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ABSTRACT

Summarized are the findings and recommendations of a 2-year study of all major services and service delivery systems in Nevada for persons with mental health disorders, mentally retarded persons, and abusers of alcohol and other drugs. Considered are the following areas of basic service needs: prevention of the mentally handicapping conditions, identification of the mental handicaps, direction to appropriate service providers, special education, treatment for mental health disorders, developmental training and other services to ameliorate the effects of mental retardation, alcohol and drug abuse treatment, medical care, vocational services, residential care, and income assistance. Described is the research strategy which involved taking a comprehensive view of the service system and the population served, estimating the size and service needs of the mentally handicapped population, and analyzing the characteristics of all Nevada service programs for meeting those needs. Considered are the objectives of participants in the service system and dimensions on which to measure progress toward the objectives. Described are problems with the current service systems, and presented are recommendations for resolving those problems, such as the following: allocate special education funds by specific handicap and enforce current standards, establish rehabilitation houses for rural alcohol and drug abusers, provide vocational education for emotionally disturbed youth, and establish health and developmental screening of new school enrollees. The 71 recommendations are presented in tabular form by degree of change needed and by area of basic service need. (IM)

MENTAL HEALTH AND MENTAL RETARDATION SERVICES IN NEVADA: EXECUTIVE SUMMARY

PREPARED UNDER A GRANT FROM THE MAX C. FLEISCHMANN FOUNDATION

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PREFACE

In the summer of 1973, as a result of numerous applications for grants in the field of mental retardation, the Max C. Fleischmann Foundation was considering having a research organization conduct a study of mental retardation services. In the fall of 1973, the Chairman of the Mental Health Care Facilities and Programs Subcommittee of the Nevada Legislature inquired if the Foundation would finance a broad study of the mental health and mental retardation service system in Nevada. The request received the support of the Director of the Nevada Department of Human Resources. As a result, the trustees of the Foundation elected to broaden the scope of the study to include all mental health and mental retardation services and service delivery programs in Nevada.

At the invitation of the Foundation, The Rand Corporation applied for and was awarded a grant to conduct such a study. After the grant award, The Rand Corporation conducted the study independently of the Foundation. All inquir. concerning this executive summary or the main text of the report, and request. or copies, should be directed to The Rand Corporation.

Rand reports do not necessarily reflect the opinions or policies of the sponsors of Rand research. The Max C. Fleischmann Foundation is not responsible for the findings and recommendations of the study, and therefore this report should not be construed as indicating what action, if any, will be taken by the Foundation based on the information and recommendations contained herein.

The study, conducted over a two-year period ending in early 1976, describes the current status of services and service delivery programs for four different groups of mentally handicapped Nevadans, identifies major prob. with present services and programs, and recommends solutions. The overall goa. furnish information to the Max C. Fleischmann Foundation, to Nevada officials, nd to the public, on what can be done to improve the quality and quantity of mental health and mental retardation services in Nevada.

This is an executive summary of report R-1800-FLF, *Mental Health and Mental Retardation Services in Nevada*, April 1976; this summary has been issued for the convenience of people who might be interested in the findings and recommendations, but not the details, of the study.

ABSTRACT

At least 11,000 people with mental health disorders, at least 11,000 mentally retarded people, and at least 44,000 alcoho. or drug abusers needed some type of substantial service in Nevada in 1975. This report summarizes the findings and recommendations of a two-year study of all major services and service delivery programs for these different groups of people. It describes all major public and private programs intended to meet their needs, documents problems with services and programs, and presents recommendations for improvement. Over 60 Nevadans were given the opportunity to review and comment on a draft of this report in early 1976 (including people responsible for every major existing service program) and to update material where any major substantive changes had taken place since the time of our original data collection.

Nevada's official goal for the Division of Mental Hygiene and Mental Retardation with respect to the delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."

The $35 million being expended annually in Nevada on services for different groups of people with mental health disorders, mental retardation, and alcohol and drug abuse problems is producing beneficial results. Service programs in the state have expanded and improved in recent years, and progress has been made toward achieving the official goal. Numerous major problems still persist, however. Many people are receiving no services, the wrong services, or inadequate services.

Major problems include insufficient service capacity in relation to need, inequitable distribution of services by geographic location, lack of coordination and direction of the service system, poor facilities, inadequately trained personnel in some programs and hence poor-quality services, failure to provide a full range of services, lack of a continuum of levels of intensity of service, failure to have a variety of treatment modalities available to match the variety of people's needs, and a deficiency of information needed for program management and evaluation of program effectiveness.

The report presents 71 recommendations for improving services to people in Nevada with mental health disorders, mental retardation, or alcohol or drug abuse problems. These recommendations are summarized in Table A, grouped by type of service and by three different levels of effort which government officials may choose to make to remedy the problems. The arabic number beside the summary of each recommendation in the table indicates the numerical order in which the complete detailed recommendation is presented in Chap. 2.

Even if there is to be only a slight increase or no increase in the level of effort, by which we mean a 5 percent or less increase in annual expenditures, many of the low-cost recommendations shown in Table A can be implemented. Our several recommendations on management practices and organizational structure, for example, can be implemented at little or no additional cost but can enhance the control, coordination, and performance of the service system. Better program management and service effectiveness information can be obtained. The client focus can be shifted

Table A

Summary of Areas of Recommendations and Costs, by Desired Change in Level of Effort
(Fiscal Year 1974 expenditures = $35 million)

	Suggested Priority Areas of Recommendations by Desired Change in Level of Effort		
	Slight or No Change	*Modest Increase*	*Meeting All the Needs*
Service Need	Estimated Annual cost increase of $1.8 million (5 percent)	Estimated annual cost increase of $16 million (46 percent); adopt all "slight or no change in desired level of effort" recommendations in each service need area, plus those listed below	Estimated annual cost increase of $27 million (77 percent), adopt all "slight or no change" and "modest increases in desired level of effort" recommendations in each service need area, plus those listed below
Direction	1. Establish Regional Direction Centers 2 Strengthen state advisory boards		
Prevention	6 Assign specific responsibility for prevention of mental retardation		3. Expand genetic counseling with respect to mental retardation. 4. Ensure provision of immunizations, Rh desensitization and PKU screening 5. Expand family planning services, and create a high-risk registry for newborns
Identification		10 Provide behavioral and psychological screening once for each child 11 high-risk groups for mental health disorders	7. Establish health and developmental screening of new school enrollees 8. Improve Medicaid early screening and follow-up 9. Expand Special Children's Clinics' mental retardation diagnostic services
Special Education and Training	13 Allocate special education funds by specific handicap and enforce current standards 16 Revise preschool program focus in Community Training Centers 17 Revise preschool program focus in Special Children's Clinics 18 Increase referrals from schools to other service agencies 19 Obtain better information on special education and training programs	12. Increase the number of special education units funded 15 Provide appropriate special education and training to mentally retarded Nevada Mental Health Institute (NMHI) residents	14. Increase state special education technical advisory staff and provide technical assistance to rural counties
Mental Health Services	20 Fill authorized professional staff positions at the Las Vegas Mental Health Center 23 Increase Rural Clinics efforts for people with substantial mental health disorders 26 Revise the Las Vegas Children's Behavioral Services staff and the service focus 29 Provide specified staff mix and client focus in Children's Behavioral Services residential programs 34 Restrict use of Mentally Disordered Offender Facility to prisoners 36 Provide a physically secure mental health unit at NMHI 37 Revise the role of NMHI to fulfill four specified functions 38 Obtain better information on mental health programs	22. Upgrade rural mental health staff, and add part-time traveling service teams based at NMHI 28. Establish an upgraded mental health technician personnel classification and a university-based training program 31 Improve follow-up treatment of people released from residential mental health programs 32. Create programs to provide an intermediate level of mental health services over an extended time period for children and adults	21. Provide 24-hours-a-day emergency crisis-intervention service in mental health centers and Rural Clinics 24. Establish a second community mental health center in Clark County 25. Expand the Reno Mental Health Center into a full community mental health center 27. Provide mental health services to mentally retarded people if needed. 30. Correct major deficiencies in mental health services noted in the NMHI accreditation report 33. Establish halfway houses for people with mental health disorders 35. Provide specified mental health services in Nevada State Prison

Table A (Continued)

	Suggested Priority Areas of Recommendations by Desired Change in Level of Effort		
	Slight or No Change	*Modest Increase*	*Meeting All the Needs*
Mental Retardation Services	40. Do not reduce existing NMHI mental retardation staff size when Desert Developmental Center opens 42. Consolidate state mental retardation program control by removing control of mental retardation services from the NMHI Director 44. Expand special education and training, as appropriate, for Eagle Valley Children's Home residents 46. Obtain better information on mental retardation programs	39. Improve the NMHI mental retardation program to meet JCAH accreditation standards 41. Provide the equivalent of the Desert Developmental Center *services* to northern Nevadans, but defer major *facility* construction 43. Improve training of state "Technicians" serving mentally retarded people 45. Provide special services to mentally retarded prisoners	
Alcohol and Drug Abuse Services	47 Obtain better information on alcohol and drug abuse programs and prevalence rates 48 Streamline the organizational structure for alcohol and drug abuse programs	49. Create a comprehensive alcohol abuse treatment program for the Las Vegas area 50. Provide alcohol and drug detoxification services throughout Nevada 51. Establish rehabilitation houses for rural alcohol and drug abusers 52. Establish a full inpatient treatment program for drug abusers	
Vocational Services	53 Provide specified general vocational services in rural areas, with short-term more specialized services in urban areas for rural residents 55 Consolidate the Vocational Training program with specified vocational program 57 Increase referrals from Employment Security to the Vocational Rehabilitation program 58 Obtain better information on vocational service programs 59 Increase referals from nonvocational to vocational service programs		54. Double the Community Training Center minimum funding per client 56. Provide vocational education for emotionally disturbed youth 60. Expand the Vocational Rehabilitation program or shift the caseload emphasis to serve more severely handicapped clients
Medical Services	61 Study the effects of mandatory mental health and mental retardation service coverage in private health insurance 62 Supplement state-operated program funds by billing private and public health insurance to extent feasible		
Residential Living Services	64 Establish standards for developmental homes and sheltered living apartments 65 Consolidate developmental home supervision responsibility	63. Double the size of the developmental home and sheltered apartment living programs	66. Implement standards and supervision for foster homes and Adult Group Care and Family Care Facilities serving mentally handicapped people 67. Refer mentally handicapped foster children for services as appropriate 68. Screen residents of Youth Services Agency facilities for mental handicaps, followed by services as appropriate
Income Assistance	70 Transfer mentally handicapped Aid to Dependent Children recipients to the Supplemental Security Income program, if they qualify		69. Identify financial assistance recipients with mental handicaps, and refer for services as appropriate 71. Provide a state supplement to the SSI payments to mentally handicapped people

in certain programs. And Regional Direction Centers, a key recommendation to improve coordination of the service system, can be established. To begin to resolve most of the major problems, however, expenditures and staff will have to expand.

If the level of annual expenditures is to be increased, we would add certain priority types of recommendations to those cited above for the "slight or no increase in level of effort." Recommendations listed in the "modest increase in level of effort" column of Table A are those which we feel address the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that are now provided.

For people with mental health disorders, we assign priority to recommendations associated with identifying people in need of service by screening high-risk groups and screening each schoolchild once, expanding special education to serve all seriously emotionally disturbed children the law now says must be served, restructuring and expanding rural mental health services, providing improved follow-up treatment of people released from residential mental health programs, providing intermediate levels of mental health services to those needing them over an extended time period, and substantially upgrading the skills of mental health technicians.

For mentally retarded people, we assign priority to identification of people in need of service by screening each schoolchild once, increasing special education resources to serve all those children the law now says must be served, providing appropriate special education and training to mentally retarded Nevada Mental Health Institute residents, expanding developmental homes and sheltered apartment living opportunities in the community, providing the equivalent of the Desert Developmental Center's range and quality of services to northern Nevadans, improving the training of state "technicians" who serve mentally retarded people, providing special services to mentally retarded prisoners, and bringing the severely deficient mental retardation program at the Nevada Mental Health Institute up to standards of the Joint Commission on Accreditation of Hospitals.

For alcohol and drug abusers, we assign priority to recommendations dealing with the creation of statewide drug and alcohol detoxification services, of a comprehensive alcohol abuse treatment program in the Las Vegas area, of an inpatient drug treatment program analogous to the one for alcohol abuse treatment at the Nevada Mental Health Institute, and of a program for rehabilitation houses plus outpatient treatment in rural Nevada.

If Nevada officials approve an increase of approximately $16 million in annual expenditures, or 46 percent above the FY 1974 level of effort, they will be able to implement all of the recommendations listed in the "modest increase in level of effort" column of Table A. They will not be able, however, to implement many other of our recommendations that we regard as necessary to resolve major service system problems.

If Nevada officials decide to make the effort required to meet all the needs of each different group of mentally handicapped people, then all the recommendations should be implemented. We estimate this would require an increase in annual expenditures of approximately $27 million, or 77 percent above the FY 1974 level of effort. This is not inexpensive, but we believe it will be necessary if Nevada is to achieve its official goal for the mental health and mental retardation service delivery system. Despite recent improvements, great unmet and inadequately met serv-

ice needs still prevail. It is up to Nevada to say how far it is willing to go in meeting those needs.

The study is described and its findings and recommendations are summarized in this volume. The full unabridged main text of the report, R-1800-FLF, provides details and supporting data for our findings and recommendations.

ACKNOWLEDGMENTS

The authors wish to thank the many people and organizations who lent their cooperation and assistance in the course of this study. Foremost is the Max C. Fleischmann Foundation, without whose support the study would not have been conducted. Senator Lee Walker and the joint subcommittee of the Nevada Legislature concerned with mental health and mental retardation care facilities and programs requested and provided public impetus for and endorsement of the study, thereby increasing the cooperation we received. Roger Trounday, in whose Department of Human Resources most mental health and mental retardation programs are administered, provided us with complete access to all program staff and all available information. We received excellent cooperation in our many interviews with both officials and direct service personnel in every major public and private service program in Nevada for mentally handicapped people. Dozens of program clients and their families also contributed their experiences and views, thereby adding a vital component to this study. As we think back over the study, we are gratified by this extraordinary cooperation and assistance.

Several Rand colleagues and consultants provided valuable assistance. Expertise in psychology, psychiatry, medicine, and special education, together with knowledge derived from extensive experience in delivering mental health and mental retardation services, were provided by our consultants Eli M. Bower, Arnold Milstein, Irving Philips, and Robert Rubenstein. Fred Blackwell analyzed computer-based information on Nevada programs. John Pincus, the manager of Rand's Education and Human Resources program, oversaw the progress of the study. Will Harriss edited and significantly improved the comprehensibility of this report. Patricia Fleischauer and Velma Thompson reviewed and made helpful comments concerning earlier drafts of this report. Additionally, coauthor G. D. Brewer benefited from the environment and fellowship of the Center for Advanced Study in the Behavioral Sciences, Stanford, California, during the academic year 1974-75.

We are grateful for all of this assistance.

CONTENTS

Chapter 1

DESCRIPTION OF THE STUDY

This is a summary of a report on the results of a two-year study of all major mental health and mental retardation services and service delivery programs for people in Nevada. In the summer of 1973, as a result of numerous applications for grants in the field of mental retardation, the Max C. Fleischmann Foundation was considering having a research organization conduct a study of mental retardation services. In the fall of 1973, the Chairman of the Mental Health Care Facilities and Programs Subcommittee of the Nevada Legislature inquired if the Foundation would finance a broad study of the mental health and mental retardation service system in Nevada. The request received the support of the Director of the Nevada Department of Human Resources. As a result, the trustees of the Foundation elected to broaden the scope of the study to include all mental health and mental retardation services and service delivery programs in Nevada.

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SCOPE OF THE PROJECT

The study provides information on the size of the current and projected populations of various types of mentally handicapped people, information on the current status of services and service delivery programs for them, information on problems with present services and programs, and recommendations meant to solve those problems and hence improve mental health and mental retardation services throughout the state. The primary focus is on Nevadans of all ages who are afflicted with what are generally called mental health and mental retardation problems that result in a substantial need for special services. A secondary focus is on people with alcohol and drug abuse problems, since alcohol and drug abuse are considered by many to be special types of mental health problems. Major differences exist among those four types of mentally handicapping conditions mentioned above, and hence among service requirements of people afflicted with those different conditions. Consequently, major differences exist among our recommendations for programs to alleviate service problems for those four different groups of mentally handicapped people. We believe a single report provides a more unified perspective than would a separate report for each of those different conditions, however, because several programs in Nevada's current service system serve all four groups of mentally

handicapped people, and because the needs of the different groups are similar in some service areas. In general terms, the major service areas of concern to this study are: prevention of mentally handicapping conditions; identification of people with mental handicaps; direction to appropriate service providers; special education; treatment of mental health disorders; developmental training to ameliorate the effects of mental retardation; alcohol and drug abuse treatment; medical care; vocational services; residential care; and income assistance. The study is concerned with all service delivery programs in both the public and private sectors that serve mentally handicapped Nevadans.[1]

The time-frame of concern in this study includes both the present and the next ten years. We chose a ten-year planning horizon because many major substantive program and facility changes require five to ten years for full implementation, and hence require planning now. It is both less essential and less feasible to plan fully for more than ten years in the future, because of uncertainties concerning Nevada's population growth beyond ten years, and because it is not necessary to make intermediate decisions on most program changes that would take place so far in the future.

The scope of this project is necessarily large and comprehensive, because the service needs, programs, and problems of serving mentally handicapped people are also large and comprehensive. The literature in the field is vast, but researchers in nearly every phase of the field run up against the same persistent problem we encountered: a serious lack of data upon which to base definitive analyses. Hence, guarded provisos and caveats are often required. Because this is an overview study that must work with available data, it does not pretend to answer all questions.

RESEARCH APPROACH

We have taken a *policy-analytic, comprehensive view of the whole system serving mentally handicapped people* to enable us to assess the relationships of the system's constituent parts to its whole.[2] Admittedly, because we have chosen to be comprehensive, we may very well have erred in reporting or failing to report details about the service system's various components; we have worked diligently to minimize this possible problem.

We have also taken a *comprehensive, target-population view of the service needs of each different type of mentally handicapped population,* to enable us to identify the relationships among service needs and to assess how well the current and proposed service system policies are providing and will provide the mix of services needed by the target population.

In looking at the needs of mentally handicapped people, we found it essential to *disaggregate our analysis of the population by type and degree of handicap, by age, and by geographic location,* since needs and accessibility to the service system vary with those factors.

[1] We use the term "program" in a generic sense to describe a set of interrelated activities with some common unifying concept, such as delivery of a common service (e.g., a special education program), administration by a separate bureaucratic entity (e.g., the Vocational Rehabilitation program), or possession of a common goal (e.g., a program for preventing birth defects).

[2] For a more detailed description of our approach, see J. S. Kakalik et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1420-HEW, May 1974.

