibility of the Mental Hygiene and Mental Retardation Division for NMHI and its Ward 10 alcohol abuse program. Thus far the overlap has not led to overt conflict; NMHI and the state Bureau seem to go pretty much their own ways. But conflict may occur in the future as the state or other local agencies plan for more comprehensive inpatient care analogous to that offered by NMHI. As mentioned at the beginning of this chapter, one of the continuing problems of alcoholism treatment throughout the country is its association with mental illness. Most authorities now believe that alcoholism is a separate entity, and that treatment is more successful if clients are not labeled as mental patients. In this context one can speculate that NMHI, with its image as a "mentonal hospital," may be driving away many alcoholics who would otherwise benefit from Ward 10's inpatient program. In any event, full and successful coordination of alcohol programs will be difficult so long as one of the main treatment programs functions totally outside the main delivery system.

Finally, there is an administrative problem. Although consolidation of drug and alcohol program coordination within a single agency makes for some bureaucratic efficiency, especially in a small state like Nevada, it must be recognized that, at the local level, separate agencies normally will handle alcohol and drug treatment. This reality was reinforced by the recent creation of separate drug and alcohol agencies at the highest federal level, and Tables 9.2 and 9.3 reveal the same division in practice at the Nevada level. Accordingly, any coordination effort must recognize that separation if it is to be efficient and successful. It is our opinion, for example, that the NASAC-DETRAP conflict in Northern Nevada reflects essentially drug-alcohol battle lines. Whether future coordination takes place at the umbrella level or within the state Bureau and its branch office, alcohol and drug program coordination probably should be kept as separate as possible up to the Bureau chief level.
In this connection the recent emphasis, in the Division of Rehabilitation's Facility Plan, on integrated planning and facilities for both drug and alcohol abuse needs further justification. There is no clear evidence that "future funding sources [in the Federal Government] will be for combined substance abuse services," particularly when drug and alcohol programs are being coordinated by newly created and separate federal institutes. But even if there were such a trend, most local treatment centers would not be likely to offer combined services for drug abusers and alcoholics, because of the differences between the two client populations.

Facility and Service Deficiencies

Alcohol Programs. Since need is a relative concept, it is not easy to say whether the treatment programs described for alcoholism are sufficient to meet the service needs of Nevada's 33,000 or so alcoholics. Clearly, the number served annually is much less than the number of alcoholics in the state. And, as is to be expected, the consensus of the large number of persons we interviewed during our field investigation was that current service capacity was insufficient. That consensus is confirmed by the almost total lack of certain types of services in major geographic regions.

For FY 1974 the Federal Government (NIAAA) spent approximately $110 million on treatment and rehabilitation in the form of grants to states and direct grants to local treatment programs. Given the estimated number of alcoholics in the United States in 1970, that amounts to about $31 a year per alcoholic. Similarly, California has an estimated 600,000 alcoholics, for whose treatment and rehabilitation the state spent approximately $25 million during FY 1974, or about $40 a year per alcoholic. All corresponding figures are much lower for Nevada. If our estimates of Nevada's alcoholic population are correct, by contrast the Federal Government will spend only about $9 per alcoholic in Nevada during FY 1975 ($285,000, comprising the full $143,000 alcohol figure in Table 9.1 and $142,000 for NIAAA grants in Table 9.3). Nevada state expenditures on treatment and rehabilitation of alcoholics—excluding the formula monies—are the $415,000 for NMHT's Ward 10, $66,000 for vocational rehabilitation (see Chap. 11), and about $20,000 by the Las Vegas Mental Health Center; these combined amount to about $15 per alcoholic, less than half the figure for California. In other words, it appears that Nevada is receiving (or at least spending) less than its fair share of federal funds for treatment of alcoholism, and is spending much less per alcoholic out of state funds than is neighboring California.

Although federal formula grants are made largely on the basis of gross population and not alcoholism rates, NIAAA also spends about $60 million annually in the form of direct grants to local treatment agencies. If Nevada has about 0.8 percent of the country's alcoholic population, as Chap. 3 suggests, then it should be able to make a good case for claiming about $480,000 of the federal community grant money—considerably more than the $142,000 it is now receiving.

To this point we have been speaking of financial resources for the state as a whole. What about deficiencies within specific regions? First, we are convinced that

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† See the California State Plan for 1974/75, published by the California Office of Alcohol Program Management. This report gives an estimated 1.2 million alcoholics, our Jelinek formulas yield about half as many. Only a small part of this $25 million comes from federal formula grants.
the Las Vegas area has by far the largest concentration of alcoholics in the state, and yet it has fewer facilities and receives less in public expenditures than the Reno area—largely because of the location of NMHI. Although NMHI is open to anyone in the state, its long distance from Las Vegas undoubtedly deters many Clark County alcoholics and families desiring help. Even excluding NMHI expenditures, the public expenditures for alcohol abuse treatment in Reno are only slightly less than those for the Las Vegas area. We have already discussed the dearth of publicly supported alcohol programs in rural areas. Thus, from a regional standpoint, considering public expenditures in relation to the number of alcohol abusers in the region, it is clear that the Las Vegas area and rural regions are significantly less well funded than the Reno area.

Some specific facilities also are needed. Service personnel agree almost unanimously that the most important need in Nevada is for nonmedical detoxification facilities, especially in the Las Vegas area. The new four-bed EOB unit in Las Vegas will be the only publicly financed detoxification unit in the entire state. That is obviously insufficient for an area with over 15,000 alcoholics. The detoxification problem has become especially acute since drunkenness has been decriminalized by the same statutes, ironically, that created the new state alcohol program. The jails now cannot hold a drunk alcoholic beyond two days under a "disorderly" charge; after that there is no place to send the person. It has been alleged that this situation may have contributed to four deaths during this past year because of the victims' insufficiently treated withdrawal symptoms.

Aside from the statewide deficiency in detoxification facilities, there is a deficiency of outpatient care capacity in the Reno area as compared with the relative predominance of halfway or live-in rehabilitation houses. Service system capacity of all types is deficient in the Las Vegas and rural areas. In Las Vegas, for example, halfway or live-in rehabilitation houses for alcohol abusers are in particularly short supply, and full inpatient care which is accessible to people who cannot afford private treatment is lacking (by which we do not mean medical hospital care, but rather alcohol abuse treatment analogous to that provided by NMHI).

Finally, there are staff training needs in the facilities that do exist. Most treatment personnel have little professional training other than AA experience or other personal experience as an alcoholic; important as these experiences may be, they do not necessarily equip a person to deal effectively with the variety of personal and social problems an alcoholic brings to the therapeutic setting. Furthermore, although AA techniques and philosophy have helped hundreds of thousands of alcoholics, many alcoholics spurn AA because they do not find its moral and religious appeal acceptable. The same holds for programs that are exclusively work programs; while many alcoholics need this type of rehabilitation experience, perhaps just as many do not.

There is wide agreement nationally within the alcoholism treatment community today that the key treatment-system concept is "comprehensiveness." A regional treatment system should have a centralized information and referral service, as well as a set of facilities (probably decentralized) that can be used as deemed appropriate to the needs of a particular alcoholic for detoxification, inpatient treatment, halfway

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* Interview with Dr. V. LeCicero, Nevada Mental Health Institute, Sparks, Nevada, November 1974; see also, for example, "Jail Cell Deaths," Nevada State Journal, July 21, 1974.
house or rehabilitation service, outpatient therapy or counseling, or some combination of these.

**Drug Programs.** Since the number of drug addicts is harder to estimate, it is difficult to do a financial analysis similar to that for alcoholism. Nonetheless, one can at least note that the 1975 NIDA budget includes about $122 million for grants to community treatment agencies; if this amount were allocated on a total population basis (since we are not sure of the size of the drug addict population), Nevada would receive about $400,000. The $500,000 NIDA grant to SNDAC in Las Vegas therefore appears to satisfy the state of Nevada’s fair share of federal funds (although areas of Nevada outside Las Vegas receive none of this money). On the other hand, the state itself has few expenditures for drug abuse other than the federal formula grant monies; in particular, it has no comprehensive treatment facility on a par with NMHI’s Ward 10, which will accept drug abusers but which is primarily an alcoholism unit. The lion’s share of the drug abuse funds then, goes to the Las Vegas area even though Reno also has a significant drug abuse problem. And whatever drug abuse problems exist in rural Nevada are not attacked with any significant level of funding.

As with alcoholism, there are insufficient detoxification facilities for drug abusers. The shortage may have become especially acute with the recent cessation of Cedarbrook’s detoxification operation in the Las Vegas area. Reno has no professionally staffed program for the hard-core addict. The drug abuse treatment system also has some other kinds of facility problems. Following up on the concept of a “comprehensive” treatment system with a full range of services that can be used as deemed appropriate to the needs of a particular drug abuser, we have noted earlier that there is no full inpatient care program analogous to the NMHI Ward 10 program but designed for drug abusers. Regarding halfway or live-in drug rehabilitation houses, it is of some concern that some of the live-in drug treatment facilities in the Las Vegas area are operating at less than capacity and a few have been embroiled in controversies about possible drug use. Our investigation was not exhaustive enough to discover what all the problems might be, but it is certainly true that before additional funds are spent in the Las Vegas area (and perhaps in the Reno area as well) there should be a careful analysis of existing facilities and services, and any modifications deemed necessary to render those services more effective should be made.

**RECOMMENDATIONS**

The problems described in the previous section call for concerted action on the part of state and local officials if the problems of alcohol and drug abuse are to be handled effectively in Nevada. It would be inappropriate for us to try to prescribe that action in detail, but we can provide an action agenda as a starting point. We believe our recommendations will be found consistent with the general goals and objectives specified in the 1975 Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse.\(^\text{10}\)

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\(^{*}\) At the time of our interviews only one inpatient was a drug abuser. He received the same treatment as the alcoholics, including watching films on alcoholism and listening to tapes aimed at alcoholics.

\(^{10}\) Nevada State Bureau of Alcohol and Drug Abuse, Carson City, Nevada, April 30, 1975.
In making these recommendations we recognize that organizational structures and service programs are still evolving in this area. Some of these developments are reflected in the 1975 state plan for substance abuse, in particular, the detailed planning for the proposed detoxification program for Washoe County sponsored by NASAC. But most of our recommendations, while consistent with goals in the state plan, are not yet implemented and not yet reflected in current detailed planning, especially those pertaining to Clark County—which encompasses between one-half and two-thirds of Nevada's alcohol and drug abusers. We are also concerned that the 1975 state plan reflects continued use of the words "Drug Abuse Council" in the SNDAC name (with no mention of alcohol), by its failure to propose realistic detailed plans for implementation of service program improvements for Clark County alcoholics, and by its use of underestimated alcoholism incidence rates, rates that are well below even the most conservative estimates available using NIAAA methods of estimation.

We recommend that comprehensive information systems be established for monitoring alcohol and drug abuse treatment programs, as well as alcohol and drug abuse rates. For alcohol abuse rates, it should be easy to tabulate cirrhosis deaths and beverage sales on a county-by-county basis and thus to make estimates of abuse rates like those in Chapter 3 to assist in regional planning. For drug abuse rates, the state should look into methods used by the National Institute on Drug Abuse. Information for monitoring service programs should be required from every local program receiving any federal or state funds, and should be requested from all others. IDARP may suffice for drug programs, particularly if supplemented by a simple form to obtain total funds by source, and staff members by background; a similar system should be implemented for alcohol programs. A prototype of such a system is available from NIAAA, and some funds are available to states that want to implement it.

The proper focus for these information systems is the state Bureau. In addition to these routine monitoring functions, the Bureau should also provide for periodic outcome evaluations of treated populations to determine the effectiveness of treatment.

A more streamlined organizational structure should be considered that eliminates overlapping jurisdictions on the one hand and recognizes separate spheres of activity on the other. A key feature of the arrangement we envision would be the creation of two councils, one for drugs and one for alcohol, in each of three regions: Clark County, Washoe County, and the remaining, predominantly rural, region of the state. Council membership would include all local treatment program directors (or perhaps a rotating subset) and selected local officials and leaders (e.g., representing the public, police, courts, schools, city councils, etc.). The council's main function would be to advise the state on plans for future services, current financial assistance, and certification. (Programs under certification review would not be represented during those deliberations.) In this way, some of the functions of the county Comprehensive Health Planning agency and the present umbrella organizations could be consolidated into a single structure. Representation on the councils would be much broader than it is in the present umbrella organizations. Certain functions of the current umbrella organizations, such as acting as a funnel for funds, seem unnecessary in a state the size of Nevada, which has a functioning state Bureau of Alcohol and Drug Abuse; hence those functions would be abolished. The separation of drug and alcohol councils recognizes the current realities both of local treatment organi-
zations and of federal financing agencies. It also should solve some of the local conflicts that have been observed since the creation of the NASAC and SNDAC umbrellas.

In recommending a modification to local umbrella agencies, we are not rejecting an umbrella concept of local coordination. On the contrary, the recommendation is intended to bring this concept into reality, since local coordination is clearly suffering at the present time (especially in Clark County). Moreover, we recognize that adequate permanent staffing for these councils may require continued state support (support similar to that provided for the current umbrella staff) and that Federal guidelines may make it desirable for continued direct service delivery by the councils (when local agencies are not adequate). Indeed, it is not suggested that the term "umbrella" need be eliminated, but only that the current structure is not fully meeting the objectives of local coordination.

A second major feature of the reorganization would be the transfer of administrative and budgetary control of the NMHI "Ward 10" to the Bureau of Alcohol and Drug Abuse. (We recognize that such a transfer would require legislative action.) We do not envision physically removing Ward 10 from the Nevada Mental Health Institute at the present time, although that might happen in the future. Instead, we would give administrative and budgetary control of the alcohol and drug abuse treatment program to the alcohol and drug abuse agency rather than to the Mental Hygiene and Mental Retardation Agency, which has different priorities. Auxiliary services and facilities for Ward 10 patients, such as medical care, recreational facilities, and "industrial therapy" (jobs), could be obtained from the other segments of the NMHI as they are now. The bookkeeping system at NMHI is such that it would not be too difficult to arrange for an interagency transfer of funds to cover those services and the use of facilities.

We are not necessarily arguing that direct clinical supervision of Ward 10 be placed at the Bureau of Alcohol and Drug Abuse, since its present structure may not include sufficient professional staff for such responsibilities. Rather, we are recommending an administrative and budgetary realignment, since we do not see how full program planning and coordination is possible with the current fragmentation of programs across different divisions. Ward 10, the largest treatment program for alcohol abuse in the state, is now effectively separated from the Bureau of Alcohol and Drug Abuse.

We recommend the creation of a comprehensive alcoholism treatment program for the Las Vegas area. Although a number of new or expanded programs are needed for alcoholism treatment throughout the state, the most pressing needs are undoubtedly in the Las Vegas area. Federal funds may be available to help fund such a program. By a "comprehensive" program we mean the provision of several types of care appropriate for different types of clients. The following services should be included: a nonmedical detoxification unit and holding center that can handle up to 10 clients; a short-term (e.g., 30-day) full inpatient treatment facility with perhaps 20 to 40 beds (similar to the NMHI Ward 10 program and accessible to those who cannot afford private treatment); rehabilitation or halfway houses for longer-term recovery with at least 20 to 40 beds; and a full range of outpatient services including individual and group therapy and antabuse treatment. The staff should include at least three full-time therapists with training in therapeutic counseling at the master's degree level. Some of these services might be arranged by expanding or working with existing facilities and programs.
Both drug and alcohol detoxification services should be provided throughout the state. The present lack of these essential services has been documented earlier.

A few small halfway or live-in rehabilitation houses for alcohol and drug abusers should be established throughout rural Nevada, with provision for outpatient services at those same facilities. As with many other services, rural Nevada is currently lacking in alcohol and drug abuse treatment programs. Full inpatient treatment programs are probably not practical in rural Nevada because of sparse populations, difficulty in obtaining qualified staff, and hence the high cost per person served; full inpatient services can probably be more adequately provided to rural alcohol and drug abusers through short-term residence in Reno (NMHI) or the Las Vegas treatment center we recommended above. However, it does appear feasible and desirable to provide the less intense live-in rehabilitation house and outpatient services in small programs directly in the larger rural communities. That is, some of the larger rural communities appear to have sufficient numbers of people needing halfway or rehabilitation house and outpatient treatment so that small programs in those communities can be fully utilized and be economically feasible.

We recommend creation of a short-term, professionally staffed, full inpatient treatment program for drug abusers in Nevada, analogous to the NMHI Ward 10 program, which is designed primarily for alcohol abusers. This would fill a notable major gap in the service system. Another important issue in the drug abuse treatment area is the existing delivery system in the Las Vegas area. Before any other new expansion is contemplated (other than detoxification), there must be a careful analysis of the reasons for underutilization of some existing facilities (those reasons do not appear to include lack of need for the services) and a determination of the reasons for controversy over alleged drug use in some halfway houses in the Las Vegas area.

Finally, we reiterate the need for direction and coordination of services, and refer the reader to Chap. 4 for our recommendations for the creation of Regional Direction Centers.

An alcohol and drug abuse facility plan prepared in 1974 for the Nevada Division of Rehabilitation\(^{11}\) indicated no need for additional treatment facilities prior to 1980 with the exception of nonhospital detoxification facilities. Although we have recommended that services be expanded, our recommendations are not necessarily inconsistent with that facility plan. The reason is that while hospital and intermediate care facilities exist in the state, as do facilities that could be used for outpatient treatment, alcohol and drug abuse treatment services are not now being provided in most of those existing facilities.

\(^{11}\) Rehabilitation Facility Plan, 1975-1980.
Chapter 10

RESIDENTIAL MENTAL HEALTH AND MENTAL
RETARDATION SERVICES

INTRODUCTION

Residential programs required to meet the diverse needs of mentally handicapped people range from full inpatient care facilities, through less service-intensive intermediate care facilities, to semi-independent residential living programs that offer minimal supervision and assistance. Because the residential service needs of people with mental health disorders are vastly different from those of people with mental retardation, the needs of these two groups of people are discussed separately in this chapter.

We focus in this chapter on residential service programs intended to provide more than the supervised residential living discussed later in Chap. 13. For people with mental health problems, the residential service programs discussed here include: the Nevada Mental Health Institute's (NMHI) mental health and geriatrics programs, the Las Vegas Mental Health Center's residential treatment program; the new Children's Behavioral Services residential treatment program; Cedarbrook Hospital; Rancho Vegas Nursing Center; Southern Nevada Memorial Hospital; Washoe Medical Center; the Nevada State Prison; the newly formed institution for developmentally disabled individuals; the Veterans Administration Hospital program discussed in Chap. 8; and various out-of-state residential treatment programs where Nevadans are sent when appropriate in-state services are not available for them. For mentally retarded people, the residential service programs include the NMHI's mental retardation program, the Eagle Valley Children's Home, the Northern and Southern Nevada Mental Retardation Centers, the new Desert Developmental Center, and out-of-state residential treatment programs where a few mentally retarded youth with mental health disorders are sent.

In Chap. 9 we discussed residential service and residential living programs for alcohol and drug abusers, including those at NMHI. In Chap. 12 we discuss medical facilities in Nevada that do not have special programs for provision of mental health or mental retardation services. Chapter 13 concentrates on programs that provide supervised residential living for people who are unable to live with their own families or fully independently in the community, but that are not intended to and do not provide any substantial mental health or mental retardation services.

Figure 10.1 depicts the organization of the residential mental health and mental retardation service system discussed in this chapter. The system has three major sectors: public facilities, private facilities, and out-of-state facilities where some Nevadans are sent when appropriate in-state services do not exist.

Table 10.1 is a summary of the estimated number of people served, staff, and expenditures for these residential service programs in FY 1974.

For Nevadans with mental health disorders, approximately $6 million was spent for residential care and treatment in FY 1974. Note that in terms of daily average bed-capacity filled, the NMHI was the largest (160), followed by local and private
Fig. 10.1—Organization of major residential mental health and mental retardation services in Nevada

* Not yet in operation in July 1976.
** To be remodeled in 1976.
Table 10.1

SUMMARY OF MAJOR RESIDENTIAL MENTAL HEALTH AND MENTAL RETARDATION SERVICES IN NEVADA, FY 1974

<table>
<thead>
<tr>
<th>Programa</th>
<th>Estimated Number Served</th>
<th>Estimated Service Episodes Per Day</th>
<th>Estimated Total Staff (Service and Support)</th>
<th>Estimated Annual Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Service (Shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annuallyb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMHI: Mental Health Program</td>
<td>80</td>
<td>750</td>
<td>100</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>NMHI: Geriatrics Programs</td>
<td>80</td>
<td>&lt;120</td>
<td>80</td>
<td>950,000</td>
</tr>
<tr>
<td>Las Vegas Mental Health Center: residential treatment</td>
<td>30</td>
<td>650</td>
<td>46</td>
<td>550,000</td>
</tr>
<tr>
<td>Children's Behavioral Services: residential treatmentc</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Local and private general hospitals: psychiatric units</td>
<td>64</td>
<td>1776</td>
<td>100d</td>
<td>2,900,000d</td>
</tr>
<tr>
<td>Nevada State Prison</td>
<td>12</td>
<td>&lt;24</td>
<td>6</td>
<td>100,000</td>
</tr>
<tr>
<td>Mentally Disordered Offender Facilityc</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Veteran's Administration Hospitalc</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Out-of-state residential services</td>
<td>20</td>
<td>&lt;25</td>
<td>NA</td>
<td>200,000</td>
</tr>
<tr>
<td>Total, mental health</td>
<td>286</td>
<td>&lt;3345</td>
<td>332</td>
<td>$6,000,000</td>
</tr>
</tbody>
</table>

| Mental Retardation Services |                         | Service (Shared) |                     |                              |                               |
|-----------------------------|-------------------------|-------------------|----------------------|-------------------------------|                               |
|                             |                         | Annuallyb       |                      |                              |                               |
| NMHI: Mental Retardation Program | 140 | <160 | 130 | $1,600,000 |
| Desert Development Centerc | 0 | 0 | 0 | 0 |
| Eagle Valley Children's Home | 10 | <15 | 7 | 40,000 |
| Mental Retardation Centers | 54 | 75 | 46 | 650,000 |
| Out-of-state residential services | 4 | — | NA | 40,000 |
| Total, mental retardation | 208 | <250 | 183 | $2,330,000 |

NOTE: NA = not available.

aSee text of this chapter for sources of data. Total NMHI staff were split among the different programs in proportion to program expenditures.

bSince a person may be a resident at more than one facility in a year, or be readmitted to the same facility after an earlier discharge the same year, the number of people served will be smaller than the number of resident service episodes.

cNot in operation in FY 1974.

dData on total staff and actual expenditures were not available for all facilities. We assume an average of $125 per day including hospital, drug, physician, and other fees, and we assume the same average total staff level as that existing in the Las Vegas Mental Health Center inpatient units.
general medical facilities with psychiatric units (64), and the Las Vegas Mental Health Center (30). However, in terms of the number of service episodes annually, the largest residential service program by far is that provided by local and private medical facilities (1776), followed by NMHI (up to 870) and the Las Vegas Mental Health Center's residential program (650). In FY 1974 the Nevada state service system (i.e., all except local and private medical facilities with psychiatric units) accounted for about 78 percent of the utilized bed-capacity, 47 percent of the annual service episodes, 70 percent of the staff, and 52 percent of the expenditures. Thus, the state system is significantly less expensive per bed-year, but incurs about the same cost per service-episode since the service-episodes are longer than they are for local and private medical facilities. Such direct comparisons are difficult to interpret, however, because the types and severity of the mental disorders seen in the two sectors were quite different in FY 1974. Since FY 1974, the residential mental health service system has been undergoing major changes: the geriatrics program at NMHI has been greatly reduced and the staff transferred to the NMHI neuropsychiatric program, which has decreased the median patient-stay for discharged patients to 17 days in 1975; a new Mentally Disordered Offenders Facility has been constructed (bed-capacity 32); two Children's Behavioral Service residential treatment facilities are being created (each with a planned bed-capacity of 16); and the Rancho Vegas Nursing Center has planned to open a long-term psychiatric care section (bed-capacity 39). The probable net effect of these changes will be an increase in the utilized bed-capacity in Nevada of about 11. The prime reason the utilized bed-capacity will not increase substantially in spite of the new construction is that the number of residents at NMHI is being substantially reduced so that those remaining can receive better mental health services (the staff has not been reduced) and be served in NMHI's better buildings.

For mentally retarded Nevadans, about $2.3 million was spent for residential services in FY 1974. The Nevada state service system (which includes all but the Eagle Valley private facility) accounted for over 95 percent of the people served, staff, and expenditures.

Since FY 1974, the residential mental retardation service system has begun major change: a new Desert Developmental Center is being constructed in Las Vegas (bed-capacity 56); when it opens, the NMHI mentally retarded resident population will be cut to less than half of the FY 1974 level. The plan is to reduce the number of residents at NMHI without reducing the staff, so that those remaining can receive better services and can be served in improved facilities. With these and other changes, the NMHI may be able to achieve accreditation as a mental retardation facility.

We note that merely to maintain the 1974 quantity of service per capita in 1985, the bed-capacity and annual budget (in constant value dollars) of the residential mental health service system would have to be increased from 286 to 380 beds and from $6.0 to $8.0 million (see Chap. 3 for population projections). To maintain the 1974 quantity of residential service per capita for mentally retarded Nevadans, the service system's bed-capacity would have to increase from 208 to 276 and the annual budget from $2.3 to $3.7 million.

The next sections of this chapter discuss the above-mentioned residential service programs and their deficiencies. We then present recommendations for improvement. Mental health services are covered first, followed by separate sections on mental retardation services.
NEVADA MENTAL HEALTH INSTITUTE

Located in Sparks just outside Reno, the NMHI is a 412-bed facility serving people with mental health, mental retardation, and alcohol and drug abuse problems.¹ It has been undergoing tremendous change. The total number of residents with all types of mental handicaps has declined from about 550 in 1966 (including about 150 mentally retarded residents, about 20 alcohol and drug abusers, and about 380 with mental health disorders), to an average of 326 in FY 1974, and finally to about 220 in July 1975 (including about 110 mentally retarded residents, about 16 alcohol and drug abusers, and about 94 adults with mental health disorders). Most of this massive decline occurred as the mental health program at the Institute shifted from chronic patient care toward short-term acute patient service.

The NMHI served a total of 716 clients in the last six months of 1973.² Given the July 1975 census of about 220 people, of whom about half are long-term mentally retarded residents and about 50 are short-term neuropsychiatric patients whose median stay is 17 days, we estimate that the FY 1976 number of patient-stays may be as high as 1500 on an annualized basis. Some of those patient-stays, however, will be repeat admissions in the same year. In January 1976, 49 percent of the NMHI neuropsychiatric admissions were readmissions of clients who had been previously served. In that same month, the average daily number of inpatients was 227; the average daily census in January 1976 was 270, including inpatients, day care and partial hospitalization patients, outpatients, those on home visits, and those who were "AWOL".

In FY 1974 the NMHI had 867 additions to its inpatient population. This amounted to 157 per 100,000 civilian resident population in the state; the national average was 208 and 14 states had a lower number of additions per 100,000 population than did Nevada. In terms of inpatients at the end of FY 1974, the NMHI had 59 per 100,000 civilian resident population; the national average was 103, and 15 states had a lower number of inpatients per 100,000 population than did Nevada.³

In FY 1973, 40 percent of the admissions to the NMHI were readmissions of previous patients. In that year, the geographic distribution of all admissions was: Clark County, 56 percent of the state’s population and 18 percent of NMHI admissions; Washoe County, 24 percent of the state’s population and 61 percent of the admissions; and all other counties combined, 20 percent of the state’s population and 21 percent of the admissions.

In FY 1974 there were 335.5 authorized staff positions at the NMHI. That figure remains almost unchanged. Despite nonaccreditation of the NMHI partly because of staff deficiencies in the mental retardation area, and despite the serious deficiencies in psychological services staffing in the neuropsychiatric area pointed out by the

¹ Information in this section was obtained from NMHI statistical records; interviews with Dr. V. LoCicero, Medical Director, and various other staff members between April 1974 and August 1975; Governor M. O’Callaghan, The Executive Budget, Fiscal Years 1975-76 and 1976-77, State of Nevada, Carson City, Nevada, January 20, 1975 (hereinafter cited as Executive Budget); and a letter from T. Pippmeyer, NMHI, Sparks, Nevada, to J. Kakaik, The Rand Corporation, Santa Monica, California, February 27, 1976.
survey team of the Joint Commission on Accreditation of Hospitals, the 1975 session of the state legislature approved only one new service position for the Institute.  

The deficiencies in the physical facilities at the NMHI are numerous and were well documented in a series of three reports in 1974. The Nevada Division of Mental Hygiene and Mental Retardation described the Institute's facilities to the state legislature in 1975 in the following terms:

Currently, the Nevada Mental Health Institute physical plant is not geared toward positive images and structures for mental health. As a cross between the county jail and the poor farm, the Institute facilities have been physically built up over the years to provide custodial care for the mentally ill who are excluded from life in their communities, their families and friends. The current residential facilities, in their present form and condition, are not fit as living quarters for persons expected to feel and act according to positive social conventions. Opportunities for productive, healthy activities during the day are minimal, often replaced by sleeping, aimlessness, disturbances, and occasionally by assignments in the laundry and food service. . . .

In response to a request by the Division of Mental Hygiene and Mental Retardation to remedy some of those deficiencies, the Nevada Public Works Board and the 1975 session of the state legislature approved several capital improvement projects:

- A Desert Developmental Center in Las Vegas, described elsewhere in this chapter, providing a range of services to mentally retarded people, some of whom are now residents of the NMHI (total funds $2,494,800).
- An NMHI Site Development project to provide landscaping, security lights, parking, and walkways (total funds $675,000).
- Improvements to 6 mental health and mental retardation buildings, NMHI, mostly for interior remodeling and furnishing (total funds $540,900).
- A Day Activities Facility, NMHI, to provide a central activity area off the living unit for normal day activities (total funds $391,500).
- An Inpatient Residential Facility, NMHI, to provide three new buildings to serve as living units for 16 inpatients each (total funds $1,335,600).
- Renovation of Building No. 11, NMHI, to provide a transitional living unit for about 16 persons not ready to assume complete independent living, but who are beyond the need for a highly supervised living environment (total funds $135,900).  

Just over $3 million, then, will be spent directly at the present NMHI site. The result will be a substantial improvement in some of the existing facilities used by

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4 A new geneticist position was approved, and a previously authorized slot for an Institute Director was also funded. Information provided by H. Clemons, Management Analyst, Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975. The Joint Commission on Accreditation of Hospitals survey is discussed in detail later in this chapter, and in App. B.


6 Nevada Division of Mental Hygiene and Mental Retardation, Nevada Mental Health Institute Capital Improvements, report prepared for presentation to the Nevada Legislature, February 1975.

7 Ibid., and information provided by H. Clemons, Management Analyst, DMHMRI, Reno, Nevada, June 19, 1975.
neuropsychiatric and mentally retarded residents, and substantial new facilities for
europsychiatric patients. As detailed later, the Division's intention is to construct
two new facilities for mentally retarded people elsewhere (the already-approved
Desert Developmental Center in Las Vegas is one of these two).

In FY 1974, NMHI's total expenditures were $4,557,000. Beginning in June
1974, the established rates for inpatient hospitalization at the NMHI, reflecting the
actual costs per patient-day, were: $40.70 per day for neuropsychiatric service ($14.856 per patient year; $31.17 per day for mental retardation service ($11,377 per patient year); and $32.37 per day for geriatric service ($1,815 per patient year).\(^6\)

Since June 1974, the number of neuropsychiatric and geriatric patients has been
decreasing substantially while their staffs have been retained and combined, resulting
in a substantial and continuing rise in costs per neuropsychiatric patient-day.

The four very different service programs within the Institute (mental health,
geriatric, mental retardation, and alcohol and drug abuse) are separately described
below, except for the alcohol and drug abuse program, which was described in Chap.
9.

**NEVADA MENTAL HEALTH INSTITUTE: MENTAL HEALTH PROGRAM**

The massive decline in the number of NMHI residents with mental health
disorders, from about 380 in 1966 to less than 100 in the fall of 1975, was due
primarily to the discharge of long-term inpatients with mental health disorders—
people who typically were classified by the Institute in the mid-1960s as having
chronic organic brain syndrome or schizophrenic reactions.\(^6\) Some had been in the
Institute for 20 to 30 years. Thus, in the past ten years the neuropsychiatric section
of the Institute has shifted its primary emphasis from chronic residential care to
primarily short-term treatment. The median length of stay for neuropsychiatric
patients discharged from the Institute in 1975 was only 17 days (down from 109 days
as recently as FY 1973). That is, half of those people discharged in 1975 stayed 17
days or less. The average length of stay in 1975 was 30 days. The NMHI residential
program, however, does continue to serve a few longer-term neuropsychiatric cli-
ients. Not counting the 33 geriatric clients the NMHI plans to discharge, one neu-
ropsychiatric client had been in NMHI over a year as of February 2, 1976; seven other
clients had been in NMHI 6 to 12 months; and 13 others had been there 3 to 6 months
as of February 2, 1976. In terms of length of stay, at least, the Institute is now
primarily functioning much the same as the inpatient units at Washoe Medical
Center, Southern Nevada Memorial Hospital, and the Las Vegas Mental Health
Center. The Institute is not functioning primarily as a place for treatment of pa-
tients who need longer term care than that typically provided by those three com-
community-based facilities. For discussion of the NMHI's plans for discharge of the 33

\(^{\text{6}}\) Information provided by T. M. Reynolds, Business Manager, NMHI, Sparks, Nevada, May 13, 1974.

\(^{\text{\textit{}}}\) Information in this section was obtained from NMHI statistical records; several interviews between
April 1974 and August 1975 with the Institute's Medical Director, Dr. V. LoCicero; interviews in mid-1974
with numerous Institute staff members including the psychiatrist, nurse, social worker, and most mental
health technicians on each neuropsychiatric ward; and individual interviews in July 1974 by a Rand
consultant psychiatrist with about 20 percent of the residents on the neuropsychiatric wards, NMHI,
Sparks, Nevada.
geriatric patients, see a later section of this chapter on services to NMHI geriatric residents.

While the resident neuropsychiatric population at the Institute has been declining, the size of the staff has not; consequently the remaining patients can receive significantly better services. Also, after completion of the facility improvements for the Institute approved by the 1975 Nevada Legislature, less than half the remaining neuropsychiatric patients will be housed in facilities that were used in 1974. With the discharge of long-term neuropsychiatric and geriatric patients, with the building of the Desert Developmental Center and the planned transfer of half the mentally retarded Institute residents to it, with the completion of the new Mentally Disordered Offender Facility, and with the new buildings being constructed on the grounds of the Institute, we note that the majority of the Institute's wards used in 1974 will be vacated. The Nevada Legislature, in effect and in piecemeal fashion, has approved reconstruction of more than half the Institute, in a partially decentralized manner, in some cases in the form of facilities with different names. Improved facilities for residential treatment of mentally handicapped Nevadans will result, and the change also means that some of the old and admittedly deficient facilities could be used temporarily to expand the currently inadequate capacity of the mental health service system if new staff were approved for them (see the recommendations sections of this chapter for areas of needed service expansion).

The NMHI admission procedure involves an officer of the day, who may or may not be a psychiatrist and who screens all referrals in deciding on admissions. Subsequent to admission, the neuropsychiatric patient is assigned to one of the wards and an intake interview is conducted by the ward psychiatrist. In addition to these two initial interviews by Institute personnel, a psychiatrist from the Reno Mental Health Center conducted a third preadmission interview at the Institute for applicants from Washoe County in 1974. This Mental Health Center screening recommended admission to the Institute for 90 percent of those screened. Most of the 10 percent screened out were said to be alcoholics; because we suspect they would not have been admitted by the Institute's officer of the day anyway, the added screening at the Institute by the Reno Mental Health Center seemed to be a superfluous and largely inefficient use of scarce professional talent. Moreover, information gathered in the interview by the RMHC psychiatrist was not passed on to the Institute. The screening form given to the Institute by RMHC gave only three lines of information: name, age, sex, and attestation by the RMHC psychiatrist that he believes the patient is unwilling or unable to be served outside the Institute at the present time. An Institute psychiatrist opined that the RMHC preadmission screening is "meaningless" and "so superficial that it is a waste of time," but that it did increase RMHC caseload statistics. The Reno MHC preadmission screening of NMHI clients has been terminated.

Statements by the RMHC psychiatrist who did preadmission screening at the Institute, concerning the total lack of day treatment programs, highlighted the problem of the lack of a range of levels of mental health care in the Reno area. He said: "I don't want to take a chance on those patients on an outpatient basis;" and therefore "I put them in the hospital [the Nevada Mental Health Institute] when
they really need day care."

In sum, they are placed in a residential institution in which, in his professional opinion they need a more appropriate type of treatment which, if it were available, almost certainly would be less expensive.

This issue of acceptance of patients at the Institute who really need another type of care was also mentioned by one of the Institute's psychiatrists, who said that he admitted as "overnight cases" one-third of all the patients he screened because no other appropriate community facilities were available to meet their needs. He indicated that a major need exists for very-short-term or overnight residential treatment and day-care facilities in the state. He also said he has sent people to the Nevada State Prison because the Institute had no locked facilities in which to keep them. (This situation has been partially remedied since our interviews by a court-ordered evacuation of noncriminals from the prison psychiatric unit [discussed elsewhere in this chapter], by the temporary creation of a secure unit at the Institute, and by the Mentally Disordered Offender Facility now under construction.)

The daytime staff on each of the three NMHI neuropsychiatric units in mid-1974 typically was composed of one psychiatrist, one psychiatric nurse, one social worker, and four or five mental health technicians who are assigned as "primary therapists" to patients. There were only 1½ full-time-equivalent psychologists in the entire NMHI, and they provided only very minimal counseling and consultative psychological services to the neuropsychiatric units.

In contrast, San Francisco's outstanding Mt. Zion Hospital (with 18 inpatients, 8 outpatients, and 20 partial care patients in late 1975) had 8 psychiatrists, 3 psychologists, 3 psychiatric social workers, 3 occupational therapists, 4 part-time activities specialists, and 18 nurses. The staff also includes private psychiatrists who come to treat their patients. The patient's day is individually programmed with services from early morning until after dark. Admittedly, this level of services is exceptional. It is an order of magnitude more intense than that provided at the NMHI or anywhere else in Nevada. We are not saying Nevada services should all be upgraded to that expensive standard, but it does indicate what one of the better programs is providing.

One possible problem area we observed concerned the planning of daily activities for the NMHI neuropsychiatric units. They apparently were often planned on a catch-as-catch-can basis by the unit's nurse and mental health technicians rather than by the unit's psychiatrist or by a team of professionals. There also appeared to be little supervision or control of the mental health technicians by the psychiatrists. Upon our inquiring into this situation, the mental health technicians told us that, typically, any supervisory time provided by a unit's psychiatrist, psychiatric nurse, or social worker that was therapy-related usually was for crises and not for regular psychotherapy. There reportedly is little one-to-one consulting on individual patients between psychiatrists and technicians. Two of the psychiatrists told us that the nursing department is quite independent, so much so that the nurses threatened to go on strike in response to the doctors' efforts in early 1974 to obtain more control of activities on the units. The nursing department hires and fires the mental health technicians; the physicians' opinions on personnel are obtained but not always followed.

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10 Interview with Dr. Hamilton, Reno Mental Health Center, Transition Unit, Sparks, Nevada, July 2, 1974.
11 Information provided by Dr. R. Rubenstein, Mt. Zion Hospital, San Francisco, California, July 1974.
As an example of daily activities for NMHI residents with mental health problems, one unit typically had mental health technicians talking with various patients on a one-to-one basis for a total of 2 to 3 hours per day, plus group therapy for about 1½ hours per day. Approximately half the patients were said to meet with their primary therapist (mental health technician) on any given day. Many of the patients worked in various jobs at the hospital, e.g., in the kitchen or laundry, in what is called "industrial therapy." Arts and crafts and recreational facilities were available. Usually, one organized recreational activity was scheduled for patients each day. By Institute policy, patient participation in activities was voluntary.

Several patients told us it was difficult to get to see a psychiatrist in the three neuropsychiatric units at the NMHI. On investigation it appeared that less than half of the three psychiatrists’ time is available for patient therapy. One unit’s psychiatrist had 11 to 15 hours per week for direct patient contact. Another said his typical week consisted of 35 day-shift hours, plus some night and weekend coverage. Of the 35 hours, he said he spent about 8 hours as officer of the day for admissions, about 10 hours in committee meetings that were not directly service-related, about 5 hours on records, and the remaining 12 hours for direct patient therapy. (All three psychiatrists mentioned a heavy time requirement for meetings, but the Director of the NMHI indicates, for example, that the March 1976 schedule has only 6½ hours of meetings all the psychiatrists are expected to attend.) The third psychiatrist reported having 15 hours per week for direct contact with patients to provide therapy.

The psychiatrist on each unit typically spends 1½ to 15 hours per week in direct therapeutic contact with patients. Not all patients meet individually with the psychiatrist for treatment even once a week. One psychiatrist conducts a group psycho-drama session on his unit for an hour a week. Given this limited available direct contact time between psychiatrist and patient, other staff members must carry a heavy responsibility for patient care. On the average, each unit’s psychiatrist has on the order of only one-half hour per week in direct contact time, exclusive of record keeping, per patient in his unit. Since the median length of stay at NMHI is only a little over two weeks, it is obvious that the psychiatrists can spend very little time with a typical patient during the entire stay at NMHI.

The social worker on the unit typically consults with mental health technicians, meets with patients’ families if they come in, writes a social history on each patient, attends meetings, and does some predischarge work (e.g., with respect to financial assistance for medication after discharge), but provides little direct treatment. One social worker commented that all the records and forms required would have tremendous meaning if the Institute “did the therapy part.” It is clear that most staff members on the neuropsychiatric units, from the psychiatrists to the technicians, spend less than half of their work time in actual direct treatment of patients.