A series of questions that we posed and attempted to answer illustrate various facets of our research strategy:

- What are the *service needs* of each major subpopulation of mentally handicapped people?
- What are the characteristics of the *current service programs* for meeting those needs?
- What are the *objectives* of various participants in the service system, and how can progress toward the objectives be measured? (See the "Service System Goals" section of this chapter for a discussion of criteria on which the services and programs can be evaluated.)
- What are the *problems* with the present mix of services delivered and in the present structure of programs for achieving the objectives?
- What *recommended policy changes* appear desirable, at what costs, for alleviating problems and improving services?
- Depending on the level of expenditures officials decide to make and depending on objectives, what *priority* recommendations should be selected for implementation from the full set of recommended policy changes?

With the data at hand, we can answer these questions only partially. We discuss the problems created by data deficiencies, and try scrupulously to identify assumptions, limitations, and the extent of data quality and reliability throughout the report.

We use a *multimethod approach*, for in an evaluation as complex as this, no single analytic method will suffice. The specific method used in any given case depends on the question at hand and the available data. Furthermore, the comprehensive, problem-centered approach we have taken is beyond the skill and endurance of any one person; it calls for *interdisciplinary* research. Our group includes people trained in policy analysis and evaluation, psychology, psychiatry, medicine, education, management, political science, sociology, and demography. Our staff and consultive specialists all came from outside Nevada and were independent of the state, to enable us to be as objective and unbiased as possible.

We used *a wide variety of information sources.* To gain an overview of the public and private system of services for mentally handicapped people, it was necessary to collect and analyze a great deal of information. The service system we found was fragmented, which implied that information about it would also be fragmented and that great effort would be required to collect and synthesize the data into a coherent picture. Our information came from several basic sources: interviews with officials responsible for overall service system policy; interviews with direct service personnel and administrators in every major service delivery program in Nevada and many small ones, including many whose primary purpose is not service to mentally handicapped people; interviews with dozens of clients of the service system and, in some cases, their families; interviews with organizations representing mentally handicapped people; program reports and unpublished information from service program data files; direct observations of services being delivered; literature in the various relevant fields; and consultation with professional experts. Finally, in early 1976, over 60 Nevadans were given the opportunity to review and comment on a draft of this report (including people responsible for every major existing service program) and to update material where any major substantive changes had taken place since the time of our original data collection.

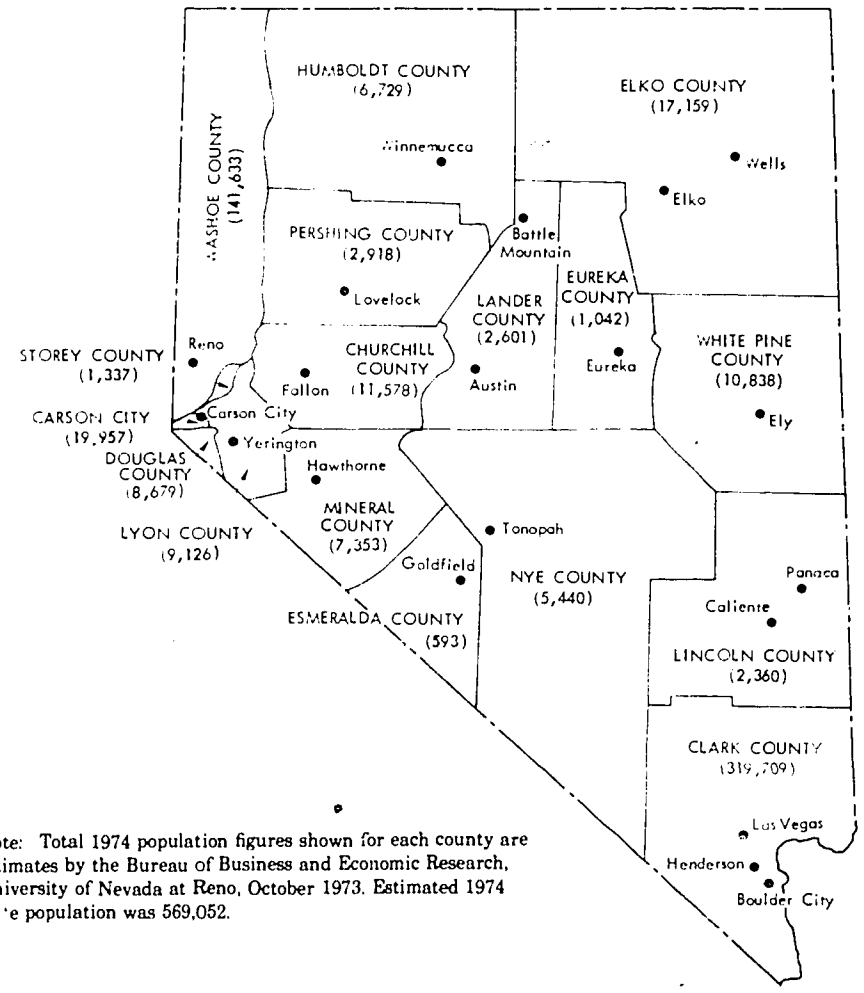
THE MENTALLY HANDICAPPED POPULATION

People's degrees of mental health, mental retardation, or alcohol or drug abuse vary on a continuum in several dimensions. Those dimensions can be defined in terms of various types of functional capabilities, or various types of need for services. Consequently, any definition of a mental handicap must be rather arbitrary. Definitions used are not always consistent among service agencies, nor should they be, since an agency's definition of a particular handicap, used for establishing a client's eligibility for service, should be based on the potential client's need or functional capability as well as ability to benefit from the particular service or services offered by the agency. Chapter 3 of the main text presents various definitions used in Nevada and the best definitions available in Nevada and nationally for each type of mental handicap, along with a discussion of various estimates of the prevalence of each type of mental handicap. Citations to the relevant literature are provided in that chapter for those readers who may wish to pursue the issues of definitions and prevalence rates.

For the purposes of this study, we broadly define a mentally handicapped person as a person with a significant mental impairment that substantially limits his or her functioning in one or more major life activities, and results in a substantial need for special services that nonhandicapped people do not require. Need for service is a relative and not an absolute concept. The admittedly vague term "substantial need for special services" is meant to indicate that the population of concern in this study consists of those people that the majority of society would believe clearly require services. As mentioned at the beginning of this chapter, the study focuses primarily on people afflicted with what are generally called problems of mental health and mental retardation, and secondarily on people with problems of alcohol and drug abuse. Our occasional use of the shorthand generic term "mental handicap" refers to people with one or more of these four problems who need service, but in no way assumes a commonality of need for particular services by so widely diverse a group. The needs of people whose primary problems are with other types of mentally related handicaps, such as cerebral palsy, epilepsy, Parkinson's disease, and stroke, are equally important but beyond the scope of this study.

Nevada is a mountainous and semiarid state of approximately 110,000 square miles, with a northern border about 400 miles long, and with eastern and western borders about 500 and 600 miles long, respectively (see Fig. 1.1). The Federal Government controls 87 percent of the land in the state. The state's total population was about 573,000 in 1974, and Rand's best estimate is that it will grow to about 759,000 by 1985 (see Chap. 3 of the main text for the method of estimation). The population is clustered primarily in two metropolitan areas. The Las Vegas metropolitan area in southern Nevada has about 56 percent of the population. The Reno metropolitan area in northwestern Nevada has about 24 percent of the population, and the remaining 20 percent is in the large, sparsely populated rural counties. The map of the state shown in Fig. 1.1 contains the estimated 1974 general population by county.

Estimates of the number of mentally handicapped people in the state vary widely depending on the definition used, the data accepted, and the type of service for which the definition is to be used in establishing eligibility. Although we are not fully satisfied with the reliability of the estimates we present, we are confident that they represent the correct order of magnitude of those groups of people requiring



Note: Total 1974 population figures shown for each county are estimates by the Bureau of Business and Economic Research, University of Nevada at Reno, October 1973. Estimated 1974 state population was 569,052.

Fig. 1.1—Nevada population by county (1974)

at least some of the special services described in this report. Our approach has been to develop a range of credible estimates of the prevalence of each disorder, using the best available data in Nevada and nationally, and then to use the *minimum* estimate in the range throughout the report; that way we are reasonably sure that *at least* the specified number of people need service, and that program service capacity below that level is insufficient to meet the need.

Using the low prevalence estimate for each mental disorder yields a conservative total of *at least* 66,000 people who needed some type of substantial services in Nevada in 1975 because of mental disorders; the minimum number in need of services will grow to an estimated 89,000 by 1985, assuming the percentage of mentally handicapped people in the general population is the same in both years. Of the 1975 total, we estimate that at least 11,000 people had mental health disorders, at least 11,000 were mentally retarded, at least 33,000 were alcohol abusers, and at least 11,000 were drug abusers. If we were to use the upper rather than the

lower end of our range of estimates of prevalence for each type of disorder, the estimated *maximum* number in need of some services is about 122,000 in 1975 and 163,000 in 1985. Of the 1975 total, we estimate that a maximum of 55,000 people had mental health disorders, a maximum of 17,000 were mentally retarded, and a maximum of 37,000 were alcohol abusers. We did not estimate the maximum number of drug abusers, because of lack of data.

Definitions and prevalence information for each of the types of mental handicaps are summarized next.

Mental Retardation

The most widely accepted definition of mental retardation, both in Nevada and nationally, is "substantially subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period."[3] Adaptive behavior refers to how proficiently the person functions in society: the developmental period extends up to age 18; and substantially subaverage means an IQ test score at least two standard deviations below average (i.e., an IQ score of approximately 70 or below). Using a relatively low estimate of prevalence of 2 percent of the population yields a prevalence of approximately 11,000 retarded Nevadans in 1975 and 15,000 in 1985 (assuming our best estimate of the total Nevada population in 1985). Using the most widely quoted estimate of prevalence, 3 percent of the population, yields a prevalence of approximately 17,000 in 1975 and 23,000 in 1985. (See Chap. 3 of the main text for sources of those estimates.)

Alcohol and Drug Abuse

There are no universally accepted, precise definitions for either alcoholism or drug addiction. The legal definition of an alcohol or drug abuser in the Alcohol and Drug Abuse chapter of the *Nevada Revised Statutes* is "a person whose consumption of alcohol or other drugs, or any combination thereof, interferes with or adversely affects his ability to function socially or economically."[4] In spite of the definitional and empirical difficulties, however, at least an order of magnitude estimate of the size of the alcohol and drug abuse problem is needed to enable intelligent planning of service programs.

The two techniques in widespread use at the present time for estimating rates of alcoholism or alcohol abuse are based on: (1) deaths due to cirrhosis of the liver (a disease associated with heavy alcohol consumption); and (2) a statistical analysis of alcohol consumption data per capita (to estimate the number of people who regularly drink more than the equivalent of five ounces of ethanol, absolute alcohol, per day). A close correspondence exists between estimates of Nevada's alcoholism rate based on consumption and on liver cirrhosis deaths (8.8 percent of the general population compared to 7.8 percent). Because cirrhosis is a long-term disease that usually does not lead to sudden death, the cirrhosis death rate is most likely a characteristic of the resident population, with few occurrences among nonresidents,

[3] American Association of Mental Deficiency, *A Manual of Terminology and Classification in Mental Retardation*, monograph supplement to the *American Journal of Mental Deficiency*, 3d ed., Washington, D.C., 1973.

[4] *Nevada Revised Statutes*, 458.010.

and hence probably leads to a more accurate estimate for Nevada residents. Nevada has the highest rate of alcohol abuse of any state in the country, a rate that yields an alcoholic or alcohol abuser population over age 15 in 1975 of at least 33,000 (using the lower estimate, the cirrhosis-based rate of 7.8 percent). Projecting these figures to 1985 yields an estimated 44,000 people in the alcoholic or alcohol abuser population.

Drug abuse, as the term is used in this report, includes abuse of opiates, hallucinogens, stimulants, depressants, and other dangerous drugs as defined in Chap. 453 of the *Nevada Revised Statutes*.

It is even more difficult to estimate drug abuse rates than it is to estimate alcoholism rates. Few diseases are associated specifically with drug addiction, as liver cirrhosis is with alcoholism. Even deaths caused by overdoses of certain drugs cannot necessarily be attributed to addiction. Moreover, since the drugs are illegally produced or purchased, there are no gross quantitative data on usage rates analogous to per capita alcohol consumption. Using Nevada survey results as the best available estimate, opiate and other dangerous drug abusers (as distinct from drug users) numbered approximately 11,000 in 1975 and are projected to number approximately 15,000 in 1985 (assuming the percentage of drug abusers in the general population is the same for both years). See Chap. 3 of the main text for a discussion of these and other estimates.

Mental Health

The difficulties of defining and measuring the prevalence of mental retardation and alcohol abuse pale in comparison with those associated with defining and measuring mental health.

As defined in the *Nevada Revised Statutes*, "mental illness" means "any mental dysfunction leading to impaired ability to maintain oneself and function effectively in one's life situation without external support."[5]

The Nevada requirement for involuntary court-ordered admission and emergency admission to a mental health facility is that a person "has demonstrated observable behavior the consequence of which presents a clear and present danger to himself or others, or presents observable behavior that he is so gravely disabled by mental illness that he is unable to maintain himself in his normal life situation without external support."[6] An emotionally disturbed child is defined as someone aged 2 to 17 years

> whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment:
>
> 1. For reasonably accurate perception of the world around him;
> 2. For impulse control;
> 3. For satisfying and satisfactory relations with others;
> 4. For learning; or
> 5. For any combination of the above.[7]

[5] Ibid., Chapter 433, as amended by Senate Bill 374, Sec. 19, Nevada Legislature, 1975.
[6] Ibid., Sec. 22.
[7] Ibid., Sec. 14.

For purposes of this study, we consider a person to have primarily a mental health problem if he or she has a substantial need for psychological or psychiatric services primarily due to a mental disorder other than mental retardation or alcohol or drug abuse. Of course, people with primarily mental retardation or alcohol or drug abuse problems may also need psychological or psychiatric services, but such people are considered separately in this report. Thorough evaluation of each client is desirable, however, since more than one disorder may be present; for example, a drug abuser's primary problem may be a severe psychological disorder. The term "substantial need" is meant to indicate that the population of concern in this study consists of those people the majority of society would believe clearly require mental health services. The term "mental health problems" will include primarily the problems of people in five of the American Psychiatric Association (APA) categories: virtually all psychotic people, but only people with the more severe disorders within the categories of organic brain syndrome, neurosis, personality disorder (not due to alcohol or drug abuse), and transient situational disturbances. (See Chap. 3 of the main text for APA definitions of those categories.)

The question then is how one estimates the prevalence of need for substantial psychological services in Nevada. The answer is that one cannot do so accurately. The best we can say is that the prevalence is on the order of 2 to 10 percent of the population based on national data presented in Chap. 3 of the main text, and that 2 percent is probably a conservatively low estimate. We could also resort to a variety of indicators. Although the annual suicide rate is not an unambiguous indicator of the rate of mental health disorders in a population, the two rates are related. In 1973, the latest full year for which statistics are available, the annual rate of suicides per 100,000 population was 12.0 nationally and 22.3 in Nevada. Thus, as suggested by one measurable scale at least, the prevalence of mental health disorders in Nevada may be above the national average. Using the minimum 2 percent figure for the prevalence of mental health problems in Nevada yields an estimate of about 11,000 people in 1975 and about 15,000 in 1985. Using the maximum 10 percent figure yields an estimate of 55,000 people in 1975 and 75,000 people in 1985.

SERVICE SYSTEM GOALS

Having considered the nature and size of the mentally handicapped population in Nevada needing some type of substantial service, we now turn to the issue of goals for the service delivery system. We note a similarity in the stated goals of various service system participants in Nevada. We also note a tendency for goals to be stated in rather general terms, such as to "ensure needed services are available to all citizens." Since need is a relative and not an absolute concept, to be most useful such goals should be and often are operationalized with detailed statements of the characteristics of people eligible for services, and estimates of the number of people with those characteristics. See Chaps. 3 to 14 of our main text for details that make the following goals more operational.

The official state goal for the Nevada Division of Mental Hygiene and Mental Retardation with respect to delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the

least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."[8]

The concept of "normalization" as a goal of the service system is often heard in Nevada with respect to mental retardation, although it is more general. Normalization has been defined in various ways; one definition, stated in terms of mental retardation, is "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society"; another definition, more generally stated, is "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible."[9]

The state goal for the Nevada Bureau of Alcohol and Drug Abuse is "to provide a network of services for the prevention of addiction, treatment, and rehabilitation of the chemically addicted."[10]

The Nevada Developmental Disabilities Council[11] has pledged to work for "the protection of the rights of every individual who, by reason of being classified as developmentally disabled, is in any way restricted in his liberty or otherwise deprived of his human and civil rights by any external authority *and* the development and utilization of a full range of services and resources for the individual with a developmental disability. . . ."[12]

From our discussions with handicapped people, their families, and organizations supporting their cause, we surmise that if mentally handicapped people were to set goals for the service system, those goals would be consistent with the stated goal of the Nevada Division of Mental Hygiene and Mental Retardation, the objectives of the Nevada Developmental Disabilities Council, and the concept of normalization. In reality, however, these goals have been attainable only for selected individuals because serving all mentally handicapped persons requires a financial commitment that the state and society in general have not been willing to make. Governor Mike O'Callaghan and the Nevada Legislature have demonstrated agreement with the above-stated goals through their actions in approving expansion and improvement in services to mentally handicapped people in recent years, including 1975. However, state officials have other important program goals that can conflict with and prevent complete fulfillment of goals for improving services to mentally handicapped people. For example, Governor O'Callaghan, in his inaugural address in January 1975, set forth a fiscal goal that limits all state expenditures: "I will ask no new general taxes or increases in existing general taxes during the 1975 legislative session," a restatement of a pledge made at his first inauguration in 1971.[13] The actions of the Nevada Legislature demonstrated agreement with the Governor on this fiscal goal. As a consequence, not enough resources have been available to

[8] Office of the Governor, *State Goals*, State of Nevada, Carson City, Nevada, March 1, 1974.

[9] Wolf Wolfensberger et al., *The Principle of Normalization in Human Services*, National Institute of Mental Retardation, Toronto, Canada, November 1972.

[10] *State Goals*.

[11] Mental retardation is one major type of developmental disability.

[12] Nevada Developmental Disabilities Council, *Principles of Policy and Action*, Carson City, Nevada, May 29, 1974.

[13] Governor Mike O'Callaghan, in his inaugural address in Carson City, Nevada, on January 6, 1975, as reported in "Governor: No New Taxes or Increases," *Nevada State Journal*, Reno, Nevada, January 7, 1975.

permit full achievement of the goals of the mentally handicapped population and the primary state agencies that serve them.

Multiple measures are required for assessing service system performance in relation to complex goals. Because we are dealing with complex goals, it is useful to consider a set of dimensions on which services and programs can be measured and evaluated:

- Effects on the quality of life of the mentally handicapped person, and of other people in his or her social orbit
- Future economic effects
- Equity of service distribution to the population
- Protection of civil and human rights of mentally handicapped people
- Sufficiency of service capacity in relation to need
- Quality of services available
- Degree of coordination of the service system
- Availability and accessibility of a full range of types of needed services
- Availability and accessibility of a continuum of levels of intensity of service
- Availability and accessibility of a range of treatment modalities to match the range of people's needs
- Current costs—resources consumed

While these goals and dimensions are laden with words requiring value judgments, they are nonetheless useful in evaluating service policy options. In general terms, enhanced performance of the service system on all but the last dimension or measure is desirable in helping to achieve the mentally handicapped population's goals and the stated goal of the Nevada Division of Mental Hygiene and Mental Retardation. The last measure listed—current costs—indicates the current resources consumed to achieve enhanced performance on the other dimensions. These dimensions are discussed in some detail in Chap. 8 of the main text under the heading "Desirable Features of a Service System."

The difficulty is that basic information is necessary before one can use those multiple measures to make comparative judgments about policy options in relation to goals. The application of those measures to Nevada is restricted by the deficient data available, especially on service effectiveness. Great precision should not be expected. With the available data, often all one can say with any confidence is that such-and-such a policy change would result in "major quality-of-life improvement" or "low cost relative to future economic benefits," or "filling a gap in needed services." Nonetheless, that may be enough. A sound policy choice can often be made if such general statements are known to be valid.

Chapter 2

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

This chapter summarizes the findings and recommendations of a two-year study of all major mental health and mental retardation services and service delivery programs for people in Nevada. By conservative estimates, at least 11,000 people with mental health disorders, at least 11,000 mentally retarded people, and at least 44,000 alcohol or drug abusers needed some type of substantial service in Nevada in 1975.

We have arrived at recommendations for improving services to these very different types of mentally handicapped people, beginning with their basic service needs. A client's specific service needs will depend on such factors as type and severity of mental handicap, age, previous services received, and others. The different basic service needs considered in this study are:

- Prevention of the mentally handicapping condition
- Identification of the mental handicap
- Direction to appropriate service providers
- Special education
- Treatment for mental health disorders
- Developmental training and other services to ameliorate the effects of mental retardation
- Alcohol and drug abuse treatment
- Medical care
- Vocational services
- Residential care
- Income assistance

Our research strategy, as outlined in Chap. 1, involves taking a comprehensive view of both the service system and the population needing service. We estimate the size and service needs of the four different types of mentally handicapped people, and analyze the characteristics of all major public and private Nevada service programs for helping to meet those needs. We consider the objectives of various participants in the service system, and several dimensions on which to measure progress toward those objectives. We then describe problems with the current service system, and present recommendations for resolving those problems and approaching the official state goal for the mental health and mental retardation service delivery system. Finally, considering the anticipated costs and effects of each recommendation, we suggest priorities for which recommendations to select for implementation from the full set of recommendations. Those priorities are suggested as a function of three different levels of expenditure effort Nevada officials may decide to make in resolving current problems and improving services.

In early 1976, over 60 Nevadans were given the opportunity to review and

comment on a draft of this report (including people responsible for every major existing service program) and to update material where any substantive changes had taken place since the time of our original data collection.

This chapter summarizes public and private expenditures for services to mentally handicapped Nevadans; discusses problems with those programs; summarizes our recommendations in each area of service need; and, in the last section, suggests priorities on implementation of our recommendations according to three different levels of expenditure effort state officials may choose to make to remedy the problems. Chapters 3 to 14 of the main text, published separately from this executive summary as Rand report R-1800-FLF, present the detailed data and analysis.

TOTAL SERVICE EXPENDITURES AND STAFF

Programs providing services to mentally handicapped Nevadans spent more than $35 million in FY 1974, as shown by type of service in Fig. 2.1. The number of full-time-equivalent staff providing those services was about 1150. Refer to Chaps. 4 to 14 of the main text for sources of these data by type of service. We have not summed the number of people served by all programs because one cannot meaningfully do so with the available data; people often are served by more than one program in a year, with the result that adding the numbers served by all programs entails an unknown amount of multiple counting.

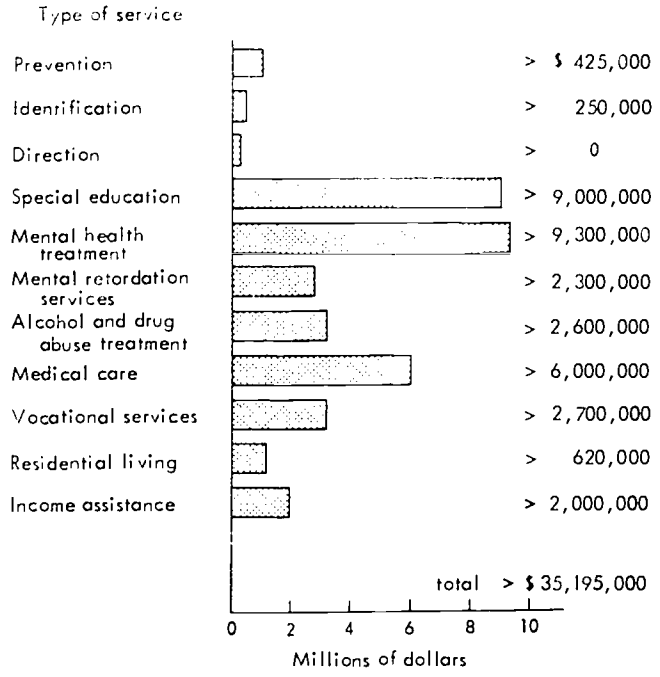


Fig. 2.1—Estimated FY 1974 expenditures for mentally handicapped Nevadans

Later sections of this summary discuss each type of service separately and present available data on expenditures, staff, and numbers of people served by each different type of mental handicap (mental health disorder, mental retardation, and alcohol or drug abuse).

PROBLEMS WITH THE PRESENT SERVICE SYSTEM

To place matters in perspective, the $35 million expended annually on services for mentally handicapped Nevadans is producing beneficial results. Although service programs in the state have expanded and improved in recent years, Nevada still has a long way to go to provide all the services that are needed. Major problems still abound, and many people are still receiving no services, the wrong services, or inadequate services.

Given insufficient resources to meet all the needs, compromise and priority-setting are necessary; tradeoffs must be made between the number of people served and the quality of services provided to each of them. Nevada's mental health and mental retardation service system superficially appears to be nearly comprehensive, since it offers programs in most areas of service need. Unfortunately, that appearance is deceptive. Some programs are embryonic; although well intended, they are small and fall far short of filling the needs. Some programs are shallow; although they serve relatively large numbers of people, they are often not providing adequate substantial services to those people.

Later sections of this chapter summarize, for each type of service and for each current program, the many problems Nevada should resolve if it is to improve services for people with mental health disorders, mental retardation, and alcohol and drug abuse problems.

In reviewing the various problems after completing our work, we noted that certain classes of problems occurred again and again among the services and programs: insufficient service capacity in relation to need, inequitable distribution of services by geographic location, lack of coordination and direction of the service system, poor facilities, inadequately trained personnel in some programs and hence poor-quality services, failure to provide a full range of services, absence of a continuum of levels of intensity of service, and failure to have a variety of treatment modalities available to match the variety of people's needs. Finally, too little information is available for program management and for evaluating the effectiveness of programs. Professionals working in the service system in Nevada are well aware of most of these problems, which are not new—nor are they unique to Nevada by any means.

The lack of sufficient service capacity in relation to need is the single most important problem we noted. Still, inadequate service capacity is not the only problem. As we detail later in this chapter, even without major increases in funding levels, some things can be done to improve the services themselves, the organizational structure of the service system, the matching of services with clients, and information on the service programs.

In sum, Nevada's mental health and mental retardation service system is providing needed and beneficial services; with improved organization and support, the system could be far better.

Concerted action on the part of state and local officials is called for if the problems of mental health disorders, mental retardation, and 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. Chapters 3 to 14 of the main text provide the detailed rationale for this agenda, which is summarized below.

SUMMARY AND RECOMMENDATIONS: INDIVIDUAL SERVICE NEEDS

In the following eleven sections we consider the service needs of the individual mentally handicapped person in the following order: direction, prevention, identification, special education and training, mental health treatment, mental retardation services, alcohol and drug abuse treatment, vocational services, medical care, residential living, and income assistance. Whenever appropriate, each section separately discusses and makes recommendations for people with mental health disorders, mental retardation, or alcohol or drug abuse problems. This procedure is essential because there are great differences in the service needs of people with those very dissimilar handicaps, and great differences in the problems associated with current programs intended to meet those needs.

Following the discussion for individual services, we conclude by considering priorities and costs for our recommendations, which are summarized in Table A in the Abstract of this report.

DIRECTION

People who are searching for needed services find a labyrinth of ill-coordinated and highly specialized programs that tax their ingenuity and perseverance in the search. Each current program and its staff usually provide only one or a few specialized services; even if each program and professional does perform well, a single service may meet only a small fraction of the mentally handicapped person's total service requirements. Of course, it is not fair to blame individual professionals for the lack of coordination and direction; they almost never are given the specific responsibility and resources to provide coordination and direction of each client to all needed services. A specially designed direction program is needed for that purpose. For a more detailed discussion of direction and coordination of services than appears below, see Chap. 4 of the main text.

Direction is an information-based service that attempts to match a client's needs with an appropriate mix of available services. It also provides coordination and continuity among the many programs designed to meet those needs. Because a client's needs change over time, the direction concept further requires periodic and systematic reassessment of needs to ensure a "best mix" of services, a mix that is appropriate in amount, quality, and costs of services. The direction service program also could coordinate such important services as prevention and identification, which are not the prime responsibility of any agency in Nevada and are provided unevenly now.

Direction is not well developed in most public service systems in the United States; for mentally handicapped people in Nevada, it is in a primitive state of development. No single identifiable program in Nevada, either public or private, is primarily concerned with direction. In the scattered offices that do provide some direction, it is not the main order of business and is typically provided only on an ad hoc basis. Some slight and incomplete direction service is to be found in the two Special Children's Clinics in the Division of Health, in the two Mental Retardation Interdisciplinary Committees run by the Division of Mental Hygiene and Mental Retardation (only for mentally retarded applicants and clients of the Division's residential treatment programs at the Nevada Mental Health Institute, the two Mental Retardation Centers, and the program of sheltered residential living in developmental homes), and at Nellis Air Force Base (only for military-related people). And, doubtless, some individual public health nurses, social workers, teachers, psychologists, physicians, and others working within the system try to secure a complete range of needed services for individual clients. However, needed services are not always available, as later sections of this report will make abundantly clear. The lack of coordinated services and direction to services that *are* available remains a major deficiency in Nevada as elsewhere.

In sum, there is almost no comprehensive direction service in Nevada. Information about the overall service system and its components, its clients, its effectiveness, and its deficiencies is simply not available in comprehensive form either to those who need services or to those who are responsible for providing them. In this situation, much of the responsibility for matching an individual's needs with the available services falls by default to the handicapped person or to family and friends. Mentally handicapped people are likely to be poorly equipped for that task, and friends and relatives confront the same lack of information as everyone else. Poor direction and coordination of services have stark implications for the overall operation of the service system. The system should not be expected to work very well when poor direction and coordination exist, and it often does not work well.

Adequate coordination and direction have not been achieved and probably cannot be achieved by relying solely on the individual staff members of *various* programs. We believe it is better to establish a separate state program responsible for direction and coordination of the service system on behalf of individuals. The information essential for direction and coordination comes from all service programs, and it is more efficient to have that information available and up to date in one place than to try to keep every program up to date on every other program in sufficient detail so that every program could provide a complete and effective direction service. Assigning direction and coordination responsibilities to a separate program staff also would visibly place primary responsibility for direction with that staff, and would eliminate the possibility of having direction and coordination neglected because attention is diverted to meeting other pressing service demands (as can easily happen when a program is primarily responsible for some other service). Another argument in favor of having a separate state direction program is that there are interdependencies among different service programs that may not be adequately taken into account if direction were to be provided by each of those various programs rather than by a separate state-level program. For example, benefits and costs of a service program may be received or borne beyond the bounds of that particular service program; these benefits and costs can be termed "externalities" from the

viewpoint of that particular service program. If direction and coordination of client services by each of these particular service programs is provided by a separate state program, then certain factors that are external from a particular service program's viewpoint can be internal from the viewpoint of the state direction program with its broader perspective.

Furthermore, it is unlikely that anything less than a separate state direction program will achieve the desired coordination of services for individuals, since it is unlikely that other existing state service programs can be effectively coordinated in practice by personnel who are not placed above those programs in the bureaucracy.

We consider the following to be critical requirements for a quality direction and coordination service program, to be administered by the Regional Direction Centers we recommend below. The program should:

- Be a well-publicized *point of entry* to the service system and a one-stop source of information to match the individual's needs with available services and facilitate access to the most appropriate available services.
- Maintain information about all components of the public and private system, so that individuals can be effectively matched with the most appropriate available services.
- Maintain the information base of the service system on paper rather than merely in people's heads, so that the information is readily transferred when personnel turnover occurs.
- Create a specific and comprehensive service plan for meeting each client's particular needs to the extent feasible with the existing service system, and coordinate with other programs to obtain needed available services for the client.
- Collect and maintain information on each with adequate privacy safeguards, to facilitate planning and delivery of services for the individual.
- Serve as a representative for individual clients in interacting with the service system, to facilitate service delivery.
- Provide for periodic review, through active follow-up, of the appropriateness of the mix of services being provided to each client in light of changing needs and programs.
- Provide a multidisciplinary staff, since people trained in a single discipline generally cannot provide all the expertise needed to plan for the wide range of services needed by mentally handicapped people.
- Provide separate staff expertise for people with needs due to mental health problems, mental retardation, and alcohol or drug abuse problems, since the service needs and programs for serving those groups are significantly different.
- Provide direction and coordination as the primary service of the program, so that attention is not diverted to meeting other pressing service demands.
- Be separate from other major direct service programs in the bureaucracy, so that it is not captured by those programs, and so that too much emphasis is not placed on direction to certain services.
- Be publicly rather than privately provided, since it is unlikely that the private sector could coordinate public sector programs.

RECOMMENDATION 1: Establish two Regional Direction Centers: one in Reno to serve all of northern Nevada, and one in Las Vegas to serve all of southern Nevada, with separate but cooperating staff for mental health, mental retardation, and alcohol and drug abuse clients. We further recommend that these centers be placed under the operational control of the Nevada Department of Human Resources, and be placed above the administrative level of the various divisions providing the services that the Regional Direction Centers would coordinate. Since not all service programs are within the Department of Human Resources, e.g., education and private service programs, the Direction Centers may need legal authority to coordinate with and exchange information with other public programs, and to provide limited information (with the individual's permission) to private service programs. Privacy safeguards on the information will be essential.

The direction center personnel would not duplicate other services, such as diagnosis, if those services are already provided adequately for an individual in another program such as a mental health center. Initially, the direction center personnel would not have direct authority over other operating program personnel, but would attempt to coordinate services to individuals through persuasion and the exchange of information. Later, if the voluntary approach proves inadequate in Nevada, the direction centers might need to be given greater power. The intent is not to duplicate existing services or dictate to existing programs, but to make them more coordinated, responsive, and effective.[1] While these Regional Direction Centers are highly placed in the bureaucracy, the Centers themselves should be located regionally within Nevada to be near the direct service programs and clients they are supposed to match together. Some mechanism will have to be developed for providing direction to rural clients, perhaps a traveling component of the Las Vegas and Reno Centers.

We recommend starting small, with a staff of perhaps 6 at the Northern Nevada Regional Direction Center and perhaps 12 at the Southern. The operating procedures could be developed, tested, and refined on this small scale with a limited number of clients. If shown to be worth the relatively small cost per client, they could be expanded later.

Offsetting cost reductions and other significant benefits are to be gained if Regional Direction Centers are created. Standardized, accurate, and rapidly accessible management information (necessary for effective and efficient management, but currently not adequately available) could be provided. Additional quality-of-life benefits would accrue to mentally handicapped people and their families from receipt of appropriate services. Dollar-benefits are to be derived from savings in services that people will not need later in life because of more adequate provision of services needed now. Savings in needless rediagnosis and recertification also would be realized by a simple transfer of client records from the direction center to various other servers (although the diagnosis itself might be made originally by some other program, e.g., a mental health center or rehabilitation program). Savings would result from more efficient matching of the needs of a handicapped person with locally available services. The cost per person for a direction and coordination service is not in itself high, and the potential benefits and later savings from that service could be large, but they cannot be accurately estimated using available data.

[1] The Regional Direction Centers we propose are significantly different from the California Regional Mental Retardation Centers (see Chap. 4).

The Regional Direction Centers would provide coordination for the individual client. Other bodies functioning at the service system level and involved in overall interprogram planning are the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Board, the Nevada Alcohol and Drug Abuse Advisory Board, and the Nevada Developmental Disabilities Council. The essential difference between these bodies' planning and the Regional Direction Centers we propose is that these bodies are primarily concerned with planning for the service system whereas the Regional Direction Centers are primarily concerned with planning for service to particular individuals.

The Governor's Advisory Board presently functions at the Division of Mental Hygiene and Mental Retardation level; its responsibilities include reacting to goals, budgets, and program plans prepared by the division, and acting as a liaison body between the division, the community, and the legislature.[2]

The Nevada Alcohol and Drug Abuse Advisory Board and the Developmental Disabilities Council presently function at the bureau level within the Nevada Division of Rehabilitation. (Developmentally disabled people include those who are afflicted with mental retardation, cerebral palsy, or epilepsy to the degree that their condition is substantially handicapping and is expected to continue indefinitely.) The responsibilities of the Developmental Disabilities Council include developing a state plan and evaluating programs for the state's developmentally disabled population; it also has a federal- and state-supported budget of about $111,000 in FY 1975 to support its activities and use in providing grants for projects.[3] Like the Governor's Advisory Board, the Developmental Disabilities Council does not presently see preliminary budgets, preliminary goal statements, or preliminary program plans for the various service agencies in the state.[4] Consequently, the Board and the Council do not have as much input to major service system decisions as they might have.

RECOMMENDATION 2: Inputs to major service system decisions by the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Board, the Nevada Developmental Disabilities Council, and the Nevada Alcohol and Drug Abuse Advisory Board should be strengthened significantly. To carry out this recommendation effectively, consideration should also be given to having the Developmental Disabilities Council placed in a higher position within the bureaucracy. Since the functions of the two boards and the council are complementary to those of the Regional Direction Centers, and since the centers will have a great deal of information that can be of use to those other bodies, some formal relationship between them could be developed.

For a more detailed discussion of direction and coordination, see Chap. 4 of the main text.

PREVENTION

Three classes of prevention can be distinguished. Primary prevention denotes

[2] Interviews with members of the Governor's Mental Hygiene and Mental Retardation Advisory Board, Las Vegas, Nevada, January 6, 1975.