One of the most serious problems with NMHI mental health services is the low level of skills of the mental health technicians, who must carry much of the responsibility for patient treatment at the Institute. Most are not skilled enough to perform that work adequately. In practice, consequently, the primary mode of therapy for most mental health patients at the Institute appears to be chemotherapy. Although psychopharmacological intervention has become increasingly useful, it is primarily useful as an adjunct to other kinds of treatment (e.g., psychotherapy), which it may facilitate but does not replace.
One psychiatrist in the Division of Mental Hygiene and Mental Retardation who was in a position to know about neuropsychiatric services at the Institute indicated that, in his professional opinion, "There is not much effective psychotherapy on the wards... The techs [mental health technicians] have no real training... most of their psychotherapy is just 'chit-chatting.'"12

One NMHI psychiatrist indicated that his unit's staff is not capable of carrying out detailed psychiatric treatment orders, and therefore he does not write them.

Another indicated that "a few of the MHTs can work well with the patients... but most are not well trained." Yet another said that drugs must be used extensively because the Institute does not have staff to provide "good psychotherapy." One talked of only "covering up" (i.e., reducing symptoms of the mental disorder) but not "uncovering" and systematically addressing patients' problems.

Another NMHI professional likened the present psychotherapy at the Institute to giving a drowning man a tube of air at the bottom of a swimming pool instead of helping him out of the water.

Mental health technicians reportedly spend a good deal of their time doing patient escort, housekeeping, phone-answering, and similar nontherapeutic work. Most technicians we interviewed said less than half their time was available to provide therapy to patients.

The patients interviewed by one of Rand's consultant psychiatrists confirmed that patient treatment occupied less than half of the mental health technicians' time. On one unit, none of the four patients we interviewed even knew which technician was assigned as his or her primary therapist, although patients on the other two units did know. The patients on that one unit were not told who their primary therapist was because the nurse in charge said she did not want the staff to become "too possessive" with respect to individual patients.

Some of the mental health technicians we interviewed who were assigned as primary therapists did not know their patients well. For example, they might not know what medication the patient was on, and its effects and side-effects for which to be alert. The supervising nurse on one of the three units did not know most of the patients and their problems when we questioned her; the same was not true of the other two units.

One favorable aspect of the Institute is that the neuropsychiatric patients interviewed generally liked the staff members and believed they were trying to help. None had any complaints of sadism by staff members or inadequate protection, by the staff, of one patient from another.

Turnover of the NMHI's mental health technicians, the most prevalent type of direct service employee, was 48 percent in FY 1974 for the neuropsychiatric program and about the same for the mental retardation program. Of those who quit, 40 percent do so after having worked six months or less. The employee turnover rate for the Institute as a whole was 34 percent in FY 1974.13 Turnover rates were 10 percent for all Nevada state employees, 30 percent for St. Mary's Hospital, 29 percent for the Nevada mining industry, and 48 percent for the Nevada manufacturing industry. In 1975, the turnover rate of mental health technicians was reduced.

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12 Anonymity was assured to this and several other interviewees.

13 H. Robert Quilitch, "Employee Turnover and Sick Time," NMHI, Memorandum to All Interested Persons, Sparks, Nevada, December 3, 1974.
to 22 percent for the neuropsychiatric and geriatric programs. Thus, while the turnover rate of mental health technicians has been high in an absolute sense, it is not clear how hard it would be to significantly and permanently reduce the rate. We also note that if salary and hiring qualifications were upgraded for some types of mental health technicians, past turnover rates probably would not be a reliable predictor of turnover among the more highly skilled mental health technicians (see Chap. 8 for a discussion of the training and use of more highly skilled technicians).

The Mental Health Technician I job class definitions and minimum qualifications are basically a high school education (or substitute work experience) plus one year of work experience (or one year of college as a substitute). The Mental Health Technician II, III, and IV job classes officially require additional work experience (or substitute years of college) plus substantial amounts of training of the employee in a course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation. For illustration, the following are official state job class definitions and minimum education and experience qualifications for Mental Health Technicians I, IV:

- **Mental Health Technician I**
  
  Definition of the class:
  Under direct supervision, assists in the care of the mentally ill patients or mentally retarded residents at an entrance level; receives classroom and on-the-job instruction in patient care; maintains living quarters of patients; assists in the care and habilitation of the mentally retarded by applying beginning habilitative techniques as obtained in the classroom and on-the-job instruction; does related work as required.
  
  Minimum Education and Experience:
  Graduation from high school or equivalent education and one year of full time paid experience. (Two years of employment in an institution or agency providing care, treatment, and/or training for the mentally ill or mentally retarded may be substituted for the high school education.) (Appropriate college training may be substituted for the work experience on a year for year basis.) (During the first 12 months of employment the employee will be expected to participate in a 150 hour training course. An additional 150 hour course will be offered to enable the employee to qualify for Mental Health Technician II.)

- **Mental Health Technician IV**
  
  Definition of the class:
  Under supervision, performs the most responsible subprofessional tasks in the care and treatment of mentally ill or mentally retarded patients; supervises patient activities; and does related work as required.
  
  Minimum Education and Experience:
  Graduation from high school or equivalent education and four years of full time paid work experience, three of which must have been as a Mental Health Technician under professional supervision in the care and treatment of the mentally ill or mentally retarded plus completion of a 900 hour course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation. (Two additional years of employment in an institution or agency providing care, treatment and/or training for the mentally ill or mentally retarded may be substituted for high school education) or appropriate college training may be substituted for all but one year of the required work experience on a year for year basis provided the candidate qualifies on testing equivalent to Mental Health Technician I, II, III and IV written examinations. Each candidate must have at least
one year of experience in the care and treatment of the mentally ill or mentally retarded in Nevada State service. (Employees qualifying with college training for the Mental Health Technician III must have met a special 300 hour curriculum requirement prior to promotion to this level during their employment as a Mental Health Technician III and employees qualifying with college training for Mental Health Technician II must have completed the 600 hour course curriculum sponsored by the Division of Mental Health and Mental Retardation prior to promotion to this level during their employment as a Mental Health Technician II and III.)

Note that one of the official stated requirements of a Mental Health Technician I is participation in a 150-hour training course in the first year of employment. A 300-hour "course curriculum" sponsored by DMHMR or "appropriate college training" or a "commensurate education program" completed elsewhere are officially required for an MHT II job, and officially an MHT IV must have at least 300 hours and up to 900 hours of training depending on the person's background. So much for what training is officially supposed to be provided. In practice, we learned in our interviews that in mid-1974 there was no formalized training program for all mental health technicians working in the neuropsychiatric section of the NMHI. We were told that a 40-hour staff training program was due to start soon, but that is a far cry from what is needed and what is theoretically supposed to be provided, based on the descriptions of the minimum job qualifications. While we have no doubt that the technicians learn by doing on the job, and we have no doubt that other employees informally offer suggestions that increase job skills, this haphazard approach and inadequate formal training is a major problem at the Institute. We were also told in our interviews that the almost totally untrained Mental Health Technicians I, II, and III, who need only a high school education, all perform much the same duties on the neuropsychiatric units and that each level of technician can and does serve as what the unit staffs called the "primary psychotherapist" for mentally ill patients. While each unit has a psychiatrist, none has a full-time psychologist to help provide therapy. According to unit staff members, some patients in practice in mid-1974 did not have individual therapy sessions with the psychiatrist after the initial intake interview and prior to the time for discharge consideration. Thus, much of the responsibility for therapy is given to mental health technicians who are not fully trained to handle that responsibility.

Unit staff meetings are intended to help the mental health technicians with their therapy, and could serve as a training and supervisory mechanism for mental health technicians. However, from what we could learn of them from the staff and from observing two of those staff meetings, they appear inadequate in time and in depth to serve as effective training sessions.

About 15 mental health technicians in the past have undertaken a "family support program" training course provided with federal funds. The training was for two-person teams to help families, and occupied eight hours a week over nine months. However, the technicians were assigned to work with inpatients, not families, after their training.

Inadequate training in relation to assigned responsibilities of mental health technicians is not unique to the Institute. Essentially the same situation prevails in

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the Henderson and Las Vegas Mental Health Centers and in the Rural Clinics mental health program, as discussed in Chap. 8.

The occupational therapy program at the Institute in 1974 was an arts and crafts program that included occasional field trips with 20 to 25 residents for a luncheon. Providing residents with an opportunity for arts and crafts activity is commendable, but the limited hours of operation (34½ per week in 1974) and the very low resident utilization rates are not. For the three-month period on which we collected statistics (March-May 1974) the average number of patient-hours of program usage per month was 1316 and the average of staff-hours per month was 870. Thus, the average Institute resident receives only about one hour per week of “occupational therapy” and there is significant underutilization of this program’s staff in that the ratio of patient-hours to staff-hours is only about 3 to 2 and could be much higher for this type of program. Residents could drop in whenever the center is open but the director indicated that few do. Rand staff members dropped in at the occupational therapy center unannounced four separate times over a period of months, and never saw more than four residents participating; the center’s staff explained to us that most of the patient-hours of usage were accumulated via group usage. For example, one staff member escorting 27 residents out to lunch for three hours counts as 81 hours of occupational therapy. Geriatric patients were brought to the OT center in groups of about 15, three days a week, for one hour (the average was 213 patient-hours per month over the three-month period). Retarded people were also served in groups of about 15 each for one-half to one hour per week since most of them were on locked wards and were unable to come to the center alone (an average of 100 patient-hours per month for Ward 1 residents, 30 for Ward 2, 38 for Ward 3, and 136 for Ward 4). Participation by neuropsychiatric patients was voluntary.

When asked why use of the center was not higher, the director responded that residents of four of the five MR wards could not come by themselves, people on unlocked wards were not urged to come by the wards’ staff, and that patients “hate two of my staff members.”

One resident also told us that patients who had “success experiences” with certain crafts and wanted to pursue those crafts further were told they would be charged for materials, so they were discouraged from going back; the director of the OT center later confirmed this. The staff at the OT center consisted of six OT technicians who had no professional training, plus one professional occupational therapist who directed the center.

Since 1975, the occupational therapy and recreational therapy sections of the NMHI have been combined, and are now open to all residents 5 days a week from 8 A.M. to 8 P.M. and on Saturday from 8 A.M. to 4 P.M. With a new person in charge of this combined “activities therapy” program, the NMHI Director indicates significant change has occurred since we interviewed there.

At the time of our interviews and observation in mid-1974, the NMHI program for people with mental health disorders was seriously deficient in the area of predischarge planning and follow-up treatment after release of a patient. Continuity of care after discharge from NMHI was the exception rather than the rule. On the surface, everything appeared fine at first. A discharge planning committee exists,

15 Information in this section based on interviews with OT Center staff on April 24, 1974 and July 3, 1974, NMHI, Sparks, Nevada.
as do procedures for predischarge planning and for smooth transition of patients from an Institute therapist to a mental health center therapist. Unfortunately, at the time of our interviews in 1974, neither the committee nor the procedures were functioning well. We were told that follow-up was provided not only by the mental health centers and Rural Clinics programs, but also by the Institute itself, which sent personnel into the field in addition to providing follow-up care to some patients at the Institute on a day care or outpatient basis. Subsequent interviews with direct service personnel in the Institute and in the other programs mentioned, and with former patients back at the Institute for another round of inpatient treatment, revealed that adequate follow-up services after discharge did exist for some patients, but apparently in practice were not provided for the majority of released neuropsychiatric patients who needed them. Rand's psychiatric consultants viewed this as a major problem with the Institute's program.

After describing the situation as it existed in mid-1974, we will outline plans the Institute has already made and some actions they have taken to partially remedy this problem, of which the Institute's administration was well aware.16

In the areas of predischarge planning and transition of a patient from an Institute therapist to another program's therapist to promote needed continuity of care, the mid-1974 reality was as follows, as best we could determine from our interviews. For Nevadans released to rural areas of the state outside of Clark and Washoe Counties, there was usually 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, the Rural Clinics staff reportedly almost never saw a patient at the Institute prior to discharge. The Rural Clinics personnel were not providing adequate follow-up for most rural residents discharged from the Institute, and the Rural Clinics program lacked a sufficient number of skilled personnel to provide effective follow-up mental health services for all rural Nevadans released from the Institute and also fulfill their other responsibilities (see Chap. 8 for a discussion of the Rural Clinics program's deficiencies). For Institute patients from Clark County, none of the mental health programs in the Las Vegas area sent staff to meet with Institute patients from the Las Vegas area prior to discharge. Once back in Clark County, although the transition from treatment by the Institute to treatment by the Las Vegas Mental Health Center was an abrupt one, that Center had the capacity to provide adequate follow-up services. For Institute patients from Washoe County (the Reno area), the transition of a discharged patient to the follow-up care of the Reno Mental Health Center should have been easier because the Center and the Institute are in the same urban area. According to Institute staff, the typical predischarge transition of patients to the Reno Mental Health Center was accomplished in mid-1974 by taking 7 to 10 patients in a group for one hour with a Reno Mental Health Center staff member. In the professional opinion of Rand's psychiatrist-consultant who conducted the interviews concerning follow-up,17 10 patients cannot be effectively transferred with continuity of therapy from one therapist to another in one hour in a group setting. In the words of one of the Institute's psychiatrists, discharge and follow-up was a deficient and hasty matter of "bang, no transition."

16 Interview with Dr. V. LoCicero, Medical Director, NMHI, Sparks, Nevada, August 6, 1975.
17 Dr. A. Milstein.
The follow-up for discharged Institute patients by the Reno Mental Health Center was primarily medication. Two of the three direct service psychiatrists at the Institute, when asked to tell us what problem areas existed at the Institute, charged that the Reno Mental Health Center typically left the Institute psychiatrists' evaluation in the file (i.e., did not usually obtain the full Institute records on patients to be followed up), and a follow-up visit to the Center usually consisted solely of the Center's staff asking questions related to current medication before prescribing future medication. Follow-up by the Reno Mental Health Center typically consisted of only drug therapy, according to two Institute psychiatrists. Therefore, even if the Institute did an excellent job of diagnosis and treatment, the after-care provided at the Reno Mental Health Center was typically only medication supervision. Reno Mental Health Center records indicated that 75 percent of the patients receive primarily chemotherapy. As an example, one formerly discharged patient now back at the Institute told a Rand consulting psychiatrist that he had been sent to the Reno Mental Health Center after discharge, but he assumed it was for medication only, since that was all the Center staff member talked about in their 20-minute meetings every few weeks. The patient said he did not think to ask the staff member if he could talk about this problems. Instead, he tried to burn down his house to get the insurance money. One Institute psychiatrist posed the question of whether the Institute (i.e., the state) could be held legally responsible if a discharged Institute patient commits murder, because the follow-up by the Reno Mental Health Center "is known to be terrible." One Institute psychiatrist said he preferred sending his ex-patients to a private Reno psychiatrist if the patient could afford it.

According to Reno Mental Health Center personnel, the 25 percent of the patients primarily receiving psychotherapy had the opportunity to attend a group session three times a week. Predischarged and discharged people were seen in the same group, and 60 percent of those who attended at least one session were said to attend sessions for less than a month (including perhaps once before discharge). While Institute inpatients were permitted to come to the groups, the social worker who ran the groups said that they usually forgot to come or the staff on the ward did not remind them.

In defense of the Reno Mental Health Center, we note that in 1974 the center's Transition Unit at the Institute had only had one psychiatrist, one social worker, and a half-time secretary assigned to do preadmission screening, predischarge planning, and postdischarge follow-up of all Institute patients from Washoe County. In July 1974, the active caseload of the Transition Unit was 140. The unit also was supposed to provide psychiatric consultation to the child and adolescent day treatment programs of the Reno Mental Health Center, and theoretically to provide outreach to patients who do not show up for appointments at the Transition Unit following discharge from the Institute. NMHI made follow-up appointments with the Reno Mental Health Center for about 90 percent of the Washoe County patients discharged. Most of those with appointments came to the Transition Unit for follow-up services at least one or two times. If they were active outpatients of the Transition Unit they were telephoned and sent a letter if they missed an appointment. Twice a week the social worker made field trips to the community to contact patients. Despite the Transition Unit's heavy responsibilities, the work done by the two staff

18 Interviews at the Reno Mental Health Center, Transition Unit, Sparks, Nevada, July 2, 1974.
members probably could have been increased. We scanned several weeks of scheduled appointments for the two staff members of the unit and found that a typical day had the two of them seeing a combined average total of only about 8 patients per day over a period of 2 to 3 hours. They also typically screened about two people per day prior to admission to the Institute. About 1 1/2 hours per day, three days a week, were expended on group sessions by the social worker. Of the 80 work-hours per week the two men had, 40 hours were unscheduled. The men explained that this time was kept free so that one of them was available at all times during the working day to do immediate admission screening if needed. That time was also used for drop-in patients. The psychiatrist also said he typically spent an additional 18 hours per week in private practice outside his full-time job with the state. We note that with a different policy—namely, not requiring that someone be available at the Transition Unit immediately for admission screening—the effective time for direct service to patients could have been nearly doubled without adding any new staff members. This inefficient use of professional staff would have been more tolerable if patients were already getting all the follow-up they needed.

The Institute staff's perception of inadequate follow-up services by the Reno Mental Health Center led them to do some of the follow-up work themselves in 1974, even though they were already overburdened.

In mid-1974, the Institute provided several kinds of follow-up services. One neuropsychiatric ward had set up its own day treatment program, and those day-only patients (about 15) who came about three days a week accounted for about half the ward's caseload. We note that this amounted to inefficient use of an expensive full residential treatment facility for part-time day care only; it excluded patients in need of 24-hours-a-day, seven-days-a-week residential treatment. This day care was said to use a ward designed for residential treatment because no other day-treatment program exists in Washoe County, and outpatient follow-up services offered by the Reno Mental Health Center were felt to be inadequate for these patients.

Another type of follow-up was performed by one ward psychiatrist who had a private practice in which he saw about 8 ex-patients of the Institute, and by another who allowed ex-residents to see him at the Institute for follow-up therapy. Outreach and follow-up of former patients was also provided by one of the Institute's psychiatric nurses, who worked full time on these tasks. She saw only patients discharged to Washoe County, and of those only the 10 percent with the greatest need for follow-up in the opinion of the staff.

In 1975, the Institute staff stopped using the Reno Mental Health Center for follow-up service for Washoe County residents, and began to provide it themselves. The Reno MHC Transition Unit was phased out in November 1975.

According to the medical director of the Institute, the new neuropsychiatric service concept to be implemented will provide continuity of care and follow-up services by assigning responsibility for each Institute patient to a team of staff members.

For a patient from the Reno area, that team would comprise Institute staff members who would treat the person in the Institute, do all follow-up in the Reno area, including outpatient and day treatment if needed, and serve as a contact and coordination point to make sure that the person gets all services needed from all

19 Interview with Dr. V. Locicero, August 6, 1975.
other service agencies. Under this plan they must therefore be "knowledgeable about all services." We do not endorse the concept of requiring already overburdened Institute staff members to be fully knowledgeable about and to coordinate all other service agencies for the individual. There is a clear need for coordination, or a direction service as we call it, but it can be provided better by the Regional Direction Centers we recommend in Chap. 4. For Institute patients from the Las Vegas area or rural counties, according to the Institute's medical director, the primary responsible staff member will be a therapist in the Las Vegas Mental Health Center or in the Rural Clinics Program. The Institute would then be seen as a secondary server providing temporary acute residential treatment services to an individual who is under the primary care and concern of the prime contact point in the hometown mental health program. The idea is for the Institute not to function as a chronic care institution, but to provide acute residential treatment followed by day treatment or outpatient treatment if needed. The actual residential population at the Institute would be reduced below what it is now, to free staff members from evening and night shifts and enable them to provide better service to the greater number of people who would be there during the day only. It is too early to tell how this will work out, but improved follow-up was clearly a major need throughout the state in 1974. Both improved day treatment capacity and outpatient services were clearly needed for ex-patients of the Institute. We also note that having a Rural Clinics program team responsible for follow-up is a good idea in theory, but that the program needs major staff improvements (see Chap. 8) before it will be a good idea in practice.

Since 1974, a "Community Liaison Program" has been in effect at the Institute. It currently has two staff members. The Institute's Director, T. Piepmeyer, indicates that "discharge planning has been upgraded and aftercare [outpatient] visits in January 1976 totaled 505." He also indicates "a fourth psychiatrist has been added to the Institute staff to coordinate the day care and partial hospitalization aspects of the Institute." In January 1976, NMHI provided 172 day care patient-days of service.

Problems of payment for drugs after the patient is discharged from the Institute (often running as high as $40 to $60 per month) were resolved by having the Institute provide free drugs to indigent discharged patients and sell them at cost to others.

A patient can apply for the Supplementary Security Income financial assistance program for disabled people only after discharge, and approval usually takes at least two months. In the interim, the county welfare departments reportedly will not provide financial assistance. Applications for Medicaid are not accepted until the person is officially accepted on a financial assistance program (see Chap. 14 for a discussion of those programs, and Chap. 12 for a description of Nevada's Medicaid program).

One other problem with follow-up services concerns those patients who were receiving chronic residential care at the Institute but were released to their families or to other residential facilities that usually have no mental health services. Other than the prescription of drugs and a visit from an Institute nurse to those other residential facilities every few months, we were told there is no follow-up by the Institute in 1974. The Mental Health Centers and the Rural Clinics mental health

80 This problem is not unique to Nevada. Julian Wolpert and Eileen R. Wolpert have prepared a stunning critique of the California system which contains many lessons of relevance and consequence.
program could provide additional mental health services and supervision for those chronic patients, but they seldom do so.21

Dr. LoCicero, medical director of NMHI, said he is "not too happy" with the placement of people with chronic mental health problems from the Institute into group living facilities (e.g., skilled nursing facilities, intermediate care facilities, adult group care, and family care facilities described in Chaps. 12 and 13). He agrees they are "better than nothing," however, although "there could be much richer programming." He indicated that the residents receive drug therapy in those facilities, nursing care sometimes, but rarely any psychiatric or psychological services.22 The Nevada Welfare Division's Chief of Adult Services expressed his view that Nevada residents in adult group care and family care facilities (for which he has some responsibility) are provided a place to live, drugs if needed, and "nothing else" in the way of special services for any mental handicap if they have one (see Chap. 13 for a further discussion of those and other types of longer-term care types of facilities).23

In a February 27, 1976 letter to Rand, Institute Director T. Piepmeyer points out that the "Community Liaison Nurse" made 148 contacts with discharged clients in January 1976 and that a "Geriatrics Community Action Team" from NMHI made 34 contacts that same month with discharged geriatric clients in skilled nursing facilities in the Reno area. Thus, he states, "the Institute, since 1974, has been able to visit most of our residents in skilled nursing facilities on a much more frequent basis than every few months, and to expand greatly the follow-up by the Community Liaison Nurse for discharged clients."

A major problem confronts the chronically mentally ill person who cannot function adequately in the community. There is a gap in the service system, well recognized by Dr. LoCicero and others at NMHI, between the full inpatient treatment NMHI is supposed to provide and the care provided with "normal" people in nursing homes or in the family. The administrator of the other Division of Mental Hygiene and Mental Retardation inpatient mental health treatment facility, Dr. L. Miller of the Las Vegas Mental Health Center, also pointed out the need for some type of longer-term residential mental health service program for people who do not need an intensive inpatient treatment program but cannot live in the community and need an extended residential mental health program of an intermediate level.24

Some type of intermediate mental health care program is needed that provides loosely structured but sheltered living and perhaps sheltered work for some. Some direct mental health services also would be provided at this intermediate care facility (more than drugs) and some residents would be free to move about in the community during the day but return to this long-term sheltered living facility in the evening. The facility might also serve as a halfway house for someone who does not need full NMHI inpatient care but cannot live independently in the community.


21 Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.

22 Ibid.

23 Interview with James Faehling, Chief of Adult Services, Nevada Welfare Division, Carson City, Nevada, August 1974.

24 Interview with Dr. L. Miller, Las Vegas Mental Health Center, Las Vegas, Nevada, May 6, 1974.
In 1974 a task force of various service agencies was formed, chaired by Dr. Young of NMHI. Its original concern was what to do with chronic alcoholics, but it has expanded its attention to include all mental cases in which chronic care of an intermediate nature is needed. The task force had representatives of NMHI, the police, Indian service programs, welfare, rehabilitation, employment security, OEO, etc. According to Dr. LoCicero, the task force can name 50 or 60 people who have been involved with at least three agencies in the past year, and who need this intermediate care today in northern Nevada, but have no place to go for it. The task force was formed because some of these people had been routed from agency to agency and no one was adequately serving them. For example, Dr. LoCicero reported that one person cost the Nevada public at least $30,000 and perhaps $40,000 in one year by cycling from agency to agency.

The intermediate facility described above would serve people with chronic mental problems, such as ex-alcoholic patients with brain damage, organic brain syndrome mental patients in need of chronic care, and chronic schizophrenics, some of whom have been released from the Institute in the past and have come back to "haunt" other service agencies and even the Institute (which refuses to readmit them, according to Dr. LoCicero). A new facility is not necessarily needed; a new program in existing private or public facilities may be entirely adequate. We note that extended care facilities are not now in excess supply, at least in some parts of Nevada. For example, the Clark County Plan for Health, covering an area containing about half the state's population, has stated that "the critical shortage of adequate and well coordinated facilities and services for long-term treatment and care has emerged as one of the major health problems."25 However, we note that some of the residents in existing long-term care facilities without mental health services are the same ones who need long-term intermediate levels of mental health care; for them, the need is not for all-new bed-spaces, but for new mental health services.

The point is that a progression of levels of service is needed in the state's mental health service system, ranging from outpatient to intensive inpatient residential treatment. If a portion of the service system does not exist, such as a longer-term intermediate care program, that gap should be filled. Until it is, portions of the existing service system should compensate for the gap. For example, in the current trend toward deinstitutionalization, if one discharges people from NMHI into group facilities without mental health services when those people really need an intermediate level of mental health services, those people may be worse off in the long run than they would have been if they were kept at NMHI. In other words, releasing people into an environment in which they are ill equipped to function may be worse than not releasing them.

The NMHI is accredited by the national Joint Commission on Accreditation of Hospitals as a psychiatric facility, but not as a mental retardation facility. Despite granting the Institute accreditation as a psychiatric facility, the JCAH included the following stern warning in its report:

Particular attention is drawn to the major deficiencies outlined above in sections:

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Environment
Dietetic services
Patient education services
Psychological services
Outpatient services
Partial hospitalization services
Pharmaceutical services
These and other deficiencies must be corrected in order that accreditation may be maintained.  

The deficiency in outpatient services and partial hospitalization services pertains to lack of a written plan for the referral of services not provided by the Institute. Since they were looking only at the Institute, the reviewers did not mention that in most geographic areas outside the Institute, outpatient services and partial hospitalization services (e.g., adult day treatment) are deficient (particularly in rural counties and Washoe County). Hence, even if the NMHI creates a written referral plan, there in effect may be nowhere to refer patients. Services by other programs as alternatives to residential treatment at the Institute or as follow-up to residential treatment at the Institute are beyond the scope of the JCAH survey of the Institute, but are a major area of deficiency we note in Nevada's mental health service system.

Another major deficiency noted in the JCAH survey pertains to psychological services: "There should be available a sufficient number of appropriately qualified staff and necessary supporting personnel to provide psychological services."

A major point is that even though a facility is accredited, the facility can still have "major deficiencies" in its programs. Some of those deficiencies are readily identified in the brief survey by JCAH; others are identifiable only after extensive probing (e.g., the low quality of the "psychotherapy" provided by the poorly trained mental health technicians on the neuropsychiatric wards, or the seriously deficient follow-up of discharged patients). In other words, there can be a chasm between policy and reality, theory and practice.

NEVADA MENTAL HEALTH INSTITUTE: GERIATRICS PROGRAM

In 1974 the NMHI had two wards housing about 80 geriatric patients. Since the time of our interviews, the majority have been transferred out of the Institute, and the remaining 33 temporarily integrated with the Institute's neuropsychiatric wards pending transfer to facilities outside the Institute. In August 1975, we were told that only 33 of the 80 remained at the Institute, and nearly all of them were to be transferred to a new long-term skilled nursing facility in Las Vegas that has large fenced grounds that give patients some freedom of movement but prevent them from accidentally wandering off. The facility staff will administer drugs and

26 The report was attached to a letter from J. H. St. Louis, Psychiatric Hospitals Division, JCAH, Chicago, Illinois, to T. Piepmeyer, NMHI, Sparks, Nevada, April 18, 1975. It is given in its entirety in App. B.

27 Information in this section is based on interviews with staff and residents of the Geriatrics wards, NMHI, Sparks, Nevada, July 1974.

28 Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.
provide nursing and sheltered residential living service, but will not provide mental health services. Within the constraints of available work time, an Institute psychiatric nurse, and possibly other neuropsychiatric staff members, will provide some follow-up services after these residents are released from the Institute. However, since the Institute staff already has a very heavy inpatient workload, follow-up will probably be quite limited. Procedures call for the psychiatric nurse periodically to visit each long-term care facility that houses Institute residents, to check on the quality of care, the level of drugs needed by the patient, and so forth. Such follow-up is severely limited by the size of the staff assigned to it. The transfer of geriatric patients from the Institute has freed a number of staff members, who are now being used to improve services to the remaining neuropsychiatric patients.

In February 1976, the Institute Director informed us that references to the new long-term skilled nursing facility are premature since the contemplated facility is still trying to obtain financing for its construction. He indicates that follow-up for geriatric residents released has improved. The NMHI community action team made 34 contacts with discharged clients in January 1976, and 3 psychiatric teams are assigned to each of 3 skilled nursing facilities in Reno to provide consultative services on request.

A summary description of the former geriatric wards, their residents, and services for them, is provided here to point out how deficient services were for geriatric residents at the Institute as little as a year ago, because 33 of those residents are still at NMHI, and to caution against efforts to reinstate a geriatric program at NMHI like the one that is being terminated.

On the unlocked geriatric ward, the approximately 40 residents were all elderly. Few personal possessions were in evidence when we visited the ward. A nonpsychiatric physician was assigned to the two wards, but no psychiatrist or psychologist regularly provided direct services to patients. The one full-time NMHI psychologist, however, did help set up a toilet training program for incontinent geriatric residents, ran some problem-solving groups for residents, and provided consultation for the geriatric staff on setting up and running daily activity programs. The mental health technicians indicated that some physical therapy was provided on the unlocked geriatric ward, there were occasional bus rides and picnics, occupational (arts and crafts) therapy and recreational therapy were offered, and the physician provided annual physicals plus intake and discharge reviews of each patient with the staff. Residents engaged in one of various activities about once a day; a half-dozen people might go bowling or play cards, 15 or 20 people might go to a local church or social activity center, or a recreational therapist might come and sing with them. Rand's psychiatric consultant interviewed residents of the ward and concluded that most appeared to be merely passing the time; he believed there should have been many more activities.34 The staff members did not appear to actively encourage residents to leave the ward or participate in activities. Both Rand's psychiatric consultant and the Institute physician assigned to the ward believed that a majority of the residents needed an intermediate level of residential care, but did not need to be in the Mental Health Institute.

The locked geriatric ward housed some nongeriatric patients who were brought in from unlocked neuropsychiatric wards reportedly because of intractable behav-

34 Observations by Dr. A. Milstein, July 1974.
ior. Personal possessions were strongly discouraged on this ward; those that were allowed were kept in the nursing station. No personal possessions were allowed in residents' rooms. As on the unlocked geriatric ward, residents of this ward were not directly served by either a psychiatrist or a psychologist, even though many of the residents had major psychological problems. About 60 to 70 percent of the residents reportedly had a definite therapy program outlined for them. We asked specifically about the therapy programs for two of the nongeriatric residents on the ward. After considerable probing (by one of Rand's consultant psychiatrists) of mental health technicians responsible for implementing the "therapy programs," we learned that one of those patients had no specific therapy program in practice. The program for the other, a young female resident, consisted of trying to keep her looking attractive, plus psychotherapy—which, after considerable probing, was said to consist primarily of trying to teach her to say "cigarette" when she wanted one. Probably because of the small size of the staff assigned to the ward and the relatively low level of the staff's expertise and training, service to residents appeared to be primarily kindness and personal care. We stress that we are not criticizing the hardworking and dedicated staff, most of whom were doing their best within the limits of their skills.

The lack of purposeful activity among residents of the geriatric wards was documented in detail in an article published in 1974 by the Institute's psychologist. Quoting from the abstract to that article:

Of 43 residents in a hospital geriatric ward for regressed and disabled persons, only 3 were found to engage in some purposeful daily activity; the rest were relatively inactive. Under a regimen of programmed activities (e.g., bingo games) for one hour each afternoon, the daily average number of residents engaged in purposeful behavior rose to 13, but dropped to 3 again when the daily activities were discontinued.  

When we asked why the program was discontinued, we were told that the wards did not have sufficient staff to continue it.

For the locked ward, it was the opinion of both Rand's psychiatric consultant who interviewed on the ward, and the Institute physician assigned to the ward, that the majority of the residents had stabilized conditions and needed a long-term intermediate level of residential care; it was believed that they could be adequately served in a fenced group-care facility and did not have to be in the Mental Health Institute. The Institute physician in charge of the geriatric wards indicated to us that up to 70 percent of the residents of both these wards could be served outside the Institute in group care facilities if funds were available and the facilities were fenced. We note that new fences and group care facilities providing intermediate levels of care can be significantly cheaper than the nearly $12,000 per year per geriatric resident it cost the Institute until recently.

LAS VEGAS MENTAL HEALTH CENTER: RESIDENTIAL TREATMENT

The Las Vegas Mental Health Center provides a wide spectrum of services to

31 Interview, NMHI, Sparks, Nevada, April 22, 1974.
32 Expenditure data for the Institute provided by Dr. V. LoCicero, April 22, 1974.
residents in a portion of Clark County: outpatient and inpatient services, partial hospitalization, emergency services, and consultation and education as required by the federal Community Mental Health Centers Act of 1963, which partially funds this center. Another large portion of Las Vegas and Clark County is served by the Henderson Mental Health Center, which has no inpatient services. Chapter 8 of this report, on nonresidential mental health services, describes most of the services provided at the Las Vegas Mental Health Center; the present chapter considers only the center's inpatient mental health services, which are provided in a 16-bed adolescent unit and a 24-bed adult unit. As can be seen in Table 10.2, both units are operating well below full capacity; they were only about two-thirds full in the first quarter of FY 1975. The monthly turnover of inpatients (admissions/average census) was about 37 percent in the adolescent unit and 260 percent in the adult unit. Total FY 1974 inpatient admissions were about 50 adolescents and about 600 adults.

### Table 10.2

**Residential Treatment at the Las Vegas Mental Health Center**

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 1974</th>
<th>FY 1975 (First Quarter Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent inpatient (16 beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average monthly admissions</td>
<td>4.08</td>
<td>3.7</td>
</tr>
<tr>
<td>Average daily census</td>
<td>9.73</td>
<td>10.1</td>
</tr>
<tr>
<td>Adult inpatient (24 beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average monthly admissions</td>
<td>49.67</td>
<td>43.0</td>
</tr>
<tr>
<td>Average daily census</td>
<td>19.15</td>
<td>16.4</td>
</tr>
</tbody>
</table>


Theoretically, the center is supposed to offer short-term care, while "long term patients from Clark County are transferred to the Nevada Mental Health Institute for extended care." The number of patients transferred from the center to the Institute ranged from 0 to about 15 per month and averaged 9.3 in 1973. The center does provide short-term residential care, but the neuropsychiatric section of the Institute in practice accepts no children and almost no adolescents, and has a median stay for adult neuropsychiatric inpatients of only about two weeks—which is hardly "long term." The fact is that no state-operated mental health program in Nevada is providing any significant amount of "long-term" or "extended care." Only one or two neuropsychiatric patients at the Institute have been there over one year, and the medical director there indicated that the Institute is now functioning primarily as an acute care facility providing "temporary" services.

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33 Information in this section was obtained through interviews with Dr. L. Miller, T. Burke, and various staff members and inpatients of the Las Vegas Mental Health Center 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.

34 *The Executive Budget*, p. 320.

35 Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.
In 1974 the Las Vegas Mental Health Center had 52 staff positions for inpatient services (26½ for adolescents and 25½ for inpatient adults). However, 6 of those positions were not filled. In particular, the adult inpatient unit lacked its full-time psychiatrist, a half-time senior psychologist, and one social worker. The adolescent inpatient unit lacked both its full-time psychiatrist and its psychiatric social worker. At the time of our various summer 1974 interviews, the primary service personnel in the adolescent unit were mental health technicians supervised by a psychiatric nurse. We were told that outside of regular day-shift hours, inpatient admissions were made by mental health technicians, who typically had the same lack of training as their counterparts at NMHI. The Administrator of the Las Vegas Mental Health Center, in a February 27, 1976 letter to Rand, indicates that the “vast majority” of these senior professional positions are now filled, so several of the problems and situations that were observed in 1974 should no longer exist.

The center’s actual FY 1974 expenditures were just over $1.1 million, of which salaries accounted for about $880,000. If one assumes that operating expenditures are split among units of the center in approximately the same proportions as staff, then the inpatient units (with about 50 percent of the filled staff positions at the center in mid-1974) incurred expenditures of approximately $550,000; this amounts to about $19,000 per inpatient-year.

**LVMHC Adolescent Unit.** During our interviews at the LVMHC unit, the staff present on the unit consisted of three to five mental health technicians. Key senior staff positions were unfilled, as we indicated earlier, and hence the inadequately trained mental health technicians carried heavy treatment responsibilities without the guidance and supervision of the missing professionals. The problems we note below arise largely, but not entirely, from the unfilled senior staff positions.

Upon arrival, we and our psychiatrist-consultant observed a technician using what appeared to be excessive force on a patient who was walking on the grounds toward the parking lot. On the unit, the technician staff members were working on records, talking with one another, and engaging in what appeared to be unstructured discussions with the adolescent patients. There was little structure to the technicians’ activities during our periods of observation; the staff members kept to themselves much of the time and the adolescents did pretty much what they wanted to without much direct contact with the staff. An impromptu informal staff meeting of available technicians was called in mid-afternoon; three of the adolescents were discussed, but not mainly in terms of their therapy. From what we could gather, the activities we observed were not atypical.

The general details of one particular case illustrate some apparent weaknesses in the unit’s operation. A young adolescent girl had had prior admissions to the unit. The mental health technician directly responsible for the girl, her “advocate,” was hazy and vague about key substantive points in her case. The technician could not adequately characterize her problem, could not indicate what, if any, treatment modality was being used for her, and did not even attempt to discuss what plan was being developed for the post-inpatient phase of her treatment. None of the other staff members on the unit had any knowledge of post-discharge service plans for this

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26 The unit was visited twice at unannounced times by both a Rand staff member and a Rand psychiatrist-consultant. A number of daytime hours were spent observing the unit and interviewing every staff member on duty. One of Rand's psychiatrist-consultants also talked with two randomly selected patients.
patient either. Finally, none of the staff members present on the unit, including her 
"advocate," were aware of the traumatic sexual molestation event that had immedi-
ately preceded the onset of her hallucinations, which twice had led to her admission 
to the unit as an inpatient. Rand's psychiatrist-consultant learned of this event in 
a brief interview with the patient. (One of the unit's missing professionals probably 
would have made the same discovery.)

The patients on the unit like the mental health technicians, however, and in 
general the technicians themselves appeared to be hard-working people who are 
interested in helping the patients. The problem is that the technicians are inade-
quately trained for their highly important and responsible jobs, and they were 
inadequately supervised and directed in mid-1974. The subsequent filling of the open 
professional positions should have resolved many of the problems of supervision and 
of discharge planning, but the problem of lack of training of the technician staff will 
still require special attention. It is a problem throughout the state's mental health 
service programs wherever "mental health technicians" are employed. (See Chap. 
8 and other sections of this chapter for particulars.)

LVMHC Adult Inpatient Unit. As in the adolescent unit, our observations 
and interviews at the adult inpatient unit of the Las Vegas Mental Health Center 
indicated a rather unstructured unit, staffed primarily by relatively untrained and 
unsupervised mental health technicians in mid-1974. Key professional staff posi-
tions were unfilled, and the following scenes probably resulted partially from that 
fact.

The scene was frankly rather chaotic on the unit. A young girl about 12 years 
old (a resident of the adult unit) was very actively agitating patients, attempting to 
agitate technicians, throwing her dinner around, and being generally uncontrolled 
and disruptive while the staff did nothing about her behavior.

Another patient, an uncommunicative older woman, was unrestrained in her 
agitation of other patients for a long time period. First, she poured glasses of water 
on herself and other patients. Then she nearly got into a fist-fight with a highly 
distressed young man who was just being admitted (a process that took almost an 
hour in the confusion). At one point a staff member came in from the day-care unit 
and offered the young man a cigarette if he would calm down. He did so until the 
woman grabbed his extra clothes and started throwing them around the area. He 
became further agitated and had his cigarette taken away. Finally, a technician 
ye 
emerged from the office and tied the woman in a wheelchair, where she was ignored 
while screaming at the top of her lungs. In the opinion of Rand's psychiatrist-
consultant, based on interviews with the staff, such drama was probably due neither 
to a lack of mental health technicians nor to his presence and that of a Rand staff 
member on the unit, but instead was probably due to the technician staff's not 
knowing what to do—again, that is, due to their inadequate training and supervi-
sion.

One patient interviewed was in the process of being discharged that afternoon. 
His situation further illustrated the problem of lack of preplanning and follow-up. 
Neither he nor the technician staff knew where he was going after discharge or 
where he would sleep that night; he had no family or friends to receive him; and a 
member of the technician staff said they had begun to plan his discharge only about 
two hours earlier. The man's primary mental health technician (whose name the 
man did not know) said the patient was ready for discharge, but Rand's psychiatrists-
consultant, who interviewed the patient, did not share that opinion.
To check on the level of knowledge the mental health technicians on this unit had concerning the patients they were primarily responsible for, our psychiatrist-consultant selected a few patient records at random, found the technicians responsible for the patients, and quizzed them about key information on the patients. The technicians' responses were typically weak, or they did not know the information that, in our consultant's opinion, was fundamental and essential to providing good treatment. As an illustration, the technician responsible for the man described above who was about to be discharged could not answer our question. "Where is he going to sleep tonight?" The technician also did not know the circumstances of the man's admission, his family situation, or his economic situation, nor had the technician sought out higher-level professional assistance in the care of this nondisruptive patient. The discharge rates of inpatients from this facility within a short time after admission are respectably high, but we had serious doubts about the preparedness of the patients for discharge.