[3] Nevada Rehabilitation Division, *Biennial Report*, Department of Human Resources, Carson City, Nevada, 1975.

[4] Interview with M. Keehn, President, Developmental Disabilities Council, Carson City, Nevada, May 9, 1974.

activities performed for the entire population at large, not specifically the handicapped population; secondary prevention is done for the limited population of identified high-risk groups of people who are vulnerable to developing mental disorders; and tertiary prevention includes all treatment and rehabilitation of handicapped people. Prevention of mental disorders is so self-evidently a "good" objective that no one can dispute its usefulness or desirability, but only its costs, methods, and feasibility.

Prevention is far harder to practice than to preach, however. Nevada's programs for the prevention of mental disorders are in an embryonic, underdeveloped stage, but the state is not alone in that regard.

Current expenditures in Nevada for the prevention of mental handicaps are impossible to estimate accurately; so is the number of handicaps prevented. Some very small but inestimable fraction of programs to improve societal-environmental living conditions for the general population can be considered as going for primary prevention of mental handicaps. More directly, some small fraction of expenditures for maternal and infant care, counseling, family planning, nutrition, immunizations, Medicaid, and other programs contribute partly to the prevention of mental handicaps, but we have no meaningful way of estimating that fraction with available data. The only expenditures we identified that we could specifically attribute to the primary and secondary prevention of mental handicaps were: alcohol and drug abuse education, about $300,000 a year; genetic testing and counseling for mental retardation, about $75,000; and less than $50,000 for Crisis Call and Suicide Prevention telephone programs. For a more detailed discussion of prevention of mental disorders than appears below, and for citations of the literature on prevention, refer to Chap. 5 of the main text.

Prevention of Mental Health Disorders

So little is known about the specific causes and prevention of mental health disorders that preventive measures lack precision and it is difficult to evaluate their effects. Prevention of mental illness is not a new idea, but it is seldom made into an operational program. How does one "prevent" disorders whose causes are so poorly understood?

Genetic control programs are of no significance in practice today. In the absence of etiologic data, genetic counseling for mental health problems has yet to pass from the realm of academic inquiry into application. Providing a stable and stimulating living environment is a preventive "good," but then so are many similar activities. Teaching people how to know themselves, to perceive and understand reality, to make realistic plans, to relate to others, to care and be cared for, to accept and deal with change, to accept responsibilities, and to practice effective birth control are all potential preventive approaches. For all of these approaches there exist related intervention practices, but for all of them—approaches and practices alike—the preventive aspect of reducing mental health disorder is still open to question. There is less doubt about the need to increase public awareness of mental health problems, but even here there are few clear prescriptions, many all-too-clear problems, and not many notable successes.

Society is somewhat better equipped to provide secondary prevention to help "identified vulnerable, high-risk groups," but there are problems here, too. A person with a high risk of developing a mental disorder is too seldom in touch with skilled

mental health providers to be identified early, so that secondary preventive measures can be taken. More often than not the disorder develops and advances over an extended period of time. Ultimately, if fortunate, the person is taken on by a competent psychologist or psychiatrist, by which time the object is treatment, not prevention. Procedures should be designed to make the mental health service system and its prospective clients more readily accessible to each other.

Characteristic practices identified as secondary prevention include counseling for people who are grappling with one of life's many crises, such as the death of a family member, serious illness, handicaps, accidents, and economic deprivation; helping people resolve problems of interpersonal relations; and identifying "developmental" and "situational" conflicts early enough that appropriate treatment can be pursued (the distinction between *treatment* and *prevention* blurs at this point).

Faced with so many possible secondary prevention practices, the problem from a policymaker's viewpoint is exceedingly complex. Which practices are the most effective? Which ones work at all? The lack of data poses fundamental and unresolved difficulties. All that can be said responsibly is that any or all of these practices *may* reduce the incidence and prevalence of mental health disorders.

Allocating scarce resources, the practical matter at hand, involves setting priorities. In light of the rudimentary state of knowledge about the primary and secondary prevention of mental health disorders, we believe there are more demonstrably effective ways for Nevada to spend money than on additional primary and secondary prevention, important though that is. Consequently, we make no recommendations for additional expenditures in this area. However, we do note that some of our recommendations later in this report, such as those for improving the identification of people with mental health disorders and for improving the service capability of the mental health service system, will enhance early treatment of mental health disorders and hence improve tertiary prevention.

Prevention of Mental Retardation

There are more than 200 identified specific causes of mental retardation, including metabolic errors, genetic anomalies, drug abuse, environmental pollution, radiation of pregnant women, infections, accidents, and improper nutrition. Societal conditions affecting behavioral adaptation are also related to mental retardation, but the data are poor on the nature and extent of the relationships.

Many types of mental retardation can be prevented, including several of the more prevalent types. Reliable genetic information for a host of retardation-causing disorders can be provided to parents and prospective parents (e.g., those most likely to have abnormal children) but social, emotional, and moral problems are associated with this procedure. For example, society knows how to detect Down's Syndrome (mongolism) in the unborn fetus, but prevention at the fetal stage depends on family decisions regarding therapeutic abortion. Immunization can prevent infectious diseases that cause retardation, but many children are not immunized. Although very low in prevalence, retardation caused by PKU (phenylketonuria) is largely preventable through dietary means in children whose disorder is diagnosed early enough. Development and use of the Rh desensitizing gamma globulin for mothers has reduced jaundice in the newborn and thus has also reduced incidence of the associated mental disorder, kernicterus.

Nevada offers direct service programs for people who are already mentally retarded. Those programs can be called tertiary prevention programs in the sense that they work to help mentally retarded people to alleviate or eliminate their functional retardation. Nevada has only a few programs for the secondary prevention of mental retardation, however, and they are uncoordinated, highly undeveloped, and, as a consequence, not available to all Nevadans in need.

RECOMMENDATION 3: Expand genetic testing and counseling capabilities, and create a high-risk registry for parents and potential parents of mentally retarded children. We stress that genetic testing and counseling would be provided on a voluntary basis; the intention is not to tell families what to do, or to offer value judgments on a family's decisions, but to provide them with information they can use in arriving at their own decisions to conceive and bear children. The Special Children's Clinics provide a limited amount of this service now. The expansion we are recommending is to have a full-time genetic testing and counseling team in northern Nevada, and another in southern Nevada. Those two teams could also travel to rural areas part-time to provide service. The creation of a high-risk registry (with information and direction-like referral built in) would help make genetic counseling available to those most likely to benefit from it. The registry could include, among others, pregnant women over 35 and under 17, and families with a history of a retardation-causing metabolic disorder or an inherited genetic disorder capable of causing mental retardation. The various medical, mental retardation, and special education programs in the state would serve as sources of referrals.

RECOMMENDATION 4: Implement monitoring and enforcement mechanisms to help ensure that all children of early school-age are immunized against potentially handicapping infectious diseases, that all newborn children are screened for PKU, and that Rh desensitization is provided when needed. PKU screening, Rh desensitization, and immunization for measles and rubella are effective and economically justifiable in helping prevent mental retardation and other handicapping conditions. (See Chap. 5 of the main text for details.) In accord with Nevada law, PKU screening is supposed to occur routinely for newborns. These preventive services are relatively well provided in Nevada, but mechanisms are needed to ensure that coverage of the subject populations is as nearly universal as possible.

RECOMMENDATION 5: Soon after the birth of a child, provide family planning information to the parents, and create a registry and provide follow-up for children born abnormal or at high risk of being mentally retarded or having some other handicap. Family planning practices are related to the likelihood of having a mentally retarded child. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services (tertiary prevention) could begin at an early age. The Southern Nevada Special Children's Clinic has a pilot project underway to develop a registry and follow-up for children born abnormal or at high risk.

Good prenatal and perinatal medical care is an important factor in preventing retardation. The main question is how to secure such care for pregnant women and new mothers if they are not receiving it. One can envision increased outreach by public health nurses and others to women who are not likely to seek good prenatal health care, and to women who do not return for routine and periodic checkups of their babies. Perhaps the largest improvement, however, would come from lowering financial barriers to good medical care. The state, for example, might consider

requiring that private insurance carriers cover prenatal and perinatal care fully, without deductibles, including coverage of the child from the moment of birth.

RECOMMENDATION 6: Establish specific responsibility for mental retardation preventive services within the Department of Human Resources (perhaps in combination with the new unit for direction services recommended earlier). We are not saying that these personnel who are assigned overall responsibility for prevention should operate all prevention programs, since some functions reside appropriately elsewhere in state government. Rather, we are saying that preventive efforts need to be coordinated, and someone needs to take responsibility for guiding the building of a high-quality system of preventive services in Nevada. Placing this responsibility at the state level would help ensure that at least a minimum level of preventive services is provided in each geographic area of the state.

Prevention of Alcohol and Drug Abuse

Unlike many mental health problems, alcohol and drug abuse often involves acts of choice, at least insofar as a person decides to drink or use drugs in the first place and often decides when and how often to do so. For this reason prevention programs may well have important long-term consequences in reducing and controlling alcohol and drug abuse.

At the present time, however, there has not been a major investment in prevention programs at federal, state, and local levels; the great bulk of funds has been invested in direct provision of treatment services to alcoholics and drug addicts. Nevada is no exception. Aside from some educational programs for schoolchildren, there is very little prevention in Nevada; some TV spots have been prepared by various groups, but there is no really major "public education" campaign in progress. In total, we estimate that the annual alcohol and drug abuse prevention expenditures by all sources in Nevada are on the order of $300,000 to $400,000, with a full-time-equivalent staff of no more than five people.

Preventive measures have not proved to be especially effective, with the possible exception of the strict supervision and regulation of the production of drugs and alcohol, which cannot be done effectively at the state or local level. Alcoholism is similarly resistant to prevention. Prohibition, a thirteen-year "social experiment" in prevention and social control, was a failure. Some deterrent effect of unknown extent is probably achieved, however, through high liquor taxes, prohibition of sales to minors, and restrictions on locations and times of sale, all of which at least reduce drinking opportunities. Treatment and public education undoubtedly reduce the problem to some extent, but no conclusive work has been done to establish the relative merits and effectiveness of the few preventive options available.

Unfortunately, no one can say with certainty what kinds of alcohol and drug abuse prevention programs are effective and should be promoted. The volitional element in alcohol and drug abuse, which makes prevention theoretically attractive, affords a ray of optimism in this otherwise murky picture. But until better information is available on the effectiveness of alcohol and drug abuse prevention programs, we cannot recommend any major expansion in the current prevention program in Nevada.

For a more detailed discussion of prevention programs, see Chap. 5 of the main text.

IDENTIFICATION

Identification, in the context of this study, is the recognition and accurate assessment of a person's disabilities and abilities. Four observations were corroborated again and again in our interviews with agencies and in our investigations of data on services provided: (1) agencies usually do not serve a significant portion of the population in need; (2) agencies generally do not even know approximately how many unserved people there are, much less who they are; (3) very few agencies have effective outreach or screening programs to identify the population in need; and (4) referral and follow-up for those who are identified are often lacking.

All of Nevada's efforts to *screen* for potential mental handicaps prior to full diagnosis, and to *reach out* to find potential clients for service programs cost perhaps $200,000 to $250,000 in FY 1974. These cost figures do not include the cost of diagnosis following screening, nor do they include the cost of personnel who notice a possible mental disorder while they are primarily involved in providing some other service (e.g., education, medical, or social welfare services). The primary screening and outreach efforts were the early screening program for Medicaid-eligible children; a school screening program for all children in one rural county (the two counties with large populations, Clark and Washoe, do not screen all schoolchildren for mental handicaps); an outreach program of the two state Special Children's Clinics; and small, still rudimentary outreach programs at the Reno and Las Vegas Mental Health Centers. For a more detailed discussion and analysis of identification services than appears in this section, refer to Chap. 6 of the main text.

In general terms, people who have mental health disorders, mental retardation, or alcohol or drug abuse problems, currently become identified to the service system primarily through either of two mechanisms: (1) personnel in some segment of the service system (e.g., police, private physicians, and teachers) have "trouble" with an individual, or notice symptoms of a disorder, or (2) the individual or his or her family seeks assistance. Even after a mentally handicapped person is identified by one part of the service system, the mechanism of making referrals to all other appropriate service programs is often not used; therefore, the person is often unidentified to, and unserved by, some or all of those other programs. Regional Direction Centers would help resolve this latter problem.

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

- Not all of those with the greatest need or the greatest ability to benefit from services are among those known to the service system. Since service needs exceed service capacity in most areas, each program could set priorities and use its limited resources accordingly. However, even if they have defined high-priority types of clients, they cannot be serving as many of the high-priority clients as they might serve, since not all those high-priority clients have been individually *identified.*

- Were more of those in actual need identified, then the service system might eventually decide to respond with a more adequate level of services. If a clear picture is lacking of the overall population's needs, including the names of people needing service, it is unlikely that sufficient service system capacity and a range of adequate services to meet these needs will be provided; that situation currently prevails in Nevada.
- People in need can benefit from knowledge of the nature of their condition, even if we assume that the public sector cannot serve them or chooses not to. With accurate and reliable information about the basic condition and services required, people with mental problems and their families are somewhat better prepared to help themselves and to seek out private sources for service.

The following recommendations are aimed at the problems noted above.

Certain of the ideas developed above on prevention are relevant to identification. In particular, recall our earlier recommendations for creation of a registry and follow-up of children born abnormal or at high risk of being mentally retarded or having some other handicap. Reporting to the registry by medical personnel could be mandatory. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services could begin at as early an age as is desirable.

RECOMMENDATION 7: Require parents of children beginning their first year of school, or entering a Nevada school for the first time from out of state, to present to the school as a condition of admission of the child either (1) the results of an approved health and developmental screening by an approved professional, or (2) a statement that the parents have decided not to have their child receive the screening services. There is no formal mechanism to screen and identify children, a key target population for any physical health, mental health, or mental retardation service system, after they leave the newborn nursery and until they enter elementary school. In this case we are speaking of a medical examination designed to detect a range of potentially debilitating mental and physical conditions so that services may be offered at as early an age as is desirable to help alleviate the effects of the mental or physical disorder. This screening is valuable but not infallible for two primary reasons: parents may choose not to have their children screened for various reasons; and the screening methods for the detection of mental disorders at the age of 4 or 5 years are not as valid and reliable as we would like them to be. Nonetheless, most of the more severely disordered children can be detected with existing screening methods. Care must be taken, however, not to label children for whom the results of the screening and later diagnosis are not clear-cut. Before implementing this recommendation, the screening mechanisms to be used would have to be carefully considered. If these recommendations were adopted, the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program would pay for the screening for Medicaid-eligible children. The results of the screening would be forwarded to the state (to a Regional Direction Center, ideally), where they could be used to follow up to see that the various appropriate mental health and mental retardation programs provide needed service at as early an age as is desirable, and to aid in planning future service programs. Implementation of privacy safeguards for people identified will be essential. Churchill County already has a commendable screening program

provided by both medical and school district personnel for every child entering the school system. California has recently implemented a related program (see Chap. 6 of the main text for descriptions of those different but related programs).

RECOMMENDATION 8: Adopt procedures to help ensure that (1) all Medicaid-eligible children and youth up to age 21 years receive early and periodic screening unless such screening is formally refused, and (2) follow-up steps are taken to obtain diagnosis and treatment for those who need them. Nevada has implemented the federally required Medicaid Early and Periodic Screening, Diagnosis, and Treatment program, but the program as implemented does not check to see that all Medicaid-eligible children are screened, and does not always adequately follow up on the results of the screening. The Regional Direction Centers (if created) would be useful in making referrals and coordinating needed services and follow-up. We note that implementation of this Medicaid screening would facilitate not only the provision of needed services, but also the transfer of eligible clients from the Aid to Dependent Children program to the more desirable Supplemental Security Income program (see the "Income Assistance" section of this report for details).

RECOMMENDATION 9: Provide increased funding for the two existing Special Children's Clinics, distributed between the two clinics more equitably on a per capita basis than it is now, including stable funding of a traveling multidisciplinary team to perform diagnoses in rural areas for people of any age thought to be potentially mentally retarded. This would provide improved diagnostic services for mentally retarded people. We note that some rural counties do not even have a school psychologist who could help with diagnoses.

RECOMMENDATION 10: Establish a screening program in every county school district to identify all mentally retarded and seriously emotionally disturbed children who need special education and other services. A school district cannot adequately serve children with mental handicaps and refer them for other services if it does not know who they are. The schools are an ideal setting for identification of mental handicaps in young people of school age, since nearly all children are assembled, observed, and compared on a routine basis. Since screening of schoolchildren is feasible and not excessively costly, and the human and economic costs can be great if young handicapped people do not receive timely special services, all children should be entitled to at least one behavioral and psychological screening to detect possible mental retardation or serious emotional disturbance. Nevada lacks such a program. School psychologists in most counties do not screen all children; and since there are *many* unidentified mentally handicapped children in school, the mechanism of relying solely on teacher referrals has not been very effective. We earlier suggested that a medical and developmental screening program reach children before they first enter school. Here we are recommending that the schools conduct a different *behavioral and psychological screening* of all children when they reach a specified age (perhaps 7 or 8 or 9 years old) to identify any who were missed in the preschool *medical and developmental screening* or whose mental health or mental retardation problems developed or became identifiable in the years since the preschool screening.

RECOMMENDATION 11: Screen high-risk populations to identify people who might be offered immediate mental health and other needed services to help alleviate existing mental health disorders before the subjects become more seriously ill or dysfunctional. While a mechanism does not exist to readily reach everyone in high-

risk populations, many can be reached by the mechanism of screening people who are in contact with public service systems for other reasons. For example, likely candidates for screening would be abused children and their abusers who come to the attention of health, welfare, and criminal justice personnel, juvenile and adult offenders, residents in the two Nevada Children's Homes, emotionally disturbed schoolchildren, children of a psychotic parent who is in contact with the mental health service system, and some callers to Crisis Call and Suicide Prevention lines.

For a more detailed discussion of identification, see Chap. 6 of the main text.

SPECIAL EDUCATION AND TRAINING SERVICES

Nevada law requires special education of all handicapped minors of particular ages. We are primarily concerned here with special education services for seriously emotionally disturbed children and youth to age 18 years, and special education and developmental training of mentally retarded people. While highly important, the special needs of children the education agencies term "learning disabled" are not within the central scope of this report if they are not primarily mentally retarded or seriously emotionally disturbed. However, we present data on the special education programs' services to children the education agencies term "educationally handicapped," since children who are primarily emotionally disturbed, mentally retarded, or learning disabled are sometimes served together in Nevada under the label of "educationally handicapped," and since many children can be classed as either or both emotionally disturbed and learning disabled under the rather vague definitions of those terms (see Chap. 7 of the main text for a detailed discussion of those definitions).