Another possible problem concerns the participation of physicians in these patients' cases, which one of our psychiatrist-consultants described as "shadowy." For example, two separate cases were found in which the mental health technician staff told our psychiatrist-consultants that a patient's condition had been described over the telephone to a Mental Health Center physician, who then prescribed drugs. According to the mental health technician staff, telephone orders allegedly included the administration of lithium without the prudent accompanying lab test recommended for its safe use. Such lab tests would be particularly important when ordering lithium for a patient without having a physician clinically evaluate the patient firsthand. This and similar practices, where physicians and their employers assume responsibility for the administration of potentially toxic medications without thorough firsthand appraisal of the patient at the time, involve potential vulnerability on legal grounds. Recall that the psychiatrist positions were unfilled at both the LVMHC inpatient units when we interviewed; the subsequent filling of those positions probably has resolved the alleged drug-prescription problems.

The foregoing anecdotes illustrate some of the problems whose existence is confirmed by numerous interviews with high- and low-level staff members and with patients, and by a review of patient records. The following were the major deficiencies apparent in the Las Vegas Mental Health Center's inpatient operations in mid-1974: unfilled key professional staff positions; inadequate training of mental health technicians; insufficient supervision of mental health technicians by higher-level professional staff; and inadequate planning for the period following discharge as an inpatient. However, in defense and explanation of the situation at the Las Vegas Mental Health Center, we note that it is a fine, relatively new facility that was not yet fully professionally staffed at the time of our series of visits in 1974. When it is fully staffed, and when supervisory follow-up and other procedures are ironed out and fully implemented as the center's programs mature, all of the problems noted except one can be readily solved. In the area of follow-up, for example, the center now has developed an "Advocacy/Aftercare Program" whose major function is to provide follow-up services to former inpatients of the Las Vegas MHC and the NMHL, and generally to monitor and implement continuity of care. The problem we feel most difficult to resolve is that of the inadequate training of the mental health technicians—the staff members who have the most contact with the inpatients.
CHILDREN'S BEHAVIORAL SERVICES: RESIDENTIAL TREATMENT

The 1975 session of the Nevada Legislature approved $1,450,800 for the construction of a Northern Nevada Emotionally Disturbed Children's Facility in Reno, to be part of the Children's Behavioral Services (CBS) program. The building complex will be identical to that already under construction for emotionally disturbed children up to age 13 in Las Vegas. It includes residential units for short-term intensive inpatient treatment of a maximum of 16 highly mentally disturbed youths, plus a classroom and outpatient service building. The levels of services to be offered in Reno range from 24-hour residential inpatient service, through transitional residential placement with specially trained professional parents outside the facility, conventional foster home care, services during the full day, and on through outpatient services. Residential services existing in early 1976 in the Las Vegas CBS program are similar, and are detailed in Chap. 8. 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.

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 years in Nevada, this means at least about 4000 need substantial services for emotional disturbance. About 2500 are aged 0 to 12 years. In February 1974, the Nevada Division of Mental Hygiene and Mental Retardation conducted a survey of agencies in Washoe County and the surrounding northern Nevada area, asking how many children aged 0 to 12 years they knew of who were emotionally disturbed. The agencies reported 57 very severely, 147 severely, and 1461 moderately disturbed children. Those results exceed the 2-percent figure we are using in this report, but our figure is a conservative minimum estimate.

Both parents and children will be involved in CBS services. CBS will offer family counseling, group therapy for parents and children, classes for parents in effective management techniques, individual therapy for children, and an evaluation service. Evaluation will include a medical and a behavioral assessment of the child, and an evaluation of the strengths in his or her social environment. See Chap. 8 for a description of the February 1976 CBS program in Las Vegas.

Since the CBS facility in Washoe County is not yet complete, the 1975 session

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The Executive Budget, and an attachment to a letter from J. Burnett, CBS, Las Vegas, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

Nevada Division of Mental Hygiene and Mental Retardation, Children's Behavioral Services—Washoe County, Department of Human Resources, Reno, Nevada, February 1975.

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:

1. Very severely emotionally disturbed (typically called psychotic, autistic, etc.). Such behavior might include: bizarre thinking, hallucinations, nonspeaking and noncommunication, severe self-mutilation, and the like.

2. Severely emotionally disturbed. Such children may have 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.

3. Moderately disturbed. Such behavior may be marked by habitual lying, truancy, theft, emotional dependency, lack of friendships, continual feelings of worthlessness and unhappiness, etc.
of the legislature approved only about $47,000 in salaries for four staff positions to start up the new program. Since the CBS facility in Clark County was near completion, the 1975 legislature approved $161,000 a year in salaries for new staff positions there, over and above the 17 FY 1974 staff positions: a pediatrician or psychiatrist, two child development specialists, three sets of "professional parents," a relief parent, and a custodial worker. Seven additional positions were authorized, conditional on receipt of sufficient federal Social Services funds which have now been obtained. We have two comments about the staffing. First, a physician with specialty training in psychiatry should be hired since some of the children undoubtedly will need psychiatric services (see Chap. 8 for a discussion of the desirability of offering a range of treatment modalities). 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 psychiatric services on at least a part-time consultant basis. Second, the staff conditionally authorized can be effectively used; services would have suffered markedly if the funds had not been there to hire them.

MEDICAL FACILITIES WITH PSYCHIATRIC UNITS

While Nevada’s medical facilities are discussed in general in Chap. 12, we discuss the four psychiatric units here. In 1973, for all Nevada general hospitals with psychiatric services, there was a total of 1776 psychiatric patient-discharges.

Cedarbrook Hospital

The 21-bed Cedarbrook Hospital in Las Vegas primarily provides inpatient chronic care for psychiatric patients. The patient census of October 31, 1974 included one alcoholic and ten adult psychiatric patients. Until it changed ownership recently, it was primarily an alcohol detoxification and treatment hospital. The primary professional staff consists of three psychiatrists; a child psychiatrist also is affiliated with the hospital. It is the only Las Vegas hospital that nearby Nellis Air Force Base uses for psychiatric patients. The fees (October 1974) were $82.50 per day plus the cost of group therapy if appropriate ($20), doctor’s fees, medication, and any special procedures.

Rancho Vegas Nursing Center

Rancho Vegas Nursing Center planned to reopen a 39-bed wing of a building in October 1974 for the provision of long-term psychiatric care.

Southern Nevada Memorial Hospital

The neuropsychiatric unit of Southern Nevada Memorial Hospital in Las Vegas

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40 Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.
41 Unpublished data provided by the Office of Demography and Mental Health Statistics, Survey and Reports Branch, Division of Biometry, National Institute of Mental Health, Department of Health, Education, and Welfare, Rockville, Maryland, September 29, 1975.
42 Interview with T. Mikkelsen, Administrator, Cedarbrook Hospital, Las Vegas, Nevada, October 31, 1974.
43 Interview with Mr. Feist, Director, Rancho Vegas Nursing Center, Inc., Las Vegas, Nevada, September 1974.
has 24 beds. About half the beds are used for private patients and half as a "disposition and holding area" for patients with court decisions pending on their mental health status. 44 Dr. W. B. Pike, the psychiatrist in charge of the unit in 1974, served the private patients and also provided psychiatric information on patients to the 8 to 10 judges responsible for commitment hearings on a rotating basis. Juveniles were seen on the unit only as private patients; rural residents were said to be rare. The unit had about 80 to 100 patient admissions per month. In mid-1974 the average patient-stay was 5 or 6 days, and the primary treatment modality was drug therapy. Follow-up after discharge was not done in 1974 except for private patients or other patients who specifically requested it; the stated reason was that the nearby Las Vegas Mental Health Center would be providing the service. At the time of our interviews, however, there was a conspicuous lack of communication and cooperation between the hospital and the mental health center, and referrals to the center for follow-up services were only rarely made. The psychiatrist in charge of the neuropsychiatric unit at the Hospital disliked referring his patients to the mental health center because, in his opinion, "They don't have adequate psychiatric back-up." (Since our interviews in mid-1974, the mental health center has improved its psychiatric staff.)

Washoe Medical Center

The Washoe Medical Center, a general hospital in Reno, has a 30-bed psychiatric unit. It is the only private inpatient psychiatric unit in the Reno area, and all admissions are voluntary. 45 No outpatient psychiatric services are provided. A few private psychiatric patients go to St. Mary's Hospital in Reno, but there are reportedly no special psychiatric services there.

In April 1974, the nonunionized hospital charged psychiatric patients $65 per day plus private physicians' fees, drugs, and laboratory fees. There were no psychiatrists or psychiatric social workers on the hospital staff. All psychotherapy was provided, usually daily, by each private psychiatrist to his or her own patients; none was provided by the hospital, although a psychiatric nurse supervised the unit. Five of the ten psychiatrists in the Reno area in April 1974 regularly used the Washoe Medical Center.

Each patient could participate in two hours of arts and crafts per day, one-half hour of exercise, and three or four hours of work (considered to be therapy to build work skills, work tolerance, and social interactions). An occupational therapist tried to make sure each discharged patient had a job, if working was appropriate, and a nurse followed up after patient discharge.

NEVADA STATE PRISON

In August 1974, when we gathered information 46 on mentally handicapped

44 Interviews with Dr. W. B. Pike and Dr. O. Ravenholt, Southern Nevada Memorial Hospital, Las Vegas, Nevada, July 16-17, 1974, and August 8, 1974.
45 Interview with Carroll Ogren, Washoe Medical Center, Reno, Nevada, April 23, 1974.
46 Interviews with Warden Pogue, the Correctional Officer on the psychiatric unit, and the inmate-attendant on the unit, Nevada State Prison, Carson City, Nevada, August 1974. Later information in this
people in prison in Nevada and the services or lack of services for them, there were five different groups of people of concern to this study: an unknown number of mentally retarded prisoners; about 10 mentally ill convicted prisoners not living in the "psychiatric unit" of the Nevada State Prison; about 5 mentally ill prisoners convicted of crimes and living in the psychiatric unit; 8 unconvicted prisoners in the psychiatric unit and elsewhere in the prison with criminal charges pending against them but whom the court has deemed temporarily mentally unfit for trial; and one or two unconvicted mentally ill persons against whom no criminal charges are pending but who have been sent from the NMHI to the Nevada State Prison because the Institute by policy choice did not have a secure locked unit for them. (See also Chap. 13 for a discussion of the juvenile justice system, which handles some youths with mental health service needs.)

We found conditions for mentally handicapped people at the Nevada State Prison in August 1974 to be extremely bad. We shall proceed to describe conditions as we found them at the prison, but inform the reader that the warden and new consultant mental health professionals have improved the program since we interviewed, that a court order was issued in early 1975 evacuating people from the psychiatric unit who had not been convicted of crimes, and that a new small Mentally Disordered Offender Facility was approved by the legislature in 1973 and is to open in 1976. However, the majority of the mentally handicapped prisoners were not in the psychiatric unit, and the number of prisoners with mental health problems exceeds the capacity of the small Mentally Disordered Offender Facility under construction. We also think it important to show how bad the programs have been at the Nevada State Prison recently both by way of illustrating how services are improving and as a caution that there is still a long way to go—and only a short way back if matters go awry.

**Nevada State Prison: The Psychiatric Unit**

The psychiatric unit of the Nevada State Prison was a special area of the maximum security prison that was supposed to provide residential treatment for inmates needing mental health services. As described by the Nevada Commission on Crime, Delinquency, and Corrections,

> ... this unit is concerned with the treatment of those inmates requiring intensive care. Through the help of inmate attendants, these patients are under 24 hour care and observation. A recreational day room on the unit provides opportunities for intensive psychotherapy on both a group and individual level.\(^{47}\)

Several prisoners on the unit had not been convicted of crimes in mid-1974. Some had not even been charged with crimes but had been civilly committed, their only "crime" being a district court finding that each was "mentally ill and, because of that illness...likely to injure himself or others if allowed to remain at liberty..."\(^{48}\)

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section was provided in a letter from Warden Pogue to J. S. Kakalik, The Rand Corporation, Santa Monica, California, March 8, 1976 and a letter from Dr. D. Molde, psychiatrist, Reno, Nevada, to The Rand Corporation, March 11, 1976.


\(^{48}\) *Nevada Revised Statutes*, 433.695. This definition applied at the time of our interviews in 1974; it has been revised somewhat by the 1975 legislative session (see Chap. 3).
They received very little treatment in mid-1974 other than drugs. The inmate-attendants did not "help" provide direct 24-hour care—they provided nearly all of it. Almost no psychotherapy was provided since there was no regular staff on the ward qualified to do so, and professionally qualified staff spent very little time on the unit.

The psychiatric unit was located on the prison's former death row, in an old Territorial prison building that was in use before Nevada became a state. The unit has room for 12 beds; there are eight cells in the main area, two beds in an open-office area (which are used only in emergencies), and two beds in the "condemned area" facing the gas chamber. The small area of each cell contains a single bed and a sink-toilet combination. We observed no personal possessions in most cells. Floors are concrete and some were damp; one cell had broken plumbing repaired with towels. The activity room contained a Ping-Pong table, some chairs, and a television set. The unit's office, where we were told the prison psychiatrist was supposed to provide direct services, also contains the gas chamber secluded by curtains. The private psychiatrist serving the unit part-time in March 1976 points out that the physical facility is "quite satisfactory, given the alternatives within the maximum security prison." He continues: "In fact, this unit is the most desirable place to live of any of the housing arrangements which are available at that prison."

One correctional officer functioned as manager of the psychiatric unit. He stated that all he did was guard the prisoners, that he had no responsibility for treatment. The unit had a staff of four inmates, one on duty at night and three during the day. No one working each day on the psychiatric unit had any formal training in the mental health area. We were told that the inmate-attendant in charge administered psychotropic drugs. One might well ask, as we did extensively of the warden, the correctional officer, and the inmate-attendant on the psychiatric unit, where the professional mental health personnel were and what services they provided. After all, like Nevada's legislators who approved the budget and staff, we knew that the administrator of the Division of Mental Hygiene and Mental Retardation is responsible for the supervision of the psychiatric care and treatment provided for the mentally ill prisoners at the Nevada State Prison, and that the prison had staff positions for a psychiatrist, a psychologist, and a psychiatric social worker. In reality, those positions are under the warden's supervision and are intended to serve the maximum security prison, which holds about 425 men; the medium security prison, which holds about 375; and a women's prison, which holds about 35. In effect, however, even these staff positions exaggerate the psychological services available to the prison population. At the time of our interviews at the prison in August 1974, the psychiatric social worker worked his 20 hours a week at the medium security prison, running encounter groups for drug offenders. The prison psychiatrist and psychologist had recently terminated their employment with the prison, and the warden indicated that the budget for the psychologist position probably would be used to hire a male registered nurse. Before he quit, the psychiatrist split his 40

40 This unit has been described by a psychiatrist, Dr. R. Komisaruk, as "a macabre example of what the inmate technician called behavioral modification. The two cells which were historically used as the night-before cells (on death row) are now used as a positive reinforcement.... Because there is more room in the cells, patients are rewarded for good behavior by being kept in those cells. It seemed like an unusually grisly situation." The Nevada State Journal, May 11, 1974.

50 Nevada Revised Statutes, 433.320.
hours a week among the three prisons and had to spend a large fraction of his time on administrative and testing matters (e.g., classification of new prisoners, parole meetings, and parole reports). According to the correctional officer on the psychiatric unit in August 1974, the psychiatrist who had recently terminated employment provided little psychotherapy for prisoners on the unit. In a separate interview, the inmate-attendant corroborated this. The warden, however, indicated it was his understanding that the psychiatrist in mid-1974 was providing “daily attention to the people in the psychiatric unit as well as in the general populations at the other institutions.”

Until a new psychiatrist could be hired, two private psychiatrists were filling in at the prison for ten to fourteen hours a week between them. Thus, a job that left little time for direct services at 40 hours a week was left to be performed in less than half that time. Prior to the departure of the psychologist from prison employment, he was used to train staff members throughout the prisons.

As of March 8, 1976, the warden still had not been able to recruit a full time psychiatrist; the March 1976 mental health services personnel include approximately 10 to 14 hours per week of psychiatric coverage, primarily to the Maximum Security Prison and to the Women’s Prison, and approximately 20 hours per week of a certified psychologist’s time to provide direct clinical services to the maximum and (primarily) medium security prison’s population. Currently these two private mental health professionals see approximately 30 to 40 inmates per week. As of March 1976, some of these individuals are in extended treatment; some are seen for drug treatment or other brief contact; some are seen for parole board reports, for recommendations for jobs, housing, or other institutional activities; and some are seen on an emergency basis.

The private psychiatrist serving the psychiatric unit part time in March 1976 indicated that the chief inmate-attendant still distributes medication on the unit. The inmate-attendant does so under supervision of the correctional officer in charge and also under the supervision of the medical technicians and (in the past) also under the supervision of a registered nurse. The psychiatrist also stated that “because the Nevada State Prison, like many other institutions, depends upon inmate assistance for its full operation and because there is simply no sufficient budget to employ civilians in all the desirable capacities, we are forced to use inmates for this purpose.” The warden desires to increase the quantity and quality of mental health services at the prison, and plans to increase the amount of psychological and psychiatric coverage, probably on July 1, 1976.

The typical day of psychiatric unit inmates consisted of breakfast, medication, exercise (if they wanted it), lunch, and more exercise. From 3:30 p.m. until 7:30 a.m. they were locked in their cells, since no correctional officer was assigned full-time to the unit on the evening and night workshifts, or on weekends.

Of the ten men housed in the psychiatric unit, over half were in the prison on civil commitments.

Criminal commitments have determinate maximum sentences. If considered mentally ill when it is time for release, the prisoner is taken to court and the judge is asked for a civil commitment. If the judge grants it the former prisoner is sent to the Nevada Mental Health Institute. Technically, he could be sent back to prison from the Institute, but the warden says that has never been done.

Civil commitments usually have indeterminate sentences. Theoretically, a per-
son charged but never convicted of a crime could remain incarcerated longer than if he were convicted. Also theoretically, a physician is supposed to review the mental condition of prisoners with civil commitments every six months.

As can be imagined, length of stay varied greatly. Some stayed in the psychiatric unit for three to six months, others as long as five to seven years. In August 1974, only two had been there less than a year. Three had been there more than five years, of whom one convicted criminal was a 13-year resident.

It came as no surprise to us when U.S. District Judge Bruce Thompson, ruling in February 1975 on a class action suit on behalf of inmates, ordered that prisoners who had not been convicted of crimes be evacuated from the prison psychiatric unit. As a result of the order, several inmates of the unit were sent out of state to other facilities (e.g., Atascadero State Hospital, and a private psychiatric facility in Walnut Creek, California). Two were transferred to the NMHI; of those two, one walked away from the Institute, which at the time had a policy of not having any locked neuropsychiatric unit, and one was sent to county jail after allegedly abusing a female mentally retarded resident of the Institute. Since that time, and while awaiting completion of the new Mentally Disordered Offender Facility, the Institute has created a secure neuropsychiatric unit with a capacity of 10 to 12 inpatients.

Nevada State Prison: Nonpsychiatric Units

The Nevada State Prison system does not know even approximately how many mentally retarded prisoners it has, and provides no special services for them, other than allowing them to participate in basic adult and remedial education classes. According to national 1963 prison population figures, approximately 10 percent of the inmates in the entire United States prison system were mentally retarded (defined by the source of the data as having measured intelligence below IQ 70). Approximately 40 percent had a measured IQ below 85. This proportion is well above the 3 percent of the entire United States population with measured IQ below 70. Yet, there is no provision for removing the mentally retarded offender from the Nevada State Prison and providing him or her with special services elsewhere in the mental retardation service system.

Women in 1974 received no psychiatric services at the women's prison; those most in need were sent to California prisons for care and treatment (one was in California at the time of our interview).

For men, in addition to the psychiatric unit (with 10 prisoners), the prison has set aside one tier of the maximum security prison (with 42 prisoners) for men described to us as either psychotics or sociopaths. Nearly all were said to be on behavior-controlling drugs but received no other psychological services. It was reported that one man on this tier was there on a civil commitment.

In general, in mid-1974, apart from chemical restraints used primarily to control behavior, no psychological services were offered outside the psychiatric unit other
than group therapy to drug offenders. In response to a prisoner's public complaints about lack of psychiatric care, the warden testified that there was no group therapy or other psychiatric resources readily available to "normal" inmates of the maximum security facility—that such care went primarily to mental cases in custody and others who were committed as psychotic.\textsuperscript{44}

Six months later, the director of the NMHI said that a sex offender who had been declared insane "while housed in the medium security area of the state prison, would have access to psychiatric treatment and might some day be declared fit for release."\textsuperscript{55} Such public statements, which wrongly imply the general availability of mental health services, can only worsen an already serious situation.

\section*{MENTALLY DISORDERED OFFENDER FACILITY}

The new Mentally Disordered Offender Facility (to be called "Lake's Crossing Learning Community") will be a 32-bed residential mental health treatment facility. Now under construction at a cost of $1.6 million, it is scheduled to open in 1976. It is to be operated by the Nevada Division of Mental Hygiene and Mental Retardation and is intended to serve four groups of people. All four are groups that formerly were supposed to have been receiving mental health services in the Nevada State Prison system: persons judged not guilty because of mental disorders; persons judged not competent to stand trial because of mental disorders; persons who develop mental disorders while convicts; and persons who commit certain sex offenses. Division of Mental Hygiene and Mental Retardation personnel, including the medical director of the NMHI, have also spoken of using the new facility for service to those people requiring mental health treatment in a secure facility who formerly would have been served by the NMHI when it had a secure ward in its neuropsychiatric unit.

The staff approved by the 1975 legislature for the Mentally Disordered Offender Facility includes a clinic administrator, a psychiatrist, two psychologists, a psychiatric nurse, a psychiatric social worker, an occupational therapist, a recreational therapist, a security officer, 23 mental health technicians, and four secretarial and housekeeping personnel.

The number of prisoners in the Nevada State Prison system at the time of our interviews who belong to the four groups cited exceeds the planned capacity of the Mentally Disordered Offender Facility. It is therefore obvious that either treatment at the new facility will be short term and the prisoners will be returned to the criminal justice system (i.e., the court or a prison facility), or some prisoners will not be served at the new facility. The program statement given in the January 1975 \textit{Executive Budget} points to short-term treatment:

The concept of a therapeutic community will be emphasized with an effort made by the program staff to develop a normalized community within the Facility which will support productive, appropriate behavior. Hopefully, treatment will be of a relatively short-term nature, with the goal of returning the individual as quickly as is consistent with competent treatment to his natural environment or the criminal justice system.

\textsuperscript{44} \textit{Nevada State Journal}, January 20, 1974.
\textsuperscript{55} \textit{Las Vegas Review Journal}, June 6, 1974.
We note that the "therapeutic community" concept, widely used in short-term facilities, is difficult to implement in the short term since the concept is based on patients becoming meaningful participants in a "community" in which power and other values are shared. No matter how the Mentally Disordered Offender Facility functions, the Nevada State Prison will continue to house prisoners who have an unfulfilled need for mental health services because the Mentally Disordered Offender Facility could not make room for them, or because they need follow-up mental health services after intensive treatment at the new facility.

OUT-OF-STATE RESIDENTIAL SERVICES

In 1974 there was no residential mental health treatment program for children and youth, either public or private, in northern Nevada. The NMHI only accepts mental health patients in their high teens or older. The only public facility in the entire state with a residential mental health treatment program for youth was the Las Vegas Mental Health Center, and it accepted only youths over 12 years of age from the Las Vegas area. Children under 12 were not served anywhere in the state in a public residential mental health treatment program, and were served only on a very short-term basis with adults in psychiatric units of local and private hospitals.

Consequently, some children with the most severe mental health problems requiring residential treatment were sent to mental facilities out of state. Others were not served at all. Still others ended up in places such as the two Nevada Training Centers for delinquent youth or in the two Nevada Children's Homes, which are not intended to offer mental health treatment programs (see Chap. 13 for details). The two CBS facilities, when completed, will partially rectify this problem.

The following case studies, provided to us (without identifying names) by Washoe County Juvenile Probation Department personnel and Child Welfare personnel of the Nevada Welfare Division, trace the bouncing of emotionally disturbed children through the various agencies of the social service delivery system until they are finally sent out of state:

One case involved an emotionally disturbed 16-year-old juvenile who had been in and out of various mental health and correctional institutions since he was 8 years old. When we saw him in the fall of 1974, he had run away from the NMHI twelve times in the past two months. Probation officers complained bitterly to us that he sometimes got out of NMHI so fast that on one occasion they passed him hitchhiking on the road just after they had dropped him off at the Institute. At the time of our interview, he was being held at Wittenberg Hall (a temporary juvenile holding rather than treatment facility). The Department of Juvenile Probation was preparing to take the Welfare Division to court in order to force them to provide services not otherwise available in the state for this emotionally disturbed boy.

56 For example, when we interviewed in July 1974 at the day-care program for emotionally disturbed children and youth run by the Reno Mental Health Center (see Chap. 8), the program's administrator listed 24 youth whose emotional disturbances were too severe to be treated in a day-care program. They were unserved because there was no residential service program for them.

57 Three years ago the Department of Juvenile Probation reportedly took the Welfare Division to court to make the state accept responsibility for a child who was not getting essential residential mental health services. According to the Juvenile Probation officials, Welfare has taken the position that no matter how emotionally disturbed or mentally retarded a child is, once he has been declared a delinquent, Welfare is not responsible. In each of the six cases thus far tried, the judge has ruled that the Welfare Division...
One 18-year-old emotionally disturbed and mentally retarded Nevada youth had been placed in various institutions in Utah, Texas, and California over a period of years by the Welfare Division prior to his return to Nevada at age 18 for "normalization." On return, he threatened his new foster parents and was taken to the NMHI, which reportedly refused to accept him because it was after 5 p.m. He spent the night in jail.

One brain-damaged, severely emotionally disturbed 10-year-old was placed in an institution in Texas after NMHI reportedly refused to admit him because they had no appropriate service program for him.

Another 17-year-old severely emotionally disturbed youth had been shuffled from agency to agency. He had been in various foster homes, the Las Vegas Mental Health Center, the Nevada Youth Training Center for delinquents, the NMHI, and an institute in Texas. It appeared that service to him was uncoordinated (to say the least) and that the various service programs were saying, in effect, "This program doesn't have appropriate services, so let someone else take care of him." Meanwhile, no program adequately met his needs.

One 16-year-old runaway girl described as emotionally immature could not be successfully placed in a foster home and therefore was sent to a facility in Texas.

One 6-year-old emotionally disturbed hyperactive child repeatedly had failed foster home placements at age 4, had been placed on a mental retardation ward at NMHI for a while but was soon released as not being retarded, had been repeatedly rediagnosed due to failure of his records to follow him as he progressed through the system, and eventually was placed in a California facility.

We could go on and on, but the cases presented illustrate the pattern. It is a sad and distressing picture of young children bounced from agency to agency and finally out of state for service because: (1) appropriate services were not provided in Nevada before the need for residential mental health services arose; (2) various Nevada agencies took the stand that their programs were not appropriate for the provision of the residential services currently needed by the child; and (3) no one took the responsibility for creating or providing the services in Nevada. It is tragic that most seriously emotionally disturbed children must have remained unserved in Nevada, since only a fortunate few were sent for service elsewhere.

During FY 1974, there were usually 20 to 30 emotionally disturbed Nevada children placed in out-of-state institutions at any given time. For example, at one point in FY 1974 four emotionally disturbed and mentally retarded youth were placed out of state, and another 20 emotionally disturbed youth were placed in out-of-state institutions by the Nevada Welfare Division at a typical cost of approximately $800 to $1000 a month. As of December 1975, the number of children placed out of state had grown to 45. Assessment of the quality of services provided out of state were beyond the scope of this study. The CBS program in Las Vegas noted

is indeed responsible for the child. Welfare, however, apparently has not accepted this precedent and each case is fought. This legal wrangling between agencies is, of course, at government (i.e., taxpayer) expense. (Information provided by Frank Sullivan, Washoe County Department of Juvenile Probation, Reno, Nevada, September 1974.)

Interview with G. Handley, Nevada Welfare Division, Carson City, Nevada, August 1974.

Placement was first sought at NMHI for mentally retarded youth before sending them out of state. December 1975 information was provided in a letter from W. J. LaBodie, Nevada Welfare Division, Carson City, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, March 3, 1976.
that 16 Clark County children who needed residential mental health services were in out-of-state institutions in late 1974.\textsuperscript{60}

In December 1975, the 45 children placed in out-of-state institutional care by the Nevada Welfare Division had the following characteristics. Seven were under 12 years of age; 12 were aged 12 to 14 years; and 26 were 15 years of age or older. Four were mentally retarded; 5 were emotionally disturbed and mentally retarded; 18 were emotionally disturbed; 3 were psychotic; one had delinquent behavior; and 14 were emotionally disturbed with delinquent behavior. Approximately half had had no prior institutional placement, but 9 had had 3 or more prior institutional placements. Eight had been in the current institutional placement for 0 to 6 months; 12 had been there 6 to 12 months; 16 had been there 1 to 2 years and 8 had been in the current institutional placement 2 years or more. The cost per month of each out-of-state placement ranges from $450 up $1500, depending on the child's needs and the institution; the average cost per month is about $1000.

In recognition of their role in providing residential mental health services by default (since the Division of Mental Hygiene and Mental Retardation did not provide those services), staff members of the Nevada Welfare Division proposed that the legislature give them funds for construction of a residential treatment center for severely emotionally disturbed teenage children. We were told by a Welfare Division administrator that the proposal was meant only to call the legislature's attention to the lack of treatment facilities in the state and to the seriousness of this situation.

In addition, the Welfare Division staff has proposed asking for state monies to build two halfway houses for 20 emotionally disturbed children each (one in Las Vegas and the other in Reno), for children 16 years old and up. For the younger emotionally disturbed child, they propose to train and provide special foster care parents (see Chap. 13 for our recommendations regarding foster homes).

The Specialized Children's Services team [a welfare social worker and the foster home parents] will provide service to the emotionally disturbed child—ages 3 to 13—who are [sic] not severely physically handicapped or severely mentally retarded. These will be children who cannot function in a regular foster home setting and/or who are returning from institutional care or who may be potential for institutional care. The staff-child ratio will be on approximately one-to-one basis.\textsuperscript{61}

To the extent that the new CBS and the Las Vegas Mental Health Center’s residential treatment programs serve the types of children and youth that the Welfare Division staff would serve in their proposed programs, the problem is lessened. William LaBadie, of the Nevada Welfare Division, pointed out in a March 3, 1976 letter to The Rand Corporation that: "The problem is that the Division of Mental Hygiene and Mental Retardation views these residential facilities as only very short-term. Without some type of residential intermediate mental health facility, the state would continue to be faced with the problem we have presently. Not only would the number of children in out-of-state placement not be reduced with the increasing population, the numbers would be increased." In any event, we suggest that the direct provision of mental health and mental retardation services is not the most appropriate function of Welfare Division personnel.

\textsuperscript{60} The Executive Budget, p. 326.
\textsuperscript{61} From a draft proposal, Nevada Welfare Division, Carson City, Nevada, undated (copy provided in 1974).
NEEDED IMPROVEMENTS: RESIDENTIAL MENTAL HEALTH SERVICES

Residential mental health services in Nevada are improving. The following recommendations are therefore intended not as criticisms of recent changes but as guidelines to further improvement. Three years ago, for children and youth with mental health problems, there were essentially no residential services in Nevada, but the legislature has since approved three major new programs providing relatively short-term services (the Las Vegas Mental Health Center and the two CBS programs); however, there is still a need for longer-term, in-state, intermediate levels of residential mental health services for children and youth. For adults, the NMHI, the prison, and a few local and private hospital beds existed three years ago, and the legislature since has approved two major new programs (the Mentally Disordered Offender Facility and the Las Vegas Mental Health Center adult programs); however, there is still a need for short-term residential capacity in conjunction with the two improved mental health centers we recommended in Chap. 8, and the recent massive shift of the mental health section of NMHI from chronic care toward short-term acute treatment has left those adults in need of intermediate level chronic care inadequately served.

The two newly approved CBS residential facilities help fill a gaping hole in the Nevada mental health residential service system for young people, and we fully endorse them. In 1974 there was no residential mental health treatment program for children and youth, either public or private, in northern Nevada. The only public mental health facility in the entire state accepting youth on a residential basis was the Las Vegas Mental Health Center, and it usually accepted only youth over 12 years old from the Las Vegas area. Consequently, 20 to 30 of those children with the severest mental health problems requiring residential treatment were sent to mental facilities out of state. (Forty-five were placed out of state in December 1975.) Other less fortunate children were not served at all. Still others ended up in places such as the state juvenile Training Centers or the state Children's Homes, which are not intended to offer mental health treatment programs.

When construction is completed on the CBS residential facilities in Reno and Las Vegas, this lack of residential mental health services for youngsters in Nevada will be partially rectified. However, the CBS program in the south accepts only 0-to-12-year-old children, while the Las Vegas Mental Health Center serves those over 12. If the CBS program in the north accepts only those less than 13 years old, there will still be no residential mental health program for children over 12 years old in northern Nevada. Also, both the northern and southern Nevada CBS residential programs will provide only short-term intensive residential services and short-term transitional residential placement with specially trained "professional parents." Any child who cannot live in his or her own home or in a foster home over the longer term will not have longer-term, in-state, intermediate levels of residential mental health services available (a subsequent recommendation deals with this problem). The emotionally disturbed children served by the Welfare Division represent a rather unique group of children. These are children who do not have parents or have been removed from the custody of their parents because of neglect, abuse, or abandonment. For many of these children, their natural parents either do not exist or their own problems are so severe that the family does not represent a placement resource to the child. Consequently, the child is not only in need of mental health
services but also is in need of a roof over his or her head. In addition, emotionally disturbed youth in rural areas need provision for residential services from the CBS or some other program and outpatient services from an upgraded Rural Clinics program. Finally, the CBS nonresidential program in Las Vegas currently does not provide a full range of treatment modalities to meet the range of children's needs; rather, it focuses primarily on the "behavior modification" treatment modality, as discussed in Chap. 8. We recommend that the two CBS residential treatment programs be adequately and unconditionally staffed, specifically including positions for both physicians with training in psychiatry, and psychologists so that a broader range of treatment modalities can be provided; that the Reno CBS residential facility serve children and youth through age 18; and that both facilities combined accept rural children so that a difference in the level of service per capita does not exist between the Las Vegas, Reno, and rural areas of Nevada.

Although the mental health section of NMHI is accredited, the facility's program still has major deficiencies that must be corrected to maintain accreditation. We recommend correction of the major deficiencies noted in the JCAH accreditation report for the psychiatric section of the NMHI.

A major problem exists with the quality and quantity of psychological services provided at NMHI. The psychiatrist in each NMHI neuropsychiatric unit is able to spend an average of only about one-half hour per week in direct contact time per patient exclusive of record-keeping (recall the median stay of 17 days). Other staff members therefore must carry a heavy responsibility for patient treatment. Since the units do not each have a direct-patient-services psychologist, and since the social worker has other responsibilities, the one supervisory psychiatric nurse and the unit's mental health technicians who are assigned as each patient's "primary therapist" must shoulder a heavy load. But the technician's job requires only a high school education, and at the time of our interviews their training was grossly inadequate; there was no formal training program for all the technicians at NMHI (contrary to the officially stated job requirements). Consequently, most of the mental health technicians, although hardworking and dedicated, are not skilled enough to adequately do the work they are responsible for. The upshot is that drugs appear to be the primary mode of treatment for most mental health patients at the Institute. However, psychopharmacological intervention is primarily useful as an adjunct to other kinds of treatment (e.g., psychotherapy) which it may facilitate but does not replace.

Essentially the same lack of skills and inadequate training of "technicians" prevails in the Las Vegas Mental Health Center residential treatment program, and in the state's other mental health centers and rural clinics mental health programs. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's 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. To resolve this situation, we recommend that the requirements for the job of mental health technician be upgraded to the master's degree level; that the University of Nevada create a new master's degree program in mental health; and that on-the-job training programs in the various mental health facilities be substantially upgraded. The new master's degree program in mental health is detailed in Chap. 8, and provides a broad range of mental health service skills. Along with
upgrading the skills of mental health technicians, certain other changes are necessary: it must be recognized that technicians who serve mentally retarded people and those who serve people with mental health disorders need different skills. Moreover, much of the existing mental health technicians' work involves escorting people, doing housekeeping, and other tasks that should be assigned to people with lower skill levels, not to the proposed master's level technicians.

In addition to the deficiencies in mental health services within NMHI, noted above, another major deficiency of the NMHI mental health program in mid-1974 was in the area of postdischarge follow-up treatment. Continuity of care and adequate follow-up treatment after discharge from NMHI was the exception rather than the rule in 1974. This is a major problem with the state's mental health service system since two primary objectives of inpatient treatment are (1) to help the patient through a severe mental health crisis (a few days of treatment will usually help a patient past an episode of acute decompensation) and (2) to engage the patient in a treatment process which will be ongoing and which will address itself to the basic problems that made him or her vulnerable to the acute decompensation. Whereas the first objective can usually be satisfied in a brief hospitalization of a few days' duration, the second objective usually requires substantial treatment over a longer period of time extending beyond the period when hospitalization is required. Psychotherapeutic services, for example, usually cannot be satisfactorily completed within a 17-day period (the median NMHI length of stay). The Reno Mental Health Center's lack of adequate follow-up (other than drugs) in 1974 has led the NMHI to attempt its own follow-up in the Reno area, but the limited NMHI staff has enough difficulty merely providing its residential services. The Rural Clinics personnel were not providing adequate follow-up for most rural residents discharged from the Institute and it is doubtful that they have the personnel to do so and also fulfill their other responsibilities (see Chap. 8). For Clark County residents, the transition is abrupt from the Institute to Las Vegas Mental Health Center, but that center has the capacity to provide adequate follow-up services, and has recently developed an "Advocacy/Aftercare" program, which provides follow-up services to former inpatients of the Las Vegas MHC and NMHI, and generally monitors and implements continuity of care. 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 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. The expanded mental health centers and rural clinics staff improvements we recommend in Chap. 8 are necessary to provide fully adequate follow-up treatment for NMHI ex-patients, since outpatient services are not in adequate supply and day-treatment services are nonexistent outside the Institute in most geographic areas (particularly in rural counties and Washoe County).

Since changing a patient's primary therapist in the transition from residential to nonresidential service is difficult and can disrupt treatment, ideally it would be preferable to have the same primary therapist in both the inpatient and nonresidential phases of treatment. Professionals such as psychiatrists or Ph.D. level psycholo-
gists could be used as the single primary therapist in all phases of treatment. However, the new master’s degree level of mental health service personnel we recommended above 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.

We reiterate from Chap. 8 our recommendation that two new Community Mental Health Centers be created, one in the Las Vegas area and one in the Reno area, with provision in each for short-term (a few days or weeks) inpatient treatment, as well as day and outpatient treatment. About 100 new bed-spaces will be required by 1985 merely to maintain the present level of residential mental health service capacity on a per capita basis in Nevada.

The Las Vegas Mental Health Center’s residential treatment program had a number of problems in 1974, which we noted earlier. In our view, they stemmed from the newness and rapid startup of the program, from the fact that it was not yet fully professionally staffed when we interviewed, and from the low skills of the mental health technicians. Time and administrative attention should have taken care of the former two reasons by now, and the latter reason is the subject of our earlier recommendation regarding upgrading mental health technicians’ skills throughout all programs.

A major problem with Nevada’s mental health service system is the nearly total lack of intermediate services between full inpatient treatment and outpatient treatment. For example, service system capacity is lacking in the areas of halfway houses, day-treatment facilities, and chronic care programs that provide more than drugs. Most mental health care in Nevada today is episodic, and little or no intermediate level aftercare is provided following discharge from residential treatment. The lack of day-treatment facilities would be alleviated by the two new Community Mental Health Centers recommended above. Chronic care programs and halfway houses are discussed below.

A large remaining gap in the mental health service system is in service to people with chronic mental health problems. Ironically, this gap was created for adults only recently by an administrative policy shift in the type of residential service to be provided by the NMHI (from chronic and acute toward primarily short-term acute mental health service). In reducing the number of mental health residents at NMHI from about 380 to less than 100, long-term patients receiving chronic residential care were released to the care of their families or other residential facilities that usually have no mental health services (e.g., intermediate care facilities, nursing facilities, and adult group care facilities). Other than the prescription of drugs, periodic visits by an NMHI nurse to those other residential facilities, and psychiatric consultative services provided on request to three skilled nursing facilities in the Reno area, there is no follow-up. The follow-up has improved since 1974, but there is still a gap in the service system between the full intensive inpatient treatment NMHI is supposed to provide and care with "normal" people in nursing homes, group care homes, or with the person's family. A similar gap in services exists for children, as we discussed above in the section on the CBS residential programs. We recommend the creation of mental health service programs, for children and adults, providing an intermediate level of mental health services over an extended period of time to people with chronic mental health disorders. Both children and adults may need this type of extended-term intermediate level of mental health services, and
the service system should provide for serving people in both age groups in separate programs. This should not be a long term hospitalization or institutional program. It could be a program providing substantial outpatient, day treatment, and other services (as appropriate to the individuals' needs) for people residing in various types of supervised facilities in the community. This intermediate care program, discussed more fully earlier in this chapter, would provide some direct mental health services (more than drugs) and some of the residents would be free to move about in the community. The lack of such a program has resulted in some children and adults not being served, some people cycling from agency to agency (one such person reportedly cost the service system $30,000 to $40,000 in one year), and children being sent to institutions out-of-state.