The major special education and training programs serving mentally handicapped Nevadans spent more than $9 million for them in FY 1974; those programs are operated in two state departments, in county school districts, and in the private sector. The county school district special education programs provide the vast majority of all special education and training services, and operate under standards of the Nevada Department of Education with partial state funding; the Community Training Centers program consists of six very small private centers operating under guidelines and partial funding from the Nevada Division of Mental Hygiene and Mental Retardation; the Special Children's Clinics operated by the Nevada Division of Health have two small preschools and infant stimulation programs (the one in Reno is a cooperative program with the Washoe County School District); and the Washoe County School District operates a special education and training program at the Nevada Mental Health Institute for retarded youth. In addition, a small federally funded program, P.L. 89-313, provides special education personnel at some state facilities (see Chap. 10 of the main text for a description).

Of the more than 3700 mentally or educationally impaired children receiving special education in FY 1974, only about 100 emotionally disturbed children are identified as being served in Clark, Churchill, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education service in any of the other counties in Nevada. About 1644 mentally retarded children and youth received special education in FY 1974. Over half of the possibly mentally impaired children served are not identified as either men-

tally retarded or as seriously emotionally disturbed; nearly 2000 "educationally handicapped" children received special education in FY 1974. The characteristic most often possessed in common by educationally handicapped children is low academic achievement, and some of these children undoubtedly are mentally retarded or seriously emotionally disturbed, or both. Even so, the total number of children served with all types of mental and "educational" handicaps combined is far below the minimum estimate of the total number of seriously emotionally disturbed and mentally retarded children needing those services. Nevada is below the national average in terms of the number of seriously emotionally disturbed and mentally retarded children in special education in relation to total school enrollment, and even the national average leaves much to be desired. Despite the state law requiring special education of all handicapped minors, we estimate that in relation to the *minimum* number of Nevadans needing special education and training services, only about 4 percent of seriously emotionally disturbed children are identified as such and served, and only about 54 percent of mentally retarded children and youth are served. Even if one assumes that every educationally handicapped child served is either mentally retarded or seriously emotionally disturbed (which is certainly not true), only about 63 percent of those in need are being served.

Although Nevada's special education and training programs are improving, several problems with those services for mentally handicapped children and youth can be identified. They include insufficient funding and service (less than half of those conservatively estimated to be in need are served); inequities in service by type of mental handicap (services specifically for seriously emotionally disturbed children are nonexistent in most Nevada counties and are provided to a token number in a very few other counties); a questionable allocation of about half of the limited special education resources available for serving mentally handicapped people to people with the generally less severe "educational handicaps"; differential service by sex (boys outnumber girls in special education in Nevada two to one, and we seriously question whether there are twice as many handicapped boys handicapped girls in the general Nevada population); and inequities in service by geography (for all handicapped children in the remoter rural areas of every county, and for trainable and more severely mentally retarded children in the entirety of all but a few counties). Those problems also include insufficient attention to the transition from school to adult services (e.g., to the vocational rehabilitation program if those services are needed); lack of programs in schools for comprehensive identification of all mentally handicapped children needing services (none of the three largest school districts, which contain three-quarters of the state's school-age population, has a screening program reaching all children); lack of direction to other service providers; and lack of information (at the state level, even the number of mentally handicapped children in special education is not accurately known, and quantitative data on the effectiveness of Nevada's special education are virtually nonexistent). Finally, there is a problem of an inadequate number of professional staff to manage the special education program at the state level (only two consultants), and of triplication of preschool education responsibility at the state level (among the Department of Education, the Division of Health, and the Division of Mental Hygiene and Mental Retardation). Of all the problems listed, the greatest by far is the large fraction of seriously emotionally disturbed and mentally retarded children who receive no special education at all.

The primary concern, then, is to expand special education services and make them available to all seriously emotionally disturbed and all mentally retarded children and youth who need them, as is required by law. In our view, the two factors most responsible for restricting the number of mentally handicapped children receiving special education are: (1) the limited number of units (basically, special education professionals) for which the state will provide financial support, and (2) the lack of identification programs for mentally handicapped children in the county school districts. Obviously, a school district cannot serve mentally handicapped children if it does not know who they are. To help remedy this lack of knowledge, we earlier recommended that a screening program be implemented in each school district.

RECOMMENDATION 12: Provide state financing for an additional 230 special education units above FY 1974 levels specifically for seriously emotionally disturbed children, and an additional 163 units above FY 1974 levels specifically for mentally retarded children. This would furnish special education to a total of 2650 seriously emotionally disturbed children and 3030 mentally retarded children, the minimum number we estimate need such services. If more than those minimum numbers of handicapped children are identified by the screening program we have recommended, the number of special education units can be adjusted accordingly. The Nevada Legislature has been ambivalent by mandating special education for all handicapped children but failing to allocate funds to cover the expense. The legislature did significantly increase the number of units in 1975, however, and thus continued the growth of the special education system. Since special education of all handicapped children is legally required in Nevada, we suggest a state goal of having every handicapped child in special education by 1980. (A lawsuit also has been filed in Nevada to force the provision of special education to all handicapped children; this is essentially the same lawsuit that has been won in other states on constitutional grounds.) While spreading the action over a five-year period does not solve the problem of unmet needs immediately, it will allow time to identify the children in need, to modify facilities and retrain personnel, and to hire high-quality new special education teachers. Cost estimates for implementing this and other special education and training recommendations are developed in Chap. 7 of the main text.

RECOMMENDATION 13: Make the definitions of handicapping conditions issued by the Nevada Department of Education more specific, place limits on the number of units by type of handicap, including seriously emotionally disturbed children as a separate category, and enforce all special education standards. Inequities in service by type of handicap may be only partially resolved by increasing the number of units funded. Under current definitions used in Nevada education, children with significantly different service needs are lumped together under the term "educationally handicapped." The term is so broad that large numbers of children could find themselves labeled unnecessarily, and many children who do not have substantial handicaps (e.g., children who need only remedial reading) might be placed in special education, while those with substantial handicaps might go unidentified and unserved if funds are not earmarked for them.

RECOMMENDATION 14: Significantly increase the special education staff of the Nevada Department of Education to at least 10 full-time-equivalent professional staff members so that they can provide guidance and consultative technical assistance to rural county school districts, and so that they can more adequately manage their

major responsibilities in the area of special education. The two consultants who currently make up the state special education professional staff are to be commended for the fine job they are performing, but they are only human; a much larger staff is needed. Since it is not reasonable to expect the rural school districts to have, on their full-time county staffs, all of the specialized and expensive special education expertise they may need, the Nevada Department of Education should provide for consultation and technical assistance to rural special educators.

RECOMMENDATION 15: Provide nearly all mentally retarded Nevada Mental Health Institute residents with special education and training services appropriate to their level of development; provide those special education and training services away from the institutional setting for nearly all residents; and provide a teaching aide and adequate equipment and materials for each special teacher. The present numbers of teachers, aides, equipment, and materials are inadequate in relation to the clear need. Service away from the institutional setting would enhance the education, training, and quality of life of residents by giving them wider exposure to the normal situations and experiences of everyday life.

RECOMMENDATION 16: Focus the preschool portion of the Community Training Center (CTC) program in rural areas on developmental stimulation and training for the more severely retarded children below age 3 only. In the Las Vegas and Reno areas, have the CTCs serve only adults, leaving developmental stimulation and training for the more severely retarded children below age 3 to the Special Children's Clinics. The CTC program as presently operated is a dichotomous entity that provides two basically different kinds of service to mentally retarded people: a preschool program, and a program of day-care, activities of daily living, prevocational, and vocational (including sheltered work) services for the more severely mentally retarded people about age 18 or above. This recommendation for a change in CTC focus arose primarily because the age range for mandatory special education of mentally retarded children by the public school system was lowered by the Nevada Legislature to age 3 in 1975. These changes in focus will decrease the present fragmentation and triplication of responsibility for preschool special education and training programs. Also see recommendation 54, which concerns the funding of Community Training Centers.

RECOMMENDATION 17: Have the Special Children's Clinics program transfer their 3- and 4-year-old nursery-school children to the county school districts and concentrate its very limited resources on identification of preschool-age retarded children, direction of their families to other service providers, counseling of families with retarded children, and developmental stimulation and training for the more severely mentally retarded children below age 3. The Nevada Division of Health's Special Children's Clinics program presently operates two small nursery schools and infant stimulation programs, primarily for preschool mentally retarded children who were not served by the county school districts in FY 1974. This recommendation is made possible by 1975 legislation which requires the special education by public schools of 3- and 4-year-old mentally retarded children.

RECOMMENDATION 18: Improve referral from special education to other programs serving mentally handicapped children and youth. In particular, increase the number of referrals to Vocational Rehabilitation of mentally handicapped youth well before they leave school, and increase the number of referrals of seriously emotionally disturbed youth (whether or not they are in special education) to the local

mental health center or rural mental health clinic, or Children's Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other programs exist to provide those services. These referrals could all be made and followed up by Direction Centers, if they are created. In the event that other programs do not have adequate resources to serve all those in need of service, then priorities should be established and all referred youth should be screened so that high-priority needs are met first.

RECOMMENDATION 19: Obtain improved program management and effectiveness information for each Nevada special education and training program. Available information on special education and training in Nevada is inadequate for effective program management, accountability, evaluation, and planning (recall that we are not even sure exactly how many mentally handicapped children are in special education).

For a more detailed discussion of special education and training services and cost estimates for the above recommendations, see Chap. 7 of the main text.

MENTAL HEALTH SERVICES

Nonresidential Mental Health Services

Nonresidential mental health services include outpatient, emergency care, and day treatment psychological services. They are delivered in Nevada primarily through Mental Health Centers, Children's Behavioral Services programs, Rural Clinics, Suicide Prevention and Crisis Call lines, by psychological counselors in schools, by the military, and by psychiatrists and psychologists in private practice. Residential treatment services for mental health disorders, and all services by the Nevada Mental Health Institute, are discussed in the next subsection. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 8 of the main text. Desirable features of a psychological service system are described in some detail in a separate section of that chapter. Basically, we take the eclectic position that people experience a variety of kinds of mental health problems, which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency.

We have estimated that, as of 1975, at least 11,000 Nevadans have significant mental health disorders that result in a substantial need for psychological or psychiatric services. That figure is a conservative *minimum* estimate; the true figure may be as much as five times that, or 55,000 people. The two predominant segments of the nonresidential mental health service system currently intended to meet those needs are the private psychiatrists and psychologists, and the Nevada Division of Mental Hygiene and Mental Retardation. Of the estimated $3.3 million in public and private funds spent in FY 1974 for nonresidential mental health services in Nevada, the Nevada Division of Mental Hygiene and Mental Retardation accounted for about 51 percent, private psychiatrists and psychologists accounted for about 42

percent, and the remaining 8 percent was provided through various other agencies. A total staff of about 171 people provided services in person to a maximum caseload of about 10,500; another approximately 6800 callers to Suicide Prevention and Crisis Call Centers were served by telephone. To some degree, however, these numbers represent apparent rather than actual service achievements for the mental health service system. For reasons given immediately below, the number of *different people with mental health disorders* served in person in FY 1974 is significantly less than 10,500; one cannot conclude that nearly all 11,000 people needing substantial psychological or psychiatric services (our minimum estimate) are being served. The 10,500 figure is a count of the number of cases served by the various agencies, and includes: double-counting if people were served by more than one agency in a year or were admitted to the same agency's program more than once; counting of people served who do not have substantial mental health disorders (e.g., some parent-effectiveness trainees in the Children's Behavioral Services program, some consciousness-raising group participants at the University of Nevada, some mildly neurotic people served by private professionals, and various types of people served by Rural Clinics, such as those receiving premarital counseling); and counting of people who are not really served (e.g., those who are counted as cases but who do not return after an initial intake interview—33 percent of outpatient cases at the Las Vegas Mental Health Center were of this type). Finally, cases reported by the agencies may represent people served who have substantial mental health disorders, but who were inappropriately served because of the nonexistence of a service they needed, such as day treatment, or inadequately served by a relatively unskilled and untrained mental health technician.

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

In two of the recommendations in this section we urge specific Nevada programs to increase the emphasis on service to people with the more severe mental health disorders. This means a shift in emphasis for those specified programs and should not be interpreted to mean that only severely mentally handicapped people should be served. There also is a clear and important need to serve people with less severe mental health disorders when effective treatment methods are available. Several of our recommendations are specifically aimed at improving services to less severely handicapped people.

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

difference in the level of service per capita in different geographic regions also exists in the public service system considered by itself, despite the fact that the public service system is state operated.

The problems we note with respect to nonresidential mental health service include: insufficient service capacity to meet the minimum need in each area of the state, with the greatest deficiency being in rural counties; mental health technicians inadequately trained and supervised in relation to their mental health treatment responsibilities; lack of a continuum of levels of nonresidential services in each area; excessive reliance on a single treatment modality in some programs in 1974; inadequate follow-up service to people released from the Nevada Mental Health Institute; few services to emotionally disturbed children in the schools; and almost no mental health services for mentally retarded people.

RECOMMENDATION 20: Fill all authorized professional staff positions at the Las Vegas Mental Health Center. A number of problems noted with both residential and nonresidential services at the center in 1974 (problems with intake assessment, staff supervision, and smooth transition from one level of care to another) could be resolved if the center had all authorized professional staff positions filled. The administrator of the Las Vegas Mental Health Center indicates that as of February 1976, the "vast majority" of these professional positions are filled. The one major problem that cannot be resolved by filling those professional positions is the lack of training and skills of the mental health technicians; a subsequent recommendation will deal with this problem for mental health technicians in all programs.

RECOMMENDATION 21: Provide 24-hours-a-day emergency crisis intervention service in every mental health center and in the Rural Clinics mental health program. While it is obvious that people with mental health disorders require emergency help at times other than weekdays from 8 a.m. to 5 p.m., some of Nevada's major current mental health programs do not have 24-hours-a-day emergency crisis intervention service. This emergency service should include an in-person crisis clinic plus the ability to provide emergency care on an overnight basis if needed, so as to provide needed service and also help avoid unnecessary hospitalization. For details see the section of Chap. 8 of the main text entitled, "Desirable Features of a Psychological Service System." We assume that staff members on duty evenings, nights, and weekends would provide more than just emergency services, to the extent possible, so they are efficiently utilized. For example, emergency services can now be provided by non-weekday staff on the residential service units of the Las Vegas Mental Health Center.

RECOMMENDATION 22: Substantially increase (at least double) the staff of the Rural Clinics mental health program; have a full range of professional skills represented on the staff so that a full range of treatment modalities can be used; substantially upgrade the skills levels required of mental health technicians as described in a subsequent recommendation; continue in operation the present offices in rural areas; and provide for visitation of each rural office one day a week by a traveling multidisciplinary team of senior mental health professionals to supplement the lower-skilled rural office staff. Nonresidential mental health services to rural Nevadans are substantially worse, in both quantity per capita and quality, than those available in Las Vegas and Reno. Because it is probably not feasible to staff each rural office with a full team of professionals, we suggest a set of two traveling teams, each on the rural office circuit about half the time. Thus, skills such as those

of a psychiatrist, which are needed for chemotherapy and other modes of treatment but are not needed full time, would be available in each rural area. Local rural office staff would provide outpatient follow-up and emergency services. Traveling teams would complement and supervise the local office staff, assist on difficult cases, and help to follow up discharged residential patients. Residential mental health services needed by rural residents would be provided by the Nevada Mental Health Institute, probably by the same personnel who make up the two half-time traveling teams. Thus, two full-time teams could serve rural residents; each would work half-time with patients from rural areas at the NMHI while the other was visiting Rural Clinics offices.

RECOMMENDATION 23: Increase the Rural Clinics efforts on what appears to be the greatest need, service to people with substantial mental health disorders. The current Rural Clinics personnel are spreading themselves thin trying to do many different things and are not adequately serving most people with substantial mental health disorders. Rural Clinics is an excellent example of a small, embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans, especially those with the more severe disorders, are concerned.

RECOMMENDATION 24: Establish a second community mental health center (CMHC) in Clark County. The present Las Vegas Mental Health Center is operating at nearly full capacity and there are still clear unmet needs in the county, e.g., in the areas of follow-up of released residential service patients, service to emotionally disturbed children and adolescents, service to rural residents of Clark County, and service to mentally retarded people with mental health problems. The main problem with the existing Henderson Mental Health Center is that it is extremely small in relation to the two-thirds of the Clark County population in the geographic catchment area it is supposed to be serving. The small Henderson Mental Health Center does not provide a full range of services and is not located near the center of the population it is supposed to serve. We suggest the present Henderson Mental Health Center be retained as a satellite office of a new community mental health center designed on the order of the present Las Vegas Mental Health Center and located on the opposite side of Las Vegas. Population growth in Clark County that will occur before a new CMHC could be operational adds further weight to arguments favoring a new CMHC. No one really knows for sure how many people need mental health services in any of the three major areas of the state, but the existing pressure on the service system in *each* of the three areas (Clark, Washoe, and rural counties) indicates a critical need for expanded service capacity. Given Las Vegas's current and projected populations, there appears to be ample evidence to support two full community mental health centers for the metropolitan area.

RECOMMENDATION 25: Expand the Reno Mental Health Center to a full community mental health center on the order of the one now operational in Las Vegas. In the Washoe County area, the main problem with nonresidential mental health services is that a full continuum of services is not provided. The Reno Mental Health Center functions primarily as an outpatient program for adults plus a small day treatment and outpatient program for adolescents. Both the adult and adolescent programs are operating at full capacity, still not meeting the need, and people must be turned away. Day treatment for adults is not provided, nor are 24-hours-a-day emergency services or short-term residential care outside the NMHI in Sparks. Rural residents and mentally retarded residents are not now served. Population

growth will significantly increase the need for a new community mental health center before it can become operational. We do not believe the NMHI should function as a community mental health center for Washoe County; it has enough other functions (described later in this section) for which it appears better suited and which will use its staff to full capacity. The catchment area for the new community mental health center would be all of Washoe County plus the Lake Tahoe and Carson City areas, since we believe these would be better served by satellite offices linked to a community mental health center in Reno than by the Rural Clinics program, which does not provide a full range of mental health services.

When the northern Nevada Children's Behavioral Services (CBS) program is fully implemented, the Reno MHC Family Unit service program and staff for children and adolescents should work in close cooperation with it to maximize coordination of services and continuity of care for children and youth. If the northern Nevada CBS program serves only children under age 13, as the Clark County CBS program now does, there will be a need for services to youths aged 13 to about 18 that the Reno MHC program could concentrate on.

RECOMMENDATION 26: Have the Children's Behavioral Services program provide more complete initial assessment of the mental health problems and service needs of the children it serves than it did in 1974, concentrate more of its resources on those children with the more severe mental health disorders than it did in 1974, and broaden the mix of professional skills on its staff to include specifically both physicians with specialty training in psychiatry and psychologists so that a more complete range of treatment modalities can be provided. The program in Clark County in 1974 was dominated by one mental health discipline (psychology) and one mode of treatment (behavior modification), which is not always the most appropriate mode of treatment for every mental health disorder. CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. In addition, some of the CBS client children whose cases we reviewed may not have had significant mental health disorders. The CBS program justifies serving children with mild behavior disorders by saying serious mental disorders are being prevented; while we fully support the goal of prevention, it is very hard to tell if a serious mental disorder would have occurred in a child with a mild behavior disorder if CBS had not served the child (see Chap. 5 of the main text, on Prevention, for a discussion of this issue area).

The schools are not presently providing adequate special education for emotionally disturbed children. But even if they did, there would still be a need for nonresidential mental health services for the more severely emotionally disturbed children. Rather than make the schools take on the functions of mental health service agencies, recall our earlier recommendation for increasing the number of referrals of seriously emotionally disturbed children and youth in school, whether or not they are in special education, to the appropriate mental health center, Children's Behavioral Services program, or rural mental health clinic for service. The schools are not designed to provide every type of service well, nor should they be, since other service programs exist.

RECOMMENDATION 27: Provide mental health services to mentally retarded Nevadans and their families if they need them. Such is usually not done now, and consequently a substantial gap exists in services provided for these people (see the next section on "Mental Retardation Services").

RECOMMENDATION 28: Substantially upgrade the skills of "mental health technicians" involved in treatment of mental health disorders by: (1) eliminating the existing personnel classification and creating three new classifications, one for those employees who primarily treat mental health disorders, one for those who primarily provide mental retardation services, and one for those who primarily perform non-treatment support functions such as clerical work, housekeeping, and patient escort; (2) upgrading the job requirements for the mental health treatment positions to the master's degree level; and (3) creating a training program at the University of Nevada at the master's degree level to provide people skilled in a broad range of mental health services to fill the mental health treatment positions. This recommendation is necessary because many mental health technicians, in both residential and nonresidential mental health programs, currently carry a heavy responsibility for direct treatment of people with mental health disorders, but many of them are seriously underqualified or unqualified to fulfill that responsibility. The job requirements include only a high school education, plus experience and training for higher levels in the "mental health technician" job series. Unfortunately, the training of many technicians is clearly substandard. The officially required training levels are low to begin with. However, the Division of Mental Hygiene and Mental Retardation did not appear to have provided even those minimum amounts of training in most cases, and had certainly not adhered to the spirit of the training requirements. Each program is supposed to provide training for its own technicians. At the time of our interviews in 1974, we were told about the existence of some very brief training, but saw no high-quality, formal training program. For example, the Rural Clinics program (where mental health technicians directly treat mental health patients), provided *no* formal training program at the time of our interviews. A tendency we noted in some nonresidential mental health programs was for the program's administrators to tailor the services provided to fit the skill levels of their personnel, rather than tailoring their personnel to fit the greater service needs (either by revised hiring or revised training policies). Thus, some personnel who do not have the skills to help treat severely mentally ill people are assigned work for which they are more qualified (e.g., parent effectiveness training and premarital counseling), while people with more severe mental disorders go unserved. The new master's degree level of mental health personnel that we propose 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 in that treatment role. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's degree level professionals. The NMHI Director also told us he is "proceeding to replace mental health technicians with more highly skilled professionals." As of February 1976, the NMHI had converted 2½ such positions. However, as detailed in Chap. 8 of the main text, the graduates of the proposed university-based work-study program would be skilled in a broad range of disciplines and services needed by people with mental health disorders; they would have significantly broader training than people with master's-level preparation in disciplines such as social work or psychology.

Along with upgrading the skills of mental health technicians, certain other changes are necessary: It must be recognized that technicians who serve mentally retarded people need different skills from those of technicians who serve people with

mental health disorders; and both kinds of technicians should be free of many of the lesser tasks that mental health technicians currently perform, such as escorting people from place to place, and doing housekeeping and other tasks. Those tasks should not be done by technicians at the proposed master's degree level, but should be assigned to people with lower skill levels. We believe it is time for a frontal assault on the issue of quality of personnel; in Chap. 8 of the main text we propose a university-based work-study program to address this issue.

Finally, the above recommendation will not mean the elimination of all paraprofessionals from mental health service positions, which is neither desirable nor feasible.

Residential Mental Health Services

Residential programs required to meet the diverse needs of mentally handicapped persons range from full inpatient care programs to semi-independent residential living programs that offer minimal supervision and assistance. We focus here on *residential service* programs intended to provide more than the supervised *residential living* discussed later. For people with mental health problems, these residential service programs discussed here include: the Nevada Mental Health Institute's mental health programs, the Las Vegas Mental Health Center's residential treatment program; the new Children's Behavioral Services residential treatment program; local medical facilities with psychiatric units; the Nevada State Prison; the new Mentally Disordered Offender Facility; the Veterans Administration Hospital; and out-of-state residential treatment programs where Nevadans are sent when appropriate in-state services are not available for them. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 10 of the main text.

For Nevadans with mental health disorders, approximately $6 million was spent for residential treatment in FY 1974. The total full-time-equivalent staff numbered about 330. The daily average number of people in these residential programs was just under 300, and the total number of different service episodes (i.e., patient-stays at a facility) in FY 1974 was approximately 3300. The actual number of different people served is less than 3300, since some unknown number of people had more than one patient-stay at a facility or were served at more than one facility in FY 1974. In terms of daily average bed-capacity filled, the NMHI was the largest (160), followed by local and private general medical facilities with psychiatric units (64), and the Las Vegas Mental Health Center (30). 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 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 to 17 days in 1975; a new Mentally Disordered Offenders Facility has been constructed (bed-capacity 32); two Children's Behavioral Services 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 NMHI is substantially reducing the number of residents so that it can offer better mental health services to those who remain (the staff has not been reduced), and serve them in NMHI's better buildings.

We note that merely to maintain the 1974 level of service in 1985, the bed-capacity and annual budget 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 (in constant-value dollars).

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, there were essentially no residential services in Nevada for children and youth with mental health problems, but the legislature has since approved three major new programs providing relatively short-term residential services (the Las Vegas Mental Health Center and the two Children's Behavioral Services 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 program); however, there is still a need for short-term residential capacity in conjunction with the two improved mental health centers we recommended earlier. The recent massive shift of the mental health section of NMHI from a mixture of chronic and acute care toward short-term acute treatment has left those adults in need of intermediate-level chronic care inadequately served.

The two newly approved Children's Behavioral Services 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 that accepted 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 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.

RECOMMENDATION 29: The two Children's Behavioral Services (CBS) residential treatment programs should be adequately and unconditionally staffed, specifically including positions for both physicians with specialty training in psychiatry and psychologists so that a more complete range of treatment modalities can be provided; the Reno CBS residential facility should serve children and youth through

age 18; and both facilities combined should accept rural children so as to prevent differences in the level of service per capita between the Las Vegas, Reno, and rural areas of Nevada. When construction is completed on the CBS residential facilities in Reno and Las Vegas, the lack of residential mental health services we noted above for youngsters in Nevada will be partially rectified. However, the CBS facilities are small and the program in the south accepts only 12-year-old and younger children, while the Las Vegas Mental Health Center serves those over 12. If the CBS program in the north accepts only 12-year-olds and younger, there will still be no residential mental health program for children over 12 years old in northern Nevada, since the Reno MHC currently has no residential capacity and NMHI does not serve children. Also, both the northern and southern Nevada CBS, and the Las Vegas MHC, residential programs will provide only relatively 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. (This problem is dealt with in recommendation 32.) 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 mode of treatment.

RECOMMENDATION 30: Correct the major deficiencies noted in the Joint Commission on Accreditation of Hospitals (JCAH) accreditation report for the mental health section of the NMHI. Although the mental health section is accredited, NMHI's mental health program still has major deficiencies that must be corrected to improve the quality of services and to maintain JCAH accreditation.

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 carry a heavy responsiblity for patient treatment. Since the units have no regular full-time direct-patient-service psychologist and since the social worker has other responsibilities, a heavy load rests on the one supervisory psychiatric nurse and the unit's mental health technicians who are assigned as each patient's "primary therapist." As indicated above, however, 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 psychopharmacological intervention (drug therapy) appears 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 training of technicians prevails in the Las Vegas Mental Health Center residential treatment program. Recall our earlier recommendation for upgrading mental health technician skills to resolve this situation for both nonresidential and residential mental health programs.

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 followup treatment after discharge from NMHI was the exception rather than the rule in 1974, although some significant improvements have been made since then. 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' treatment will usually help a patient past an episode of acute decompensation), and (2) to engage the patient in a treatment process that will continue and will address 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 extending beyond the period when residential inpatient treatment 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. For Clark County residents, the transition is abrupt from the Institute to the Las Vegas Mental Health Center, but the center can 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 the NMHI, and generally monitors and implements continuity of care.

RECOMMENDATION 31: Implement improved follow-up treatment to provide a continuity of care for mental health patients released from NMHI; mandatory improved follow-up procedures also should be established to help ensure that people released from other state-operated residential mental health treatment programs (Las Vegas MHC and CBS programs) receive adequate follow-up services. This includes both short-term and long-term follow-up, e.g., for people who have a chronic need for some intermediate level of mental health services and are residing in extended care facilities that do not provide those services. The expanded mental health centers and Rural Clinics program staff improvements we recommended earlier 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, it ideally would be preferable to have the same primary therapist in both the inpatient and nonresidential phases of treatment. Professionals such as psychiatriats or Ph.D.-level psychologists 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 treatment at rela-

tively low cost compared with using only psychiatrists or Ph.D.-level psychologists as primary therapists.

Recall our earlier recommendation that two new community mental health centers be created, one in the Las Vegas area and one in the Reno area. These centers would include provision for short-term (a few days or weeks) inpatient treatment, as well as day, emergency, 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. 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 take care of the former two reasons (in fact, the Center's administrator indicates that the "vast majority" of the Las Vegas MHC professional positions are now filled), 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. These long-term patients apparently were released for a variety of reasons, including: lack of need by most of the long-term patients for the full intensive inpatient treatment the NMHI administration wants to provide; and the recent substantial reduction in the number of NMHI residents allows better mental health services to be provided to the smaller number of patients remaining and needing full intensive inpatient treatment. The follow-up has improved since 1974, but there still is a gap in the service system between the full intensive inpatient level of treatment NMHI now is supposed to provide and the level of essentially no mental health treatment for mentally disordered people living with "normal" people in nursing homes, group care homes, or with the person's family.

RECOMMENDATION 32: Create mental health service programs for children and adults that provide 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: 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 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, other people cycling from agency to agency (one such person reportedly cost the service system between $30,000 and $40,000 in one year), and children being sent to institutions out-of-state. For children and youth, the two new CBS facilities and the Las Vegas Mental Health Center provide for relatively short-term residential mental health needs. William LaBadie, of the Nevada Welfare Division which is responsible for children placed in out-of-state institutions, indicated 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."

RECOMMENDATION 33: Create 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 individual's needs) for people residing in these halfway houses. 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 no such houses in the entire state for people with mental health disorders. A small transitional facility is planned for the NMHI, but it can hardly be called community-based. These halfway houses not only would provide a missing level of needed service and a means of avoiding unnecessary hospitalization or unnecessarily extended hospitalization, thereby improving the quality of people's lives, but also would be much 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. 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 provided to some people who are returned to the Nevada State Prison following intensive treatment at the new facility. The Clinical Director of the new facility acknowledges that it "cannot handle all of the mental health problems (broadly defined) of the State Prison." The new 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.

RECOMMENDATION 34: Use the Mentally Disordered Offender Facility primarily for treatment of prisoners with mental health disorders, and not (as some state personnel have considered) for persons who have neither been charged with nor convicted of crimes but who need treatment in a secure facility. In a March 4, 1976, letter to Rand, R. Hiller, the Clinical Director of the new facility, indicated that "its purpose is quite clearly to serve those individuals who have been in contact with the criminal justice system."

RECOMMENDATION 35: Make provision 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 disordered 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.

RECOMMENDATION 36: Assign the Nevada Mental Health Institute the 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 community-based facilities. Having described problems with the various residential mental health service programs and made some recommendations for improvement,

we can now summarize what we believe to be the most appropriate functions for the NMHI.

RECOMMENDATION 37: Use the mental health section of the Nevada Mental Health Institute for 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 the units are temporarily filled to capacity. Thus, we see the mental health section of the current NMHI facility as complementing the state's community 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 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.

RECOMMENDATION 38: Establish an improved information system for monitoring and managing mental health program operations as well as the effectiveness of services. The deficiencies in existing information make it difficult to effectively manage, plan, and evaluate service programs for people with mental health disorders. Needed information improvements are described in Chaps. 4, 8, and 10 of the main text.

For a more detailed discussion of nonresidential and residential mental health services, see Chaps. 8 and 10, respectively, of the main text.

MENTAL RETARDATION SERVICES

Nevada provides a broad range of residential and nonresidential programs to meet the diverse needs of mentally retarded people, although not every program has

enough service capacity. Programs for Nevadans discussed in this section include inpatient care in the mental retardation section of the Nevada Mental Health Institute, residential care at the small private Eagle Valley Children's Home, intermediate levels of residential care at the Northern and Southern Nevada Mental Retardation Centers, a range of levels of residential and nonresidential services at the Desert Developmental Center to be constructed soon, and out-of-state residential treatment programs to which a few mentally retarded youths with mental health disorders are sent. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 10 of the main text; for an economic benefit/cost analysis of various services for mentally retarded people, see Conley's work cited in the "Prevention" chapter of our main text. In other sections of this summary, we discuss various additional programs that provide mental retardation services to people with higher levels of functioning who do not need the more service-intensive programs listed above, e.g., the Community Training Centers program, which provides prevocational and vocational services, and the Developmental Homes, which provide community-based residential living.

About $2.3 million was spent for residential programs for mentally retarded Nevadans in FY 1974. The total full-time-equivalent staff was about 180. The daily average number of people in these residential programs was just over 200, and the total number of different people served in FY 1974 was probably not over 250 since most were long-term residents. In terms of utilized bed-capacity, the NMHI was largest (140), followed by the Mental Retardation Centers (54); the one private facility had only about 10 residents. In FY 1974, the Nevada state service system (which includes all but the Eagle Valley private facility) accounted for over 95 percent of the staff and expenditures and of people served.

Since FY 1974, the residential mental retardation service system has begun major changes: 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 from the Joint Commission on Accreditation of Hospitals as a mental retardation facility.

To maintain the 1974 quantity of residential service per capita for mentally retarded Nevadans in 1985, 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 (in constant-value dollars).

Residential mental retardation services are improving in Nevada and current staff people by and large are dedicated and hardworking. Adequate services are still a far-distant goal, however.

RECOMMENDATION 39: Improve the NMHI mental retardation program to meet JCAH accreditation standards. The greatest inadequacy in the present system is in the NMHI Mental Retardation program. The program twice has failed to receive accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), for a large number of reasons, mostly stemming from a staff that is deficient in numbers, training, and mix of professional skills, and consequently unable to provide adequate services to residents. (See Chap. 10 and Appendix B of the main text for details.) 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 as residents are transferred to the new center. Since 1974, the Nevada Mental Health Institute's mental retardation program has made 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 that "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.

RECOMMENDATION 40: Given the extensive service program planned and needed for the population of more severely mentally retarded southern Nevadans, and given the new facility approved by the legislature in 1975, the Desert Developmental Center staff should be approved by the legislature in 1977; when that center's staff is approved, the mental retardation staff of the NMHI should not be cut, so that the Institute will then be able to provide more nearly adequate services to the mentally 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.

RECOMMENDATION 41: Provide services through the NMHI and the Northern Nevada Mental Retardation Center for northern Nevadans equivalent to those services that the new Las Vegas Desert Developmental Center will provide for southern Nevadans; defer approval for the construction of the northern Nevada equivalent of the Las Vegas Desert Developmental Center facilities until other higher-priority expenditures have been made. We agree that the concept of a new northern Nevada equivalent of the Desert Developmental Center is a good idea and that improved services should be provided, but we question the priorities and timing on the facility construction. The Institute already exists; on the other hand, facilities are either totally absent or too small for services to some other groups of mentally handicapped people, and for some 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 facilities exist that could be improved. 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 that services for mentally retarded people in northern Nevada can be sufficiently improved within the existing facilities at the NMHI and elsewhere in the Reno area, so that construction of new facilities can be deferred while other higher-priority needs are met.

RECOMMENDATION 42: Separate control of the mental retardation program from that of the mental health program at the Nevada Mental Health Institute, and

give it to the Associate Administrator for Mental Retardation of the Nevada Division of Mental Hygiene and Mental Retardation. This would consolidate, in one person, responsibility and accountability for all mental retardation programs in the Nevada Division of Mental Hygiene and Mental Retardation. This also 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 the current NMHI site now, although that might be done in the future. The intent of this recommendation is to consolidate the administration of, and responsibility and accountability for, 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; this seems to be an unnecessary and undesirable disaggregation of responsibility and accountability. 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, but the NMHI Director would retain no control of the mental retardation program; NMHI's bookkeeping system is such that it would not be overly difficult to arrange for the appropriate interprogram transfer of funds.

RECOMMENDATION 43: Provide the state technician staff working with mentally retarded people with improved formal training in the provision of developmental services. 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. Recall our earlier recommendation for splitting the mental health technician job classification into three new classifications, one of which could be an upgraded mental retardation service specialist.

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. As argued in the "Desirable Features of a Psychological Service System" section of Chap. 8 of the main text, no single mode of treatment, such as chemotherapy, is the most appropriate for every mental health disorder. Although not all mentally retarded people and their families need mental health services, some clearly do. Recall our earlier recommendation that provision be made for mental health services to those mentally retarded people and their families if they need them. A difficulty that must be overcome, however, is that the mental health service system in practice seldom serves mentally retarded people and is separate from the mental retardation service system, which itself typically does not hire mental health professionals who could provide psychotherapy or other modes of treatment.

RECOMMENDATION 44: Provide nearly all Eagle Valley Children's Home residents with needed special education and training through the Carson City School District. At the private Eagle Valley Children's Home, which primarily serves severely and profoundly retarded youth, only three of the ten residents were receiving special education and training in September 1974. However, nearly all residents need those services. An additional special education unit ($16,000) should be provided by the Nevada Department of Education for that purpose, since not all the home's residents originally come from Carson City.

RECOMMENDATION 45: Mentally retarded prisoners should be identified and a special program of services should 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 note the persistent tendency in Nevada to plan and approve facilities of the same size in Reno and Las Vegas (e.g., the Mental Retardation 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 of the main text).

RECOMMENDATION 46: Establish an improved information system for monitoring mental retardation program operations, including the effectiveness of services. During 1974 the Division of Mental Hygiene and Mental Retardation began to use a computerized, individualized data base for mentally retarded clients of certain division programs. This data base 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 with privacy safeguards, 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, 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 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 recommended above, if those centers are created.

For a more detailed discussion of mental retardation services, see Chap. 10 of the main text.

ALCOHOL AND DRUG ABUSE SERVICES

Prior to the 1960s, most mental health professionals considered alcohol and drug

abuse a form of mental pathology. Consequently, it was often treated in the same facilities and with the same techniques used for mental illness. But the past decade has witnessed a major transition. 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. Also, many alcohol and drug abusers have strongly resisted being classified as mentally ill, and will avoid treatment in a setting which allows such identification to take place. Consequently, most drug and alcohol treatment is now administered in separate facilities by a specially trained staff, a trend likely to continue.