Halfway houses provide a community-based intermediate level of residential service for short periods (weeks or months) for people released from residential intensive treatment programs but still incapable of living independently in the community. Halfway houses also provide an alternative to hospitalization. In 1974, we were aware of none in the entire state for people with mental health disorders, although some existed for alcohol and drug abusers (see Chap. 9) and for mentally retarded people (see Chap. 13). A small transitional facility is planned for the NMHI, but it can hardly be called community-based. We recommend the creation of halfway houses operated in conjunction with mental health centers in both northern and southern Nevada for people with mental health disorders. The mental health centers could provide substantial outpatient, day treatment, and other services (as appropriate to the individuals' needs) for people residing in these halfway houses. These halfway houses not only would provide a missing level of service and a means of avoiding unnecessary hospitalization or unnecessarily extended hospitalization, but also would be less expensive than full residential treatment programs.

We found conditions for mentally handicapped people at the Nevada State Prison in mid-1974 to be extremely bad. The state has recognized the severe problem of lack of psychiatric treatment for prisoners with mental health disorders, and has acted by beginning construction on the new 32-bed Mentally Disordered Offender Facility. We endorse this greatly needed new mental health program. However, the current number of Nevada prisoners in need of mental health services exceeds the bed-capacity of the Mentally Disordered Offender Facility, and the rapidly expanding population of the state is likely to be accompanied by a rising population of mentally handicapped prisoners. The courts recently ordered that certain types of prisoners be evacuated from the prison's "psychiatric unit," but most mentally ill prisoners were not on that unit at the Nevada State Prison. The stated intention of the Division of Mental Hygiene and Mental Retardation is to use the Mentally Disordered Offender Facility for treatment of a "relatively short-term nature" and then to return the individual to "his natural environment or the criminal justice system." Consequently, because of the small size of the Mentally Disordered Offender Facility, it is clear that at least follow-up mental health services will have to be

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provided to some people who are returned to the Nevada State Prison following
intensive treatment at the new facility. In a March 4, 1976 letter to Rand, the
Clinical Director of the new facility, Robert Hillar, acknowledged that "it is quite
obvious that we cannot handle all of the mental health problems (broadly defined)
of the State Prison." The facility's small size is acceptable, provided the rest of the
mental health service system operates appropriately. If all prisoners with mental
health problems are to receive the services they need, we believe it essential to
implement the following three recommendations.

We recommend that the Mentally Disordered Offender Facility be used primarily
for treatment of prisoners with mental health disorders, and not for persons who have
neither been charged with nor convicted of crimes but who need treatment in a secure
facility.

We recommend that provision be made for mental health services within the
Nevada State Prison for mentally disordered prisoners who do not need the intensive
level of treatment provided by the Mentally Disordered Offender Facility, or who need
follow-up services after intensive treatment at that facility. Providing services at the
new facility will solve only part of the problem; there should be no false impression
that a new small facility can furnish adequate services to all mentally ill prisoners.
To provide those services within the prison, additional mental health staff positions
will be required; we suggest that those staff members be under the direct supervision
of the administrator of the Mentally Disordered Offender Facility rather than under
the sole supervision of the warden.

We recommend that the Nevada Mental Health Institute accept responsibility for
providing a secure neuropsychiatric unit for those patients who need it and have not
been charged with or convicted of crimes. While drugs and other therapy have in
most cases eliminated the need for physical restraints at the Institute, some patients
need a locked unit or area where they can be monitored to help prevent them from
physically abusing themselves or other patients, and to restrain them from leaving
the Institute. The Mentally Disordered Offender Facility already has more than
enough responsibility and should not have to serve patients the Institute could
adequately serve.

The median length of stay for discharged NMHI mental health patients was
about 17 days in 1975. In those terms at least, the Institute is now primarily
functioning much the same as the inpatient units at Washoe Medical Center, Southern
Nevada Memorial Hospital, and the Las Vegas Mental Health Center. The Institute
currently is not functioning primarily as a place for treatment of patients needing
more prolonged care than that typically provided by those three mentioned com-
community-based facilities.

Having described problems with the various residential mental health service
programs and made some recommendations for improvement, we can now summa-
ize what we believe to be the most appropriate functions for the NMHI. We recom-
mand that the mental health section of the Nevada Mental Health Institute concen-
trate on inpatient mental health treatment for rural Nevadans, for those who need
a secure facility, for those who need more than short-term residential treatment at
the mental health centers, and for those unable to enter the inpatient units of mental
health centers because they are temporarily filled to capacity. Thus, we see the mental
health section of the current NMHI facility as complementing the state's commun-
ity mental health centers in the overall service system, rather than acting as a
community mental health center itself (although the recommended new Reno area community mental health center might be located at or near the Institute). Each of the four service functions mentioned in the above recommendations for NMHI is essential and is not now being filled adequately by the state's mental health centers. Of course, one could define other functions for the soon-to-be-improved Institute facilities, but some other facility or facilities would still have to provide the four service functions we outlined for NMHI. The Las Vegas Mental Health Center does not have the bed-capacity to provide both short-term and longer-term residential services (by longer term we mean here 3 to 12 months, only occasionally more); the Institute has a larger capacity and a secure facility capacity, which it would seem wasteful not to use since funds for new construction are very limited. One could also recommend a second Nevada Mental Health Institute in southern Nevada; while that may be justified at some future point in Nevada's population growth, it seems unnecessarily expensive now in relation to other needs.

Given the current sparse populations in rural areas of Nevada, no single rural area currently appears capable of fully using an intensive inpatient mental health treatment facility. We believe that rural Nevadans can be more effectively and less expensively provided with intensive residential mental health services in one of the urban areas. Provision should be made to assure rural Nevadans of access to those services, including transportation to urban areas if required. Rather than have rural Nevadans compete with urban Nevadans for available bed-spaces in each of the mental health centers, it may be preferable to designate one facility to be responsible for residential mental health services to rural Nevadans. We suggest the Institute be so designated, since the only existing mental health center with residential capability already is supposed to serve the half of the state's population concentrated in the Las Vegas area.

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 people 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, program management information being deficient, we recommend that an improved information system be established for monitoring and managing mental health program operations, as well as the effectiveness of services. Details of information deficiency were described earlier in this chapter, and also in Chaps 4 and 8.

NEVADA MENTAL HEALTH INSTITUTE: MENTAL RETARDATION PROGRAM

The Institute primarily provides longer-term residential care, treatment, and training for mentally retarded persons who are incapable (or not yet capable) of functioning in a less restrictive environment.\(^\text{63}\) However, judging from our observa-

\(^{63}\) Information in this section is based on several interviews in 1974 with mentally retarded residents of the Institute; Dr. V. LoCicero, Institute Director; D. Davis, D. Edwards, and J. Gray, each of whom has been Clinic Administrator for Mental Retardation (or acting in that position as head of MR programs
tions and the opinions of several staff members we spoke with at the Institute, a significant portion of the mentally retarded residents appeared to be capable of living in a less dependent setting if they were given adequate training, some community-based services, and the opportunity. A recent Nevada Department of Human Resources deinstitutionalization study concluded that about 30 to 40 of the current mentally retarded residents of the NMHI "require continued intensive life maintenance care." As of February 1976, there were 108 persons in the NMHI mental retardation program, and there had been 39 discharges and 8 admissions since mid-1974.

Since 1974, the NMHI's mental retardation program has made several internal changes that have changed the quality and quantity of services provided for the current residential population. These changes have been implemented using the JCAH accreditation standards as a guide and are seen by NMHI only as beginning steps that are necessary to ultimately bring the residential program into compliance with accreditation standards. An attachment to a letter from NMHI Director T. Piepmeyer to Rand on February 27, 1976 stated, "these program changes are pitifully inadequate unless additional resources outside the existing program are obtained in the form of staff, training and proper mix of professional skills." The NMHI mental retardation program also has identified a program goal for a specific population it feels it can reasonably serve at this time, given available resources. This goal is for:

NMHI-MR to change the major focus of the NMHI-MR program from a custodial long term residential program to a shorter term, residential and day training oriented service for profoundly and severely retarded persons and their families residing in the northern area of the state by January, 1977.

The 1974 cost per day per mentally retarded resident at the NMHI was approximately $33, or about $12,000 per year per resident, using the Institute's method of allocating costs among residents.

Admissions of mentally retarded people to the Institute are handled by Interdisciplinary Committees of the Division of Mental Hygiene and Mental Retardation. The committees are described in the section of this chapter on the two mental retardation centers, whose admissions those committees also handle. After admission an interdisciplinary team plans the individual's program. The interdisciplinary team consists of the NMHI mental retardation administrator, a nurse, a social worker, an occupational therapist, a physical therapist, a vocational rehabilitation counselor, a speech therapist and direct residential care staff (and when appropriate, a psychologist, a dietitian, a chaplain, a pharmacist, a physician, and/or a special education teacher if the person is between the ages of 3 and 18). Other disciplines (e.g., dentist) and referral agencies (e.g., the Washoe Association for Retarded Citizens) are included in this group when appropriate. This interdisciplinary team serves as both a review team for individual client programs on a continual review schedule and as an initial evaluation team for newly admitted clients. The team is

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responsible for performing all of the tasks identified in the JCAH standards that deal with interdisciplinary teams, including the identification of long and short range placement needs, protection of legal and human rights, etc. This team has been functioning since March 1975. As of February 1976, 86 clients have been reviewed, individual client needs identified and a corresponding treatment/training plan developed. According to an NMHI administrator, about 50 percent of the activities identified in these plans have been deferred due to inadequate staff. The deferment of needed activities is seen by NMHI staff as discouraging but it is perceived as a tool to identify more accurately the kind and number of staff required and to further identify staff training needs.

About 43 percent of the mentally retarded residents of the Institute are from Clark County (which has about 56 percent of the Nevada population), 34 percent are from Washoe County (which has about 24 percent of the state’s population), and 23 percent are from the remaining primarily rural counties (which have about 19 percent of the state’s population). As of June 1974, the median length of stay for retarded residents at the Institute was about 10 years; 49 percent had been there over 10 years, while only 23 percent had been there less than 5 years, and only one percent less than one year. About 55 percent of the NMHI mentally retarded residents were 18 years of age or over in 1974; only 2 percent were less than 5 years old.\textsuperscript{63}

The Institute’s psychologist has conducted a study of mentally retarded resident activity.\textsuperscript{66} Residents were observed over a period of weeks at random times between the hours of 9 a.m. and 11 a.m. each day. A resident was counted as active “if he is doing a chore, grooming himself, reading or writing, conversing with another person, or using recreational materials.” Of the 95 residents on Wards 1 through 4 at the time of the study, the daily average number of active persons was 6 prior to the time attempts were made to induce the ward staff to increase activities. First, a memo was sent instructing all staff members to lead daily activities, and some days later a short workshop was conducted to teach them how to do so. Several more days later, specific staff members were assigned to be activity leaders, and performance feedback was provided by posting the daily average number of active residents on each ward. The study found that “Neither the memo nor the workshops motivated staff to lead activities, but after staff were scheduled to lead activities and given performance feedback the average daily number of residents engaged in activities on four wards for 95 retarded persons increased from 7 to 32.” The author of the study indicated to us that when the experimental scheduling and staff performance feedback was stopped, activity returned to its previous low level. However, the most important observation is that during prime hours for activity (9 a.m. to 11 a.m.) only 7 of the residents were active on the average. The rest were “... usually napping, staring, rocking, pacing, or engaged in stereotypies.”\textsuperscript{67}

Another study was conducted on ward 5, which had about 25 residents. A demonstration program was created to measure purposeful activities of residents and to teach staff to lead activities. Prior to the demonstration, observations were made at

\textsuperscript{63} Data in this paragraph are taken from Rehabilitation Facility Plan, 1975-80, Rehabilitation Division, Nevada Department of Human Resources, Carson City, Nevada, January 1, 1975.


\textsuperscript{67} Ibid. Stereotypy is defined as the frequent and almost mechanical repetition of the same posture, movement, or form of speech.
half-hour intervals from 8 A.M. to 4 P.M. for several days. It was found that the average number of residents engaged in purposeful activity ranged from one to two. It also was found that when the planned activities were instituted, this figure quickly rose to an average of 12 residents. After the demonstration program was stopped, it was found that the average number of residents engaged in purposeful activity "dropped to zero."68

According to the NMHI psychologist, the staff incentive structure needs to be changed.69 He said the staff realizes that people visiting the NMHI can see the cleanliness and orderliness there, and the staff know that they are more likely to be criticized for lack of cleanliness and order on the ward than they are for inactivity of residents. Also, NMHI is inspected at random times by Health Division personnel who have the power to order correction of "cleanliness" deficits.

To begin to resolve the problem of lack of resident activity and training, a new Day Training Center has been created in one building at the NMHI, using existing mental retardation unit staff. Unit staff accompany a small number of clients (5-10) from their unit to the Day Training Center. In the Center, both the staff and the clients are assigned specific activities; the staff are consistently assigned to the same clients. Clients are involved in either one-to-one or small group training activities that are in keeping with the client’s skill deficits. The supervision of these activities and the curriculum have been developed by a staff member who has formal educational preparation and has served a one year internship under the NMHI Psychologist. A second feature of the center is that the staff receive on the spot training and immediate feedback from the supervisor of the Center. However, the primary focus is on the client’s training and staff’s interaction with the client. The schedule has been coordinated so that the client attends the Day Training Center during those periods of the day when there are no other scheduled activities for him or her. The Center is then supplemental to other activities such as school, occupational therapy, physical therapy, etc., and is alleviating "dead time" on the units.

According to NMHI administrators, this program is only embryonic at present, convening 5 days per week from 8:00 A.M. until 5:00 P.M. The program administration has been actively pursuing additional sources of funding for the program. If additional staff can be obtained, this program can be offered to severely and profoundly retarded persons living in the community as an extension of their present activities. It could be available 7 days per week, 16 hours per day. As more clients are placed in living environments outside of the Institute, but in the general area of Reno/Sparks, they could continue to utilize the service. The longer range NMHI plan would place this day training center for severely and profoundly retarded persons in a community setting away from the NMHI grounds.

During our visits to the Institute, we were struck by how few mentally retarded persons there were outside off the wards, even in midmorning and midafternoon on beautiful spring and summer days. Outdoor recreation facilities seemed to be used but little. On the baseball diamond the grass between home plate and first base was growing as vigorously as it did in the outfield, and the weeds under the monkey bars in the play area were a foot high and untrampled. In the summer, retarded residents are allowed outside on the grounds (although on all but one ward they must be

69 Interview with H. Robert Quillitch, NMHI, Sparks, Nevada, November 15, 1974.
escorted by staff), but in the winter they are kept inside on the orders of an Institute medical doctor. When asked why retarded residents were not escorted off the wards more often, ward technicians said they were too busy. The director of recreation therapy for the Institute also indicated that retarded residents do not come because the locked wards lack staff to escort them.

Retarded residents do very little work. In mid-1974, five of the 140 retarded residents worked in paid "industrial therapy" jobs at the Institute, and seven participated in a sheltered workshop in Reno. Two portions of the Institute—the laundry and the kitchen—that could be used for industrial therapy to build vocational skills of residents and thus facilitate deinstitutionalization, reportedly did not accept mentally retarded workers.

About two-thirds of the retarded residents of the Institute were on what the MR administrator called "control" drugs (not including antispastic or anticonvulsive drugs). The general practitioner physician specified the type of drug and dosage. The nursing staff supervised the administration of the drugs and told the physician if they thought the drug or dosage needed changing. Basically, we were told the nurses interact with the residents regularly, and the physician usually sees a resident only if he or she is sick or needs an annual physical. The physician, however, must sign each resident's chart monthly. At the time one of Rand's physician-consultants visited the MR wards, three residents had what might have been major Thorazine reactions. Medical supervision of residents appeared to be minimal. The special education teachers at NMHI alleged that not all the young residents they served had had hearing or vision tests, and that at least one child had not received needed glasses. The rather extensive use of drugs, and what appeared to be relatively minimal medical supervision of retarded residents, is probably an additional manifestation of the small staff size.

Psychological counseling or psychiatric services are not regularly provided directly to mentally retarded residents of the Institute, not even to those with mental health problems. Institute psychiatrists do not work with any retarded residents. The one full-time psychologist, who must serve the entire Institute, not just the mental retardation section, attempts to help other staff members help residents since he has insufficient time to help the residents directly. The psychologist recently helped set up a toilet training program, reportedly spends 5 to 10 hours per month counseling staff members on how to help individual residents, and directly served one resident in 1974. (An aversion-therapy behavior modification program—in this case employing a cattle prod—was used on a resident who was physically abusive of herself and others). More recently, the psychologist has led problem solving groups for ward 4 residents.

At the time of our visits, each of the five NMHI Mental Retardation wards was staffed during the day with three or four "technicians," including a supervisor, who typically have no prior training in working with mentally retarded people. The evening and night shifts have one or two such technicians. The technicians are assisted professionally by one clinic administrator, who is in charge of all MR activities at the Institute, only one social worker, and five special education teachers (beginning only in 1973 and serving only residents aged 18 or less). Since 1974, one technician position has been reclassified to a master's level social worker position; the current two social workers also have 1½ full-time-equivalent staff assistants.

70 Interview, November 22, 1974.
The technicians also receive part-time assistance from the following types of personnel, who also serve MNHI’s geriatric and neuropsychiatric residents: one medical doctor, one psychologist, one physical therapist, occupational and recreational therapists, and nine Institute nurses. Two of the wards also benefit from several half-time “foster grandparents” (who outnumber the regular staff on those wards during the day). Thus, the 1974 direct-service staffing for the 140 residents numbered about 25 to 30 full-time-equivalents on the day shift and 5 to 10 on the evening and night shifts. The total direct-service staff for mentally retarded residents is 65. This level of staffing is clearly insufficient to provide adequate services and programming for the residents, as attested to by the JCAH non-accreditation rating as a facility for mentally retarded people. Full details of that non-accreditation rating are discussed later in this chapter and in App. B. The administration of the MR section of the NMHI clearly recognizes and acknowledges the deficiency in the level of staff, and requested a total of 72 new staff members prior to the 1975 legislative session. Before that request left the Division of Mental Hygiene and Mental Retardation, it reportedly had been pared by higher-level administrators of the division from 72 to 3½ new staff members for the mental retardation section of NMHI. The Governor’s office subsequently cut the request even further, and recommended that the legislature fund only three new staff members for the entire Institute (including the alcohol and drug abuse, mental health, and mental retardation sections).

The Institute’s medical director71 indicated to us that he would much prefer asking the legislature for the total staff needed, so that legislators will vote on staffing with full knowledge of the need, but he said he is not allowed to do so. The insufficient staff situation in the mental retardation section of the Institute was described in more graphic terms by that section’s administrators:

“We’re keeping the pants dry and puddles off the floor.”

“We couldn’t function without foster grandparents.” “On days when they’re not here [the foster grandparents], I’m not sure they [the residents on Ward 1] get three meals a day.”

“[A program for an individual is] a euphemism here.” “[We have] the ability to design a beautiful program but don’t have the people to implement it . . . . A small percent are being given a real program.”

“[More staff is needed because] we in essence teach abnormal behavior in this environment.”

The orientation and training program for new staff members (“technicians”) of the MR section of the Institute is two weeks in duration (as of 1974). During the first week the new staff member spends half the time in class and half the time observing other staff members. Class time is primarily devoted to administrative matters and is reportedly administration and maintenance oriented, not service oriented. However, a library is maintained for new staff members and one videotape training aid (“The Dentist”) had been prepared. The second week of orientation finds a new staff member working on all five wards and on all shifts, on a rotating basis. By the third week on the job, the new staff member is working at his or her regular assignment. The greatest deficiency in training new staff members was in teaching them how to train residents and help them develop their functional abilities. Ongoing on-the-job

71 Interview with Dr. V. LoCicero, August 20, 1974.
training for staff members was mostly not training-oriented either; it covered such subjects as safety, record-keeping and charting, and dental care. Approximately two hours per month of ongoing training were available to each employee, but attendance was not mandatory. As of June 1975, the toilet training program mentioned earlier involved the instruction of three staff members for from 40 to 80 hours in how to train the residents. The new day training center for residents currently provides some opportunity for on-the-job training of staff members. Still, the level of staffing is inadequate, and technicians are not adequately trained to fulfill their program responsibilities.

The Institute's director was aware of the problem of the lack of staff training; he frankly admitted, "We don't have adequately trained staff." Note that the training provided is significantly less than what is officially required for mental health technicians (see above, "NMHI: Mental Health Program").

Supervision of existing staff appears to be minimal. The administrator of the MR section is the supervisor of the ward managers, but indicated there is not enough time to really be on the wards and see what is happening, and therefore "the ward manager is pretty much on his own."

**Description of NMHI Mental Retardation Wards**

This section describes the mental retardation wards as they existed in mid-1974. Since that time the living units have been reorganized. There are currently four residential units, and an NMHI administrator indicated that this relocation has not necessarily improved clients' living quarters, but it has facilitated better utilization of direct care staff. The new units are organized as follows: Unit A is for 22 people who are at a non-ambulatory profound retardation level of functioning (see the AAMD definition in Chap. 3) and have restricted mobility; Unit B is for 20 people who are independently mobile, have limited aggression, have the beginning of self-help skills, and are of small stature; Unit C is for 33 people with a profound to severely retarded level of functioning who are independently mobile and have limited self-help skills; Unit D is for 33 people who are responsibly mobile, have independent self-help skills, and severe to lower range of moderate retardation.

**MR Ward 1.** In August 1974, this ward had 34 nonambulatory severely and profoundly retarded residents who, typically, also were physically handicapped. The age range was 3 to 28 years, but only two residents were over age 21.

The technician staff devoted about an hour a day to activity (such as playing with a ball or finger painting) other than feeding, changing diapers, and dressing the residents. The day-shift technicians reported spending about 6½ hours out of 8 in merely feeding the residents. The ward staff indicated they were very dependent on the foster grandparents who assist on the ward.

The Institute's Clinic Administrator for Mental Retardation indicated that some of the nonambulatory residents on Ward 1 might become ambulatory if they received orthopedic surgery for uncorrected problems. However, such surgery is classed as "elective," and neither the Institute nor the Crippled Children's Service (see the medical services chapter of this report) had funded such surgery for all mentally retarded people who reportedly need it. There were also said to be very few

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72 H. Robert Quillitch, NMHI, Sparks, Nevada, as reported in *Nevada State Journal*, June 5, 1975.
73 Interview with Dr. V. LoCicero, August 20, 1974.
funds available for prosthetic and orthotic devices. A local man repaired existing devices free of charge for the state-funded Institute.footnote{74}

Equipment was very scarce on the ward. Even the wheelchairs were purchased by private groups. The playground equipment consisted only of sewer tiles and rubber balls.footnote{76}

**MR Ward 2.** In August 1974, most of the 21 residents of this ward, aged 3 to 17, were ambulatory. The program emphasis on the ward staff was on training in self-help skills. All ward residents also were eligible for special education and training from the Washoe County School District with partial state financial support, and all but two were served for up to 5 hours each school day. However, the state did not provide the school district with enough teachers to serve all residents of ward 2. In fact, nearly half of the mentally retarded residents eligible for special education and training at the Institute were not receiving it, because of lack of funding for staff (see Chap. 7 on special education and training for details and our recommendations).

The atmosphere on ward 2, the Institute’s "showcase" ward, was markedly better than that on the other four wards. Many playthings and personal possessions were in evidence, a stereo was playing, the walls were gaily decorated, the door to the well-equipped fenced play yard was open, and staff members and foster grandparents were working actively with the children on each of our three visits. This ward was the most pleasant and homelike; when we asked why it was physically different from the others, we were told that the facility and play yard were fixed up with volunteer and ward-staff work and funds, rather than the Institute facility improvement staff and funds.

Ten foster grandparents were assigned to this ward. Children were outside 3½ hours a day (much longer than in any other ward), and the ward 2 playground had adequate equipment. During meals some children received training in how to feed themselves, and we also noted walking and grooming training in progress. We contrast this ward with wards 3 and 5, where we saw no staff members working with residents to improve their functional skills on any of our three or four visits to those wards. On Ward 2, other activities included one hour of guitar playing and singing daily, plus a field trip each week to such places as a petting zoo. A physical therapist came to the ward one half-day a week and concentrated on teaching the ward staff and foster grandparents how to provide physical therapy for the children. The programming for the children on this ward appeared to be much more adequate than that for residents on the other wards.

**MR Ward 3.**footnote{76} This locked ward was home for 24 retarded people aged 13 to 31 years in August 1974. These were mostly long-term Institute residents. One group on the ward (approximately 7 people) function as mentally retarded people but we were told they were childhood schizophrenics who were "not mentally retarded as children, according to the records," and were not receiving any psychiatric services in 1974. This may be one tragic consequence of inadequate service in the past, and the deficiencies in service to Nevada children with mental health problems still persist. A second group of residents on the ward consisted of ambulatory but abusive patients. The treatment program on this ward was described as "primarily chemoth-

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footnote{74} Interview with D. Davis, Clinic Administrator for Mental Retardation, NMHI, Sparks, Nevada, August 20, 1974.

footnote{75} Ibid.

footnote{76} Interviews with D. Davis and D. Edwards.
therapy" with "a little" use of behavior modification techniques. All but two of the residents were on psychotropic drugs (not including antispastic or anticonvulsive drugs).

Activities on ward 3 included a one-hour bus ride for all residents once every two weeks; a visit to the canteen for about four residents daily; one hour of arts and crafts (occupational therapy) for about ten people once a week; use of the play yard, typically once every two days for an hour or two; playing of records two or three times a week; and swimming twice a week in the summer. On days when those activities were not going on, an hour of puzzles and games was typical.

Four residents were receiving toilet training (a newly instituted training program) at the time of our visits, and in the course of getting residents dressed and feeding them, some minimal training in those skills was provided.

The list of activities described may sound impressive until one realizes that, aside from the custodial services of keeping residents dressed and fed and giving them a place to sleep, the NMHI provided ward 3 residents at most with only an hour or two of meaningful activity each day. The rest of the time was spent on a locked sterile ward with almost no personal possessions.

In August 1974 this ward and ward 5 were little better than human warehouses. When asked, the Institute staff could in honesty say they had many different programs and activities for these residents, but in reality the residents were exposed to those programs and activities only for short and infrequent time periods.

**MR Ward 4.** This 34-bed unlocked ward served two different groups of people. Approximately half were higher-functioning adults, all of whom had self-help skills and were sent by Institute bus to a local sheltered workshop or to independent jobs. Clearly, not all of them needed to live in the Institute; some should have been transferred out as soon as space could be made available in the mental retardation centers. Ward staff members we interviewed also felt that many of the residents of this ward could leave the Institute permanently if they had someplace to go. The two primary factors delaying deinstitutionalization of these people appeared to be the lack of adequate special education and training for them (see Chap. 7), and the lack of space in the MR Centers due to a lack of funding for more developmental homes in the community (see Chap. 13). The second major group of people on this ward consisted of ambulatory adult retarded persons who were functioning at a prevocational level. Psychotropic drugs were provided to about one-third of the residents of this ward. Personal possessions and recreational materials were in evidence here, but the relatively sterile institutional atmosphere was still predominating.

Activities for residents of this ward included working half-time at jobs within the Institute (3 people are on this "industrial therapy" program); attendance full-time at the Washoe Association for Retarded Citizens work activity center and sheltered workshop in Reno (7 people—see Chap. 11 for a description of the program); recreational therapy (about 2 people per day); swimming in the summer (approximately 8 people per day); bus rides (about 10 people for one hour once every 2 weeks); overnight passes or home visits (1 or 2 people a week); passes for shopping trips (about 6 people a week); dancing lessons at Arthur Murray's (4 people); a dance at the Institute about once a week (all residents); arts and crafts once or twice a week (all residents as a group); and a movie once a week at the Institute (about 20 residents).
Despite the fact that this ward had the highest-functioning adolescent and adult residents at the Institute, and the Institute's goal was to release many of them into a less dependent living arrangement, none of the residents received special education. The reason was that all are over age 18 and hence beyond the age range served by the special teachers at the Institute, even though they needed extensive special education and training to facilitate the deinstitutionalization goal.

The ward staffers also indicated that "male-female acting out" (sex) was a problem. According to them, Institute policy is to "ignore" sexual activity between consenting older retarded residents that did not take place in an open area; however, it is very strongly discouraged by the manager on the ward. All females received birth control services, but no residents received sex education despite the fact that this ward had the highest-functioning residents of all five wards and many were leaving the Institute on a day or overnight basis, or would soon leave the Institute for less restricted living arrangements. The Vocational Rehabilitation program was serving only two residents in mid-1974. Although the ward manager felt that all could benefit from the sheltered workshop and training provided by the Washoe Association for Retarded Citizens, not all the residents were in that program, reportedly because it was operating at the maximum client capacity allowed under Community Training Center rules (a maximum client-to-staff ratio of 5 to 1 was set for the CTC program by the Division of Mental Hygiene and Mental Retardation), and the WARC had no more Community Training Center funds from the division to hire more staff. The WARC also did not have facility space to greatly expand its services. Again, we see the phenomenon of a good program so seriously underfunded that it could not provide service for many people in need.

**MR Ward 5.** This locked ward was "home" for 29 ambulatory severely and profoundly retarded people aged 16 to 55 years. Their average stay at the Institute had been 12 years. Residents were mentally retarded, autistic, or functionally retarded childhood schizophrenics. All but two could feed themselves, four were being toilet-trained, and six were regularly engaged in arts and crafts (occupational therapy). Only two were allowed to leave the ward unescorted. All the rest were said to be on tranquilizing medication. Residents had access to a fenced play area and a pool during certain hours of the week. The pool was above ground. It was used only during the summer and was shared by all retarded residents of the Institute.

When we visited the ward unescorted and unannounced, we found all the bedrooms locked and the residents sitting in or milling around the very sterile commons room. No activities or personal possessions were in evidence. The staff members were closeted in their office. Our later visits did not dispel our initial impression of bleakness. Striving to find something positive to say about this ward, about the best we can do is note that it was clean and the residents were up, clothed, clean, and dry. The two staff members in charge of all mental retardation programs at the Institute agreed that "there is nothing going on up there."\(^7\) There was about one hour of activity in the morning and typically a walk in the evening during nice weather.

**Foster Grandparent Program**

The federally supported foster grandparent program expended about $143,000

\(^7\) Ibid.
in FY 1975 to provide retired citizens aged 60 and over with half-time jobs working with mentally retarded children up to age 18. The number of people employed was expanded from about 60 in 1974 to 88 in 1975 with state funds supplied by the 1975 session of the Nevada Legislature. They are employed at NMHI's Mental Retardation Section (35 foster grandparents), the Northern and Southern Nevada Mental Retardation Centers (5 and 8, respectively), several Community Training Centers (4 in Carson City, 4 in Hawthorne, 4 in Elko, 6 in the Washoe Association for Retarded Citizens Center), and in other public and private facilities for children such as the Special Children's Clinic, Head Start, and other nursery schools. In addition to their direct pay, foster grandparents receive annual physical examinations, and a meal each day at most of the facilities to which they are assigned. Each foster grandparent receives initial orientation and training, which lasts about 40 hours.

Regarding the value of these employees, we note that on four separate occasions, staff members of the basically staff-starved MR section of the NMHI told us that the foster grandparents were greatly needed and appreciated (e.g., one told us "the hospital couldn't function without them"). In two places, however (one of the state mental retardation centers and one of the community training centers), we were told that the foster grandparents gave a little too much tender loving care and should be more insistent that the retarded children learn to do things for themselves. This slight difficulty, if it exists in more than a few isolated cases, might be remedied by more or different training and supervision.

Community Placement Grant

The NMHI was recently awarded a $65,000 grant for a project entitled "Community Placement of the Severely Retarded" by the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare. According to the grant proposal:

The objective of this proposal is to generate a community group home for severely handicapped institutional residents, with accompanying programs. The following elements are proposed:

- Establish a group home in Washoe County, Nevada housing 8-10 severely mentally retarded persons now in residence at the Nevada Mental Health Institute.
- In addition to regular and relief houseparents the home will have a program specialist. This position will be responsible to provide appropriate activities and to recruit, develop, and coordinate volunteer and community program resources.
- Program support will also be provided from 2 one-half time Public Service Interns recruited from the University of Nevada. Another one-half time Public Service Intern, paid for through state funds, will be assigned 100% to this project.
- Project coordination will be provided by Ms. D. Davis with training and evaluation supervision under the direction of Dr. L. L. Beermann. Overall project direction will be the responsibility of Dr. T. Piepmeyer.

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78 Interview with J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 5, 1975.
79 Ibid., August 6, 1975.
From the project goals and tasks, it appears that this activity would be most appropriately conducted by the Northern Nevada Mental Retardation Center. The center already has the expertise, and is responsible for developmental homes in northern Nevada and for service programs to people in the transition stage between needing full inpatient NMHI service and sheltered living in the community. With the Institute's program for mentally retarded people as deficient as it is, it makes little sense for the Institute to take on new and different responsibilities that greatly overlap those of the Mental Retardation Center.

**Computerized Individual Client Data Base**

During 1974 the Division of Mental Hygiene and Mental Retardation began to use a computerized, individualized data base for mentally retarded clients of division programs. This data base, developed in and using a computer in Pomona, California, is sufficiently detailed to provide not only data and reports on clients or groups of clients and the services they are receiving, but also information on clients' functional abilities that could be used for program evaluation. In mid-1974, this data system had at least partial information on over 375 mentally retarded clients of the division. This computerized data base appears highly desirable in theory, and we endorse it or one with similar objectives tailored specifically to Nevada's needs. Two improvements would be desirable, however. First, to be of most value in seeing that mentally retarded people throughout Nevada get all types of services they need, the data base should not be limited to Division of Mental Hygiene and Mental Retardation clients, but should also include retarded people served by other programs, e.g., Department of Education, Division of Health, Division of Welfare, and Division of Rehabilitation. Second, the mid-1974 plan was to use a computer in Pomona, California, with information transferred by mail. It would be desirable eventually to have the data base on a Nevada computer, where it can be used more readily and can be tailored to Nevada's needs. The data base should be associated with the Regional Direction Centers we recommend in Chap. 4, if those centers are created.

**Non-accreditation of the NMHI Mental Retardation Program**

Despite public claims to the contrary by the Division of Mental Hygiene and Mental Retardation, which may be one reason the Nevada Legislature has not provided adequate staffing and funds, the NMHI is not "fully accredited by the national Joint Commission on Accreditation of Hospitals... for mentally retarded persons..." The Institute is accredited as a psychiatric facility by JCAH, but failed to receive accreditation as a facility for mentally retarded people in both 1974 and 1975. Both the 1974 and 1975 JCAH non-accreditation reports are presented in App. B. In summary, the following were some of the Institute deficiencies in the category of mental retardation in 1974:

- Staffing of the facility should be sufficient, so that the facility is not dependent upon the use of residents, volunteers, or foster grandparents for productive services.

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81 "Nevada's Mental Health and Mental Retardation Services," Division of Mental Hygiene and Mental Retardation descriptive brochure, January 1974, p. 9, and *The Executive Budget*, p. 307.
• The facility should have an active and appropriate staff training program that includes induction training for each new employee and continued inservice training for all employees.
• Chemical restraint should not be used excessively.
• The design, construction, and furnishing of resident living units should be appropriate to the program. Furnishings should be comfortable and homelike.
• In addition to adequate resident living services, residents must also be provided with the professional and special programs that they need.
• Educational services should be made available to all residents.
• Sufficient psychological services should be provided to facilitate the optimal development of each resident.
• The facility should provide all of its residents with habilitation and rehabilitation services that will insure the optimal development or restoration of each.82

The 1974 non-accreditation report concludes with the following largely negative "Summary and Conclusions:"

The Mental Retardation Program of the Nevada Mental Health Institute is severely handicapped by physical facilities that are not well suited to a modern mental retardation habilitation program. Furnishings are inadequate and in poor condition. While some isolated attempts at improvement are evidenced in newly remodeled bathrooms and in some nicely decorated dormitories in one of the five wards, the overall physical environment is basically sterile and impoverished. The staffing of the mental retardation unit is extremely sparse. There are from two to four direct-care staff on the wards during the first two shifts, and one direct-care staff member on the wards during the third shift. Some badly-needed professional expertise, such as speech and hearing, is not represented at all on the staff that is available to the unit. Other professions, such as psychology and physical therapy, have less than one full-time staff member providing services to the program. The remainder of the special services, except for medicine and dentistry, do not have enough staff members to provide services to all the residents who need them. The foster grandparent program, with a staff of 32, does provide a variety of services to residents. Working four-hour shifts, five days a week, the program makes a valuable contribution to the mental retardation unit.

Programming decisions are made in one of three ways: direct intervention by medical personnel; contractual, cooperative agreements between ward personnel and special service staff; or team decisions by direct-care staff supervised by nursing personnel under the direction of the clinic administrator. None of these methods, of course, conform to the requirements for interdisciplinary evaluation and programming for each resident.

The staff does demonstrate a determination to improve services for the residents. In spite of only nominal community support and distressing physical conditions, it is encouraging to see this resource. It should be an invaluable asset to the envisioned progress of the program.

Considering the limitations of architecture, furnishings, and personnel resources available to the facility, it is unfortunate that no organized attempt is being made by community or parent organizations to meaningfully support the facility's staff in their attempt to secure additional resources. . . .

Rating by Accreditation Council, February 26, 1974: No accreditation.83

The 1975 non-accreditation report noted certain improvements, but the basic

83 Ibid.
deficiencies in program, level of staffing, and facilities remained. Excerpts from the 12-page list of deficiencies are given below:

- The facility remains unable to provide all the services needed to ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. Deficiencies exist in the provision of certain aspects of normalized living experiences to all residents, especially residents of Units 3 and 5, and services in speech development, education, psychology, recreation, and physical therapy are insufficient to meet the needs of the residents.
- Due to insufficient staff and the number of residents whose behavior problems are not under control, living unit staff still find it difficult to train residents in activities of daily living and in the development of self-help and social skills, especially in Unit 5.
- Additional food service staff is necessary to adequately supervise the serving of food to the residents, and the dining room should be sufficiently staffed for the direction of self-help eating procedures and to assure that each resident receives an adequate amount of food. Additional education, nursing, physical therapy, psychology, recreation, religious, social services, and speech and hearing staff are needed to provide each resident with the necessary and appropriate evaluation and therapy services.

The 1975 non-accreditation report ends with the following largely negative but hopeful conclusions:

The Mental Retardation Program of the Nevada Mental Health Institute has continued its difficult evolution toward achieving a developmental and training orientation for meeting the needs of its residents. Once the stepchild of a large psychiatric program, the Mental Retardation Program has made considerable progress in establishing its own identity. It is hoped that, with the guidance of a new administrator and with financial support from the state, this program will eventually be able to provide the services necessary to meet the needs of all its residents.

Difficulties still remain due to insufficient staff at both the direct-care and professional levels, as well as inadequate living unit design and furnishings. Progress has been made in Unit 4, where residents enjoy a more homelike atmosphere and maintain their own possessions, but Units 3 and 5 still lack the barest semblance of a homelike or normalizing environment.

Staff are enthusiastically undertaking a new interdisciplinary process which should, in time, bring the facility into compliance with the standards regarding the team's membership and function.

The community is becoming more aware of the needs of the residents in the program, and hopefully, will be helpful in persuading state officials to provide adequate funding for better staffing ratios and better living conditions for the residents. . . .

Rating by Accreditation Council, June 11, 1975. No accreditation.\textsuperscript{84}

Requesting a survey for accreditation is a voluntary matter, with part of the survey cost borne by the requesting institution. Since the establishment of the Accreditation Council for Facilities for the Mentally Retarded of the JCAH in 1973, 100 facilities have thus far requested surveys, and by the fall of 1975 evaluations had been conducted on 92. Of these, 30 percent received accreditation.\textsuperscript{85}

\textsuperscript{84} Ibid.

\textsuperscript{85} In California, for example, the Mental Retardation Program at Camarillo State Hospital and the Comprehensive Developmental Training Center at Napa State Hospital are both accredited as Residential Facilities for the Mentally Retarded by JCAH (mimeographed list of accredited facilities provided by Dr. T. Crosby, JCAH, Chicago, Illinois, dated July 20, 1975).
According to the council chairman, Dr. T. Crosby, the main purpose of the survey is to provide a method of program evaluation rather than to provide accreditation. The impetus of the survey is to improve services.

The council’s standards are established to bring mental retardation services up to an acceptable minimum level. Whereas the mental health portion of the NMHI meets most, but not all, of the minimum standards established by the JCAH, the mental retardation section of the Institute falls below acceptable minimum standards.

Since the mental retardation wards are part of the NMHI, accreditation of the whole facility can be lost if a portion of the facility fails to be accredited after four consecutive tries. This could mean the loss of certain federal funds, such as Medicaid.

The Nevada Division of Mental Hygiene and Mental Retardation is aware of the problems with service to mentally retarded people at the Institute; the Associate Administrator for Mental Retardation indicated that his strategy is, “If we can’t replace it or improve it, we’ll vacate it.” In fact, the census of mentally retarded people at the Institute fell from 140 people in mid-1974 to about 110 in August 1975, and no mentally retarded person from the Las Vegas area has been newly admitted to the Institute in the past two years. However, the associate administrator indicated that there are probably retarded people being kept in the community in Las Vegas who need full-time residential care and training but whose families are waiting for the opening of the new Desert Developmental Center rather than sending them to the Institute.

The principal of the Helen J. Stewart School in Las Vegas, which serves only trainable and more severely mentally retarded youth, claimed with apparent justification that some of NMHI’s retarded residents could be effectively served by the Helen J. Stewart School or Variety School in Las Vegas (at $3500 per year per child), while living with their families or in foster homes. They could do so, that is, if they were from Clark County instead of some other Nevada county that does not have a comparable excellent special education program for more severely handicapped children.

DESSERT DEVELOPMENTAL CENTER

The Desert Developmental Center, a $2,495,000 Division of Mental Hygiene and Mental Retardation facility, is to be constructed in Las Vegas. It will provide a broad range of services for mentally retarded southern Nevadans, from fully dependent residential care for the most profoundly retarded nonambulatory people, to training for less severely retarded people, to help them progress to the least restrictive environment in which they can become capable of living. Outpatient services, training of families, counseling of families with retarded members, and follow-up services for former residents are also planned.