The alcohol and drug abuse treatment programs in Nevada spent 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.

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. Service delivery system problems fall into three categories: inadequate information, organizational problems, and facility and service deficiencies. For a more detailed discussion of the current alcohol and drug abuse treatment programs and their problems, see Chap. 9.

We summarized the deficiencies in information on rates of alcohol and drug abuse in Chap. 1. The second information gap has to do with the current service delivery system. There is inadequate systematic detailed data collection on client loads, staffing patterns, service capacity, and the like for treatment programs throughout the state. Intelligent planning under such circumstances is very difficult. In sum, the state has too little routine program-management information, and too little information on program results—clients' conditions following release from treatment—to use in program evaluation. The Bureau of Alcohol and Drug Abuse is working diligently to resolve this information problem: a new data collection and processing system is being developed and federal funding to assist in this area has been applied for.

Organizational problems involving overlapping or ambiguous responsibilities persist 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. One overlap involves the state bureau and some of its own creations, the local umbrella coordinating organizations. Basically, both groups now seem to have responsibility for and provide some overall coordination of community programs. It is not clear why the central office in the Reno area cannot handle Washoe County coordination, nor why the Las Vegas branch office cannot handle coordination for that area. The umbrella organizations, as they are presently constituted, appear to be an unnecessary bureaucratic layer between the local service delivery agency and the state bureau, which provides no service directly to alcohol and drug abusers. 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 now, since their boards of directors do not include all heads of local treatment agencies. A second overlap occurs because all "health care" facilities must obtain licenses from the Nevada Division of Health, 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. A third overlap arises out of the continuing responsibility of the Nevada Mental Hygiene and Mental Retardation Division for the Nevada Mental Health Institute 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. In any event, complete coordination of alcohol programs will be difficult so long as one of the main treatment programs functions 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. Accordingly, any coordination effort must recognize that separation if it is to be efficient and successful.

In terms of expenditures per alcohol abuser, 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 in state funds per alcohol abuser than is neighboring California. From a regional standpoint, considering expenditures in relation to the number of alcohol abusers in the region, it is clear that the Las Vegas area and rural regions are not nearly as well funded as the Reno area.

Some specific facilities also are needed. A general problem in both alcohol and drug abuse treatment in Nevada is the absence of a comprehensive service system that offers a full range of levels of service that can be selected from to meet a particular client's needs, including detoxification, inpatient treatment for alcohol or drug abuse, halfway or rehabilitation house service, and outpatient therapy or counseling. Certain elements on the "continuum of care" are not present in Nevada or are not present in sufficient capacity. Nonmedical detoxification facilities are one such element that is either not present in certain geographic areas or is not present in sufficient capacity. Aside from a statewide deficiency in detoxification facilities, there is a deficiency of outpatient care in the Reno area for alcohol abusers as compared with the relative predominance of halfway or live-in rehabilitation houses. Alcohol abuse service system capacity of all types is deficient in Las Vegas and in rural areas. In Las Vegas, for example, halfway or live-in rehabilitation houses for alcohol abusers are in particularly short supply, and the area does not have an alcohol abuse treatment program analogous to that provided by NMHI which is accessible to people who cannot afford private tratment. Finally, there are staff training needs in the facilities that do exist.

As with alcoholism, there are insufficient detoxification facilities for drug abusers. Reno has no professionally staffed program for the hard core addict. (The NMHI Ward 10 program is designed for alcohol abusers.) The drug abuse treatment system also has some other kinds of facility problems. There is no full inpatient care program in the state analogous to the NMHI Ward 10 program but designed for drug abusers. Regarding halfway or live-in drug rehabilitation houses, it is a matter for 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 alleged drug use by people associated with those facilities.

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 *Nevada State Plan for Prevention, Treatment and Rehabilitation of 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.

RECOMMENDATION 47: Establish comprehensive information systems for monitoring alcohol and drug abuse treatment programs, as well as alcohol and drug abuse rates. Better information on current programs and abuse rates would not only make better management of current programs possible, but would also enhance the quality of planning for future programs. 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 made in Chap. 3 of the main text 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 federal or state funds, and should be requested from all others (e.g., detailed information on expenditures, staff, services, number and type of clients, and program effectiveness).

RECOMMENDATION 48: Consider a more streamlined organizational structure for alcohol and drug abuse services that will eliminate overlapping jurisdictions on the one hand and recognize 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 regional council's main function would be to advise the state on planning for future services, current financial assistance, and certification, and to improve local coordination. 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. We are not criticizing the concept of an umbrella organization, but rather the way the current umbrella organizations have been designed by the state Bureau. For example, representation on the councils could be broader than it is in the present umbrella organizations. Certain functions of the 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 of separation of both the local treatment organizations and the federal financing agencies. It also should solve some of the local conflicts that have been observed since the creation of the currently

existing umbrellas, which now cover both alcohol and drug services with a single local organization. There may be a need of state funding for staff to support the councils' activities, and the councils may be the appropriate agency to apply for certain federal funds.

A second major feature of the reorganization would be the transfer of control of the NMHI "Ward 10" to the Bureau of Alcohol and Drug Abuse. (We recognize that such a transfer may require legislative action.) We do not envision removing the Ward 10 program from the NMHI site 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 other portions 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.

RECOMMENDATION 49: Create a comprehensive alcoholism treatment program for the Las Vegas area. Although a number of new or expanded programs are needed to fill gaps in the alcoholism treatment system 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. 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. Some of these services might be arranged by expanding or working with existing public or private facilities.

RECOMMENDATION 50: Provide both drug and alcohol detoxification services throughout the state. The present lack of this essential service is a major deficiency in the present service system. The 1975 *Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse* does propose a realistic plan for detoxification services in Washoe County, but there is a lack of similarly detailed planning in the report for Clark County—which contains nearly two-thirds of the state's alcoholics.

RECOMMENDATION 51: Establish a few small halfway or live-in rehabilitation houses for alcohol and drug abusers throughout rural Nevada, with provisions for outpatient services at those same facilities. Rural Nevada is currently lacking in alcohol and drug abuse treatment programs and hence very few of the alcohol and drug abusers in rural Nevada who need service are being served now. 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 alcohol abuse treatment center we recommended above. However, it does appear feasible and desirable to provide the less intensive live-in rehabilitation house and outpatient services in small programs directly in the larger rural communities. That is, some of 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.

RECOMMENDATION 52: Create a short-term, professionally staffed, full inpatient treatment program for drug abusers in Nevada, analogous to the NMHI "Ward 10" program designed primarily for alcohol abusers. This would fill a notable major gap in the service system.

Another important issue in drug abuse treatment 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.

An alcohol and drug abuse facility plan prepared in 1974 for the Nevada Division of Rehabilitation indicated no need for additional alcohol and drug abuse 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 for alcohol and drug abuse, such treatment services are not now being provided in most of those existing facilities.

For a more detailed discussion of alcohol and drug abuse treatment, see Chap. 9 of the main text.

VOCATIONAL SERVICES

We estimate that at least 680 Nevadans with mental health problems, at least 660 who are mentally retarded, and at least 410 with alcohol or drug abuse problems had a need for vocational services in 1975—services such as vocational education, vocational rehabilitation, and job counseling and placement. These are conservative estimates; they do not include the many people who need *only* job placement assistance, and do not include youth who are not yet of age to be in their last two years of school.

About 1600 people with mental handicaps received vocational services in FY 1974 from a full-time-equivalent staff of about 120. Expenditures for those services totaled about $2.7 million, or about $1710 per person. We estimate that some service was provided to at least 170 Nevadans with mental health problems, at least 660 with mental retardation, to 140 with alcohol and drug abuse problems, and to 300 with some "other mental disorder" (described below). Additionally, 337 mentally handicapped people were served by the Department of Employment Security, for

whom data are not available by type of mental handicap. The programs providing vocational services discussed in this section include Vocational Rehabilitation, Community Training Centers, a Vocational Training program based at NMHI, special Vocational Education, and the Department of Employment Security. For a more detailed description and analysis of these programs and their clients, including the costs and benefits of both the programs and our recommended changes in them, refer to Chap. 11 of the main text.

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 health problems, 81 people with mental retardation, 140 people with alcohol or drug abuse problems, and 296 people with some other mental disability. The clients listed as "other mental" 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 people.)

Several private community training 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. About 180 adults were served in FY 1974.

A small Vocational Training program operated by the Division of Mental Hygiene and Mental Retardation served about 20 retarded adults in the Reno area.

The special vocational education programs in county school districts served approximately 400 mentally handicapped youth, most of whom are educable mentally retarded.

The Department of Employment Security primarily provides unemployment compensation plus job information and placement to unemployed people. The Department reported serving 79,073 people, including 337 mentally handicapped adults in FY 1974. 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 for supportive services (which includes referrals to the Bureau of Vocational Rehabilitation).

While the vocational service programs in Nevada are valuable, several problems for mentally handicapped people were identified. 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 and urban-rural differentials exist for some handicaps); differential levels of service by type of handicap (especially the extremely low emphasis on serving severely emotionally disturbed youth in the vocational education program and the low emphasis on referring for service or serving all types of mentally handicapped people by the Employment Security program); a questionable allocation of about half the limited available VR funds in FY 1974 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, Employment Security, 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).

RECOMMENDATION 53: Provide (1) a full comprehensive range of good-quality vocational services in the Reno and Las Vegas areas and make them available equitably to all Nevadans in need, with short-term residential arrangements in those two cities for rural Nevadans, and (2) a limited range of the more frequently needed, less specialized, and long-term vocational services in the other geographic areas. Additional vocational services are needed in rural counties as well as in Clark and Washoe Counties. While a complete range of services should be available to residents of each of the counties, and ideally one would like to locate those services 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 regard to quality of services, it is difficult to obtain specialist staff in every rural county, service specialists being in very short supply throughout Nevada. Three distinct options exist: (1) continue the present program and thus partially but inadequately meet vocational needs in rural areas; (2) undertake a very costly expansion to provide a comprehensive good-quality program of services in rural facilities; or (3) the option we recommend be adopted, 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 good-quality specialized services.

RECOMMENDATION 54: At least double the Community Training Center minimum funding level per client for those clients receiving services but not primarily funded by some other agency. 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. The state has paid a maximum of $350 per enrollee per quarter year in large centers and $15,000 per annum in small centers. However, in FY 1974 primary funding was provided for some 183 adult clients at these centers by the Vocational Rehabilitation program and for a few children by a county school district.

RECOMMENDATION 55: Eliminate the Vocational Training program and transfer its personnel and current clientele to the joint VR-WARC 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 services, provides services in northern Nevada that overlap those provided jointly by the VR program and the Washoe Association for Retarded Citizens. Our recommended organizational change would provide more adequate supervision and direction of these staff members by professional vocational service personnel, and consolidate the overlapping programs in the bureaucracy.

RECOMMENDATION 56: Expand special vocational education programs to provide vocational services to some severely emotionally disturbed youth. 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 children need and can benefit from special vocational education, too.

RECOMMENDATION 57: Increase the number of referrals from the Department of Employment Security to Vocational Rehabilitation of persons suspected of having mental handicaps who are not placed in jobs within a short time. 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. 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.

RECOMMENDATION 58: Obtain improved program management and effectiveness information for each Nevada vocational service program. The information needed to manage some of the vocational service programs effectively is severely lacking. For the Vocational Education and Employment Security 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 clearly 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 or lack of acceptance of the VR program—categories of reasons that raise more questions than they answer. Finally, with the exception of the VR program, effectiveness data for vocational service programs are severely lacking. 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 need revision so they are more illuminating (this can be done and still be consistent with federal reporting requirements).

RECOMMENDATION 59: Improve 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 Mental Health Institute, 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. The problem of lack of referrals between programs offering vocational services and other service programs for mentally handicapped people clearly needs attention. In all of FY 1974, for example, only 16 rehabilitated mentally disabled youth had originally been referred for vocational rehabilitation by the schools. 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 if referral of those clients is *actively* encouraged at the level of direct service personnel. There is a passive tendency to serve clients who present themselves or are presented 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. One

might take a dynamic and flexible approach depending on the level of vocational impairment. For example, VR might screen all mentally handicapped youth before they leave school, and automatically give mildly handicapped youth both job information and placement assistance upon leaving school; 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. We discussed referrals from the Department of Employment Security in an earlier recommendation.

RECOMMENDATION 60: Either expand the VR program to serve more of the severely mentally handicapped people in need, or restructure FY 1974 priorities to shift the VR caseload from emphasizing the generally less severe "other mental" handicaps toward emphasizing more severe mental handicaps without increasing the total budget. The VR 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 taxpayers who are paying for the vocational services to mentally handicapped people (reduced service costs later in the mentally handicapped person's life, 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.) 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 Nevada taxpaying population for every one of the prevalent types of mental handicaps that we considered (see Chap. 11 of the main text for the detailed cost/benefit analysis). 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 limited resources more heavily on more severe mental disorders, in line with current federal guidelines. 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 in Chap. 11 suggests that benefits in relation to

costs may actually rise with 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, the Administrator of the Nevada 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.

For a more detailed discussion of vocational service programs and cost estimates for the above recommendations, see Chap. 11 of the main text.

MEDICAL SERVICES

Nevada's medical service programs for mentally handicapped people can affect their lives importantly in two ways: by providing treatment for the physical health needs of people who have mental health, mental retardation, or alcohol or drug abuse problems, and by providing payments for both physical and mental health services. In addition to medical personnel and facilities, programs providing medical treatment or payment include Medicare, a federal program; Medicaid (State Aid to the Medically Indigent in Nevada), and the Crippled Children's Services program, both joint state-federal funded programs; private insurance; and the privately sponsored Easter Seal Treatment Centers. Refer to Chap. 12 of the main text for details of those programs.

Private sector expenditures for medical care are not known, nor are the fractions of public medical expenditures devoted to mental health services and other medical care to Nevadans with problems of mental health, mental retardation, or alcohol or drug abuse. Program records typically are not kept in such a way as to enable the identification of, for example, a mentally retarded person being served. The only funds we can *specifically* identify as going for service to clients with mental problems are about $282,000 in Medicaid funds for mental health services (identifiable because they went to mental health service personnel), and about $75,000 in Easter Seal Treatment Center funds for mentally retarded clients. Obviously, more money than that went for people with mental problems, but we can only estimate the total. One might assume for lack of better data, for example, that the fraction of Medicaid and Medicare recipients who are mentally handicapped is the same as the fraction in the total Nevada population, and that average expenditures for a mentally handicapped client are about the same as for all other types of clients. Under those assumptions, the programs annually spend about $1 million for people with mental health problems, $1 million for mentally retarded people, and $4 million for alcohol and drug abusers. We caution that these are only order of magnitude estimates based on rather tenuous assumptions made in the absence of better information.

Of the 27 Nevada hospitals, 12 offer mental health services, and 7 of those are on an emergency or partial hospitalization basis only. Outside of Las Vegas and Reno, only emergency mental health services are available, and then only at a few of the hospitals. Other medically related facilities include 18 facilities that provide continuous skilled nursing service, under medical direction, to convalescent patients not in an acute episode of illness, and 9 intermediate care facilities that provide

personal and health-care supervision for people who do not have illnesses, diseases, injuries, or other conditions that would require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide. Only 12 of the 17 Nevada counties have skilled nursing facilities, and only 4 have intermediate care facilities. Apart from geographic considerations of availability of services, several people we interviewed alleged that the operators of some of these facilities find ways in practice of denying admission to mentally handicapped clients. Consequently, even where a facility exists, the services may not be accessible to mentally handicapped people.

Currently, people in Nevada have three recourses in paying for mental health services, and for medical services for all types of mentally handicapped people: (1) privately financed care for those who can afford it or who have health insurance that covers needed services; (2) programs that receive payment from public funds, such as Medicaid, Medicare, and Crippled Children's Services for low-income people who cannot afford good care, and for others who qualify; and (3) publicly financed direct service programs (sometimes with charges to families of clients who can afford it), such as the Mental Health Centers and Mental Retardation Centers. On the whole, this three-part system can be readily defended, but certain aspects of the way it has been implemented need improvement.

RECOMMENDATION 61: Conduct a study of the effects of requiring a mandatory minimum level of coverage for mental health and mental retardation services in every private health insurance policy. Private health insurance often either excludes mental health coverage or offers more limited coverage for mental health than for physical health problems. The 1975 session of the Nevada Legislature extended coverage of alcohol and drug abuse treatment by making it mandatory for private health insurance to provide at least a specified minimum amount of coverage for alcohol and drug abuse treatment. Potential effects of requiring such mental health and mental retardation service coverage include somewhat higher insurance costs, some decrease in the number of people purchasing health insurance because of the higher cost, increased quality-of-life benefits resulting from the increased provision of needed mental health and mental retardation services, and decreased government expenditures for services that are newly covered by private insurance. Before implementing a mandatory coverage requirement, those potential effects require careful examination as a function of the different minimum levels of mandatory coverage being considered and the types of mental disorders and services to be covered.

With respect to publicly financed health insurance programs, the nonwelfare poor population (those who are medically but not categorically needy and hence not eligible for income assistance) are in worse shape with respect to financial access to medical services than are those who can afford private care and those who are on income assistance and hence eligible for Medicaid. County welfare offices sometimes meet the medical needs of the nonwelfare poor, but exclude most mental health needs because of strained county resources. To remedy this situation, the recent Nevada legislative subcommittee for the study of the consolidation of state and local welfare programs has recommended that "... *the legislature take action in 1975 to expand the SAMI (Medicaid) program to include the group known as the 'medically needy.'*" If SAMI were expanded to meet the federal definition of "medically needy," financial eligibility would be limited to those having an income below 133-1/3 per-

cent of the Aid to Dependent Children (ADC) grant level, after deducting medical expenses. That expansion would *not* necessarily include everyone who now receives county medical assistance. If the expansion were authorized, however, the state could obtain 50 percent federal matching funds.

Concerning ADC, yet another point bears consideration. As determined by the State Welfare Board, ADC payments are currently 70 percent of the full standard of need in Nevada. Anyone earning between 70 percent of this need and full standard (i.e., earning between $230 and $329 a month for a family of four) is deprived not only of income assistance but of Medicaid benefits.

RECOMMENDATION 62: Supplement state monies by billing private and public health insurance programs to the maximum extent feasible to pay for state-operated direct service programs for mentally handicapped Nevadans. With respect to publicly operated direct service programs, such as the state mental health centers and mental retardation centers, neither public nor private health insurance programs have been fully tapped in the past to pay for those direct services. By billing for service to those persons who have a means to pay (e.g., those on Medicaid or with private insurance), state-operated program monies will be supplemented, allowing for provision of more services. Personnel of the Nevada Division of Mental Hygiene and Mental Retardation have taken steps in that direction recently and we endorse their efforts. It does not make good fiscal sense *from the viewpoint of the state as a whole* to spend a dollar for service through the budget of the Division of Mental Hygiene and Mental Retardation, when the same service can be funded through the Medicaid budget of the Nevada Welfare Division at a cost of 50 cents to Nevada and 50 cents to the Federal Government.