86 Telephone interview conducted September 1975.
87 Interview with J. Middleton, August 5, 1975.
88 Ibid.
99 Interview with Dr. Robert Foster, Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.
90 "Desert Developmental Center," Nevada Division of Mental Hygiene and Mental Retardation, 1975.
The new center will consist of five distinct facilities: a service facility for outreach services and support staff; a residence for about 8 people, located in the community and used for training the residents for transition to a less dependent living situation; two residences for longer-term care and services to about 28 multihandicapped severely and profoundly retarded people; a residence for about 8 retarded people to be used to provide intensive training for those with behavior problems; and a residence for about 12 retarded adults, to be used for training the adults to move to more independent living situations in the community. The facilities would provide residential services to about 56 retarded people, and have a proposed staff of 61, who would not only serve those 56 but also provide some services each year to approximately 150 nonresidents (for a total of 200). In early 1976, a staff of nine were beginning to implement the community-based component of the center.

The stated intention of the Division of Mental Hygiene and Mental Retardation is to remove all 51 mentally retarded southern Nevadans from the NMHI residential program in Sparks, to place them in another residential program in Las Vegas, and (to the extent the capacity of the Desert Developmental Center allows) to prevent sending any retarded southern Nevadans to the Institute in the future. (In fact, as we indicated earlier, none have been sent to the Institute from Las Vegas for the last two years.) Note that the residents to be moved from the old Institute to the new center will still be in a 24-hour residential care setting (albeit a nicer one nearer their families). Services necessary to train these people to the point where they can live in a less dependent program could be offered either at the Institute or at the center. Our point is that the goal of deinstitutionalization is furthered more by the improved services than by the new facility. The improved services could also be provided at the Institute if it had sufficient staff, which the legislature has not approved for the Institute but apparently will approve for the new Desert Developmental Center since it has approved the center's construction. This point about services as distinct from facilities leads us to another future Division proposal.

The division also plans to request funding from the legislature in its next session in 1977 for another "Desert Developmental Center" for northern Nevada.\textsuperscript{90} If the legislature approves that request, the NMHI's mental retardation section will be vacant. Consequently, rather than attempt to improve services at an old and somewhat unsuitable physical facility, the division apparently plans to abandon mental retardation services at the Institute.

**EAGLE VALLEY CHILDREN'S HOME**

The Eagle Valley Children's Home in Carson City is a private nonprofit residential facility, primarily for severely and profoundly mentally retarded children.\textsuperscript{92} It has a capacity of 25 residents, but since September 1974 has usually served only 10. It does not advertise for additional residents.

The home was started for a trainable mentally retarded son of the founders. The rest of the children are severely and profoundly retarded, aged 4 through 8 years. Most are multiply handicapped. Charges are $300 per month per person, and 5 of

\textsuperscript{90} Letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, to J. Kakalik, The Rand Corporation, January 21, 1975.
\textsuperscript{92} Interview with M. Tomlinson, Eagle Valley Children's Home, Carson City, Nevada, September 20, 1974.
the 10 clients receive their payments through welfare. Medicaid pays for health care for those on welfare, above the $300 per month; privately financed residents pay extra for medical services. Three of the residents attend the Ormsby Association for Retarded Citizens’ School for physical therapy and training. The remainder are provided residential and nursing services, plus daily recreation and physical exercise. While separate legal entities, in 1976 Eagle Valley is under the administration of the director of the Ormsby Association for Retarded Citizens.

The Eagle Valley facility is licensed as a child care home. The physical plant is homelike in atmosphere, with well-decorated, pleasant, and well-kept rooms. Aside from the NMHI, it is the only residential facility for severely and profoundly retarded children in Nevada.

The staff consists of three persons on the day shift and two persons each on the evening and night shifts. The nurse-director has 15 years’ experience as a registered nurse and 5 years’ experience working with mentally retarded people in Illinois. All staff have had a first aid training course and are informally trained by the nurse in charge as necessary.

NORTHERN AND SOUTHERN NEVADA MENTAL RETARDATION CENTERS

The Nevada Division of Mental Hygiene and Mental Retardation operates two mental retardation centers for mentally retarded adolescents and younger adults who are not yet functioning at a level that would enable community living. Both provide residential care and training services. Northern Nevada is served by a 26-bed center in Sparks, southern Nevada by a 28-bed center in Las Vegas.

The centers offer short-term service only (on the order of weeks or months) that will prepare the resident for eventual return to his or her family or other community living (see the discussion on residential living in Chap. 13). People needing long-term residential care are served at the NMHI in Sparks, and in the future will be served at the Desert Developmental Center to be constructed in Las Vegas. Most new residents at the centers already have basic self-help skills; the centers’ programs work to increase their social, educational, and vocational skills. Some small amount of consultation and training is also provided to a minority of the resident’s families, as is short-term respite care (of a few days’ duration) for retarded persons whose parents, foster parents, or developmental home supervisors need temporary assistance or are temporarily unable to fulfill their normal responsibilities.

Applicants for residential placement, even court commitments, are considered on a space-available basis using very restrictive criteria. They are considered for admission if: “they are mentally retarded in accordance with the AAMD definition of mental retardation [see Chap. 3]”; “no other resources in the community are available, or can be reasonably developed, that can meet the physical, intellectual, and emotional needs of the applicant”; “it can be shown that the applicant can be expected to benefit from the programs available, or that programs can be reasonably

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93 Interviews with E. Pillard, Clinic Administrator, Northern Nevada Mental Retardation Center, Sparks, Nevada, August 21, 1974, and F. Cline, Clinic Administrator, Southern Nevada Mental Retardation Center, Las Vegas, Nevada, July 16, 1974, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, February 10, 1975.
modified to meet the applicant's needs"; and "wherever possible, there is a commitment of reasonable involvement by parents or other persons designated as responsible guardians." No person is admitted to a residential program if "there is clear, current evidence of an emotional, physical, or psychotic condition that would preclude benefit from the program at the time of evaluation by the Division." When immediate admission is not possible due to lack of space, the division attempts to provide consultation and training for the applicant and his or her family.

Two Interdisciplinary Committees, one for northern and one for southern Nevada, make decisions regarding admission of retarded people to the NMHI and to the mental retardation centers. The committees "serve as the primary point of contact for families, guardians, and other individuals and groups concerned with the disposition and progress of the case throughout the entire period during which any Division services are provided. . ." They review and recommend a course of services for new applicants for services in division programs and for existing clients on an ad hoc and nonperiodic basis as they may require major changes in services. The committees provide some "direction" of retarded people to the most appropriate services within and outside the division's programs (see Chap. 4 for a discussion of the direction service). They do not serve all mentally retarded people, however, but only applicants and clients of the division's residential programs at the NMHI, the two mental retardation centers, and the program of sheltered residential living in developmental homes. Community training center clients, for example, are served with division funds but in practice do not receive the benefit of attention from the interdisciplinary committees.

Each of the two committees is chaired by the clinic administrator of the corresponding regional mental retardation center. Membership consists of "a member of the Division of Mental Hygiene and Mental Retardation's] Mental Retardation Services staff, a regional social worker, a regional psychologist, a regional educational specialist, a regional vocational specialist, a regional medical consultant, and the Clinic Administrator of the Nevada Mental Health Institute—Mental Retardation Units, or his designee." Decisions require the concurrence of at least a two-thirds majority.

Residential care and activities of daily living training are provided directly by the Northern and Southern Nevada Mental Retardation Center staff members. Training techniques are diverse but are primarily "behavior modification" oriented, using positive reinforcement for desired behavior. The centers purchase medical and dental services (including annual examinations) and sometimes speech therapy from local professionals. Special educational services are provided to residents of school age by the county school district. These are supplemented by the work of one or two teachers or teaching aides at each of the MR Centers for residents under age 21 (the federal P.L. 89-313 funds used for the teaching aides cannot be used for residents over age 21). At the time of our interviews, the centers did not provide

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"Admissions Policy Statement," Administrative Memorandum No. 18, revised June 13, 1974, from J. Middleton, Associate Administrator for Mental Retardation, Nevada Division of Mental Hygiene and Mental Retardation, to all staff members, Reno, Nevada, June 21, 1974.

Ibid.

"Interdisciplinary Committee Structures and Responsibilities," Administrative Memorandum No. 16, revised June 13, 1974, from J. Middleton, Associate Administrator for Mental Retardation, Nevada Division of Mental Hygiene and Mental Retardation, to all staff members, Reno, Nevada, June 20, 1974.

Ibid.
mental health services. Residents' families are encouraged to visit, and frequent trips are made with residents into the community for social, recreational, and other purposes to increase contact with nonretarded persons.

The centers work on reducing each resident's skill deficits and sometimes set up contracts with his or her parents whereby, if the child achieves certain skills, the parents will take the child back into the family home. Children without family homes to rejoin can be discharged to private developmental homes in the community for sheltered or semi-independent living (see Chap. 13).

The physical plants of the two centers are nearly identical. They are modern intermediate care facilities, pleasantly furnished, with individual bedrooms off a central area containing living, dining, and kitchen facilities. To the extent of their abilities, residents are taught to care for their own personal needs and rooms, as well as other housekeeping skills such as cooking. Certain physical differences between the centers also were evident. One center had significantly more wall decorations and residents' personal possessions than the other rather sterile one; and one had a padlock on the refrigerator.

The full-time professional staff at the northern center consists of the clinic administrator (a social worker), two other social workers, a nurse, and one teacher. They are assisted by a full-time-equivalent staff of 19, including 14½ full-time-equivalent "technicians," 2 secretaries, 2 teaching aides (paid by a P.L. 89-313 federal grant), a custodian, a groundskeeper, and a cook. The staff has no nurse and no psychologist. A private psychiatrist meets with the northern center staff about twice a month to help with evaluation, prescribe drugs, and counsel the staff on how to work with residents. About one-fifth of the northern center's residents and about one-third of the southern center's residents are on psychotropic drugs.

The Southern Nevada Mental Retardation Center staff of 23 consists of a clinic administrator, who is a nurse with extensive experience in working with retarded people in a residential care and treatment setting, 1½ full-time-equivalent social workers, a teacher's aide, a prevocational skills training and counseling person, 14½ full-time equivalent technicians, a custodian, a cook, a clerk, a secretary, a consultant psychologist who does preadmission testing, and a consultant physician. No other psychologist's or psychiatrist's services are provided. According to the administrator, the few psychotic mentally retarded residents are treated with "behavior modification" techniques.

The southern center administrator occasionally discusses residents with the staff of the Children's Behavioral Services program, but she said the two programs were effectively split as far as day-to-day operations were concerned. Also, the CBS staff uses behavior modification techniques almost exclusively, while some retarded residents at the center primarily need other types of psychological services for mental health problems.

Because reportedly no other program in the state will accept them, chronically schizophrenic young people who have become functionally retarded are sometimes served at the mental retardation centers, even though the program is not fully appropriate for them.** In the recent past there has been no residential treatment program for emotionally disturbed children in Nevada; the neuropsychiatric section for the NMHI does not usually serve children. In the future, however, some cases of functional retardation may be prevented as the total lack of residential treatment

** Interview with E. Pillard.
services in Nevada for emotionally disturbed children is alleviated to some extent by the new Las Vegas Mental Health Center residential program, and the to-be-constructed CBS residential treatment facilities for emotionally disturbed children.

Training for new staff members of the northern center consists of orientation from the clinic administrator and the workshift supervisor, plus a first-aid course; the rest of the training is “on-the-job.” The southern center also lacks a formal in-depth preservice or in-service training program, and the technicians are untrained at the time they are hired; rather, the administrator and the two social workers provide informal on-the-job training.

In August 1974, the northern center had 26 residents, one day-only client, about 10 people placed in their own parents' homes who benefited from occasional respite care and counseling of the parents, 11 people in developmental homes supervised by MR Center personnel, and 10 people on a preadmission screening list (officially there is no waiting list, but people can be kept in preadmission screening for an extended time). The clinic administrator of the northern center indicated a clear need for expanded service capacity of the type provided by the center in northern Nevada.

The southern center typically has 22 to 24 residents, but had three more children in July 1974 who had been admitted for the summer only; the three return home to their families during the months when school is in session. Most residents were moderately retarded, a few were severely retarded, and none were mildly retarded. About half the residents (of both centers) were formerly at the NMHI and are now in a transitional phase as attempts are made to enable them to return to community living. In the summer of 1974 the residents were aged 5 to 30 at the southern center. The center also had five younger clients who were served primarily on a consultant basis in their own homes. One of the residents at the southern center is both deaf and mentally retarded; according to the administrator, no one at the center can communicate well with this child. The southern center staff also supervised 14 persons living in developmental homes in the community in July 1974.

In calendar year 1973 there were 12 residents released from the northern center and 9 residents released from the southern center. In that same year, each center made 20 to 30 respite-care admissions, and each served 6 or less persons on a day-care basis.

Rand staff members talked to half a dozen families of residents. The families were reasonably satisfied with the services received, with two exceptions: the majority cited delays in gaining admission to the center; and they expressed very strong feelings about the need for more counseling of the families regarding their feelings toward their mentally retarded children, counseling about life with the children, and counseling on how to help their children develop. We note that not only are psychological counseling needs of families not being met, but also several of the retarded residents are not receiving needed psychological or psychiatric services. The staffs of the two centers do not have the professional background needed to meet the mental health needs of the mentally retarded residents and their families, and the staffs of mental health service programs in Nevada almost never serve mentally retarded people or their families (even in Las Vegas, where the driveway separating the Mental Retardation Center and the Mental Health Center might as well be several miles wide, so seldom is it crossed in practice). For example, when asked about his Las Vegas Mental Health Center's services to mentally retarded clients,
the administrator's instant response was, "What mentally retarded clients?" Nor do mental health centers ordinarily serve mildly retarded people who are functioning above the level of those served by the mental retardation centers. In practice, consequently, any counseling they receive comes from special education personnel, and only then if the clients are of school age. Nevada's lack of adequate mental health services to mentally retarded people is a major deficiency in the current service system.

Since the mental retardation centers are intended to help residents develop the skills they need to move into less restrictive community living settings, we expected to encounter good vocationally related services. However, of the eight northern center residents over age 18 in August 1974, only three were receiving any state Vocational Training or Vocational Rehabilitation program services (see Chap. 11 for a description of those programs); those three were developing skills needed for sheltered employment. The administrator of the southern center reported that none of her residents were receiving any significant amount of services from the Vocational Rehabilitation program.

In FY 1975 the salary and fringe benefit costs of the northern and southern MR centers were about $221,000 and $239,000, respectively. Travel for staff of the two centers plus members of the division headquarters mental retardation staff was just over $10,000. Other operating expenses totaled about $175,000 (including $56,000 for food, and $27,000 for medical, dental, and other contractual expenses). Thus the total annual operating cost of the two centers combined is about $645,000. This total includes some small amount of division headquarters travel and other operating expenses that do not go directly for the MR centers, but this is offset to some degree by services the mental retardation centers' staff perform on the interdisciplinary committees that are not exclusively related to the center's operations. With an average total resident population at the two centers of about 50, the annual operating expenses per resident were about $12,900, but this includes the cost of services provided to nonresidents, such as those receiving day care and respite care, and the cost of supervising the developmental homes. Thus, the operating cost specific to the full-time residents is less than $12,900 a year, probably around $10,000.

Since FY 1975, the northern and southern MR centers have become certified Intermediate Care Facilities (ICF), and about 70 percent of the clients are eligible for $25 monthly S.S.I. benefits (see Chap. 14 for a description of the S.S.I. program), Medicaid benefits, as well as other ICF reimbursements.

Summer camping experience for some mental retardation center residents and many other mentally retarded Nevadans was provided in 1974 with support from a $35,000 grant by the Max C. Fleischmann Foundation. About 150 mentally retarded children and young adults spent a week (about 50 at a time over a three-week period) at Camp Lodestar in California. Many were from the residential programs at the NMHI and the Northern and Southern Nevada Mental Retardation Centers. Many others learned of the program from staff members of the various community training centers, special education program personnel, and newspaper
articles. The number of staff members and nonretarded campers was about the same as the number of retarded campers. A full week of staff training preceded the encampment. To help defray expenses, a small charge of up to $40 per participant was made to parents and guardians. External evaluations concluded that the program was a rewarding experience for nearly all participants. However, we question the necessity of flying participants from the Las Vegas area to the Reno area and then sending them 160 miles by ground transportation to California, when a similar camping experience (perhaps for smaller groups over a longer time) probably could be provided at existing campgrounds nearer home for less cost and travel time.

The Community Awareness program staff is affiliated with the mental retardation centers and other Nevada facilities. With an FY 1975 budget of $143,000, this program is federally funded under P.L. 89-313, which provides for financial assistance to state-operated and state-supported special education programs for handicapped youth. Nevada's program is serving about 140 mentally retarded youth aged 3 to 21 years in Reno and Las Vegas who are residents of the NMHI and the Northern and Southern Nevada Mental Retardation Centers. The program also assists about two dozen emotionally disturbed children and youth in the day program operated by the Reno Mental Health Center. Both classroom instruction and field trips into the community are used to provide special education and developmental training. In FY 1975 the program was staffed with one special education consultant, four teachers (two at the Reno Mental Health Center and one at each of the mental retardation centers), one teacher's aide, one speech therapist (at the Institute), and 2.5 public service interns. In February 1976, this program had a staff of 13 and an annual budget level of $148,000.

The Division of Mental Hygiene and Mental Retardation operates another small program in the Las Vegas area to train parents and families to deal with the problems of mental retardation in the home setting for people who might otherwise need residential care and training at the NMHI or the Southern Nevada Retardation Center. The program is called "Community Relevant Habilitation for the Developmentally Disabled." It is funded by a small Federal Developmental Disabilities grant (about $30,000 in FY 1975), and operates out of the Southern Nevada Mental Retardation Center. The staff members also perform a "direction" service function (see Chap. 4) by attempting to coordinate a full range of services to individuals. The objectives of this program are admirable, and it is unfortunate that it does not include areas of Nevada outside of Las Vegas; however, given the small staff size of three full-time-equivalents, we doubt that the need for such service is being met even in Las Vegas.

The Mental Retardation Staff at the headquarters of the Division of Mental Hygiene and Mental Retardation numbered 12 in FY 1975, for an annual cost in salaries and fringe benefits of about $166,000. The staff performs planning functions for the growing Nevada mental retardation service system. It also provides some administrative and consultative services not only for the Northern and Southern Nevada Mental Retardation Centers, but also for the to-be-constructed Desert

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101 The Executive Budget.
102 Title I—P.L. 89-313 Proposed Grant, FY 1974-75, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, April 1974, 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.
103 The Executive Budget.
Developmental Center, and for the Community Training Center, resident placement in Developmental Homes, and Community Awareness (P.L. 89-313 special education and training) programs. However, each of those programs also has its own separate administrative staff.

In addition to the intermediate type of residential care and developmental training services provided at the Northern and Southern Nevada Mental Retardation Centers, Nevada has several other intermediate care facilities that do not have a service or developmental training program designed specifically for mentally retarded people, but that do accept them for intermediate levels of residential care (see Chap. 13). The facilities include Ruby Mountain Manor in Elko, the Fallon Convalescent Center, Golden Age Gardens in Reno, and, in the Las Vegas area, the Vegas Valley Convalescent Hospital, Gaye Haven, Glen Halla, and the Torrey Pines Care Center. Note that only four Nevada counties have such facilities. The Nevada Welfare Division will pay for care of some individuals in these facilities.

NEEDED IMPROVEMENTS: RESIDENTIAL MENTAL RETARDATION SERVICES

We again emphasize that residential mental retardation services are improving in Nevada and that current staff people by and large are dedicated and hardworking. Adequacy of services is still a far-distant goal, however.

The greatest inadequacy in the present system is in the NMHI Mental Retardation program. The program twice has failed to receive JCAH accreditation, for the reasons discussed earlier, mostly stemming from a staff that is deficient in numbers, training, and mix of professional skills. We strongly recommend that the NMHI mental retardation program be improved to meet JCAH accreditation standards. The facility improvements at NMHI and the new Desert Developmental Center approved by the 1975 Nevada Legislature will help upgrade the NMHI program by improving physical living conditions at NMHI and by cutting the NMHI resident population approximately in half. Since 1974, the NMHI's mental retardation program has made internal changes that have changed the quality and quantity of services provided for the current resident population. These changes are seen by NMHI as only beginning steps that are necessary to ultimately bring the residential program into compliance with accreditation standards. An attachment to a letter from NMHI Director T. Piepmeyer to Rand on February 27, 1976 stated, "These program changes are pitifully inadequate unless additional resources outside the existing program are obtained in the form of staff, training and proper mix of professional skills." The two primary internal changes using existing staff are a new day training center and an interdisciplinary committee to evaluate and plan services for each individual resident.

Given the extensive service program planned and needed for the population of more severely mentally retarded southern Nevadans, we recommend that the proposed Desert Developmental Center staff be approved by the legislature in 1977. We further recommend that the mental retardation staff of the Institute not be cut

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105 Ibid.
when about half of the Institute’s residents are moved to the new center, so that the Institute will then be able to provide more nearly adequate services to the retarded residents remaining there. Interdisciplinary NMHI teams have been functioning since March 1975; 86 of the 108 persons now in NMHI’s mental retardation program have been reviewed, individual client needs identified, and a corresponding treatment/training plan has been developed for each of them. About 50 percent of the activities identified in these plans have been deferred due to inadequate staff, according to an NMHI administrator.

We agree that the concept of a new northern Nevada equivalent of the Desert Developmental Center is a good idea, but we question the priorities and timing. The Institute already exists, after all, and the new Desert Developmental Center in Las Vegas will provide improved services. On the other hand, facilities are either totally absent or too small for services to some other groups of mentally handicapped people, or for other types of services for mentally retarded people. It seems to us that first priority on new facility construction should go where none exists at all, rather than where a facility exists that could be better. Hence, we recommend that approval for the construction of the northern Nevada equivalent of the Desert Developmental Center facility be deferred until other higher-priority expenditures have been made. (See Chap. 2 for a discussion of priorities.) We do not mean to imply that the Institute’s mental retardation facilities are good enough or that we condone the inferior services its residents now receive. Rather, we believe the Institute’s services can be sufficiently improved within the existing facility, so that construction of a new facility can be deferred while other higher-priority needs are met. We recommend that the NMHI and the Northern Nevada Mental Retardation Center provide services for northern Nevadans corresponding to those that the new Las Vegas Desert Developmental Center will provide.

We recommend that control of the mental retardation program be separated from that of the mental health program at the Nevada Mental Health Institute, and be given to the Associate Administrator for Mental Retardation of the Nevada Division of Mental Hygiene and Mental Retardation. This is in recognition of the separate spheres of activity that now exist at NMHI and compete for resources. We do not envision physically removing all mentally retarded people from NMHI at the present time, although that might be done in the future. Rather, the intent of this recommendation is to consolidate the administration of mental retardation programs. At present, the largest residential program for mentally retarded people in the state is not the responsibility of or within the direct sphere of control of the DMHMR Associate Administrator for Mental Retardation; that seems to be an unnecessary and undesirable disaggregation of responsibility. Auxiliary services and facilities for mentally retarded residents at NMHI, such as medical care and recreational facilities, could be obtained from the non-mental-retardation portion of NMHI as they are now; NMHI’s bookkeeping system is such that it would not be overly difficult to arrange for the appropriate interprogram transfer of funds.

The current training for state-employed mental health technicians at the mental retardation centers and the NMHI is inadequate, and in practice even falls short of the officially stated job requirements. Hence we recommend that the technician staff be given formal training in the provision of developmental services to mentally retarded people.

Virtually no mental health services (other than drugs) are provided to mentally
retarded people living at the NMHI, the two mental retardation centers, or anywhere else in the entire state. Although not all mentally retarded people and their families need mental health services, some clearly do. Hence we recommend that provision be made for mental health services to those mentally retarded people and their families who need them. A difficulty that must be overcome, however, is that the mental health service system in practice seldom serves retarded people and is separate from the mental retardation system, which itself typically does not hire mental health professionals.

Rather than have both the NMHI and the mental retardation centers developing and supervising community home placements of mentally retarded people, we recommend that all community developmental home programs be under the auspices of the mental retardation centers. With the NMHI program for mentally retarded people as deficient as it is, it makes little sense to have the Institute take on different responsibilities that greatly overlap those of the mental retardation centers.

At the private Eagle Valley Children's Home, primarily for severely and profoundly retarded youth, only three of the ten residents were receiving special education and training in September 1974. We recommend that nearly all Eagle Valley Children's Home residents be provided needed special education and training by the Carson City School District, with an extra special education unit ($16,000) provided by the Nevada Department of Education for that purpose, since not all the residents originally come from Carson City.

We recommend that mentally retarded prisoners be identified and that a special program of services be established for them. At present, the Nevada State Prison system has no idea how many prisoners are mentally retarded, and provides no special services for them, other than allowing them to participate in basic adult and remedial education classes. To some unknown degree, special services would certainly improve the quality of their lives and their level of functioning following release from prison, and would probably reduce the incidence of their commission of crimes.

On the matter of geographic availability of services, we again note the persistent tendency in Nevada to plan and approve facilities of the same size in Reno and Las Vegas (e.g., the MR Centers and the Desert Developmental Centers, and to build no residential mental health and mental retardation treatment facilities in rural Nevada. We believe those practices are largely justifiable, as long as the service system is so administered that rural Nevadans have access to the Reno and Las Vegas facilities. The rural population is sparse, only a few people need residential services in any single rural locale, and it is both costly and difficult to maintain professional staffing and specialized services in small rural facilities.

Given that the Reno and rural populations are about the same size, and that the Las Vegas population is about equal to the Reno and rural populations combined, it is equitable to build equal-size facilities in the north and south only if each area gets its fair share of the service. In practice this means that about half of the Reno facility should be devoted to serving rural Nevadans, most of whom live in northern Nevada. Less service-intensive and longer-term residential living (e.g., developmental homes) could still be provided in rural Nevada (see Chap. 13).

We recommend that an improved information system be established for monitoring mental retardation program operations, including the effectiveness of services. A discussion of the existing information system and desirable improvements in it were
presented in the "Individual Client Data Base" subsection of our discussion above on the "Nevada Mental Health Institute: Mental Retardation Program."

Finally, we reiterate the need for direction and coordination of services, and refer the reader to Chap. 4 for our recommendations for the creation of Regional Direction Centers.
Chapter 11

VOCATIONAL SERVICES

OVERVIEW OF CURRENT VOCATIONAL SERVICES

This chapter discusses several major vocational service programs for mentally handicapped Nevadans, estimates vocational service needs, presents recommendations for improvement, and makes projections to 1985.

We estimate that at least 680 Nevadans with mental health problems, 660 with mental retardation, and 410 with alcohol or drug abuse problems had a need for vocational services in 1975. These are conservative estimates that do not include people who need only job placement assistance (a much larger number of people fall into this category), and do not include youth who are not in their last two years of school. Methods of estimation and sources of these and all other data in this overview are presented later in this chapter.

The five major vocational service programs serving mentally handicapped Nevadans, as shown in Fig. 11.1, are found in three different state departments and in the private sector: the Vocational Rehabilitation (VR) program in the Department of Human Resources Division of Rehabilitation; the Community Training Centers (CTC) program, which partially funds private community vocational centers, and the Vocational Training (VT) program, both in the Nevada Department of Human Resources Division of Mental Hygiene and Mental Retardation; the county special vocational education (VE) programs, partially funded through the Nevada

Fig. 11.1—Organization of major vocational service programs for mentally handicapped Nevadans
Department of Education; the Department of Employment Security (ES) programs, including those funded by the Comprehensive Employment and Training Act; and the private community vocational centers (CVC), funded partially by the Community Training Centers and Vocational Rehabilitation programs.

Table 11.1 gives an overview for each program of the number of mentally handicapped people served, staff, and expenditures in FY 1974 by major type of mental handicap. About 1617 people with mental handicaps received vocational services at an expenditure of about $2.7 million, or about $1710 per capita. The 296 clients listed under "other mental" in Table 11.1 were primarily those with disabilities the VR program calls "character, personality, or behavior disorders" (i.e., they do not fall into the other VR program categories as psychotic, neurotic, retarded, alcoholic, or drug abusing persons).

Table 11.2 shows the number of mentally handicapped people provided with vocational services (exclusive of those served by the Department of Employment Security) in the three major areas of the state. In terms of people served per thousand population, there is no major difference between the Las Vegas area, the Reno area, and the combined remaining area of the state. However, as will be discussed later, there are major differences within individual programs in service to the three geographic areas for certain types of mental handicaps.

The largest vocational service program is vocational rehabilitation, which in FY 1974 completed provision of a wide variety of services to 161 people with mental

Table 11.1

<table>
<thead>
<tr>
<th>Item</th>
<th>Vocational Rehabilitation</th>
<th>Community Vocational Centers</th>
<th>Vocational Training Program</th>
<th>Special Vocational Education</th>
<th>Employment Security</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>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>161</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>&gt; 161</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>81</td>
<td>183</td>
<td>19</td>
<td>400</td>
<td>NA</td>
<td>&gt; 635</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>140</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>140</td>
</tr>
<tr>
<td>Other mental</td>
<td>296</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>296</td>
</tr>
<tr>
<td>Total</td>
<td>678</td>
<td>183</td>
<td>19</td>
<td>400</td>
<td>337</td>
<td>1,617</td>
</tr>
<tr>
<td>Estimated staff (full-time equivalent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>2</td>
<td>71</td>
<td>4</td>
<td>12</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>5</td>
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<tr>
<td>Other mental</td>
<td>18</td>
<td>71</td>
<td>4</td>
<td>12</td>
<td>NA</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>71</td>
<td>4</td>
<td>12</td>
<td>1</td>
<td>123</td>
</tr>
<tr>
<td>Estimated expenditures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>$ 271,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>$ &gt; 271,000</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>548,000$a</td>
<td>$919,000</td>
<td>$36,000</td>
<td>$204,000</td>
<td>NA</td>
<td>$ &gt; 1,707,000</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>151,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>151,000</td>
</tr>
<tr>
<td>Other mental</td>
<td>596,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>596,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,566,000</td>
<td>$919,000</td>
<td>$36,000</td>
<td>$204,000</td>
<td>$32,000</td>
<td>$ 2,757,000</td>
</tr>
</tbody>
</table>

SOURCES: See text of this chapter for sources of data.

NOTES: In some cases, the numbers served for each program do not add to the total served by all programs combined, since a person can be counted as served by more than one program. NA = not available.

a Includes $483,000 in one-time grants for local program and facility improvement projects.
Table 11.2
VOCATIONAL SERVICES TO MENTALLY HANDICAPPED NEVADANS BY GEOGRAPHIC AREA, 1974

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Vocational Rehabilitation</th>
<th>Community Vocational Centers</th>
<th>Vocational Training Program</th>
<th>Special Vocational Education</th>
<th>Employment Security</th>
<th>All Programs Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark County (Las Vegas area, except Mental Health Institute)</td>
<td>56</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>56</td>
</tr>
<tr>
<td>Mental health</td>
<td>56</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>56</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>41</td>
<td>110</td>
<td>0</td>
<td>240</td>
<td>NA</td>
<td>391</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>76</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>76</td>
</tr>
<tr>
<td>Other mental</td>
<td>90</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>90</td>
</tr>
<tr>
<td>Total per 1000 population</td>
<td>285</td>
<td>110</td>
<td>0</td>
<td>240</td>
<td>NA</td>
<td>613</td>
</tr>
<tr>
<td>Washoe County (Reno area, except Mental Health Institute)</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>27</td>
</tr>
<tr>
<td>Mental health</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>27</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>16</td>
<td>40</td>
<td>19</td>
<td>70</td>
<td>NA</td>
<td>146</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>4</td>
</tr>
<tr>
<td>Other mental</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>93</td>
</tr>
<tr>
<td>Total per 1000 population</td>
<td>137</td>
<td>40</td>
<td>19</td>
<td>70</td>
<td>NA</td>
<td>269</td>
</tr>
<tr>
<td>All other counties combined (except Mental Health Institute)</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>16</td>
</tr>
<tr>
<td>Mental health</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>16</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>7</td>
<td>33</td>
<td>0</td>
<td>90</td>
<td>NA</td>
<td>130</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>14</td>
</tr>
<tr>
<td>Other mental</td>
<td>87</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
<td>87</td>
</tr>
<tr>
<td>Total per 1000 population</td>
<td>124</td>
<td>33</td>
<td>0</td>
<td>90</td>
<td>NA</td>
<td>247</td>
</tr>
</tbody>
</table>

SOURCES: See text of this chapter for sources of data.
NOTES: In some cases, the numbers served for each program do not add to the total served by all programs combined, since a person can be counted as served by more than one program. NA = not available.

health problems, 81 people with mental retardation, 140 people with alcohol or drug abuse problems, and 296 people with some other mental disability. These services included diagnosis, evaluation, vocational counseling, medical and psychological restorative service, vocational training and job placement, income maintenance while participating in the program, and other services such as occupational tools and equipment, and transportation. In relation to the annual need based on adults plus youth leaving school each year, the VR program currently appears to be serving about a third of those people in need who have mental health problems or problems of alcohol or drug abuse, and about a sixth of those in need with mental retardation. Since we completed our analysis, FY 1975 data have been compiled by the Bureau of Vocational Rehabilitation. It will be interesting to see the Bureau's quantitative analysis of these data so that the degree to which priorities have changed can be discerned.

Nevada State VR personnel directly provide certain services such as work evaluation, counseling, and placement, and purchase others from public and private vendors, such as medical and psychological services, and work evaluation and train-
ing. For example, the Washoe Association for Retarded Citizens and the Opportunity Village in Las Vegas provide vocational service to mentally retarded people under contract with the VR program. The role of the Federal Government is also major; it funds 79 percent of the VR program in Nevada and specifies broad guidelines for service provision.

The VR program operates from eleven offices throughout the state to help handicapped persons obtain gainful employment, which may include family work, sheltered employment, or homebound work, as well as competitive employment. Mentally handicapped clients represented 47 percent of the FY 1974 case closures, and 45 percent of the reportedly mentally handicapped persons referred were accepted for service. The nearly $1.6 million expended in FY 1974 for mentally handicapped people included a one-time expenditure of about $0.5 million for facility and program improvement for mentally retarded clients and resulted in the successful vocational rehabilitation of 49 percent of all those mentally disabled people served, attesting to the desirable outcomes of the program. The VR program basically defines success as a favorable prognosis after 30 days of gainful employment.

We are not fully satisfied with the VR program definitions in the mental health area. For example, they list three basic types of disorders: psychotic (no further definition is given); psychoneurotic (no further definition is given); and "other mental disorders" (broken down to "alcoholism," "drug addiction," and "other character, personality, and behavior disorders" but not further defined). The distinction is not at all clear between "psychoneurotic" and "other character, personality, and behavior disorders." The definition of classifications of VR clients, in practical terms, is largely up to the individual diagnostician and can be expected to vary considerably.

Some light is shed on the "character, personality, and behavior disorder" category when one understands that the two largest sources of referrals of people in the category are justice and welfare agencies, and that VR rules for classification of a person as psychotic or neurotic require a more highly educated diagnostician. However, with the above caveats, we now proceed to use the VR classification scheme since data are not available to use any other classification for this program.

The VR program heavily emphasizes people who have an "other mental" disorder of character, personality, or behavior and who are thus not classified by VR as psychotic, neurotic, retarded, alcoholic, or addicted to drugs. Of those accepted for service, 39 percent have an "other mental" disability and half of the FY 1974 closed-case expenditures went to that group alone. In comparison, only 12 percent of those mentally disabled persons accepted were retarded. Of the more prevalent types of mental disabilities, the two categories with the highest average expenditures per client are the psychoneurotic and the nebulous "other mental" categories, although people in those two categories are certainly not the most severely handicapped or the hardest to train and place in jobs. Contrary to what might be expected and desirable, the average expenditures per client accepted for service decrease in some cases as the severity of the mental handicap increases, e.g., from $742 per mildly retarded client to $468 per moderately retarded client, and from $1654 per neurotic client to $735 per psychotic client.

The VR program has recently grown very rapidly, leveling off in the most recent year for which data were available for our analysis (FY 1974), and service to mentally disabled people has kept pace with the overall program growth. The VR program emphasis on mentally disabled people is heaviest by far on those it classifies
as having personality, character, and behavior disorders, but the relative emphasis is shifting somewhat toward alcohol and drug abusers and mentally retarded people. Since FY 1974, the Administrator of the Nevada Division of Rehabilitation indicates a shift in priorities toward more severely handicapped people, in line with Federally-mandated priorities (see the Federal Register, December 5, 1974). The Division's analysis of FY 1975 and early FY 1976 data, when made available to the public, will allow assessment of the quantitative degree to which a change in priorities has taken place.

Looking at the number of mentally disabled persons rehabilitated by geographic area indicates that the figure for rehabilitants per capita is about the same in each of the three major areas of Nevada. However, in certain counties in the geographic area outside Clark County (Las Vegas) and Washoe County (Reno), mentally disabled people were markedly underserved in FY 1974 relative to the rest of the state. For example, in Esmeralda, Eureka, Nye, and Storey Counties combined, not even one mentally disabled person was vocationally rehabilitated and only two were served.

Certain VR offices also tend to "specialize" in certain disabilities. For example, rehabilitation from the Henderson office and the Las Vegas Mental Health Outreach office are predominantly in the categories of drug addiction and "other mental" disorders of character, personality, or behavior, while no other office has more than one rehabilitated drug addict.

The reasons for non-acceptance of referrals and nonrehabilitation of mentally disabled clients are not what one might expect. Only small fractions of referrals are reported to be unqualified for service, i.e., have too severe a disability, no disabling condition, or no vocational handicap. Over 80 percent of those not accepted for service were dropped because the agency was unable to locate or contact the applicant, the applicant had moved, the applicant refused service or failed to cooperate, or for some "other" reason. Similarly, the prime reason for nonrehabilitation of mentally disabled clients after acceptance into the program is that three-fourths of the nonrehabilitants "drop out," i.e., cannot be located or contacted, move, refuse further service, or do not cooperate.

In terms of economic benefit, which is only the most readily measurable one of the various types of benefits resulting from the VR program, the results are gratifying. Only 22 percent were gainfully employed at referral and the combined annualized earnings of mentally disabled rehabilitants amounted to $330,000 at time of referral; that figure rose to $1,820,000 at time of closure. The percentage of rehabilitants on public assistance dropped from 23 percent at referral to 1 percent at time of case closure. Average weekly earnings upon closure were $105, but one-third earned less than $80 per week and only 4 percent earned over $200 per week. That is, mentally disabled rehabilitants are being placed in relatively low-paying jobs, the majority in the service, clerical, and sales fields, and many of them may be underemployed relative to their abilities.

Our economic benefit/cost analysis of the VR program presented later in this chapter indicates that this program appears to yield economic benefits to taxpayers who are paying for the vocational services to mentally handicapped people (reduced service cost later in the mentally handicapped people's lives, reduced welfare, and increased taxes paid by the mentally handicapped people) that exceed the costs of the program. The benefits to society as a whole are even larger than they are for taxpayers. (By society, we mean all nonhandicapped and handicapped Nevadans
considered as a group, including both the mentally handicapped people being served and the taxpayers who are paying for the service.) We analyzed the sensitivity of economic benefits and costs to variations in the data and assumptions, and even with what we consider to be a demanding test using very conservative assumptions, the VR program still appears to offer economic benefits to both society as a whole and to Nevada taxpayers that exceed the costs for all eight categories of prevalent mental disabilities analyzed. Thus, the VR program appears justified on its economic benefits alone. Add the enhanced quality of life of the mentally disabled people served—an important consideration—and the VR program is all the more laudable.

Several private community vocational centers receive partial funding from the Community Training Center program in the state Division of Mental Hygiene and Mental Retardation, and partial funding from the VR program. These centers provide a variety of services to preschool children and to adult developmentally disabled (primarily, mentally retarded) people for whom there is no other appropriate prevocational or vocational service program. A total of about 180 adults are served by a full-time-equivalent staff of about 70 and a budget of approximately $900,000 in FY 1974. The largest two centers are run by the Opportunity Village Association for Retarded Citizens in Las Vegas and the Washoe Association for Retarded Citizens in Reno. They provide services such as work evaluation, work activity, work adjustment and training, counseling, and sheltered employment. Five other small centers in less densely populated areas of the state provide a limited range of prevocational or vocational services to retarded adults. While the number of people served per capita is about the same for each of the three major geographic areas of the state, the larger-scale programs possible in Reno and Las Vegas enable professional personnel to provide a broader range of prevocational and vocational services. While providing greatly needed services, some of these centers are somewhat thin on professional vocational service staff. However, these private programs have been in a stage of rapid growth, and the clients and their families we spoke with in the larger two centers appear quite satisfied with the services.

A small Vocational Training program is operated by the Division of Mental Hygiene and Mental Retardation for about 20 retarded adults in the Reno area who are functioning at or close to competitive employment levels. With an annual budget of $36,000, the staff of four, none of whom has prior professional vocational service training or experience, provide services in conjunction with the VR program. In 1974, the Vocational Training staff provided vocational evaluation, job placement, and typically about four workweeks of on-the-job training over a period of six calendar weeks. Since 1974, there has been a shift toward providing pre-workshop services.

The special Vocational Education program expends just over $200,000 with a staff of about 12 full-time-equivalent people at the county school district level. They serve approximately 400 mentally handicapped youth, most of whom are educable mentally retarded. We were unable to learn of any nonretarded youth with serious emotional disturbances who receive special vocational education services. Funds are about half federal and half state and local combined. Vocational or career education through the schools is not well developed even for “normal” youth, and the options available to educable mentally handicapped youth through this program appear very limited. For trainable or more severely mentally retarded youth, and for seriously emotionally disturbed youth, the special vocational education options appear
nonexistent, with the notable exception of the Helen J. Stewart School for retarded youth in Las Vegas. Insufficient attention is paid to coordination with the VR program in some counties. For example, Reno area school personnel have virtually no contact with VR personnel; hence, identified mentally handicapped adolescents are not served by the VR program before completion of school, and usually not after.

The Department of Employment Security primarily provides unemployment compensation plus, through its employment services division, services such as job information and placement to unemployed people. The Department spent at least $32,000 in FY 1974 providing employment services such as job information and placement service to the 337 mentally handicapped adults it reported serving. More mentally handicapped people may be served by this program, but were not reported as such on the client forms. Of these 337 people, 82 were placed in jobs, 8 were enrolled in training, 66 were provided counseling, 84 were referred to other training programs, and 30 were referred to supportive services (which includes referrals to the Bureau of Vocational Rehabilitation). It appears that most of the mentally handicapped people served are served by ES personnel without specialized knowledge of the vocational abilities of mentally handicapped people. Employment Security personnel are also reported to have a tendency to give lower priority to people they think will have a harder time getting jobs.

The next several sections of this chapter provide a more detailed description and analysis of vocational service programs for mentally disabled Nevadans.

VOCATIONAL REHABILITATION PROGRAM

The Nevada Bureau of Vocational Rehabilitation (VR) plays the major operating role for this program, within the Division of Rehabilitation in the Department of Human Resources. The stated goal of the Rehabilitation Division is "to provide to all Nevadans who need them rehabilitation and habilitation services in the most coordinated, efficient, and expeditious manner possible." The direction of the VR Bureau's program is based on the following philosophy: "Every member of a democratic society has an inherent right to the opportunity to earn a living, and make his contribution to society. Society has the obligation to equalize, as best it can by special services, the disabled person's opportunity to earn a living equal to the opportunity possessed by the nondisabled members of the society." Nevada State VR personnel directly provide certain services such as counseling and placement, and purchase others such as medical services and vocational training from public and private vendors.

The present role of the Federal Government is also major. It funds 79 percent of the VR program in Nevada; supports services to all types of physically or mentally disabled persons with substantial handicaps to employment but with "high" vocational potential; allows provision of virtually any service that a client might need;

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1 Other portions of the Division of Rehabilitation are not concerned primarily with vocational rehabilitation. They include the Developmental Disabilities Program and the Bureaus of Services to the Blind, of Alcohol and Drug Abuse, and of Disability Adjudication (determination of eligibility for the Social Security programs).


3 Ibid.
and supports research, the construction of physical plants, and the training of professional personnel. Thus, the Nevada Bureau of VR is responsible for providing services under broad federal guidelines and primarily with federal funds.

The Nevada-federal VR program objective is strictly vocational, to help physically or mentally handicapped persons to obtain gainful employment and lead meaningful lives. They may be provided "any goods and services necessary to render them fit to engage in a gainful occupation. . . ." The handicapped person served, however, must have a "substantial handicap to employment, which is of such a nature that vocational rehabilitation services may reasonably be expected to render him [or her] fit to engage in a gainful occupation, including a gainful occupation that is more consistent with his [or her] abilities and capabilities." That is, the person must need the services and have reasonable potential to benefit from them. A person may also be served to evaluate his or her rehabilitation potential. The term "gainful occupation" is interpreted broadly to include "employment in the competitive labor market; practice of a profession; farm or family work . . .; sheltered employment; and home industries or other gainful homebound work." 4

The Federal Rehabilitation Act of 1973 5 revised the VR program but did not change its basic aspects. The emphasis of the program's objective was shifted, however, toward serving first those persons with the most severe handicaps. With the exceptions of alcoholism and drug abuse, some people in each of the various types of mental disabilities considered in this chapter fall within the federal definition of a severe handicap. 6

The Nevada Bureau of Vocational Rehabilitation had offices throughout the state in 1974. They were located in Carson City (one general and one public offender outreach office for criminal justice system clients), in the Reno area (one general and one Nevada Mental Health Institute office), in the Las Vegas area (one general, one mental health center outreach, and one public offender outreach office), and in Elko, Ely, Henderson, and Winnemucca. With the exception of the three general offices in Carson City, Reno, and Las Vegas, these offices typically have a total staff of three or four people in each. 7 The total authorized VR staff in all offices numbered 80.3 full-time-equivalents in FY 1974. 8 At the large Reno and Las Vegas offices, the bureau operates two vocational evaluation and work adjustment centers with staffs of 10 to 15 at each center. Both centers are accredited by the National Commission on Accreditation of Rehabilitation Facilities. 9 These two VR centers, plus the Washoe Association for Retarded Citizens and Opportunity Village programs for

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4 Federal Register, Vol. 34, No. 200, October 1969.
6 As specified in the Act, the term "severe handicap" means a disability that seriously limits functional capabilities in terms of employability, that requires multiple services over an extended period of time, and that results from amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction, and any other disability specified by the Secretary of HEW in regulations he shall prescribe.
7 Interview with Lloyd Mack, Jr., Deputy Administrator, Nevada Rehabilitation Division, Carson City, Nevada, May 9, 1974.
8 The Executive Budget, State of Nevada, Fiscal Years 1975-76 and 1976-77, Office of the Governor, Carson City, Nevada, January 20, 1975. Hereafter cited as The Executive Budget. For lack of better data, we assume in the summary table at the beginning of this chapter that employees are distributed by handicap in the same proportion as VR case service expenditures.
developmentally disabled people, are the only vocational evaluation and work adjustment centers in the state. The smaller rural VR offices provide job counseling and placement, but for services such as work evaluation, work adjustment, and specialized medical evaluation, clients are sent to either Reno or Las Vegas. Of the FY 1974 mentally disabled rehabilitants, 20 and 49 percent were served at the VR program's vocational evaluation and work adjustment centers in Reno and Las Vegas, respectively.

A caution is in order concerning the meaning of some key statistics cited in the Bureau of Vocational Rehabilitation's FY 1973-74 Biennial Report, since statistics to be presented later in this chapter are significantly different. The Biennial Report indicates 9815 Nevada residents were "served" by the Bureau of Vocational Rehabilitation in FY 1973-74, with 1733 physically and/or mentally handicapped persons being rehabilitated. Our analysis of the data indicates that there were 7337 case closures in the two-year period, including referrals that were not accepted for service, and that the median service time was less than one year. If the number of active cases at the end of the year were added, then the total would approach the 9815 figure used by VR. Thus, the Bureau's report counts referrals not accepted as clients in the definition of "served," whereas we do not do so in this chapter.

In the following subsections, we are able to present detailed information on VR services to persons with various types and degrees of mental disabilities because the VR program maintains a much more comprehensive and usable management information system than any of the other major programs we analyzed.

Nevada's Vocational Rehabilitation Caseload, FY 1974 Closures

In this chapter we define disabilities as the Nevada Division of Rehabilitation does, under guidelines provided by the U.S. Rehabilitation Services Administration. We include in the term "mental disability" all disabilities the Division of Rehabilitation lists as "Mental, Psychoneurotic, and Personality Disorders," including alcoholism, drug addiction, mental retardation of various degrees of severity, psychotic and psychoneurotic disorders, and other mental disorders of character, personality, and behavior. Definitions of handicaps given in the Nevada State Rehabilitation Division's Rehabilitation Services Manual are grouped in this report as follows:

Alcoholism (Code 520)
Drug Addiction (Code 521)
Mental retardation (MR) is subjectively defined as "subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior," which may be reflected in impairment of maturation, learning, or social adjustment. Subaverage intellectual functioning is further defined as an IQ of about 85 or less on an individual test, although

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10 Data presented on mentally disabled persons have been computed at The Rand Corporation from FY 1974 "Case Service Reports." U.S. Department of Health, Education, and Welfare Form RSA-300, completed by the Nevada Division of Rehabilitation on each applicant at the time of case closure. To protect confidentiality, data that would permit the identification of individual persons were deleted from the computerized data file.

11 Rehabilitation Services Manual for Case Finding and Intake, Case Reporting, Client Service Funding, Secs. 2.330, 2.331, November 1970.
the presence of “maladaptive behavior” must also be established and is “particularly important in determining whether an individual who achieves an IQ in the 70-85 range may or may not be classified as mentally retarded.” Three levels are described:

- **Mild MR**: Persons who, with the provision of appropriate rehabilitation services, can become capable of independent living in the community and engage in competitive employment. Generally, they will require supervision and guidance only under conditions of particular social or economic stress. (Code 530)
- **Moderate MR**: Persons capable of maintaining themselves in the community and performing adequately in low-demand competitive employment, but who will require continuing supervision and assistance in the management of personal affairs. (Code 532)
- **Severe MR**: Persons capable of productive work but only under sheltered, non-competitive conditions in a protective environment. (Code 534)

Psychotic Disorders (Code 500)
Psychoneurotic Disorders (Code 510)
Other Mental Disorders (character, personality, and behavior) (Code 522)
Epilepsy (Code 630)
Cerebral Palsy (resulting in orthopedic deformity or functional impairment) (Codes 300, 320, 340, 360, 380)
Parkinson’s Disease (resulting in orthopedic deformity or functional impairment) (Codes 317, 337, 357, 377, 397)
Stroke (intracranial hemorrhage, embolism, and thrombosis resulting in orthopedic deformity or functional impairment) (Codes 312, 332, 352, 372, 392)

In this chapter, we also include in the term “mental disability” certain mentally related disorders such as epilepsy, cerebral palsy, Parkinson’s Disease, and stroke that the Division of Rehabilitation lists under “orthopedic deformity or functional impairment” or under “other disabling conditions.”

In analyzing data on the VR program by type of mental handicap, with the exception of those applicants not accepted, we used the “major disabling condition” at the time the person was accepted for extended evaluation or rehabilitation services, as determined by Bureau of Vocational Rehabilitation personnel “from the most recent document or documents prepared by physicians based on the examination of the client, and/or medical records of a hospital or clinic where the client was examined.” For persons not accepted for extended evaluation or rehabilitation, we used the “reported disabling condition” given to the Division at the time of referral.

Since the VR program serves people with many different types of mental disability of vastly diverse natures and severities, ranging from alcoholics to psychotics to criminal offenders with "character" disorders, we will disaggregate most of the information presented by type of mental disability so that a more accurate picture is obtained. However, the imprecision with which the VR program defines the various types of mental disabilities does not permit an entirely clear picture. Impre-
cise definition also affords VR personnel a great deal of latitude in selecting clients they want to accept into this service program.

Data available and presented describe the FY 1974 case closures only. Thus, data such as expenditures for active cases not closed during that year are excluded; however, data such as expenditures for the FY 1974 closures include expenditures incurred in previous years if the case was open prior to FY 1974. In short, the data we present do not cover everything the program did in FY 1974, but rather deal with a group of referrals and clients whose cases were closed in FY 1974.

In the tables to follow, care must be taken in interpreting data given in percentages for individual types of mental disabilities. For example, only one person with Parkinson's Disease applied; that person was accepted for service but not rehabilitated, and hence a table would record a 100-percent failure rate for Parkinson's Disease clients—clearly not a representative rate.

Of the 3205 case closures in FY 1974, including those referred but not served, 1520 (47 percent) had or reportedly had mental disabilities. Of the 1431 FY 1974 closures for people accepted into the VR program, 678 (again 47 percent) were diagnosed as mentally disabled. And of the 824 persons successfully rehabilitated, 334 (41 percent) were mentally disabled, as seen in Table 11.3. (Here, successful rehabilitation means that both the client and employer gave a favorable employment prognosis after a month on the job.) The Nevada VR program's rate of acceptance for service of physically disabled persons (45 percent) was the same as that of mentally disabled persons. However, the program was considerably more successful in vocationally rehabilitating physically disabled persons (65 percent) than it was for mentally disabled persons (49 percent). Even so, the rehabilitation of nearly half of the latter is a laudable program achievement.

The current VR rule concerning classification of the mental disability of clients is that a medical doctor or a psychologist must make the determination. Clients are supposed to be classified psychotic or neurotic only by a psychiatrist or by a psychologist with a Ph.D. degree. Clients are supposed to be classified as mentally retarded or "other mentally disabled" only by a psychiatrist or by a psychologist with a master's degree or Ph.D.\textsuperscript{14}

Considering the clientele by type of mental disability, Table 11.3 indicates a very heavy emphasis on people who have "other mental disorders" of character, personality, or behavior and therefore are not psychotic, neurotic, retarded, alcoholic, or addicted to drugs by VR program definitions. Of those accepted for service, 39 percent have what the VR program calls "other mental disorders," and accounted for over 49 percent of the FY 1974 closed cases expenditures for mentally disabled persons. In comparison, only 12 percent of those mentally disabled persons accepted were retarded. Of course, it is possible that many persons recorded as having "other mental disorders" actually suffered from psychosis or retardation, but that it was more expedient for the rehabilitation counselor to classify them "other mental" than to obtain the higher-quality professional psychological evaluation necessary to justify a more specific mental disability classification. While there is merit to the argument that "it's the service that counts, not the classification," the failure to obtain a higher-quality professional psychological evaluation may result in inadequate or inappropriate service.

\textsuperscript{14} Interview with Lloyd Mack, Jr.
Table 11.3

VOCATIONAL REHABILITATION BY TYPE OF MENTAL DISABILITY, FY 1974 CLOSURES

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Referred for Service</th>
<th>Accepted for Service</th>
<th>Successfully Rehabilitated</th>
<th>Accepted as Percent of Referred</th>
<th>Rehabilitated as Percent of Accepted</th>
<th>Percent of Expenditures on Mental Disability Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>160</td>
<td>11</td>
<td>76</td>
<td>11</td>
<td>36</td>
<td>11</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>114</td>
<td>8</td>
<td>64</td>
<td>9</td>
<td>46</td>
<td>14</td>
</tr>
<tr>
<td>MR, mild</td>
<td>87</td>
<td>6</td>
<td>54</td>
<td>8</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>41</td>
<td>3</td>
<td>24</td>
<td>4</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>MR, severe</td>
<td>8</td>
<td>0.5</td>
<td>3</td>
<td>0.4</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Psychotic</td>
<td>214</td>
<td>14</td>
<td>77</td>
<td>11</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Psychoneurotic</td>
<td>107</td>
<td>7</td>
<td>84</td>
<td>12</td>
<td>37</td>
<td>11</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>708</td>
<td>47</td>
<td>263</td>
<td>39</td>
<td>124</td>
<td>37</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>56</td>
<td>4</td>
<td>23</td>
<td>3</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>9</td>
<td>0.6</td>
<td>4</td>
<td>0.6</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
<td>0.2</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Stroke</td>
<td>13</td>
<td>1</td>
<td>5</td>
<td>0.7</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Total, all disabilities</td>
<td>3205</td>
<td></td>
<td>1451</td>
<td></td>
<td>824</td>
<td></td>
</tr>
<tr>
<td>Total, mental disabilities</td>
<td>1520</td>
<td>100</td>
<td>678</td>
<td>100</td>
<td>324</td>
<td>100</td>
</tr>
</tbody>
</table>

SOURCE: Rand analysis of FY 1974 “Case Service Reports.”
NOTE: Percentages may not add to 100 because of rounding.

VR Expenditures for Mentally Disabled People, FY 1974

In FY 1974 the Bureau of Vocational Rehabilitation expended $3,034,000 on behalf of all types of physically and mentally disabled people. Of that sum about 79 percent came from federal sources (see Table 11.4).\(^{15}\)

We estimate that $1,566,000 was for mentally disabled people.\(^{16}\) Of that total, $483,000 was for improvement of programs and facilities for the developmentally disabled population operated by Opportunity Village in Las Vegas, the Washoe Association for Retarded Citizens in Reno, and the Ormsby Association for Retarded Citizens in Carson City; an estimated $334,000 was for the cost of services purchased;\(^{17}\) and the remainder was for the cost of state rehabilitation counselors and for operation of the Bureau of Vocational Rehabilitation (see Table 11.4 for a breakdown by type of expenditure).

As shown in Table 11.5, the estimated total VR expenditures for mentally disabled clients whose cases were closed in FY 1974 was $794,000. An explanation of the difference between this figure and others on the VR program is in order. As

\(^{15}\) The Nevada Rehabilitation Division costs of administration (above the bureau level) were about $368,000 in FY 1974 and were paid by reimbursement from each of the Bureaus within the Division. Thus, for example, the expenditures for the Bureau of Vocational Rehabilitation include approximately $226,000 listed under “other operating expenses,” to pay for division administration costs above the bureau level.

\(^{16}\) We assume that, with the exception of the University of Nevada grant, all grants to local projects shown in Table 11.4 are for the mentally disabled population and that, for lack of better data, all other FY 1974 VR expenditures are distributed by type of disability in the same proportions as “cost of services” are distributed by type of disability for FY 1974 case closures.

\(^{17}\) Assuming that, for lack of better data, the total FY 1974 VR costs of services purchased are distributed by type of disability in the same proportions as costs of services are distributed by type of disability for FY 1974 case closures.
### Table 11.4
Funds Available to and Expended by the Nevada Bureau of Vocational Rehabilitation, FY 1974

<table>
<thead>
<tr>
<th>I. Funds available: $3,175,000</th>
<th>79%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>19</td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Total funds available</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. VR expenditures: $3,043,000</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel expenses</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>1</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>20</td>
</tr>
<tr>
<td>Capital outlay, equipment</td>
<td>2</td>
</tr>
<tr>
<td>Cost of services purchased</td>
<td>26</td>
</tr>
<tr>
<td>Client payroll</td>
<td></td>
</tr>
<tr>
<td>Employee training</td>
<td>1</td>
</tr>
<tr>
<td>Facility equipment</td>
<td>3</td>
</tr>
</tbody>
</table>

Grants to local projects:

- Opportunity Village: $221,000
- Ormsby Asn. for Retarded Citizens: 15,000
- Univ. of Nevada, Reno: Gallup Poll: 31,000
- Washoe Asn. for Retarded Citizens: 247,000

Total grants to local projects (%): 16
Total VR expenditures: 100


NOTE: These figures do not include expenditures of FY 1974 funds made after January 1975.

### Table 11.5
VR Program Expenditures for Mentally Disabled Clients, FY 1974 Closures Only

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Total Cost of Services</th>
<th>Estimated Expenditures</th>
<th>Average Expenditures per Person</th>
<th>Percent of Expenditures</th>
<th>Average Cost of Services per Person</th>
<th>Percent of Rehabilitants for Whom Cost of Services Was</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td>14,760</td>
<td>48,000</td>
<td>626</td>
<td>1,323</td>
<td>6</td>
<td>194 410 58 3</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>15,641</td>
<td>60,000</td>
<td>939</td>
<td>1,306</td>
<td>8</td>
<td>291 405 35 2</td>
</tr>
<tr>
<td>MR, mild</td>
<td>12,461</td>
<td>40,000</td>
<td>742</td>
<td>1,087</td>
<td>5</td>
<td>230 337 31 5</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>3,487</td>
<td>11,000</td>
<td>468</td>
<td>803</td>
<td>1</td>
<td>145 249 43 0</td>
</tr>
<tr>
<td>MR, severe</td>
<td>255</td>
<td>&lt;1,000</td>
<td>274</td>
<td>823</td>
<td>&lt;1</td>
<td>85 255 0 0</td>
</tr>
<tr>
<td>Psychotic</td>
<td>17,542</td>
<td>57,000</td>
<td>755</td>
<td>2,829</td>
<td>7</td>
<td>228 877 35 10</td>
</tr>
<tr>
<td>Psychoneurotic</td>
<td>43,115</td>
<td>139,000</td>
<td>1,054</td>
<td>3,758</td>
<td>18</td>
<td>913 1,165 24 14</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>122,836</td>
<td>396,000</td>
<td>1,506</td>
<td>3,197</td>
<td>50</td>
<td>467 991 28 21</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>6,921</td>
<td>22,000</td>
<td>971</td>
<td>1,716</td>
<td>3</td>
<td>301 532 46 15</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>2,898</td>
<td>9,000</td>
<td>2,339</td>
<td>3,116</td>
<td>1</td>
<td>725 966 0 33</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>1,338</td>
<td>4,000</td>
<td>4,316</td>
<td>NA</td>
<td>&lt;1</td>
<td>1,338 NA NA NA</td>
</tr>
<tr>
<td>Stroke</td>
<td>1,751</td>
<td>6,000</td>
<td>1,129</td>
<td>1,880</td>
<td>&lt;1</td>
<td>350 583 0 0</td>
</tr>
<tr>
<td>Total, all disabilities</td>
<td>586,160</td>
<td>1,891,000</td>
<td>1,323</td>
<td>2,294</td>
<td>NA</td>
<td>410 711 27 13</td>
</tr>
<tr>
<td>Total, mental disabilities</td>
<td>246,965</td>
<td>794,000</td>
<td>1,168</td>
<td>2,374</td>
<td>100</td>
<td>362 736 35 12</td>
</tr>
</tbody>
</table>

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTES: Columns may not total to 100 because of rounding. NA = not applicable.

Assumes that the average of 31 percent of total VR expenditures (exclusive of grants to local projects) for the cost of services to individuals holds for each disability group. Note that the estimates here are for expenditures over the entire active case life of FY 1974 case closures, not FY 1974 expenditures.
mentioned before, this amount includes expenditures made prior to FY 1974 on clients whose cases were closed in FY 1974, and excludes expenditures during FY 1974 for clients whose cases were still open at the end of the fiscal year. The estimated cost of services purchased in FY 1974 for all mentally disabled clients was $334,000; the estimated cost of services purchased in all years for mentally disabled clients whose cases were closed in FY 1974 was $246,065. When we divided those figures by the numbers of clients, we found that per-client expenditures were lower for case-closure clients. Probably, most of that difference was attributable to a rapid increase during FY 1974 in the cost of services purchased, which would make cases still active at the end of the year show a higher average cost. The Nevada Division of Rehabilitation has documented the rapid increase in the average cost of services per client from FY 1973 to FY 1974. It is speculated that the increase is due to the combined effects of inflation, a shift during FY 1974 to serving more severely disabled individuals as mandated by the Federal Rehabilitation Act of 1973, and a possible tendency to keep clients on the active caseload longer because of difficulties in placing them in jobs during an economic recession.

Nationally, in FY 1971, the cost of services purchased was 56 percent of the total basic program cost; the comparable figure for Nevada was the lowest of any state, 29 percent. In FY 1974 in Nevada, the cost of services purchased was 31 percent of the VR expenditures exclusive of grants to local projects.

For purposes of making comparisons across different types of disabilities, Table 11.5 is a breakdown of expenditure data by type of disability for FY 1974 case closures. Mentally disabled clients accounted for 47 percent of the case closures, and for about 42 percent of the cost of services purchased for all physically and mentally disabled clients. Estimated average total expenditures were $1168 per mentally disabled person accepted and $2374 per person successfully rehabilitated. The average cost of services purchased per mentally disabled person rehabilitated was $736 (slightly more than the $711 average for all types of rehabilitants). Figure 11.2 shows the distribution of the cost of services to mentally disabled rehabilitants. Note that about one-third receive less than $100 in purchased services while only 12 percent receive $1000 or more. Thus, funds generally are not going for extensive and expensive types of vocational training. It also can be seen from Fig. 11.2 that the mentally retarded rehabilitant generally receives significantly less costly services than rehabilitants with other types of mental disabilities. The reasons are not clear. Is it that, compared with people with all other types of mental disabilities combined, retarded people are easier and hence less costly to train vocationally or place in jobs? Are retarded people being placed in low-skill occupations rather than being allowed to develop more of their potential abilities? (As shown elsewhere in this chapter, retarded clients are much more likely to be placed in very low-paying service jobs than are other types of mentally disabled clients.) Or do retarded clients receive more vocational services not directly provided by the Bureau of Vocational Rehabilitation for their specific case? (E.g., local project grants funded by VR are clearly contributing significantly to the rehabilitation of individual clients, and private

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18 Unpublished study by Jean Wilcher, Nevada Division of Rehabilitation, 1975.
employers may be more willing to provide "free" on-the-job training for retarded people than for other types of mentally disabled clients.) Although the various categories of mentally disabled clients do not require the same types and amounts of services on the average, the variation in cost of services among those categories shown in Table 11.5 should have a perceptible relationship to variation in need. We were unable to perceive a consistent relationship. Even if we exclude categories containing very few people (and hence subject to great variation in average costs due to the unique needs of the small number of clients), we still see variations in average cost that require explanation. Why are the highest average expenditures per rehabilitant found in the psychoneurotic and the nebulous "other mental disability" categories? Taken as a whole, people in those two categories are certainly not the most severely handicapped, or the hardest to train and place in jobs. Contrary to what might be expected and desirable, the average expenditures per client accepted decrease as the severity of the mental handicap increases, e.g., from $742 per mildly retarded client to $468 per moderately retarded client, and from $1654 per neurotic client to $735 per psychotic client.

Vocational Rehabilitation Program Growth

In terms of both expenditures and the total number of physically and mentally
disabled persons rehabilitated, the VR program approximately doubled in the three years from FY 1971 (458 rehabilitations and expenditures of $1.5 million\(^{21}\)) to FY 1974 (824 rehabilitations and expenditures of $3.0 million\(^{22}\)). However, all of that growth took place between FY 1971 and FY 1973 and the total number of rehabilitations actually declined slightly from 909 in FY 1973 to 824 in FY 1974.

Total fiscal year expenditures per rehabilint show just over 3 percent per year "inflation" from $3350 per rehabilint in FY 1971 to $3680 in FY 1974.

Over recent years the number of mentally disabled rehabilitants has changed much the same as has the number of rehabilitants with all types of disabilities. The number of mentally disabled rehabilitants grew rapidly from FY 1971 through FY 1973 and then leveled off, so that FY 1974 was nearly the same as FY 1973 in terms of successful rehabilitations (see Table 11.6). This pattern of growth has not been the same for all types of mental disabilities, however. The number of alcoholics and

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### Table 11.6

<table>
<thead>
<tr>
<th>Disabling Condition</th>
<th>Number of Rehabilitated Clients</th>
<th>Percent Increase, FY 1973-74 Over FY 1971-72</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 1971 and FY 1972 Combined(^a)</td>
<td>FY 1973(^b)</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>44</td>
<td>36</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>51</td>
<td>50</td>
</tr>
<tr>
<td>Psychotic-psychoneurotic disorders</td>
<td>97</td>
<td>60</td>
</tr>
<tr>
<td>Personality and behavior disorders</td>
<td>210</td>
<td>156</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>421</td>
<td>319</td>
</tr>
</tbody>
</table>

\(^a\) Nevada Rehabilitation Division, Biennial Report, Carson City, Nevada, January 1, 1973.

\(^b\) Rand analysis of FY 1973 and FY 1974 "Case Service Reports."

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mentally retarded persons served approximately doubled from FY 1971 to FY 1973 and then held relatively constant from FY 1973 to FY 1974. On the other hand, the number of rehabilitants with psychotic or psychoneurotic disorders grew only slightly over the three-year period, while the number of drug abusers rehabilitated climbed nearly tenfold from a very small base. The number of rehabilitants with personality and behavior disorders grew more slowly than the number with alcoholism or retardation disabilities from FY 1971 to FY 1973, and then declined about

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\(^{22}\) "1973-74 Actual Expenses and Revenues—Vocational Rehabilitation (Account 101-3265)," provided by Nevada Division of Rehabilitation, February 1975 (mimeograph).
20 percent from FY 1973 to FY 1974, indicating a shift in relative program emphasis toward other types of disabled people last year.

VR Service by County and District Office

Table 11.7 shows the distribution of the mentally disabled VR caseload across Nevada by county of residence. Clark County has 56 percent of the population but, exclusive of Nevada Mental Health Institute (NMHI) residents, accounts for only 35 percent of the VR referrals of mentally disabled persons, 39 percent of the clients served, and 49 percent of the rehabilitations. Washoe County (exclusive of NMHI) has 24 percent of the population, 19 percent of the referrals, 20 percent of the clients served, and 19 percent of the mentally disabled rehabilitants in FY 1974. All other counties except Clark and Washoe account for almost 20 percent of the state’s population, 22 percent of the referrals of mentally disabled people (exclusive of NMHI residents), 18 percent of those served, and 16 percent of those rehabilitated. A mentally disabled person who is referred from any of the three major areas of the state has a relatively better chance of being accepted if he or she is from Clark or Washoe Counties rather than from the combined rural counties. However, the chance of a resident (exclusive of NMHI residents) being referred in the first place is highest in the rural counties: 1.7 reportedly mentally disabled persons referred per 1000 total population in Clark County; 2.1 per 1000 in Washoe County; and 3.2 per 1000 in all other counties combined. Once accepted, the mentally disabled client has a considerably better chance of being rehabilitated in the Las Vegas area (62 percent) than in the Reno area (47 percent) or rural area (42 percent). However, the total number of mentally disabled rehabilitants is approximately 0.5 per 1000 total population in each of the three areas. Looking at the number of mentally disabled persons rehabilitated from a geographic area in relation to the total number of physically and mentally disabled rehabilitants from that area shows a low emphasis on the mentally disabled in Las Vegas in relation to the rest of the state; 30 percent of the rehabilitants from Clark County were mentally disabled, while the comparable figures from Washoe and the other counties combined were 49 and 53 percent, respectively. A 1974 Nevada survey of activity limitations and work interference due to a mental condition showed that Clark County may have a higher prevalence rate per capita than Washoe and rural counties. In the geographic area outside Clark and Washoe Counties, mentally disabled people in several counties were markedly underserved in FY 1974 relative to the rest of the state. For example, in Esmeralda, Eureka, Nye, and Storey Counties combined, only two mentally disabled persons were served and neither was rehabilitated.

Table 11.7 also presents data by VR district office providing the referral. The Reno area office has the largest number of mentally disabled persons referred and accepted, and the Mental Health Institute is a close second.

Table 11.8 presents distribution across the state of mentally disabled people who were successfully rehabilitated. Note the tendency of offices to "specialize" in certain disabilities. Rehabilitants from the Henderson office and the Las Vegas

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22 NMHI residents who are rehabilitated are recorded in the VR program as Washoe County residents (interview with Lloyd Mack, Jr.). We have excluded them from the Washoe County figures in this analysis because they are drawn from all parts of the state.

**Table 11.7**

**VOCATIONAL REHABILITATION CASELOAD OF MENTALLY HANDICAPPED PERSONS, BY COUNTY AND DISTRICT OFFICE, FY 1974 CLOSURES**

<table>
<thead>
<tr>
<th>County or District Office</th>
<th>Referred</th>
<th>Accepted</th>
<th>Rehabilitated</th>
<th>Number Rehabilitated per 1000 Population&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Accepted as Percent of Referred</th>
<th>Rehabilitated as Percent of Accepted</th>
<th>Mentally Handicapped Persons Rehabilitated as Percent of All Persons Rehabilitated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carson City</td>
<td>82</td>
<td>41</td>
<td>20</td>
<td>1.0</td>
<td>50</td>
<td>49</td>
<td>65</td>
</tr>
<tr>
<td>Churchill</td>
<td>20</td>
<td>5</td>
<td>1</td>
<td>0.1</td>
<td>25</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Clark</td>
<td>229</td>
<td>152</td>
<td>126</td>
<td>162</td>
<td>0.5</td>
<td>49</td>
<td>62</td>
</tr>
<tr>
<td>Douglas</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>0.1</td>
<td>33</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Elko</td>
<td>90</td>
<td>24</td>
<td>5</td>
<td>0.3</td>
<td>27</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>Esmeralda</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0.8</td>
<td>50</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Eureka</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Humboldt</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>0.4</td>
<td>17</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>Lander</td>
<td>17</td>
<td>4</td>
<td>1</td>
<td>1.3</td>
<td>94</td>
<td>19</td>
<td>60</td>
</tr>
<tr>
<td>Lincoln</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0.1</td>
<td>44</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Lyon</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>0.3</td>
<td>30</td>
<td>67</td>
<td>50</td>
</tr>
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<td>Mineral</td>
<td>4</td>
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<td>0</td>
<td>0.0</td>
<td>0</td>
<td>NA</td>
<td>0</td>
</tr>
<tr>
<td>Nye</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0.2</td>
<td>17</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Pershing</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Storey</td>
<td>296</td>
<td>137</td>
<td>65</td>
<td>0.5</td>
<td>46</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Washoe (except Mental Health Institute)</td>
<td>22</td>
<td>12</td>
<td>9</td>
<td>0.8</td>
<td>55</td>
<td>75</td>
<td>64</td>
</tr>
<tr>
<td>White Pine</td>
<td>22</td>
<td>12</td>
<td>9</td>
<td>0.8</td>
<td>55</td>
<td>75</td>
<td>64</td>
</tr>
<tr>
<td>California counties</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mental Health Institute</td>
<td>364</td>
<td>154</td>
<td>55</td>
<td>NA</td>
<td>42</td>
<td>36</td>
<td>96</td>
</tr>
<tr>
<td>All counties except Clark and Washoe</td>
<td>338</td>
<td>124</td>
<td>52</td>
<td>0.5</td>
<td>37</td>
<td>42</td>
<td>55</td>
</tr>
</tbody>
</table>

**District office**

<table>
<thead>
<tr>
<th>County or District Office</th>
<th>Referred</th>
<th>Accepted</th>
<th>Rehabilitated</th>
<th>Number Rehabilitated per 1000 Population&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Accepted as Percent of Referred</th>
<th>Rehabilitated as Percent of Accepted</th>
<th>Mentally Handicapped Persons Rehabilitated as Percent of All Persons Rehabilitated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carson City</td>
<td>50</td>
<td>26</td>
<td>13</td>
<td>NA</td>
<td>52</td>
<td>50</td>
<td>38</td>
</tr>
<tr>
<td>Elko</td>
<td>84</td>
<td>23</td>
<td>6</td>
<td>NA</td>
<td>27</td>
<td>26</td>
<td>46</td>
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<tr>
<td>Ely</td>
<td>31</td>
<td>22</td>
<td>9</td>
<td>NA</td>
<td>71</td>
<td>41</td>
<td>56</td>
</tr>
<tr>
<td>Henderson</td>
<td>71</td>
<td>35</td>
<td>29</td>
<td>NA</td>
<td>49</td>
<td>83</td>
<td>21</td>
</tr>
<tr>
<td>Las Vegas Area</td>
<td>229</td>
<td>83</td>
<td>51</td>
<td>NA</td>
<td>36</td>
<td>61</td>
<td>18</td>
</tr>
<tr>
<td>L.V. Mental Health Outreach</td>
<td>182</td>
<td>129</td>
<td>82</td>
<td>NA</td>
<td>71</td>
<td>61</td>
<td>76</td>
</tr>
<tr>
<td>Mental Health Institute</td>
<td>364</td>
<td>154</td>
<td>55</td>
<td>NA</td>
<td>42</td>
<td>36</td>
<td>96</td>
</tr>
<tr>
<td>Public Offender Outreach</td>
<td>Carson City</td>
<td>84</td>
<td>29</td>
<td>9</td>
<td>NA</td>
<td>35</td>
<td>31</td>
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<td>0</td>
<td>NA</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Reno Area</td>
<td>366</td>
<td>166</td>
<td>70</td>
<td>NA</td>
<td>45</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>Winnemucca</td>
<td>55</td>
<td>11</td>
<td>10</td>
<td>NA</td>
<td>20</td>
<td>91</td>
<td>48</td>
</tr>
<tr>
<td>Total, district offices</td>
<td>1520</td>
<td>678</td>
<td>334</td>
<td>0.6</td>
<td>45</td>
<td>49</td>
<td>41</td>
</tr>
</tbody>
</table>

**SOURCE:** Rand analysis of FY 1974 "Case Service Reports."

**NOTE:** NA = not applicable.

Table 11.8
SUCCESSFULLY REHABILITATED MENTALLY HANDICAPPED PERSONS IN VARIOUS
HANDICAP GROUPS, BY AREA OF STATE AND DISTRICT OFFICE, FY 1974

<table>
<thead>
<tr>
<th>Area of State or District Office</th>
<th>Alcoholism</th>
<th>Drug Addiction</th>
<th>MR, Mild</th>
<th>MR, Moderate</th>
<th>MR, Severe</th>
<th>Psychotic</th>
<th>Psychoneurotic</th>
<th>Other Mental Disorder</th>
<th>Epilepsy</th>
<th>Cerebral Palsy</th>
<th>Stroke</th>
<th>All Mental Handicaps Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark County</td>
<td>12 (0.04)</td>
<td>43 (0.13)</td>
<td>26 (0.08)</td>
<td>5 (0.02)</td>
<td>1 (0.00)</td>
<td>6 (0.02)</td>
<td>13 (0.04)</td>
<td>51 (0.16)</td>
<td>5 (0.02)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
<td>162 (0.51)</td>
</tr>
<tr>
<td>(Number per 1000 pop.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washoe County except MH Institute</td>
<td>3 (0.02)</td>
<td>1 (0.01)</td>
<td>3 (0.02)</td>
<td>1 (0.01)</td>
<td>0 (0.00)</td>
<td>2 (0.01)</td>
<td>14 (0.10)</td>
<td>35 (0.25)</td>
<td>1 (0.01)</td>
<td>2 (0.01)</td>
<td>3 (0.02)</td>
<td>65 (0.46)</td>
</tr>
<tr>
<td>(Number per 1000 pop.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All counties except Clark, Washoe</td>
<td>5 (0.05)</td>
<td>1 (0.01)</td>
<td>3 (0.03)</td>
<td>1 (0.01)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
<td>3 (0.03)</td>
<td>31 (0.29)</td>
<td>7 (0.07)</td>
<td>1 (0.01)</td>
<td>0 (0.00)</td>
<td>52 (0.49)</td>
</tr>
<tr>
<td>(Number per 1000 pop.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Carson City</td>
<td>3</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0 (0.13)</td>
<td>13 (0.13)</td>
</tr>
<tr>
<td>Elko</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0 (0.00)</td>
<td>6 (0.00)</td>
</tr>
<tr>
<td>Ely</td>
<td>0</td>
<td>0</td>
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<td>4</td>
<td>1</td>
<td>0 (0.00)</td>
<td>9 (0.00)</td>
</tr>
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<td>Henderson</td>
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<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>11</td>
<td>1</td>
<td>0</td>
<td>0 (0.00)</td>
<td>29 (0.00)</td>
</tr>
<tr>
<td>Las Vegas Area</td>
<td>2</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>15</td>
<td>3</td>
<td>0</td>
<td>0 (0.00)</td>
<td>51 (0.00)</td>
</tr>
<tr>
<td>L.V. Mental Health Outreach</td>
<td>8</td>
<td>32</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>27</td>
<td>1</td>
<td>0</td>
<td>0 (0.00)</td>
<td>82 (0.00)</td>
</tr>
<tr>
<td>Mental Health Institute</td>
<td>16</td>
<td>25</td>
<td>7</td>
<td>0</td>
<td>12</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 (0.00)</td>
<td>55 (0.00)</td>
</tr>
<tr>
<td>Public Offender Outreach</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carson City</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
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<tr>
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<tr>
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<td>4</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>14</td>
<td>36</td>
<td>1</td>
<td>2</td>
<td>3 (0.00)</td>
<td>70 (0.00)</td>
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<tr>
<td>Winnemucca</td>
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<td>0</td>
<td>0</td>
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<td>6</td>
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<td>0 (0.00)</td>
<td>10 (0.00)</td>
</tr>
<tr>
<td>Total, District Offices</td>
<td>36</td>
<td>46</td>
<td>37</td>
<td>14</td>
<td>1</td>
<td>20</td>
<td>37</td>
<td>124</td>
<td>13</td>
<td>3</td>
<td>3 (0.00)</td>
<td>334 (0.00)</td>
</tr>
</tbody>
</table>

*See Table 11.7 for population data source. Other data are from Rand analysis of FY 1974 "Case Service Reports."
Mental Health Outreach office are predominantly in the categories of drug addiction and "other mental disorders." No other office has more than one rehabilitated drug addict. The NMHI office concentrates most heavily on alcoholism, but also emphasizes psychosis and mental retardation. The Reno area office concentrates on people with psychoneurosis and the nebulous, but most prevalent, "other mental disorder" category.

Detailed VR Client and Program Characteristics, FY 1974
Closures

See Appendix A for a detailed presentation of data on VR program client and program characteristics by type of mental handicap and outcome of the VR services. Topics discussed there include sources of referrals; destinations of persons referred elsewhere by VR; outcomes of referrals to VR and the reasons for nonacceptance of people as clients and for nonrehabilitation of clients; age, sex, race, Spanish surname, education, previous VR service, and secondary disabilities of clients; services provided; time spent in the VR program; client earnings and sources of support at time of referral and time of case closure; and occupations of rehabilitants.

Benefit/Cost Analysis of the Vocational Rehabilitation Program

The analyses in this section concentrate on economic benefits—only one of the various benefits by which the VR program should be evaluated. Earlier in this chapter we presented available data on other classes of criteria, such as the degree of change in clients' dependence and the equity of service distribution. Unfortunately, data are not available for some of the most significant effects, namely, changes in the overall quality of life of the mentally disabled people served. As will be seen, however, this VR program appears justified by its economic benefits alone. Other very significant major types of benefits, which are known to be positive but are unquantified, justify this program still further.

It is possible to do a better economic benefit/cost analysis of the VR program than it is for most other programs, because the VR program's data are generally better than those of any other program. In regard to vocational service, for example, only the VR program has data available on work status and earnings both before and after service.

Previous studies have concluded that the nationwide VR program for handicapped persons has yielded benefits that considerably outweigh costs. For example, a 1967 study by the U.S. Vocational Rehabilitation Administration found that each dollar of cost in FY 1966 generated an estimated $35 in increased clients' earnings and value of work activity over their working lives.25

A more thorough nationwide study, using more realistic assumptions, has been made by Ronald W. Conley.26 His analysis of the VR program focuses on economic

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costs and benefits, makes sophisticated use of available data, and clearly states the assumptions used in making estimates. With 1967 data, Conley estimates that for each dollar of the social cost of rehabilitation services, an increase in lifetime earnings of a little less than $5 accrues (at a 4 percent discount rate on future increased earnings). He also estimates that "the increased taxes paid by the rehabilitants and the reduction in tax supported payments for their maintenance amount to perhaps as much as 25 percent of the total increase in earnings." Critical assumptions underlying these and all other estimates relate to how one estimates what earnings would have been without rehabilitation, and what the employment record of the rehabilitant will be over his lifetime.

A recent Rand Corporation nationwide study of the economic benefit/cost relationships for eight categories of mildly to severely handicapped youth, using more conservative assumptions than those of Conley, found that the VR program for those youth could be justified on its economic benefits alone. In addition, the quality of life benefits are outstanding.\footnote{J. S. Kakalik et al., Improving Services to Handicapped Children, The Rand Corporation. R-1420-HEW, May 1974.}

The following analysis uses Conley's methodology with some significant adaptations. First, previous analyses have generally dealt with the program as a whole, not with disaggregations by type and degree of mental handicap. We will investigate the program's costs and benefits for eight categories of mentally handicapped people (those who are alcoholic, drug-abusing, mildly retarded, moderately retarded, psychotic, psychoneurotic, other mentally disordered, and epileptic) who accounted for 98 percent of the FY 1974 mental rehabilitations. Four categories of mentally handicapped people (those who are severely retarded, or have cerebral palsy, Parkinson's Disease, or stroke) were not separately analyzed, since each had three or less rehabilitants and hence would be subject to large variations in average costs and benefits. Although the VR data excel those for other programs we investigated, benefit/cost analyses must still resort to assumptions where data are incomplete. We will vary certain of those assumptions and note the sensitivity of estimated benefits to the variations.

For a more detailed description of the methodology we are using, the reader is referred to Conley's works, just cited. The methodology is briefly discussed here to lay out its underlying assumptions and mention some of our adaptations. We first describe components of cost, and then discuss the calculation of economic benefits.

Costs. The basic program costs include those of administration, vocational counselors, purchased services, and the establishment and support of rehabilitation facilities and workshops. When considering the effectiveness of the total program, it is possible to use the budget as an indicator of the program cost necessary to achieve that effectiveness. We must try to disaggregate the cost, however, if we want to make distinctions among the groups participating in the program. The only expenditures recorded in a client's file are those for services purchased, such as medical diagnostics, treatment, or vocational training. The agency generally treats the other costs as "overhead" and does not attribute them directly to individual clients. To do an analysis by type of mental handicap, we must devise some means of allocating overhead costs to each type of client. Two possible methods suggest themselves. First, "overhead" costs could be attributed on a per capita basis. This would be an accurate approximation if "overhead" services (e.g., counseling and
guidance) were independent of the length and cost of the service program designed
to help the client. Another approach, the one we have adopted, is to allocate all costs
in proportion to the costs of services purchased for the individual clients. This
implies that the types of clients who receive the most in case services, such as
medical treatment and training, also consume a higher proportionate share of coun-
seling and other expenditures. Because high service costs are likely to be associated
with the most difficult cases, such an allocation scheme is not unreasonable. Some
clients, however, have no "cost of services," and are successfully rehabilitated with,
for example, only counseling and placement services from VR agency personnel.
Our method implies that these clients actually were served cost-free, and therefore
distorts the results somewhat. Because such clients constitute only a small fraction
of the total, however, and are distributed across all handicap types, the resultant
error is likely to be small. The fraction of the cases with zero cost of services is less
than one-sixth for six of the categories of mental disability analyzed, and about
one-third for the two mental retardation categories analyzed. Hence, the average
total cost estimate for service to mentally retarded people will be biased slightly
toward the low side relative to other categories of disability in this benefit/cost
analysis.

The cost of income maintenance payments is not counted as a cost to society in
the benefit/cost analysis. This stems from the fact that the cost to the group that
pays the income transfer payment is equal to the benefits that accrue to the recipi-
ents of the income transfer payment; cost and benefits of the transfer cancel each
other out when society as a whole is considered if one assumes the marginal value
of a dollar to the taxpayer equals the marginal value of a dollar to the person being
served. This is not to say that they are cancelled out if we are considering any group
within society, such as taxpayers. In the case of taxpayers, income maintenance
costs would be considered because most recipients of the income transfer payments
are not representative taxpayers.

Some clients receive vocational services that are not financed by the VR agency
and hence do not show up in the budget of the agency or in the expenditure record
of the client. Conley has estimated that such expenditures amounted to 4 percent
of the annual program costs, and we use this estimate. We would prefer to add the
actual expenditures of other programs for vocational services to VR clients, but the
data do not permit this. For example, we do not know how many young mentally
handicapped VR clients received vocational education program services nor do we
know the cost of Employment Security Department service to mentally disabled VR
clients. The one case we know of that is expected to affect the results of this analysis
significantly is vocational service provided by the Vocational Training and Com-
munity Training Center programs funded by the Division of Mental Hygiene and
Mental Retardation and primarily serving moderately retarded individuals who
may also be VR clients. Hence the cost estimates in this analysis will be biased to
some unknown degree toward the low side for the moderately retarded, and results
must be interpreted with that fact in mind.

Some of the clients in the program have previously received service from the
VR program. Others will receive additional service in the future. Conley argues that
both these past and future costs should be included as part of the incremental social
costs for the current year's rehabilitants. We assume, as he did, that the percentage
of the year's rehabilitants in each category of disability who would become rehabili-
tation “repeaters” equals the percentage that were repeaters in 1974, and that future service costs are the same as the present average cost of rehabilitation.

This year’s clients are also recipients of the benefits of previous national research, staff training, and past expenditures on construction of facilities. These costs must be amortized to get an estimate of the program’s true cost. Conley found that public expenditures for these categories were about 20 percent of the annual basic program cost, and that private support in these categories was about 5 percent of basic program cost. This meant that an estimate of the cost of research, training, and construction programs that could be allocated to this year’s program would be equal to 25 percent of this year’s basic program cost.

One of the social costs of the VR program is the opportunity cost associated with the production that is lost when the client forgoes the labor force and enters the program. Since real data on earnings at acceptance are available, we assume the opportunity cost equals those earnings times the length of time in the VR program.

Benefits. We emphasize that the VR program produces several types of benefits for both the client and society. There are obvious psychic and other benefits to the client, notably self-sufficiency, but in this section we are concerned with the economic benefits that can be attributed to the services provided by the program.

Three major parameters must be specified to find the total increase in earnings from the VR program: the number of years the client will work, the differential in earnings for each year between what he earns after VR services and what he would have earned without them, and the discount rate. The specification or estimation of each parameter is discussed below.

To estimate the number of years worked, Conley assumes that unless the rehabilitant suffers vocational failure or dies, he works until he retires at the age of 65. Conley’s mortality rates are taken from experience with Railroad Retirement Disability annuitants. That group has high mortality rates compared with the population in general. We note that the above estimate of number of years worked will include work resulting from future VR service to “repeaters,” which is reasonable since our total cost estimate includes the cost of those future “repeat” services. A critical assumption concerns the amount of unemployment later in life. The number of years worked after rehabilitation and before reaching age 65 must be adjusted to reflect periods of possible unemployment. As described in the next section, Conley argues that after five years the decrease in earnings due to unemployment is offset by the increase in productivity (as measured by earnings) of those who retain their employment.

Conley estimates the increased productivity of rehabilitated recipients of VR services as follows:

We will accept our conclusions from the follow-up studies that 80 percent of all rehabilitants are still gainfully employed five years after closure and that their average earnings are about 25 percent higher than the average earnings of rehabilitants in the year of closure, and we will further assume that these successful rehabilitants will continue to be employed at these higher wages until death or retirement. Given these assumptions, it follows that the increase in earnings due to rehabilitation during any time period after rehabilitation will vary with the number of rehabilitants still employed (since the loss of earnings among live rehabilitants of working age who fail to maintain their employment is offset by the increased earnings of successful rehabilitants). Total increased output due to rehabilitants will,
therefore, be equal to the average number of years worked by rehabilitants
still employed five years after closure multiplied by the increase in earnings
between acceptance and closure.**

A recent follow-up survey of 4146 VR service recipients in six states one, two,
and three years after closure, conducted by National Analysts, Inc.,** suggests that
the assumed percentage working five years after closure is too high. Our later
sensitivity analysis accordingly considers what the economic benefits would be if the
figure were less. The National Analysts report indicates that in the 12 months
following closure, 47 percent of the rehabilitants worked without interruption, 29
percent did not work at all, and 57 percent were working for pay when interviewed.
Comparable figures for nonrehabilitants were 19 percent, 60 percent, and 24 per-
cent, respectively. Over a 36-month period following closure, the percentage em-
ployed for pay at the time of the interview decreased only slightly, to 55 percent.
The amount of time worked for pay averaged just over 7 months per year, varying
from about 6 months per year up to 9, depending on sex and race. The National
Analysts study also presents new data on the percentage increase in earnings one,
two, and three years after closure. In constant-value dollars, mean monthly earnings
of rehabilitants up to 24 years old increased about 25 to 35 percent for males and
20 to 30 percent for females. For rehabilitants of all ages at the end of one, two, and
three years, earnings increased 30, 32, and 32 percent, respectively, over the single
base-year starting figure.

Because similar follow-up data on Nevada rehabilitants are not available, we
must make assumptions as described above and test the sensitivity of the results of
this analysis to those assumptions.

The total stream of benefits can now be estimated by multiplying the number
of person-years of work life by the assumed increase in earnings due to the VR
program for each type of handicapped client. Given a preference, however, one
would prefer earnings this year to the same amount of earnings at some distant time
in the future. To account for that preference, future benefits must be discounted.
Just what is the proper amount to discount future costs and benefits from govern-
ment projects has been subject to extensive study and controversy. Rather than
choose a single discount rate, we will use 6 percent in our base-case analysis and
examine some other values in the later section devoted to sensitivity analysis.

**Societal Benefit/Cost Analysis: Base Case**

For the base-case analysis of the relation of benefits and costs to society, we use
Conley's methodology, modified as described above, and the data on Nevada men-
tally disabled VR clients derived from the FY 1974 case closures described earlier
in this chapter. The next sections test the sensitivity of the analysis to various other
assumptions, present our benefit/cost analysis using conservative assumptions in-
tended to put the VR program to a hard test, and analyze the relation of benefits
and costs to Nevadans and taxpayers.

The benefit/cost ratios to society using the base-case assumptions are presented

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** A Follow-up Study of Closed Vocational Rehabilitation Cases. Final Report to the Social and
April 1972.
in Table 11.9. In all eight categories of mental disability, the economic benefits far outweigh the costs (the ratio is 1.0 if benefits equal costs). The lowest benefit/cost ratios are for psychotics, psychoneurotics, and people with some "other mental disorder"; in each of these cases, higher costs, rather than lower benefits, account for most of the difference in benefit/cost ratios for these three groups relative to other disability categories. The highest ratio is for people with an alcohol problem, and comes primarily from the higher earnings for these rehabilitants relative to those in other disability categories. Considered in terms of years of work time required to "break even," that is, to earn benefits to society equal to the costs incurred, the longest break-even years of work required will be for psychoneurotic clients since they have the lowest benefit/cost ratio. For psychoneurotic clients the average required work period to "break even" under the base-case assumptions is less than two years; for alcohol abusers the figure is less than six months (the shortest for any category of disability analyzed).

In summary, some types of mentally handicapped people do better than others in a benefit/cost sense, but the program appears to offer society a handsome return on investment for all eight categories of prevalent mental handicaps. This is in line with previous findings. As we vary some of Conley's assumptions, however, the success of the program appears to be somewhat less than the base-case analysis indicates. We now turn to sensitivity analysis.

<table>
<thead>
<tr>
<th>Type of Mental Disability</th>
<th>Benefit/Cost Ratio for Rehabilitant of Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 Years</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>33</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>21</td>
</tr>
<tr>
<td>MR, mild</td>
<td>18</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>23</td>
</tr>
<tr>
<td>Psychosis</td>
<td>11</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>8</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>11</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>19</td>
</tr>
<tr>
<td>All types combined</td>
<td>14</td>
</tr>
</tbody>
</table>

**Benefit/Cost Analysis: Sensitivity to Data and Assumptions**

This section explores the sensitivity, to the above data and assumptions, of the conclusion that the VR program is highly cost-beneficial to society. Many combinations of data and assumptions are possible. Our tactic here is to vary the most significant of them one at a time so as to isolate and study their influence, and then to make what appears to be a realistic set of changes of more than one type of data and assumption.
Discount Rate. The base-case analysis used a discount rate of 6 percent. Its use assumes that government and private enterprise do not have investment opportunities that yield over 6 percent. While it is impossible to say what the correct discount rate is, since conditions in the future will change that rate, we can measure the effects of various discount rates on our conclusions. Any discount rate lower than 6 percent will raise the program benefits (the same future earnings are worth more in current dollars with a lower discount or interest rate), but leave the program cost for FY 1974 rehabilitants essentially unchanged. The opposite is true for higher discount rates, and so we must recalculate the ratios with a higher discount rate to see if the VR program still appears cost-beneficial to society. Table 11.10 shows the recalculated ratios assuming a discount rate of 10 percent; even with that change, the program still returns positive benefits relative to its cost for all eight categories of mentally handicapped clients studied.

![Table 11.10](image)

<table>
<thead>
<tr>
<th>Type of Mental Disability</th>
<th>Benefit/Cost Ratio for Rehabilitant of Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 Years</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>22</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>14</td>
</tr>
<tr>
<td>MR, mild</td>
<td>12</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>16</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>5</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>8</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>13</td>
</tr>
<tr>
<td>All types combined</td>
<td>9</td>
</tr>
</tbody>
</table>

Cost. Several of the data and assumptions about cost can be debated. However, for any reasonable changes in the cost used, the conclusion that the program is cost-beneficial does not change. If the cost goes down, the benefit/cost ratio goes up. On the other hand, if the cost goes up by, say, 25 percent, while the benefits remain the same, the benefit/cost ratios decline by only 20 percent and are still high.

Number of Rehabilitants Who Continue to Work. The base-case analysis assumes a high mortality rate and still shows the program to be cost-beneficial. We will not use a still higher mortality rate because it appears unreasonably high already. The base-case analysis also assumes that 80 percent of those with earnings at closure have earnings five years from closure, and that later increases in earnings offset later increases in unemployment. If no change is made in the assumptions about the earnings of those who remain employed, total benefits decline as the 80-percent employment figure or the 5-year figure are lowered; the benefit/cost ratios in Table 11.11 are obtained for various assumptions about the percentage that stays in the labor force after two years. As the table indicates, the benefits exceed
Table 11.11

SOCIAL BENEFIT/COST RATIO OF NEVADA VR FOR SELECTED TYPES OF MENTAL DISABILITY: SENSITIVITY TO RATE OF EMPLOYMENT

<table>
<thead>
<tr>
<th>Type of Mental Disability</th>
<th>Benefit/Cost Ratio with Employment Rate After 2 Years of:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>80%</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 20</td>
<td>Age 45</td>
<td>Age 20</td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
<td>32</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Drug addiction</td>
<td></td>
<td>20</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>MR, mild</td>
<td></td>
<td>17</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>MR, moderate</td>
<td></td>
<td>22</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
<td>11</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td></td>
<td>8</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td></td>
<td>11</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td>18</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>All types combined</td>
<td></td>
<td>13</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

the cost (ratio exceeds 1.0) for all categories of mentally handicapped clients, even if only 20 percent retain full-time employment after two years. Since no follow-up study on rehabilitants we are aware of has concluded that the rate of employment after successful rehabilitation is that low, the VR program for the eight categories of mentally handicapped persons appears to be cost-beneficial for all reasonable values of employment rate, if all other assumptions remain unchanged.

**Earnings Gain Due to VR Services.** A major assumption in the base-case analysis is that the earnings gain due to VR services is equal to the difference between reported earnings at time of referral and at closure. However, the assumption that earnings at referral are a good indication of what the client would continue to earn in the absence of the VR program is open to serious question. It is difficult to get an accurate estimate of what would happen to those clients if the VR program did not exist, since accurate data on earnings of mentally handicapped persons in the general population do not exist and because the VR program clients probably are not typical of that population.

Rather than trying to get a more accurate estimate of earnings without VR services, we use several different earnings assumptions to get an idea of their effects on the base-case analysis benefits. Table 11.12 shows the benefit/cost ratio of the VR program under three different assumptions about earnings without services. It is assumed that 25, 50, and 75 percent of those cases closed as successes would have been employed, with the average earnings equal to a 1974 minimum wage, in the absence of VR services (i.e., $80 a week on the average).

According to the table, even if 75 percent of the rehabilitants could obtain minimum wage jobs on the average without VR services, the program would be cost-beneficial for the combined client population of all mentally disabled people, but would not be cost-beneficial in solely economic terms for mentally retarded people. (Where the benefit/cost ratio shown is negative, the VR program is less effective in earning terms than a program that puts 75 percent of the rehabilitants in minimum-wage jobs.) Within all the eight prevalent categories from the more severely to the
Table 11.12
SOCIAL BENEFIT/COST RATIO OF NEVADA VR FOR SELECTED TYPES
OF MENTAL DISABILITY: SENSITIVITY TO ASSUMPTIONS ABOUT
EARNINGS WITHOUT VR SERVICES

<table>
<thead>
<tr>
<th>Type of Mental Disability</th>
<th>Benefit/Cost Ratio with Indicated Percentage Employed Without VR Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Age 20</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>27</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>16</td>
</tr>
<tr>
<td>MR, mild</td>
<td>11</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>16</td>
</tr>
<tr>
<td>Psychosis</td>
<td>8</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>6</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>9</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>14</td>
</tr>
<tr>
<td>All types combined</td>
<td>10</td>
</tr>
</tbody>
</table>

less severely disabled, including the mentally retarded clients, the VR program has
economic benefits that exceed its costs even if about two-thirds or less earn the
minimum wage in the absence of the program.

The practice of "creaming" and serving the least handicapped clients, if en-
gaged in, would not necessarily lead to the largest economic return under the base-
case analysis assumptions. This calls into question whether emphasizing service to
less handicapped clients is in fact a rational, to say nothing about equitable, policy
from the standpoint of economic return.

Societal Benefit/Cost Analysis: Conservative Assumptions Case

In the preceding section, several assumptions in the base-case analysis were
varied individually, and the conclusion that the program is cost-beneficial in an
economic sense did not change. In this section, we change three of the most signifi-
cant base-case assumptions and recalculate the benefit/cost ratios for this new set
of data and assumptions. The new assumptions are considerably more conservative
than the base-case assumptions, and should present the VR program in the worst
light that seems reasonable. If the VR program still appears economically cost-
beneficial, we will conclude that the program is effective in a total social cost-benefit
sense.

In calculating the benefit/cost ratios shown in Table 11.13, we assume the
following:

- The discount rate is 10 percent.
- Only 50 percent of the mentally disabled rehabilitants are employed 2
  years after closure.
- In the absence of the VR program, 50 percent of both the retarded and the
  psychotic rehabilitants, and 75 percent of the less severely handicapped
  rehabilitants, could have been employed and would have earned the mini-
  mum wage on the average.
Table 11.13

SOCIAL BENEFIT/COST RATIO OF NEVADA VR FOR SELECTED TYPES OF MENTAL DISABILITY: CONSERVATIVE ASSUMPTIONS CASE

<table>
<thead>
<tr>
<th>Type of Mental Disability</th>
<th>Benefit/Cost Ratio for Rehabilitant of Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 Years</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>8</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>3</td>
</tr>
<tr>
<td>MR, mild</td>
<td>2</td>
</tr>
<tr>
<td>MR, moderate</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis</td>
<td>3</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>0.6</td>
</tr>
<tr>
<td>Other mental disorder</td>
<td>1.7</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>3</td>
</tr>
<tr>
<td>All types combined</td>
<td>2.1</td>
</tr>
</tbody>
</table>

We emphasize that the true values of the above figures are not known, nor are they our best estimates. They are conservative estimates made to put the VR program to a hard test. Rather than assume, as in the base-case analysis, that without the VR program nearly all of these rehabilitants would be unemployed throughout their lives, we assume that a majority would be employed. And rather than assume a 20-percent unemployment rate for successful rehabilitants after five years, we assume a 50-percent unemployment rate after two years.

Under these much less favorable assumptions, the program still appears to have economic benefits that exceed its costs to society for each category of mentally handicapped client analyzed with the exception of psychoneurotic rehabilitants. This is true for even the severely handicapped groups analyzed, which some people might argue are "too expensive" to serve.

Many questions about the proper allocation of resources among handicaps cannot be answered with this type of analysis. However, the positive quality-of-life benefits of the program, coupled with favorable average economic benefits in relation to cost, imply that expansion of the VR program could have very desirable effects. If the program is to be expanded, however, it should be carefully and periodically reevaluated, because diminishing returns on investment can be anticipated as a larger fraction of the mentally handicapped population is served, and because our calculations have been of average costs and benefits, not the marginal costs and benefits of program expansion, for which data are not available. The above analysis also has not considered the distributional effects of the program in transferring dollars from one segment of population to another; the implicit assumption above is that the marginal value of the last dollar paid by the taxpayer equals the marginal value of a dollar to the recipient of service. Next, we consider costs and benefits from the viewpoint of the taxpayer who funds the service.

Benefits and Costs to Taxpayers

The previous analysis examined the VR program from the standpoint of society
as a whole. It did not consider the question of exactly who received the benefits and who paid the costs within society. In this section we view the VR program from the perspective of an investment decision for the taxpaying segment of society.

The costs borne and benefits captured by the taxpayer are different from those discussed in the previous sections. On the cost side, income maintenance payments during rehabilitation are a real cost to the taxpayer while the opportunity cost of withdrawing the client from the labor force is not. On the benefit side, only the increment in taxes paid by the employed rehabilitant, rather than the total increase in income, is counted as a benefit to the taxpayer. An additional benefit is the reduction in future welfare payments that is attributable to the VR program. The costs can be calculated from information presented previously.

To estimate the increase in taxes paid by mentally disabled rehabilitants, it is necessary to consider their income distribution presented earlier. The estimated federal income tax was calculated assuming the average taxpayer has one dependent other than herself or himself. (This will introduce a small downward bias in the benefits because the actual average was .7.) The Nevada sales tax payments were calculated from the federal "1974 Optional State Sales Tax Tables." Future tax payments and welfare reductions were discounted at 10 percent. We also conservatively assume (to put the program to a hard test) that only 50 percent of the mentally disabled rehabilitants are employed two years after VR case closure.

We also face the problem of estimating taxes paid in the absence of the VR program. If we use earnings at acceptance as the tax base, the taxes paid will be negligible. We conservatively assume that in the absence of the VR program, 50 percent of the retarded and psychotic rehabilitants, and 75 percent of the less severely mentally disabled rehabilitants could have been employed, earning the minimum wage on the average. Again, we emphasize that the above assumptions are not our best estimates of the unknown true values, but are conservative estimates designed to put the VR program to a hard test by making low benefit estimates.

By placing clients in jobs, the VR program also reduces the number of mentally handicapped persons who need to rely on public welfare, and the program thus benefits the general taxpayer population. We estimate this reduction using welfare payments at acceptance and at closure as a measure of the decline in the amount of average welfare payments per client in the first year after closure. We also conservatively assume that only half the clients who are removed from public welfare rolls because of vocational rehabilitation will remain off those rolls for two years (this parallels our assumption that 50 percent will be employed at the end of two years following closure). An earlier section presented data on VR clients on public assistance and the amount of public assistance payments.

The benefit/cost ratios for the general taxpayer population are 1.18 for the average mentally disabled rehabilitant of age 20, and 1.03 for a rehabilitant of age 45, and the economic benefits exceed the costs to the taxpaying population even under the "worst case" conservative assumptions we have made.

Because we have excluded all property tax benefits, with a resultant underestimate of overall benefits, the program appears cost-beneficial as a taxpayer "invest-

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ment," just as it was shown to be cost-beneficial from the viewpoint of society as a whole and is cost-beneficial from the viewpoint of the individual VR client.

PRIVATE COMMUNITY VOCATIONAL CENTERS

Several private centers operate with partial government funding in a "Community Training Center" program under the auspices of the Nevada Division of Mental Hygiene and Mental Retardation (see Chap. 7 for details). Those private centers provide a variety of services, primarily for developmentally disabled preschoolers and adults, e.g., day care activities, developmental training, individual and family counseling, supervised living, work evaluation, prevocational and vocational training, and sheltered work. Vocationally related services are described in the following subsections on the centers that provide those services; other services by the centers are described in this report's chapters on education and training, and residential living. These centers are intended to provide services not available in any other program. The state-provided funding is a minimum of $300 per enrollee per quarter year, with the actual amount depending on availability of funds. Each center receives a minimum of $14,000 per year, providing staff expenses are equal to that amount and the center has 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 eight preschoolers and one adult.31

Elko Developmental School

The Elko Developmental School is primarily a preschool for developmentally disabled children, but a small sheltered workshop for adults is also in operation. The workshop does not do work evaluation.32 About 11 persons of all ages are served,33 and some funds are received from the Community Training Center program.

Mineral County Sheltered Workshop

The Mineral County Sheltered Workshop serves about 13 people in Hawthorne.34 It is primarily a preschool but also has a prevocational and vocational training program for developmentally disabled people.35 The program is directed by a special education teacher, assisted by two half-time teaching aides plus volunteers. The adolescents' program includes supplemental activities for academic development, prevocational and vocational skills, recreation skills, socialization, and the refine-


32 Interview with M. Carroll, Community Training Center Coordinator, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, October 7, 1974.


34 Ibid.

35 Interview with M. Carroll.
ment of self-help skills. For the adult population, activities are conducted for daily living skills, prevocational and vocational training, socialization, and appropriate use of leisure time.36

**Opportunity Village Association for Retarded Citizens (OVARC)**

In addition to functioning as an Association for Retarded Citizens, Opportunity Village provides a wide variety of direct services to retarded people in the Las Vegas area. It originated in 1954 as a parents' group; lessened a gap in services by operating a school for severely retarded children not served by the public schools until recently; again alleviated a gap in the public service system in 1968 when it opened the first sheltered workshop in the Las Vegas area with an associated large thrift store; and, most recently, moved to alleviate a shortage of appropriate residential living facilities for retarded adults by establishing residential apartments in 1971.37 It closed the school it operated when the public schools expanded their service to include the group that Opportunity Village had been serving.

The Opportunity Village sheltered apartments are described in the chapter of this report on residential living facilities; the remainder of this subsection describes the vocational and other services provided.

Opportunity Village runs sheltered workshops at two locations in Las Vegas. In July 1974 a total of about 110 retarded adults (plus a very few people who were not retarded) worked in the two sheltered workshops.38 The types of work involve operation of the large thrift store, an "activity" group to develop pre-employment skills, making and selling the products of arts and crafts, making buttons and signs, printing, and a wide assortment of work on contract from other organizations. Counseling is provided to every person involved in the workshop program, to some of their families, and to other retarded Clark County residents who desire it. Staff conferences are held for each trainee in each of his or her first three months in the program, and typically every three months thereafter. Each receives a hot lunch at 50 cents per day, or free if the trainee is unable to pay. Two OVARC buses and two vans provide transportation for the 60 percent of the trainees who need it. A $1 a day charge is made for transportation, but more than half of those transported are unable to pay and hence are not required to. OVARC regards transportation as a vital part of their outreach to clients. Since public transportation is said to be inadequate, OVARC staff believe that if they did not transport people, they would be serving primarily two-car families and those who lived near enough to walk to the facilities.

The purpose of the workshop program is

... to provide work adjustment and work training experience for the mentally retarded and other handicapped individuals. The workshop program is designed for handicapped adults who are not presently employable, and who need a program that will allow them to develop under supervision into employable, productive human beings. The workshop program is also seen as a long-range activity for those individuals who may not be able to be

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36 "Description of Community Training Center Program," submitted by Mineral County Sheltered Workshop to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.
37 "Board and Staff Manual," OVARC.
38 Interview with Dr. Theodore Johnson, Executive Director, OVARC, Las Vegas, Nevada, July 17, 1974.
brought to the level of employability. Each handicapped person involved in the program is called a "trainee" with hope always present for progress toward employability. For those who must have a continuing long-range training program, it is intended that the workshop will provide partial employment.  

The eligibility requirements are that the handicapped person be an adult who is no longer in school, and for whom no other appropriate vocational service program exists. The program operates eight hours a day, five days a week, at a cost of over $250/month/trainee. Parents are asked but not required to contribute to the financial support of the program, and no individual is excluded because of inability to pay.

Workshop trainees are paid 10 cents to $1 per hour depending on their competence, with some workers paid on a piece-rate basis receiving more. Wages for piece-rate work are based on a $2 per hour wage that would be paid to a normally functioning person. A time study is conducted on each work task in order to assign a wage for the piece rate. Thus, a client who performs at one-half the pace of a normally functioning person receives $1 per hour. A worker who achieves about 70-percent productivity, however, is moved into competitive employment rather than being allowed to remain within the sheltered work environment.

The workshop atmosphere is pleasant, and the trainees we talked to seemed reasonably happy. The workshop seems to be functioning very well.

The workshop's clientele being drawn from the more severely handicapped population, it sometimes takes a long time to develop their vocational abilities. In fact, Opportunity Village has accepted clients that the VR program could not succeed with or would not accept. Opportunity Village maintains liaison with VR, however, and if people applying for service at OV have not been to the Nevada Bureau of Vocational Rehabilitation, they are sent there first. Numerous referrals of OVARC clients to other agencies providing complementary needed services are made. OVARC receives numerous referrals from VR, as well as from other service agencies.

Opportunity Village does not have a waiting list for service. Instead, they attempt to expand to meet the need. However, the July 1974 OVARC staff of 35 had been expanded too fast, according to Dr. Johnson, then the Executive Director. He indicated that the staff had expanded rapidly because of the great need for services, but he candidly admitted this had made OVARC "much too thin on qualified staff." For example, the contract portion of the workshop had about 25 clients working in July 1974, with a staff of six, two of whom were college graduates but none of whom had professional vocational service training. That staff performed a quality control function, trained workers, and did some work testing and evaluation. However, Opportunity Village is far from unique in being "thin" on professional personnel, and is providing greatly needed services. Elsewhere in this report we note other programs in Nevada with a similar personnel problem.

The 1974 OVARC budget was just under half a million dollars, with the thrift store providing about half of the income. Only about 22 percent of the income came from government sources, and only 16 percent came from United Way and other

39 "Board and Staff Manual," OVARC.
40 Interview with Dr. Johnson.
41 Ibid.
42 Ibid.
contributions. Government sources providing income were primarily the VR program (Nevada Division of Rehabilitation) and the Community Training Center program (Nevada Division of Mental Hygiene and Mental Retardation). Over 60 percent of the expenditures were for salaries and related expenses (see Table 11.14). In addition to the above budget, the Bureau of Vocational Rehabilitation has recently awarded Opportunity Village a work evaluation equipment grant (shown in the VR budget earlier in this chapter).

Table 11.14

<table>
<thead>
<tr>
<th>Support</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>$ 25,000</td>
</tr>
<tr>
<td>Special events</td>
<td>30,138</td>
</tr>
<tr>
<td>Government income</td>
<td>100,000</td>
</tr>
<tr>
<td>Membership</td>
<td>1,000</td>
</tr>
<tr>
<td>Fees</td>
<td>33,000</td>
</tr>
<tr>
<td>Sales</td>
<td>229,000</td>
</tr>
<tr>
<td>United Way</td>
<td>48,212</td>
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<tr>
<td><strong>Total, support</strong></td>
<td><strong>$462,350</strong></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Expenditures</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Salaries</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>$ 89,397</td>
</tr>
<tr>
<td>Clerical</td>
<td>22,687</td>
</tr>
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<td>Trainee</td>
<td>18,000</td>
</tr>
<tr>
<td>Other</td>
<td>119,166</td>
</tr>
<tr>
<td><strong>Total salaries</strong></td>
<td><strong>256,250</strong></td>
</tr>
<tr>
<td>Health and retirement, payroll taxes, etc.</td>
<td>32,500</td>
</tr>
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<td>Outside services</td>
<td>4,800</td>
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<tr>
<td>Supplies</td>
<td>26,000</td>
</tr>
<tr>
<td>Telephone, postage</td>
<td>6,700</td>
</tr>
<tr>
<td>Occupancy</td>
<td>89,000</td>
</tr>
<tr>
<td>Outside printing</td>
<td>4,000</td>
</tr>
<tr>
<td>Transportation</td>
<td>15,000</td>
</tr>
<tr>
<td>Conferences, publications, awards</td>
<td>5,700</td>
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<tr>
<td>Equipment</td>
<td>3,000</td>
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<tr>
<td>Cost of resale items</td>
<td>10,000</td>
</tr>
<tr>
<td>Organization dues, national support</td>
<td>9,400</td>
</tr>
<tr>
<td><strong>Total expenditures</strong></td>
<td><strong>$462,350</strong></td>
</tr>
</tbody>
</table>


Ormsby Association for Retarded Citizens

The direct service programs offered by the Ormsby ARC include one for preschool, one for school-age, and one for adult work adjustment and vocational training. The primary focus of this ARC is on the two programs for children which are discussed in the education chapter of this report. Developmentally disabled people from Carson City, Lyon County, and Douglas County are served by the Ormsby ARC, which sees itself in a 'residual role in the community by offering services to all
developmentally disabled citizens not served by public school special education programs because of age, type or severity of handicap, or behavioral problems."43

A total of eight adults were receiving vocational services in November 1974. According to the Program Director, the ARC does not operate a sheltered workshop but rather a work adjustment and work activities program. Adults are given training in daily living skills and work adjustment (e.g., group cooperation, work habits, self-control). Work activity consists of providing janitorial service at the ARC Center and some assistance at a small thrift store in Carson City. In the last half of 1974, one adult was placed in a job (as a half-time shipping clerk), and two more were thought to be placeable in competitive employment after additional training.44

The current Ormsby ARC programs are in facilities not well suited to a vocational program, and are overcrowded. Near-term future facility plans include acquiring a larger thrift store with room for a workshop area, and a large mobile home so that they can accept contract work they do not have room for now.45

Detailed budget data were not available for FY 1974. Funds come from eight sources, several of which are not stable long-term sources. The majority of funds are from government sources. In addition to VR and Community Training Center fees from the state, a total of $88,000 in other government grants was received in FY 1974. Three VR grants were used to buy equipment and to pay for a workshop/transporation coordinator, a psychologist, a speech therapist, and a secretary. A Developmental Disabilities program grant was used to pay for a "community service" person. The remainder of the funds came primarily from the thrift store ($19,000 in the first nine months of 1974), and also from tuition (based on ability to pay), contributions, and ARC membership dues.

The total ARC budget projected for FY 1975 was expected to be approximately $125,000, with less than half of that going for vocational services (8 adults out of 20 clients in November 1974). The ARC staff for all three program areas numbers 18 and includes one rehabilitation counselor, a half-time psychologist, a social worker, a half-time speech therapist, a part-time physical therapist, two teachers, one teacher's aide, and six "foster grandparents."46

**Panaca Community Training Center**

Panaca is in Lincoln County not far from the Utah border. The Panaca program operates in a room in the local community center, and serves approximately 13 people.47 The center provides a variety of types of training for retarded persons not served by any other existing program. Clients are evaluated by a psychologist, a nurse, and a special education teacher. The regular staff of three conduct daily living and prevocational training (e.g., in coordination, speech, motor skills, food preparation, social skills). Some physical therapy is provided and transportation is provided.

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43 "Description of Community Training Program," filed by Ormsby ARC, Carson City, Nevada, with the Nevada Division of Mental Hygiene and Mental Retardation, 1974.
44 Interview with S. Landis, Ormsby ARC, Carson City, Nevada, November 15, 1974.
45 Ibid.
46 Ibid.
47 Nevada Rehabilitation Division, "Rehabilitation Facility Plan."
to clients if needed. Only one preschool-age person is served, and an attempt is being made to have that child served in the more appropriate school setting.

**Washoe Association for Retarded Citizens**

The Washoe ARC serves people primarily in the Reno-Sparks area (Washoe County) but also aids residents from other counties that lack a local ARC, when it is feasible to do so. The association performs a major advisory and advocacy function. Members provide representation to at least 20 major organizations and committees, such as the Governor's advisory boards on developmental disabilities and rehabilitation. They have actively supported a lawsuit demanding equal education for handicapped children as well as various pieces of legislation to improve services to handicapped people. The Washoe ARC operates a major and diverse direct service program, including work evaluation, counseling, work adjustment, a workshop, and an associated thrift store. It also operates an educational-residential facility for retarded adults; it is discussed in this report's chapter on residential living.

The Washoe ARC first began providing direct services in 1966 and has grown rapidly since then. The original service focus was on a Child Development Center for mentally retarded children; it was phased out in 1973 when the local school district assumed the responsibility for serving those children. The residential facility program began operation in 1974, at which time the vocational service program also was significantly expanded with state-federal funding. Like the Opportunity Village program, the Washoe ARC services were first initiated to help fill gaps in publicly provided services, and are modified in response to improvements in the public programs.

The Washoe ARC evaluation program, started in October 1974, assesses each client's handicap and vocational service needs. The diagnostic evaluation, which lasts up to eight weeks for each client, includes pertinent medical, psychological, vocational, educational, social, and other factors. Work behavior, attitudes, habits, work tolerance, and ability to acquire new occupational skills are assessed in real work test situations and by other means. Following evaluation, the client may proceed to competitive employment, work adjustment training, or a sheltered workshop, and may receive a combination of other needed services. Some (expected to be a very small percentage) will be determined to have "no vocational potential."

The State Bureau of Vocational Rehabilitation also operates a work evaluation and work adjustment training center in Reno. However, the intent is for the VR program to send all mentally retarded people to the Washoe ARC program for evaluation in a cooperative arrangement rather than operating duplicate evaluation programs. The VR program is providing one full-time vocational counselor and one full-time secretary to work with the Washoe ARC program.

The Washoe ARC evaluation program will admit four people per week (and thus will expect to complete service for about 200 people per year), resulting in a signifi-

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48 "Description of Community Training Center Program," submitted by the Panaica Community Training Center to the Nevada Division of Mental Hygiene and Mental Retardation, 1974.

49 Interview with M. Carroll.


51 Ibid.
cant increase in the number of developmentally disabled people receiving vocational services in northern Nevada. All will be clients of the state VR Bureau. Expenses for the first year of the evaluation program are being paid by a grant from the state VR Bureau, and will probably be paid by direct charges to the VR Bureau for each client served in subsequent years. Prior to admission to the Washoe ARC evaluation program, potential clients will be given a medical and psychological screening by the VR program. 52

The Work Adjustment (and prevocational training) program emphasizes the retarded person’s work attitudes, plus provision of other services such as speech or physical therapy, counseling of the retarded person and his or her family, and adult educational services if shown to be needed in the prior evaluation. Prevocational training may include, if needed, skills in using public transportation, use of money, reporting for work on time, and so forth. This program will include about two hours per day in a classroom setting (or the community as a classroom) and the remainder of the day in the workshop. 53

The two thrift stores operated by the Washoe ARC receive donated articles for sale, process and sell those articles as part of the sheltered workshop program, and provide funds needed for provision of services.

The sheltered workshop for retarded adults from age 16 includes a work activities program and a regular sheltered work program, both certificated by the U.S. Department of Labor. (These were the only certificated vocational facilities in Nevada in mid-1974. Accreditation is also being sought for the newly initiated Evaluation and Work Adjustment programs at Washoe ARC.) Emphasis is not solely on vocational concerns, but also on social daily living skills that enable people to function in society. The workshop employs about 40 adults (age 16 years and up) who cannot now and may never be able to hold a competitive job. The workshop also includes diverse jobs resulting from contract work for other organizations (e.g., printing, making signs and buttons), a printing skills training program within the workshop, and a skill training program for maid service that has been arranged with a local hotel. Participants in the work activities program earn 10 cents to 90 cents per hour. All regular sheltered workers in the workshop are paid one-half the federal minimum wage or higher. 54

Fees of $0 to $150 per month are charged to the families of the developmentally disabled clients in the workshop, depending on ability to pay. For example, a family with two children and an income of $15,000 per year would be requested to pay $50 per month. 55

Following evaluation, work adjustment, and work training, clients adjudged capable of competitive employment receive job placement service, primarily from the Bureau of VR liaison counselor (with assistance from the Washoe ARC staff). 56

The total Washoe ARC staff numbered about 22 in 1974. Professional staff members number about nine; they include vocational specialists, one psychologist, two social workers, and two teachers. About seven “foster grandparents” work half-time at Washoe ARC and were said to make a valuable contribution to the

52 Ibid.
53 Ibid.
56 Interview with M. Wedge.
program, although they were alleged to be overly permissive in the behavior they will tolerate from clients. The staff members each spend one day per month for in-service training.

The 1974 Washoe ARC budget of about $347,000 is described in Table 11.15. In addition, but not listed in the table, the Washoe ARC has received a multiyear Developmental Disability grant totaling over $200,000 to pay for education of developmentally disabled adults, and a $90,000 VR program grant to help provide for equipment and remodeling for start-up of the evaluation program. Funds for the new Washoe ARC residential center are also not shown.57

Table 11.15

PRINCIPAL BUDGET OF WASHOE ASSOCIATION FOR RETARDED CITIZENS, 1974

<table>
<thead>
<tr>
<th>Support</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>$6,800</td>
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<tr>
<td>Special events</td>
<td>45,000</td>
</tr>
<tr>
<td>Government income</td>
<td>109,160</td>
</tr>
<tr>
<td>Membership</td>
<td>700</td>
</tr>
<tr>
<td>Fees</td>
<td>26,500</td>
</tr>
<tr>
<td>Sales</td>
<td>63,350</td>
</tr>
<tr>
<td>United Way</td>
<td>15,000</td>
</tr>
<tr>
<td>Other</td>
<td>11,300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$337,510</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Expenditures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>$153,585</td>
</tr>
<tr>
<td>Trainee</td>
<td>28,800</td>
</tr>
<tr>
<td>Health and retirement, payroll taxes, etc.</td>
<td>25,317</td>
</tr>
<tr>
<td>Outside services (professional and contract)</td>
<td>700</td>
</tr>
<tr>
<td>Supplies</td>
<td>11,875</td>
</tr>
<tr>
<td>Telephone, postage</td>
<td>5,310</td>
</tr>
<tr>
<td>Occupancy</td>
<td>39,107</td>
</tr>
<tr>
<td>Institutes and workshops</td>
<td>2,280</td>
</tr>
<tr>
<td>Equipment</td>
<td>18,900</td>
</tr>
<tr>
<td>Special events</td>
<td>28,000</td>
</tr>
<tr>
<td>Organization dues, national support</td>
<td>5,000</td>
</tr>
<tr>
<td>Miscellaneous expenses</td>
<td>28,115</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$346,589</strong></td>
</tr>
</tbody>
</table>


The Washoe ARC would like to be more financially independent than it is now, and plans to seek financial support of approximately $2 million to start self-supporting businesses that can provide both work and training for developmentally disabled people. One concept presented to us was a motel-restaurant-casino complex with no architectural barriers and emphasizing but not limiting service to handicapped people. Advertising would be national and the unique feature would be the combina-

tion of the casino and emphasis on serving handicapped people. The businesses would not only serve handicapped and nonhandicapped guests but also provide training and work for developmentally disabled people, and profits that could support other Washoe ARC program activities. The concept is interesting and potentially very beneficial, but its economic viability is uncertain. Employment and training for developmentally disabled people can be achieved at lower current costs and lower risks without funding such an extensive facility, but perhaps with lower potential financial rewards. Given the limited funds currently available to expand services and better meet the needs of the mentally handicapped population, it becomes a matter of priorities.

The Washoe ARC programs in general are professionally staffed and appear to be providing good services. The Washoe ARC strives to meet nationally recognized accreditation standards. The programs are currently in a stage of rapid expansion and, judging from our discussions with families of participants, are generally satisfying the people they serve. Many of the ten families we interviewed as a group agreed with one family's statement that the Washoe ARC had done more to help their child be independent than had all the other services received during the childhood years. In fairness to other service agencies, we point out that the quantity and quality of nearly all types of services are much higher today than when these families' disabled children were young.

**White Pine County Rehabilitation Center**

The White Pine County 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 attending public school, despite Nevada's new mandatory special education law, because of a conflict between the child's family and the school. According to the state Community Training Center Coordinator, there was no appropriate service program in Ely for that child). The one full-time and two part-time staff members, assisted by volunteers, train people in skills such as money handling, letter writing, cooking, cleaning, gardening, recreation, daily self-care, shopping. The approximately seven people in the program are served in the basement of a church.

**VOCATIONAL TRAINING PROGRAM**

The Vocational Training Program in 1974 provided vocational evaluation, training, and job placement to adolescent and adult mentally retarded people, primarily in northern Nevada. The program could take people of any degree of

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58 Ibid.
59 Interviews with families with developmentally disabled adults (interviewees were guaranteed anonymity), Washoe ARC, Reno, Nevada, August 21, 1974.
60 Interview with M. Carroll.
61 "Description of Community Training Center Program," submitted by the White Pine County Rehabilitation Center to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.
62 Nevada Rehabilitation Division, "Rehabilitation Facility Plan."
63 "Mental Retardation Services in Nevada," Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 1973.
retardation, but insisted that they have basic self-help skills. The goal of the program was placement in competitive employment and hence, while they could take clients from NMHI (where the program facilities are), they usually did not. According to the program’s director, “institutional types are usually just evaluated.” The caseload of 10 people in November 1974 included six referred from the community, three from the Northern Nevada Mental Retardation Center, and one referred from NMHI. Twenty-eight people were evaluated in FY 1974; 14 were placed, 2 were trained but not placed, 9 were not accepted, and 3 were still in the program in November 1974. A follow-up study of clients previously served by the vocational training program found that in the first three years of the program 44 clients were at least evaluated, slightly less than half were employed at the end of their service time, and about three-quarters of those employed at the end of service were still employed at the time of the program evaluation (i.e., had been employed for from a few days up to three years depending on when in the previous three years they had been served). The average wage was about $1.75 per hour (about the same as moderately retarded VR rehabilnants earn at time of case closure). Since 1974, there has been a shift toward providing pre-workshop services.

The program was begun in 1969 on a federal adult education grant with matching money from the Nevada Department of Education. Presently, the program is funded entirely with state money and operated by the Nevada Division of Mental Hygiene and Mental Retardation. The annual budget of $36,000 includes $5000 from the Department of Education to expand the program’s services. The staff includes a director (who has a bachelor’s degree in sociology but no prior experience or training in the vocational area), two additional people at Sparks full time (a sociologist and a teacher), and one person in Las Vegas (no special training or experience in the vocational area). All clients of this program are also VR program clients. The Bureau of Vocational Rehabilitation provides a physical and psychological evaluation, plus medical rehabilitation if needed (for example, one man in the program in November 1974 who came from NMHI reportedly had not had an eye examination for 12 years and needed a pair of glasses). The Vocational Training program staff then conduct an academic skills evaluation, independent living skills evaluation, and a vocational evaluation including various trial work tasks. Persons functioning at or close to competitive employment levels are then accepted. The VR program will then pay for some clients to go to a vocational adjustment center for prevocational training (usually the Washoe Association for Retarded Citizens’ program), and will also pay for transportation during training.

The Vocational Training staff goes into the community to develop job placement, and then trains the client on the job. The training is one-to-one, with the average training time being two weeks full time, eight hours a day, followed by two weeks of gradually withdrawn supervision, and a final two weeks of minimal supervision. A typical program would involve one week of evaluation and six weeks of

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44 Interview with S. Malley, Vocational Training Program, 480 Galletti Way, Sparks, Nevada, November 15, 1974.
45 Ibid.
47 Interview with S. Malley.
48 Ibid.
49 Ibid.
on-the-job training. The longest any person has been in the program is two years, and the shortest is one week, when a placement was made and the person did not require training in the job.\textsuperscript{70}

The major service distinctions between the VR program and this program are the higher professional vocational training and experience of the VR staff and the relatively expensive one-to-one training provided on-the-job by the Vocational Training program but not by the VR program. While one could argue that the vocational training work evaluations should be conducted by more vocationally skilled professionals, the current hard-working and dedicated staff members in this program probably have adequate skills to conduct the actual job training, given the semiskilled nature of the placements being made (e.g., laundry, kitchen, janitorial, maid, ranch, and warehousing jobs).

**VOCATIONAL EDUCATION PROGRAMS**

The Nevada Department of Education, through the provision of vocational education and special education funding to local and other state education programs, supports the provision of vocational-technical education to both handicapped and nonhandicapped Nevadans. Much of the vocational education funding is federal money ($1,266,184 for FY 1974) channeled through the Nevada Department of Education and requiring 50:50 matching funds. The matching funds come partially from the state (the FY 1974 state vocational education budget was $586,805 above the federal vocational education grants) and partially from local education sources (approximately $850,000 was required from local sources to provide the balance of the 50:50 matching funds). Actual provision of the vocational education services is usually by the local education agency.\textsuperscript{71}

While it was not feasible to determine the total vocational education expenditures for handicapped people, the federal *Vocational Education Act of 1963, as Amended*, provides that 10 percent of the vocational education funds expended must be spent on handicapped individuals. This would indicate FY 1974 vocational education expenditures for handicapped people should have been at least $253,000.

Except in the remotest rural areas of the state, some vocational education services are provided to handicapped people. Three special education vocational counselors work in rural areas, two work in Washoe County (Reno area), and five work in Clark County (Las Vegas area).\textsuperscript{72} The following paragraphs describe vocational education programs in the two metropolitan counties and one illustrative rural county.

In Churchill County, four local education employees work in the vocational field for all nonhandicapped and handicapped students. Each of them has been given in-service training in helping handicapped children by staff members responsible for special education. Most of the mentally handicapped students served by vocational education staff are educable mentally retarded youth. Nothing is presently done for career development of trainable mentally retarded students, and the special education director believes this is an important need throughout the state. The vocational

\textsuperscript{70} Ibid.

\textsuperscript{71} The *Executive Budget*.

\textsuperscript{72} Interview with L. Davis, Nevada Department of Education, Carson City, Nevada, August 19, 1974.
needs of handicapped students are also served by making every effort to get each handicapped adolescent accepted into the vocational rehabilitation program before completion of the high-school-age education program.\textsuperscript{73}  

In the Las Vegas area during the FY 1974 school year, the special vocational education program for all handicapped students consisted of four vocational counselors for mentally retarded youth plus activities at the Stewart School (for trainable or severely and profoundly retarded children) and the Variety School (for multiply handicapped children). The district had about 1600 educationally and mentally handicapped students in FY 1974. The four vocational education counselors outside the two special schools generally work with vocational rehabilitation personnel and senior high school teachers of mentally retarded youth to provide job information and placement assistance. In addition, some vocational education funds are used to pay youth to work in the schools so that they can learn job skills. The regular vocational education program may also accept some handicapped students in classes such as graphic arts, auto repair, electrical-electronics, building trades, and practical nursing, and in industrial cooperative classes (study plus part-time work), but the number so accepted is not available.\textsuperscript{74}  

The Variety School for the more severely multiply handicapped youth in Las Vegas has one vocational counselor who provides a half-day prevocational and vocational skills training program for older students, and does informal follow-up after a youth leaves school. Approximately 40 students work around the school as part of their vocational education. The school principal indicated that a major need is for improved vocational rehabilitation program services for severely handicapped youth. His view was that currently the VR program emphasizes evaluation and placement but provides little of the needed training and follow-up.\textsuperscript{75}  

The basic objective of the Stewart School for trainable severely or profoundly retarded youth in Las Vegas is vocational, which the principal broadly defines as being able to work and function as independently as possible upon leaving school. Attempts are made to teach prevocational skills to all students, for example, how to use a bus, and how to behave while waiting for and riding on the bus, so that the person can get to a job. The school also operates a small farm for vocational and other training purposes (e.g., animal care, gardening, and lawn care are taught). To supplement the school farm training for some youth, a cooperative training program has been worked out with a local nursery. At age 17 all students at the school work half-time, generally at the school. Examples of jobs are culinary skills (lunch is prepared and served for all students, and a commercial dishwasher of the same type used by local restaurants is operated), garden and yard maintenance, custodial work, and car washing. They are taught to work independently, and spend one month at each of the various jobs. Some vocational education funds are used to pay student workers. Following graduation, most of the students are placed either in competitive jobs or in the Opportunity Village sheltered workshop. Unlike other schools in the state, this one has a full-time liaison counselor funded by the VR program.\textsuperscript{76}  

\textsuperscript{73} Interview with W. Hammer, Churchill County School District, Fallon, Nevada, November 21, 1974.  
\textsuperscript{74} Interview with D. Seigle, Clark County Department of Education, Las Vegas, Nevada, October 24, 1974.  
\textsuperscript{75} Interview with H. Marr, Variety School, Las Vegas, Nevada, October 25, 1974.  
\textsuperscript{76} Interview with Dr. R. Foster, Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.
The Community College in Las Vegas also has a vocational training program funded by a Developmental Disabilities program grant. The 14 adult students are served in both a regular community college class setting and a work setting. It is the only community college program in the state specifically for vocational education of handicapped students.77

Note that vocational education programs for the mentally handicapped in the Clark County School District emphasize and focus on service to retarded children but not to people with other types of mental handicaps. Also, none of the vocational education services were provided to children in the large rural areas of the county outside of the Las Vegas-Henderson metropolitan area. Vocational counseling is emphasized, but vocational training generally is not. The transition in Clark County from vocational service while attending school to service for those who need it after leaving school is not well coordinated, and judging from the relatively small number of retarded clients on the VR rolls from Clark County, that transition is frequently not made.

In Washoe County (Reno area only), the high-school-age special education program is vocationally oriented. It includes exposure to various types of work through audiovisual tapes (made locally with vocational education funds), field trips, work at the school, and counseling and evaluation. Also part of the high school special education program is the opportunity to work half-time off-campus while studying half-time. In FY 1973 and FY 1974, approximately 125 handicapped youth worked half-time under the guidance of two vocational counselors who provided placement, some supervision, and some one-to-one counseling. A follow-up study indicated that 70 percent of these students retained their jobs after graduation. No cooperative arrangement exists between the Washoe County School District and the Vocational Rehabilitation program; VR counselors provide no service of any sort to handicapped students in this county. Other than the two vocational counselors mentioned above, there is no vocational education program staff for handicapped students in Washoe County. No vocational education services for handicapped students exist in rural Washoe County.78

EMPLOYMENT SECURITY PROGRAM

The purpose of the Department of Employment Security (ES) is to "promote employment and the re-employment of unemployed workers in the state, insure through unemployment benefits income for a worker during periods of unemployment, and through efforts in both areas reduce taxes for the state employers."79 The promotion of employment and re-employment is done primarily through job information and placement; the Department acts as a central clearinghouse where workers can learn of job opportunities, and potential employers can learn of workers' availability. In FY 1974, of the 79,073 new applications and referrals of individuals, about one-third were placed in jobs, only four percent were counseled, only about

77 Ibid.
one percent were referred for training, and only about two percent were referred for other services.\textsuperscript{80}

This program is subject to dictates from the United States Department of Labor, Manpower Administration, which supplies the majority of the total operating funds. Total FY 1974 expenditures, exclusive of unemployment compensation payments, were approximately $7,605,000.\textsuperscript{81}

To place the Department's work in context, in calendar year 1974 the annual average number of workers covered by the Nevada Unemployment Compensation Law totaled 216,987 (see Table 11.16 for a breakdown by industry). The total 1974 payrolls for those workers was over $2.0 billion. Clark County (56 percent of the state's population) accounted for 55 percent of the covered workers and 56 percent of the payroll, while Washoe County (25 percent of the state's population) accounted for 27 percent of the workers and 26 percent of the payroll.\textsuperscript{82}

Table 11.16

<table>
<thead>
<tr>
<th>Nevada Workers Covered by Unemployment Compensation, by Industry, 1974</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
</tr>
<tr>
<td>State and local government</td>
</tr>
<tr>
<td>Agricultural services</td>
</tr>
<tr>
<td>Mining</td>
</tr>
<tr>
<td>Construction</td>
</tr>
<tr>
<td>Manufacturing</td>
</tr>
<tr>
<td>Transportation, communications, utilities</td>
</tr>
<tr>
<td>Wholesale and retail trade</td>
</tr>
<tr>
<td>Finance, insurance, real estate</td>
</tr>
<tr>
<td>Service industries</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Table 11.17 presents data on the number of mentally handicapped people served in FY 1974 by (ES). Only 337 out of 79,073 new applications and referrals in FY 1974 were reported to have mental handicaps, and most of those people were thought to be retarded. No definitive breakdown or definition by type of mental handicap was available, since the reporting form has only one box for ES personnel to check to indicate a mental handicap. Those ES personnel are not skilled mental disorder diagnosticians, and may be hesitant to label a person as mentally handicapped when it serves no useful purpose to do so: The federal funding level depends on the presence of handicaps, but is independent of the types of handicap. Of the 337 reported mentally handicapped clients in FY 1974, 66 were counseled, 82 were

\textsuperscript{80} Unpublished data provided by Frank Coleman, Nevada Employment Security Department, Carson City, Nevada, November 20, 1974, and by Lawrence McCracken, Nevada Employment Security Department, Carson City, Nevada, February 27, 1976.

\textsuperscript{81} The Executive Budget.

\textsuperscript{82} Employment and Payrolls, Nevada, 1974, Nevada Employment Security Department, Carson City, Nevada, undated.
Table 11.17

NEVADA EMPLOYMENT SECURITY DEPARTMENT SERVICE TO MENTALLY HANDICAPPED PERSONS, FY 1974

<table>
<thead>
<tr>
<th>Service</th>
<th>Mentally Handicapped</th>
</tr>
</thead>
<tbody>
<tr>
<td>New applications and referrals</td>
<td>337</td>
</tr>
<tr>
<td>Counseling</td>
<td>66</td>
</tr>
<tr>
<td>Job Placement</td>
<td>82</td>
</tr>
<tr>
<td>Enrolled in training</td>
<td>8</td>
</tr>
<tr>
<td>Referrals to training</td>
<td>84</td>
</tr>
<tr>
<td>Referred to supportive services</td>
<td>30</td>
</tr>
<tr>
<td>(including VR)</td>
<td></td>
</tr>
</tbody>
</table>


placed in jobs, 8 were enrolled in training, 84 were referred for training, and 30 were referred for supportive services, including vocational rehabilitation. In response to questioning about the low number of mentally handicapped people served, department personnel estimated that less than half of those with mental handicaps who are served are identified as such, and that those who were not identified were probably higher-functioning people with higher placement rates. They also speculated that perhaps as many as 25 percent of the department's clients might have some mental problem.83

ES has offices in Carson City, Elko, Ely, Fallon, Las Vegas, North Las Vegas, Lovelock, Reno, Sparks, Lake Tahoe, Winnemucca, and Henderson. ES has a few job developers who work with individuals and in employer relations; Reno has four job developers, Las Vegas has six, and Carson City, Elko, and Fallon each have one. However, most of the mentally handicapped people served are served by ES personnel without specialized knowledge of the vocational abilities of mentally handicapped people.84

A problem with the Federal Government is that it is reportedly "consistently inconsistent" in changing priorities and setting up special programs, resulting in a great deal of uncertainty and change in both projects and budgets. The formula for payment from the Federal Government is based on such factors as duration of employment, handicapped people placed, veterans placed, and the percentage of clients who are placed. Thus, a person who is both placed and handicapped counts more in the formula than one who is only placed. Note that if the Employment Security Department could get credit for all vocational rehabilitation program closures, it could get more dollars from the Federal Government and provide better service.85

83 Interview with Lawrence McCracken, Executive Director, and Frank Coleman, Nevada Employment Security Department, Carson City, Nevada, November 19, 1974, and a letter from L. McCracken to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.
84 Ibid.
85 Interview with Lawrence McCracken.
A special problem for handicapped clients is that there is a tendency for ES employees to give lower priority to people they think will have a harder time getting jobs.86

NEEDED IMPROVEMENTS IN VOCATIONAL SERVICES

Need for Vocational Services

To estimate the maximum potential number of mentally disabled Nevadans who need vocational rehabilitation services, the Nevada Rehabilitation Division conducted a household survey asking 1750 people over age 12 to self-report their perceived activity limitations and past loss or denial of job, raise, or promotion due to a mental, nervous, or emotional condition. The Nevada Rehabilitation Facility Plan for 1975-198087 assumes that the percentage of the population saying that at some time they had lost or been denied a job, promotion, or raise because of a physical or mental condition constitutes the number of people potentially in need of vocational services.88 Of course, not all those people are currently vocationally disabled, and only a small fraction of them need vocational rehabilitation services each year; consequently, the Rehabilitation Facility Plan's use of the maximum potential need sets a high and perhaps unrealistic upper bound on the need. A better estimate, in our view, can be obtained from the same survey data by considering the number of people with hampering mental conditions who are unemployed. Of the 1.9 percent of the Nevada survey respondents self-reporting activity limitations due to mental, nervous, or emotional conditions, 15 percent were adults who were recently or temporarily unemployed, 20 percent were retired, 24 percent worked as housewives, 34 percent were employed in other occupations, and 7 percent were not in any of those categories (hence, they may have been students or long-term unemployed).89 The use of a 15-percent figure (the recently or temporarily unemployed) plus the number currently in sheltered work programs would probably be a conservative minimal estimate of the number of mentally disabled adults who currently need vocational services, since it does not include the underemployed (employed in occupations significantly below their potential abilities) or the long-term unemployed. Assuming that a minimum of 15 percent of the 16- to 64-year-old mentally disabled population with activity limitations need some vocational service each year, plus those in sheltered work programs, the estimate of need would be about 1230 adults in 1974 and about 1650 in 1985. Data from the survey do not permit categorizing the causes of the "mental, nervous, or emotional condition" into mental health problems, mental retardation, and substance abuse. For lack of better data, we have assumed that the breakdown of the 15 percent by type of mental condition is the same as for current vocational rehabilitation clients; this yields a 1974 esti-

86 Ibid.
88 Ibid., p. 101.
89 Unpublished data obtained from J. Pollard, Nevada Rehabilitation Division, Carson City, Nevada, May 15, 1975. For comparison, the monthly 1974 unemployment rate for all Nevadans varied from about 7 to 10 percent according to Department of Employment Security figures.
mate of vocational service need for 180 adults with mental health problems, 350 with mental retardation, 260 with an alcohol or drug abuse problem, and 440 people with some other mental problem. To estimate the vocational service needs of mentally retarded youth, we assume that at least 2 percent of the young adult population is retarded (see Chap. 3), and that every retarded youth of school-leaving age needs at least some vocational service. That assumption results in a 1975 estimate of approximately 200 retarded youth annually reaching an age where they need vocational services. If they receive some vocational education services over a two-year period, 400 need some vocational service each year.

The same number of seriously emotionally disturbed youth potentially need some vocational services if, for lack of better data, one uses the U.S. Bureau of Education for the Handicapped estimate of the prevalence of that condition.93

The 1975-1980 Nevada Rehabilitation Facility Plan attempts to place priorities on service needs for 1975-1980 by surveying Division of Rehabilitation counselors. Of the twelve needs ranked, psychological/psychiatric service needs were ranked number one.91

The relatively higher unemployment and underemployment rates among mentally handicapped people, as compared with the nonhandicapped, are thought to be due to such factors as employers' underestimation of the abilities of handicapped persons, employers' "fear of the unknown," and the relatively longer on-the-job training period that may be required for some. Although these handicapped persons' abilities to perform in certain occupations are impaired, there is an abundance of other occupations in which they can be as productive as persons without mental handicaps.92 While the data on the number of mentally handicapped people needing vocational services could be more reliable, we note that youth with mental health problems are presently getting virtually no special vocational education service, and the greatest proportion of those mentally handicapped people presently not accepted for VR services are rejected not for lack of a mental or vocational handicap but for other reasons. Thus, it is reasonable to assume that significantly more mentally handicapped people need vocational services than are presently receiving them.

**Problems with Current Vocational Services in Nevada**

While the vocational service programs in Nevada are valuable, several problems for mentally handicapped people were identified from inspection of the program descriptions presented earlier in this chapter. They include unemployment (a rate approximately twice that for people without mental handicaps); little effort to combat significant underemployment (by any vocational service program); too few people served in relation to need (with the possible exception of vocational education services for retarded youth); differential levels of service by geographic area (north-south or urban-rural differentials exist for some handicaps, especially in the VR, CVC, and VT programs); differential levels of service by type of handicap especially


91 "Rehabilitation Facility Plan," p. 78.

the extremely low emphasis on serving severely emotionally disturbed youth in the vocational education program and the low emphasis on serving (or at least referring for service elsewhere) of all types of mentally handicapped people by the Employment Security program; a questionable allocation in FY 1974 of about half the limited available VR funds for service to mentally handicapped people with generally less severe "other mental" disorders (i.e., people who, according to VR definition, are not primarily psychotic, neurotic, retarded, alcoholic, or drug abusing); inadequate facilities (especially for rural Nevadans in their home counties); inadequate short-term residential facilities for rural Nevadans served in Reno and Las Vegas; inadequate referral and coordination between vocational and other types of service programs (especially between VR, ES, and the schools, and between VR and some of the mental health programs); and duplication of program responsibilities (in particular the Vocational Training program overlap with the VR and Community Training Center programs). In the next section we make several recommendations for alleviating these problems.

Vocational Service Recommendations

The Nevada Rehabilitation Facility Plan for 1975-1980 sets the following priorities for vocational rehabilitation facility construction and expansion:

Vocational rehabilitation facilities are needed primarily in the rural areas of the state where virtually no facilities currently exist. Even though the urban areas have the largest numbers of persons in need of services, the priority appears to be in the rural areas where either no services are available or the existing facilities are totally inadequate to serve the need.

Priorities for construction of vocational rehabilitation facilities are:

1. Humboldt County area of North-Central Nevada.
2. Elko and Lander Counties in North-East Nevada.
3. White Pine and Eureka Counties in East-Central Nevada.
4. Clark County to serve the surrounding counties of Esmeralda, Lincoln, and Nye.

The largest number of facilities to be added or expanded is in Clark County, which needs four additional vocational rehabilitation facilities primarily in the area of sheltered employment. Washoe County needs three additional vocational rehabilitation facilities, also in the area of sheltered employment.

We agree that additional vocational services are needed in rural counties as well as in Clark and Washoe Counties. However, we question whether the specific types, numbers, and locations of facilities mentioned above are the most appropriate. In that Facility Plan the method used to set priorities ranked needs for new, expanded, and modernized facilities according to the percentage of unmet facility needs within service areas. On the surface that approach seems good, but its implementation poses difficulties. After Nevada service areas are defined (as five are

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93 "Rehabilitation Facility Plan," p. 100.
for Vocational Rehabilitation), the plan implicitly assumes, in making several recommendations, that a full range of services will be provided in facilities in each of the service areas; however, it may be better to send clients to other areas for certain types of services. And when facilities are counted to calculate the percentages of unmet needs, all facilities are counted the same; in setting priorities, however, this means the plan implicitly gives equal weight to a need for a large comprehensive service facility and a need for a small sheltered workshop. That plan projected the minimum number of individuals to be served in 1980 by multiplying the number of people presently served per capita times projected population and then adding an "adjustment" to provide flexibility. Then it projected minimum facility needs by multiplying the projected number of individuals to be served times the number of facilities per number of individuals presently served, plus an "adjustment." In several cases the "adjustment" factor was the determinant of the recommendation in facility needs. For example, in both the Humboldt and Pershing County areas and the White Pine and Eureka County area, the Facility Plan for Vocational Rehabilitation calls for construction of a "comprehensive rehabilitation facility with a complete range of services." While one should have a complete range of services available to residents of each of the counties, and ideally would like those services available close to the residents' homes, in practical terms one must establish a hierarchy of needs and recognize the quality of services that realistically can be provided in each rural county. In terms of quality of services, it is difficult to obtain specialist staff in every rural county, and those service specialists are in very short supply throughout Nevada. We suggest that rural Nevadans would be better served by a plan calling for the feasible provision in the rural county of (1) more frequently needed but not highly specialized services such as vocational counseling, placement, and follow-up, and (2) long-term sheltered work if needed, while providing short-term (days or weeks) but specialized services and living arrangements for rural Nevadans at comprehensive rehabilitation facilities in Reno and Las Vegas. (Such residential facilities are recommended in the Rehabilitation Facility Plan.) We view this as preferable to calling for several comprehensive rehabilitation facilities in rural areas that would be costly and would be difficult to staff. That is, we believe the best alternative is to furnish a limited array of good-quality, long-term services to rural Nevadans now in their home counties, backed up by shorter-term and more specialized rehabilitation services in Reno and Las Vegas. Such a middle course is preferable to the current deficiency or nonexistence of rural services, and is preferable to delaying action until the distant day—which may never arrive—when all services can be provided in facilities in rural counties.

In terms of the hierarchy of needs, for example, should the state first build several more comprehensive rehabilitation facilities when it already has such facilities in the north and in the south, or should the state first build a facility for residential care of emotionally disturbed youth in the northern part of the state, where there presently is none? The existing community vocational centers in the rural areas can be characterized as being generally small, without stable funding, occupying inadequate facilities, providing a few but not all types of vocational

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**Ibid., p. 26.**

**Ibid., pp. 88, 90.**

**Ibid., pp. 93-99.**
services needed, and with a dedicated staff working extremely hard to meet the needs of developmentally disabled adults. Three distinct options exist: (1) continue the present program and thus partially but inadequately meet vocational needs in rural areas; (2) expand to provide a comprehensive quality program of services in rural facilities; or (3) offer improved long-term services locally in rural areas (e.g., education, competitive or sheltered work, and residence) but develop a cooperative arrangement to send people to the larger metropolitan areas for short-term (weeks) provision of quality specialized services. The Rehabilitation Facility Plan calls for five vocational rehabilitation geographic service areas. We recommend that (1) a full, comprehensive range of quality vocational services be provided in the Reno and Las Vegas areas and be available equitably to all Nevadans in need, with short-term residential arrangements in those two cities for rural Nevadans, and (2) that in the other three geographic areas a limited range of the more frequently needed, less specialized, and longer-term vocational services be provided.

For those longer-term activities of daily living, prevocational, vocational, and sheltered-work services currently provided through the several community training centers in the state, we estimate that the costs that will be necessary to provide minimum quality services are currently two to four times as high as the $1200 per year minimum funding provided per client by the Community Training Center program. However, in FY 1974 primary funding was provided for some of the 183 adult clients at these centers by the VR program. We recommend that the Community Training Center minimum funding level per client be at least doubled for those clients receiving services but not primarily funded by the VR program.

The small Vocational Training program, operated within the Division of Mental Hygiene and Mental Retardation with personnel who have no substantial prior background in vocational service, provides services in northern Nevada that overlap those provided jointly by the VR program and the Washoe Association for Retarded Citizens. We recommend that the Vocational Training Program be eliminated and its personnel and current clientele transferred to the joint VR-WARC program.

The special vocational education services to mentally handicapped youth focus almost exclusively on mentally retarded youth. This differential level of service by type of handicap is hard to justify. Some emotionally disturbed youth need and can benefit from special vocational education, too. We recommend that special vocational education programs be expanded to provide vocational services to some severely emotionally disturbed youth.

The Department of Employment Security reported serving 337 mentally handicapped people among nearly 2700 handicapped people served in FY 1974; 30 or fewer were referred to the Bureau of Vocational Rehabilitation. We recommend increasing the number of referrals from the Department of Employment Security to Vocational Rehabilitation of persons suspected of having a mental handicap who are not placed in jobs within a short time. The Employment Security program and personnel are less able to adequately serve the more severely mentally handicapped people than are the VR program and personnel.

The information needed to manage some of the vocational service programs effectively is severely lacking. For the Vocational Education and Employment Secu-

97 The Nevada Association for Retarded Citizens estimates that the present CTC funding covers only 19 percent of the cost, and is officially seeking at least a doubling of current CTC funding per client (as reported in "Retarded Patients to Attend Hearing," Nevada State Journal, March 19, 1975).
rity programs, for example, even the statistics on the number of mentally handicapped people served are of dubious validity. Even in the VR program, which has relatively good information, the real reasons clients are not accepted or are not rehabilitated are not well known, partly because the information categories that can be marked on the forms do not permit the persons filling them out to fully express what they know. For example, although better reasons may be known to VR direct-service personnel, partly because of the design of the form, the reasons most often marked for clients' being not accepted or not served were the clients' lack of response to and/or lack of acceptance of the VR program. More information is needed on why referred persons do not respond and do not accept the VR program before one can say which would be desirable: a revised referral process, or more active outreach efforts, or better program information for referred persons, or a revision of the program to make it more acceptable to mentally handicapped persons, or a combination of these approaches. However, some action is needed to increase the percentage of referrals who are rejected because they are not qualified for service, and decrease the percentage not accepted for the currently prevalent reasons. Again, as with the reasons for non-acceptance of VR clients, better categories and information are needed on reasons for nonrehabilitation, especially reasons for the majority "dropping out." The VR program should take steps to reduce the current high percentage of "dropouts," but whether those steps should include changes in the services offered to better meet the clients' wishes, changes in the occupations for which clients are being rehabilitated, more active attempts to keep clients that show a tendency toward "dropping out," speeding up the time it takes to get through the program, or other actions, clearly depends on information not now available on the reasons for attrition of VR clients. Finally, with the exception of the VR program, effectiveness data for vocational service programs are severely lacking. We recommend that improved program management and effectiveness information be obtained for each Nevada vocational service program. This information gathering does not require a really major or costly effort. The present effort in the VR program is more than adequate, although some of the information categories that program uses on forms need revision so they are more illuminating. (This can be done and still be consistent with the federal reporting requirements if categories that are collapsible to the federal categories are used.)

The Chairman of the Nevada Governor's Advisory Board on Rehabilitation has indicated that significant improvement is needed in the incentive system for VR staff, and in cooperation between the VR program and other programs, such as the schools. He said that, for example, the VR liaison people who are working with the schools often do not take a personal interest in their clients, and the VR incentive system is such that the VR counselor receives the maximum reward from the program if a graduating student's VR case is closed by placement into a sheltered workshop. Hence, there is a service-system disincentive, rather than incentive, to providing a client with extensive vocational training and to seeking the highest-level job of which the client is capable. Since case closures are rewarded, he said, VR counselors often do not try to train the clients, but rather try to place them and close their cases.48 A change in incentives for VR counselors would be a clear improve-

48 Interview with Dr. R. Foster, Chairman, Governor's Advisory Board on Rehabilitation, Division of Rehabilitation, Carson City, Nevada, October 25, 1974.
ment. The problem of lack of cooperation between programs offering vocational services and other service programs for mentally handicapped people also clearly needs attention. In all of FY 1974, for example, only 16 mentally disabled youth were referred for vocational rehabilitation by the schools, and were rehabilitated. Not only should those other agencies and service personnel be strongly encouraged to refer certain types of people, but the VR program itself should consider implementing more active outreach activities, especially with respect to the schools, the Department of Employment Security, private physicians, and the public health nurses we noted earlier as having a relatively low referral rate in relation to the number of mentally disabled people they are in contact with. Once service priorities are set, they can be achieved more easily if notification of the types of clients desired is clearly communicated to each referral source, and referral of those clients is actively encouraged at the level of direct service personnel, not solely at the administrative personnel level. There is a passive tendency to serve clients who come to an agency, rather than to set out well-defined priority categories of people who need service and then actively reach out to find them. It would be inexpensive to arrange for automatic referral to or outreach by VR, for example, for all mentally handicapped people served by various programs. Such a stratagem would provide VR with fairly comprehensive rolls of potential clients from which they could select high-priority clients.

One might take a dynamic and flexible approach depending on the level of vocational impairment. For example, all mentally handicapped youth might be screened by VR before leaving school, and mildly handicapped youth might automatically be given both job information and placement assistance upon leaving school, and then if they are not vocationally successful, full VR services could be given. Severely handicapped youth could be automatically offered full VR services beginning well before their scheduled departure from school (which is permissible under Federal regulations). Whatever the priorities assigned, the program will come closer to meeting its goals with its available resources if effort is concentrated on finding, accepting, and serving clients in priority categories.

The VR program does not usually send clients to ES for placement, because it has its own placement network. Presently, the VR counselor has access to the ES job bank file. If VR clients’ placement needs were made known to the ES Department, it would be possible to alert and enlist the aid of ES staff in placement of mentally handicapped people not only in job-bank positions but also in new positions developed. Also, some clients use both the VR and ES agencies simultaneously without telling each agency, so as to maximize their chances of getting a job. Thus, to avoid duplication of effort and achieve better coordination, better information is needed on who is a client of which agency, as well as on job availability. Information privacy regulations are essential, but should not unnecessarily impede the effective delivery of services to individuals.

We recommend improved outreach and referral among vocational service programs and other nonvocational programs serving mentally handicapped people. In particular, we recommend increased numbers of referrals to Vocational Rehabilitation of mentally handicapped youth leaving school, working-age clients of the income assistance programs, and unemployed working-age clients of the NMHI, the Mental Retardation Centers, the Mental Health Centers, the Rural Clinics program, the Community Training Centers, private psychiatric service programs, and alcohol and drug abuse programs. We discussed referrals from the Department of Employment Security above. Although the VR program does not now have sufficient resources to
serve all those in need, an increase in referrals would permit screening and acceptance of more high priority types of clients.

The Vocational Rehabilitation program is not now serving all those in need because of mental health problems, mental retardation, and alcohol or drug abuse. This program improves the quality of life of mentally handicapped people by increasing their ability to function independently, to obtain employment, and to work at higher-quality employment. It also appears to yield economic benefits to society (reduced service cost later in life, reduced welfare, increased taxes paid, and increased earnings) that exceed the costs of the program. Even with assumptions designed to subject the program to a difficult test, the economic benefits exceed costs to society as a whole and to the taxpaying population for every one of the eight categories of prevalent types of mental handicaps that we considered. A recent General Accounting Office report on the VR program nationwide indicated that "the number of persons needing vocational rehabilitation services has far exceeded the number of persons that have been served under the program" and that "the number of persons rehabilitated annually, although increasing, is still not as great as RSA's estimates of the number becoming eligible each year."99 The unmet need in Nevada is also large, and the gap can be narrowed either by expanding the VR program or shifting priorities on the types of people served. The Nevada Bureau of Vocational Rehabilitation must set its own priorities subject to federal funding guidelines, but we question whether placing highest priority on people with psychoneurotic or "other mental disorders" (as evidenced by their being the two largest categories in FY 1974 in terms of numbers of clients accepted and average cost of services per rehabilitant) is consistent with current federal guidelines giving priority to more severely handicapped people. In fact, half of all VR case expenditures on mentally disabled individuals whose cases were closed in FY 1974 went for persons in the nebulous category "other mental disability"—people who were not disabled by alcoholism, drug abuse, mental retardation, psychosis, neurosis, epilepsy, cerebral palsy, Parkinson's Disease, or stroke according to VR definitions. We do not doubt that people with other mental "disorders of character, personality, or behavior" need and deserve service, but the Division of Rehabilitation may wish to concentrate its resources more heavily on more severe mental disorders, in line with current Federal guidelines. Since all those in need cannot be served with the resources available, we suggest that the division enforce explicit priorities for the acceptance of people with the different types and degrees of mental disorders. Adjustments in the referral process, and perhaps active seeking of certain types of clients from other agencies, may be necessary to implement the priorities that are set. For example, the division could not greatly increase the number of mentally retarded people served simply by deciding to accept more retarded clients, since they received only 55 more referrals than were accepted, according to FY 1974 closure statistics; the division also would have to take action to increase the number of referrals of retarded persons.

Looking at the various types of mentally disabled persons rehabilitated in FY 1974 by source of referral also raises certain questions of priorities. For example, should half the rehabilitants from the mental hospital be alcohol or drug abusers?

Should over half the rehabilitants from mental health centers be classified by VR as having some "other mental disorder" of character, personality, or behavior rather than being psychotic or psychoneurotic? Should over 80 percent of the rehabilitants referred by the public health personnel be drug abusers? The answers to these questions clearly depend on priorities set implicitly or explicitly by the VR and other programs. While certain VR offices such as the Public Offender Outreach office and the NMHI office must specialize in certain types of disabilities by virtue of the special population from which they are intended to draw clients, other offices that are supposedly serving the general population in an equitable manner probably should not specialize except according to the overall priorities of the Nevada Bureau of Vocational Rehabilitation. For example, how do the Henderson and Las Vegas Mental Health Outreach offices justify the heavy emphasis on drug addiction and other mental disorders relative to the emphasis on psychosis, psychoneurosis, and alcoholism? More explicit guidelines and priorities, or enforcement of existing guidelines and priorities, appear to be required from the Bureau of Vocational Rehabilitation. We recommend either expansion of the VR program to serve more of the severely mentally handicapped people in need, or restructuring FY 1974 priorities to shift the VR caseload from emphasizing the generally less severe "other mental" handicaps toward emphasizing the more severe mental handicaps without increasing the total budget. The quality of life benefits of successfully serving more severely handicapped people can be substantial, and our detailed analysis indicates such service can be justified in an economic benefit/cost sense for all but the most severely handicapped people. Our analysis suggests that benefits in relation to costs may actually rise with

<table>
<thead>
<tr>
<th>Table 11.18</th>
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<tbody>
<tr>
<td><strong>Alternative Vocational Service Levels for Mentally Handicapped Nevadans, 1974 and 1985</strong></td>
</tr>
</tbody>
</table>

<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></td>
<td></td>
<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>
</tr>
<tr>
<td>Mental health</td>
<td>161</td>
<td>214</td>
<td>561</td>
<td>746</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>635</td>
<td>845</td>
<td>635</td>
<td>845</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>140</td>
<td>186</td>
<td>140</td>
<td>186</td>
</tr>
<tr>
<td>Other mental</td>
<td>296</td>
<td>394</td>
<td>296</td>
<td>394</td>
</tr>
<tr>
<td>Total</td>
<td>1282</td>
<td>1639</td>
<td>1632</td>
<td>2171</td>
</tr>
</tbody>
</table>


Note: Excluding those served by the Department of Employment Security, for whom we do not have data by type of handicap.
the severity of handicap and hence with the initial vocational skill deficit of the person (up to a point in severity where preparation for any job is extremely difficult). In a February 24, 1976, letter to The Rand Corporation, Del Frost, Administrator of the Division of Rehabilitation, indicated that priorities had been shifted toward serving more severely handicapped people. His Division's quantitative analysis of data from FY 1975 and the first half of FY 1976, when made available to the public, will allow assessment of the degree to which this shift in priorities has occurred.

Looking at four basic options displayed in Table 11.18, note that if Nevada does no more than maintain, until 1985, the status quo level and quality of vocational services per capita, and the same programs, vocational service expenditures will rise from $2.76 to $3.67 million per year. There are many ways to implement the option of reallocating resources within and among the vocational service programs without increasing total annual expenditures—the second alternative listed in Table 11.18. Adjustments in the numbers of people served under that alternative will allow implementation of several of our recommendations: the Vocational Training program can be phased out and its clientele and personnel transferred to other programs; minimal services of the vocational education type can be initiated for 400 severely emotionally disturbed youth per year in schools (this might have to be done partially by the VR program, since federal VR funds are not directly transferable to the Vocational Education program); improved management and effectiveness data can be obtained; improved referral mechanisms can be implemented; and the VR program service for people with "other mental" disorders is assumed to be cut in half; allowing VR service to 150 more severely handicapped people per year (we assume more service to retarded people in Table 11.18 for illustrative purposes only). The "geographic equity" option—raising the level of service per capita in each program in each of the three major regions (Clark, Washoe, and all other counties combined) to the current level in the best-served region—would result in a small increase in total cost. The geographic equity option could be implemented in a hybrid fashion together with the reallocation of resources option, resulting in substantial vocational service improvements in Nevada at rather nominal added cost. The "minimal need" option assumes implementation of all of the recommendations of the reallocation of resources and geographic equity options, plus doubling the level of Community Training Center funds per person served and providing the current quality services to that number of people with mental health problems, mental retardation, and problems of alcohol or drug abuse we estimated earlier to be in need. While the total number of people served for some types of mental handicaps does not substantially increase from the reallocation of resources to the minimal need option, the expenditures for those people increases considerably as they are provided more services in the VR program with higher expenditures per capita. The annual expenditures to meet the minimal need in each program retained would be approximately $4.5 million in 1974 and rise with population growth to $6 million in 1985.

\*\* About 40 percent of the VR clients with an "other mental" disorder of character, personality, or behavior were on public assistance at time of referral.