We note that the Medicaid program does not provide the same coverage for all age groups in the mentally handicapped population. One effort to modify this differential coverage is embodied in the federal Social Security Amendments of 1972 (P.L. 92-603), which authorize matching federal funds for care in psychiatric hospitals for Medicaid beneficiaries under 21 years of age, if certain requirements for patient evaluation are met. Nevada might consider exercising its option of matching the 50-percent federal contribution in providing for the mental health needs of its youth. Currently, many youngsters in need of residential mental health care are unserved or have been made wards of the state and been sent to out-of-state institutions, with the Nevada Welfare Division bearing the total cost.

For a more detailed discussion of medical services, see Chap. 12 of the main text.

RESIDENTIAL LIVING

Meeting the diverse needs of mentally handicapped people requires a range of residential programs suited to the various levels of individual functioning and service needs. These programs vary from full inpatient care facilities for people who have acute mental health problems or who are nonambulatory and profoundly mentally retarded, through less service-intensive intermediate care facilities, through semi-independent residential living programs that offer minimal supervision and assistance.

Earlier we discussed mental health, mental retardation, and alcohol and drug abuse *residential treatment* programs intended to provide more than supervised

residential living. This section focuses on programs that provide supervised *residential living* for people who are unable to live with their own families or to live independently in the community; these programs are not intended to and do not provide any other substantial mental health, mental retardation, or alcohol or drug abuse services. For a more detailed discussion of residential living programs, see Chap. 13 of the main text.

Nevada's supervised residential living progams include foster homes for children, special foster homes called developmental homes for retarded children and young adults, adult group care and family care facilities, sheltered living apartments, the state Children's Homes, the state juvenile Training Centers, and the federal Stewart School for Indian children and youth. The latter three types of facilities have significant numbers of mentally impaired youth as residents, but are included in this discussion of supervised residential living programs because they provide no substantial mental health, mental retardation, or alcohol or drug abuse services.

Data are not available on exactly how many mentally handicapped people are in some of these facilities, but adding the numbers for the facilities on which some information is available yields an estimate of *at least* 290 mentally handicapped residents, for whom the expenditures for supervised residential living were *at least* $620,000 in 1974. Those numbers do not include estimates for nonwelfare clients of adult group care and family care facilities, or for residents of the state training centers or the Stewart School.

RECOMMENDATION 63: At least double the number of people served by the developmental home and sheltered living apartment programs. The developmental homes and sheltered living apartments, which permit mentally retarded residents to live in sheltered foster-home or semi-independent living situations in the private residential communities, are for those people who are not yet capable of fully independent living, but do not need the much more dependent and costly residential care and treatment programs provided by the Mental Retardation Centers and the Nevada Mental Health Institute. The major problem with these programs is their tiny size; only 30 people were served in developmental homes and only 27 in sheltered living apartments in the entire state in late 1974. The type of people now in these programs typically were served previously in the more institutionalized and much more expensive residential care programs, or were not served at all by the mental retardation programs. Based on information gathered in our interviews, it appears that at least twice as many placements into these sheltered living programs could be made if they had the capacity. As more mentally retarded people with functional abilities appropriate to these programs are identified, and as the skills of people with lesser functional abilities are improved so they can be moved out of a more restrictive environment such as NMHI or one of the mental retardation centers, it is possible that the program could more than double in size. Creating more of these sheltered community living facilities would facilitate serving more people "in the least restrictive environment possible," which is one aspect of the state goal of the Nevada Division of Mental Hygiene and Mental Retardation (see Chap. 1).

RECOMMENDATION 64: Establish facility and personnel standards and licensing specifically for private developmental homes and sheltered living apartments for retarded people, and require that staff members receive specified levels of training. While these programs are good in theory, they can be subverted by poor implementa-

tion. We see potential problems in implementation in at least three areas that presently are handled on an ad hoc basis: facility and personnel standards for the homes and apartments; training of the staff; and supervision of the staff.

RECOMMENDATION 65: Assign responsibility for all supervision of mentally retarded people living in private developmental homes in the community to the mental retardation centers, rather than having it shared by the centers and the Nevada Mental Health Institute. To help ensure the necessary continuing supervision of staff of these sheltered living facilities, to simplify the bureaucracy, to help the developmental homes to function in a coordinated manner, to facilitate servin those most in need first, and to provide the most efficient and effective support for the operators living in or near the developmental homes, it would appear that undivided responsibility for this program would be an improvement over the present situation, in which both the centers and the Institute are creating and monitoring developmental homes. To supervise rural county developmental homes, the mental retardation centers might contract with a local rural special education teacher of retarded children. The mental retardation centers, rather than NMHI, should be given this responsibility since personnel of the centers are located in both Reno and Las Vegas, and those personnel are more skilled in working with retarded people functioning at the level where they are candidates for developmental home placement.

RECOMMENDATION 66: Establish special minimum standards and supervision for foster homes and adult group care and family care facilities that provide supervised residential living for people with mental health disorders, mental retardation, and alcohol or drug abuse problems. While regular foster homes and adult group care and family care facilities presently are outside the domain of control of the mental health, mental retardation, and alcohol and drug abuse service system, it could only improve matters if those facilities that provide supervised residential living for significant numbers of people with these handicaps were subject to a few minimum facility standards and personnel selection and training standards, and received some supervision by state mental health, mental retardation, and alcohol and drug abuse personnel. These quality controls would help ensure supervised residential living of at least minimal quality for mentally handicapped people. Personnel with special expertise in serving mentally handicapped people should provide the supervision, just as the Mental Retardation Centers now do for the developmental homes. We caution that the purpose is to ensure at least minimally acceptable living conditions; care must be taken to establish reasonable standards so as not to cause existing residential living facilities simply to reject all mentally handicapped applicants because the standards are viewed as too stringent.

RECOMMENDATION 67: Refer each mentally handicapped foster child to the Division of Mental Hygiene and Mental Retardation or to a Division of Health Special Children's Clinic for evaluation, followed by appropriate service by both these Divisions and the local special education program if the presence of a mental disorder requiring services is confirmed. Of the children placed in foster homes by the Nevada Welfare Division, social workers suspect that more than one-third have mental problems. The Welfare Division has set up 15 specialized foster homes for some of these children.

The Nevada Youth Services Agency facilities and related programs providing supervised residential living for children in the two state children's homes, the two

state Training Centers, the Home of the Good Shepherd, and the Spring Mountain Youth Camp were not established to serve as mental retardation and mental health treatment centers. Many of the children receiving residential care in those facilities are emotionally disturbed, however, and some are mentally retarded. Some provision should be made to see that the mental health and mental retardation service system serves those children while they are in supervised residential care programs of the Youth Services Agency. There appear to be several reasons for the lack of delivery of mental health and mental retardation services to residents of those facilities: the facilities either have no mental health and mental retardation staff or do not have sufficient qualified staff; there appears to be considerable "buck-passing" on the part of other mental programs; and the capacity of other mental service programs in Caliente, Carson City, Elko, and Boulder City, where the four primary youth facilities are located, is not high. Most certainly, the rural locations of the training centers have strongly affected the type of program they have been able to offer. Rurality denies them easy access to the specialized personnel, programs, and skills that are much more readily available in the urban centers' mental programs. Their remoteness also has made it difficult to recruit qualified staff. Finally, the present fragmented service system lacks coordination in assuring that all different types of these children's needs are met.

RECOMMENDATION 68: Provide a professional psychological screening for all residents and referrals for residential care at the two Nevada Children's Homes and the two state training centers to identify potential mental health and mental retardation problems; once mentally handicapped youth have been identified at these state facilities, the Division of Mental Hygiene and Mental Retardation should be required to provide them with the appropriate level of services ranging from full residential treatment to day treatment to outpatient treatment. The primary burden for mental health service could be given to the Rural Clinics outpatient mental health program, which in 1974 did not serve most children from these facilities. However, before the Rural Clinic's program could adequately carry this additional service burden, it would require considerable improvement such as that which we recommended earlier in this chapter, since the Rural Clinics program is now only an embryonic program with major deficiencies. If the Rural Clinics program is not improved, some other mechanism for serving these mentally handicapped youth should be developed.

For a more detailed discussion of residential living programs, see Chap. 13 of the main text.

INCOME ASSISTANCE

Direct income assistance is available from the following sources in Nevada: federally funded Social Security Disability Insurance (SSDI), joint state and federally funded Supplemental Security Income (SSI), joint state and federally funded Aid to Dependent Children (ADC), and county funded General Assistance (GA). See Chap. 14 of the main text for more detailed discussions of these programs than are provided below.

Only in the SSDI and SSI programs can a mentally handicapping condition be a basis for receiving direct financial aid. The Nevada Welfare Division administers

ADC, Medicaid, and social services for aged, blind, and disabled people who receive their income assistance checks directly from the Social Security Administration under the SSI program. County General Assistance provides income assistance for certain needy persons excluded from federal and state aid because they are unable to meet all eligibility requirements. This group includes persons who (1) are awaiting completion of processing of their SSI applications; (2) need emergency help; (3) are members of intact families (both parents in the home); (4) are temporarily unable to work but not technically disabled under SSI and SSDI regulations; and (5) possess income and/or resources above the eligibility restrictions of other income assistance programs. Both the state- and county-operated programs (ADC and GA, respectively) provide income maintenance to a defined population of financially needy people, some of whom also may happen to have mental handicaps.

At least 1500 mentally handicapped Nevadans received income assistance, which amounted to at least $2 million in 1974. The estimated number served and expenditures by program were at least $1.1 million and 450 people by SSDI; $550,000 and 350 people by SSI; and $400,000 and 740 people by ADC. Data were not available on GA expenditures for mentally handicapped people. Data are not available to break down those totals meaningfully by type of mental handicap for any of the four programs.

RECOMMENDATION 69: Identify each mentally handicapped person receiving financial assistance, refer him or her to other appropriate service programs (or to the Direction Centers we recommended above), and maintain much more complete program planning data. Without accurately knowing both the numbers of mentally handicapped persons served and the *nature* of their disabilities, there is no adequate way to plan and evaluate the system. The collection and assessment of these types of data would provide the necessary feedback to evaluate the present system, help assess its effectiveness, and meet those service needs exposed. Without adequate information in a usable format, it is not possible to ensure the provision of other needed nonfinancial assistance services. The income assistance rolls are an excellent potential source of referrals for other programs; it is a source that has not been fully tapped, with the possible exception of referrals of SSI applicants for vocational rehabilitation.

RECOMMENDATION 70: Any mentally handicapped ADC recipients who are also eligible for SSI should be transferred to the higher-paying (and primarily federally financed) SSI program. This would not only provide a more nearly adequate income for the mentally handicapped people involved, but would do so at less cost to the state (although at more cost to the Federal Government). The improved screening recommended above would facilitate this.

RECOMMENDATION 71: Supplement the federal SSI payments to mentally disabled people with state funds to provide a more nearly adequate level of income assistance. The current SSI maximum payment schedule runs *below* that of the federal poverty level. The Office of Economic Opportunity's poverty level (as of May 22, 1974) is $2330 a year for one person, and the Bureau of the Census uses a poverty level of $2396 per year (as of 1973) for a nonfarm male individual under age 65 living alone. However, SSI payments for a disabled person living independently were a *maximum* of $1890 in July 1975; an individual's other sources of direct or indirect income may result in an actual payment below the maximum allowable. While nonfinancial assistance is also provided to mentally handicapped people on financial

assistance programs (see Chaps. 4 to 13 of the main text for discussions of those other services), most basic needs, such as for housing, utilities, and clothing, are met through the mechanism of direct cash transfers. In order for income assistance to continue to fulfill the function it was designed for, the state supplementary figure should periodically make allowances for inflation. We note that the state currently provides a supplement to the federal SSI payment for other categories of SSI recipients for whom the cost of meeting basic living needs is not clearly higher than it is for mentally handicapped Nevadans.

For a more detailed discussion of income assistance, see Chap. 14 of the main text.

PRIORITIES ON RECOMMENDATIONS

We have developed 71 recommendations for improving services to people in Nevada with mental health disorders, mental retardation, and alcohol and drug abuse problems. The choice by Nevadans on which recommendations, if any, to implement depends on the goal chosen and on the level of effort the government and other Nevada organizations are willing to make in improving services. The official state goal for the Nevada Division of Mental Hygiene and Mental Retardation with respect to delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."[5] (See Chap. 1.) In light of this state goal, Nevada officials can choose to make different levels of effort. We discuss three possible levels of effort below, and have grouped our recommendations according to those levels of effort: slight or no change in level of effort; modest change in the current effort; and the substantial change in level of effort required to meet the state goal. If Nevada officials choose not to make the substantial change in level of effort required to achieve the state goal, then not all 71 of our recommendations can be implemented and priorities must be set on those recommendations. In that case, Nevada should focus the limited available resources on the most important recommendations, rather than attempt to do everything and perhaps end up doing very few things adequately. The 11 different dimensions presented in Chap. 1 for assessing service system performance in relation to system goals are useful in setting priorities, since they represent different types of costs and effects of recommendations that should be considered in setting priorities. Recall that those dimensions were concerned with such factors as costs, availability of a full range of needed services, coordination of services, the quality of available services, sufficiency of service capacity in relation to need, equity of service distribution, future economic effects of service, and effects on the quality of life of the mentally handicapped person. Setting priorities would be easy if progress toward the state goal could be measured exclusively on one dimension for every recommendation. Unfortunately, the costs and effects of recommendations for improvement in the mental health and mental retardation service system must be measured on several different dimensions. And with the data available, it often is possible to know only the qualitative

[5] Office of the Governor, *State Goals*, State of Nevada, Carson City, Nevada, March 1, 1974.

direction, not the quantitative amount, of the changes in the costs and effects on various dimensions. Consequently, setting priorities on recommendations such as ours necessarily must be a matter of judgment about the magnitude and nature of the costs and effects of the different recommendations, and a matter of judgment about tradeoffs among the different types of costs and effects.

In setting priorities, we are suggesting that certain of our 71 recommendations be implemented before others. In selecting those that we suggest be given priority and implemented if Nevada officials desire to make only a slight or no increase in the level of effort, we have stressed low-cost recommendations. In selecting those that we suggest be given priority and implemented if Nevada officials desire to make a modest increase in the level of effort, we have stressed recommendations aimed at reducing the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that now are available. Of course, the use of different goals and criteria may result in different priorities from those we suggest below.

In our judgment, the types of recommendations we suggest be implemented at each level would contribute most toward meeting the state goal for the specified level of effort. Our recommendations are summarized in Table 2.1, grouped by type of service and by three different levels of effort government officials may choose to make to remedy the problems. The number beside the summary recommendation in the table indicates the numerical order in which the complete detailed recommendations were presented earlier in this chapter; it does not indicate priority.

The cost estimates presented later in this section are for the increase in annual expenditures required by the recommendations. The estimates were developed by using expenditure data from currently operating programs and using other information from Chaps. 4 to 14 of the main text. Each recommendation was costed in arriving at the total estimates, which we are confident are of the correct order of magnitude of the annual expenditure increase required. Extremely detailed cost analyses were not made and presented in this report, however. The actual annual cost increase will depend on exactly how Nevadans decide to implement the recommendations.

Status Quo Level of Effort

The status quo level of effort, involving slight or no increase in total resources for services, might be chosen by those who are more interested in holding the line on current expenditures than in resolving the major service problems that exist. Such a choice is understandable, but Nevada clearly is not achieving and cannot achieve its state goal with respect to delivery of services to mentally handicapped people if there is little or no change in the current level of effort. Furthermore, the wisdom of economizing on current service expenditures for people with mental handicaps can be challenged on humanitarian grounds for all services, and on long-term economic grounds for some types of services (e.g., prevention of certain types of mental retardation, and vocational rehabilitation). An implicit tradeoff is between the cost of current services and the implicit cost associated with the diminished quality of life of the person who is unserved or inadequately served.

Even if there is to be only a slight increase or no increase in the level of effort, by which we mean a 5 percent or less increase in annual expenditures, many of our recommendations can be implemented, as shown in Table 2 1. Our several recom-

Table 2.1

Summary of Areas of Recommendations and Costs, by Desired Change in Level of Effort
(Fiscal Year 1974 expenditures = $35 million)

	Suggested Priority Areas of Recommendations by Desired Change in Level of Effort		
	Slight or No Change	*Modest Increase*	*Meeting All the Needs*
Service Need	Estimated Annual cost increase of $1.8 million (5 percent)	Estimated annual cost increase of $16 million (46 percent), adopt all "slight or no change in desired level of effort" recommendations in each service need area, plus those listed below	Estimated annual cost increase of $27 million (77 percent), adopt all "slight or no change" and "modest increases in desired level of effort" recommendations in each service need area, plus those listed below
Direction	1 Establish Regional Direction Centers 2 Strengthen state advisory boards		
Prevention	6 Assign specific responsibility for prevention of mental retardation		3. Expand genetic counseling with respect to mental retardation. 4. Ensure provision of immunizations, Rh desensitization and PKU screening 5. Expand family planning services, and create a high-risk registry for newborns
Identification		10 Provide behavioral and psychological screening once for each young school child 11. Screen high-risk groups for mental health disorders	7. Establish health and developmental screening of new school enrollees 8. Improve Medicaid early screening and follow-up 9. Expand Special Children's Clinics' mental retardation diagnostic services
Special Education and Training	13 Allocate special education funds by specific handicap and enforce current standards 16 Revise preschool program focus in Community Training Centers 17 Revise preschool program focus in Special Children's Clinics. 18 Increase referrals from schools to other service agencies 19 Obtain better information on special education and training programs	12. Increase the number of special education units funded 15 Provide appropriate special education and training to mentally retarded Nevada Mental Health Institute (NMHI) residents	14. Increase state special education technical advisory staff and provide technical assistance to rural counties
Mental Health Services	20 Fill authorized professional staff positions at the Las Vegas Mental Health Center 23 Increase Rural Clinics efforts for people with substantial mental health disorders 26 Revise the Las Vegas Children's Behavioral Services staff and the service focus 29 Provide specified staff mix and client focus in Children's Behavioral Services residential programs 34 Restrict use of Mentally Disordered Offender Facility to prisoners 36 Provide a physically secure mental health unit at NMHI 37 Revise the [illegible] of NMHI to fulfill four specifications 38 Obtain information on mental health programs	22. Upgrade rural mental health staff, and add part-time traveling service teams based at NMHI 28. Establish an upgraded mental health technician personnel classification and university-based training program 31. Improve follow-up treatment of people released from residential mental health programs 32. Create programs to provide an intermediate level of mental health services over an extended time period for children and adults	21. Provide 24-hours-a-day emergency crisis-intervention service in mental health centers and Rural Clinics 24. Establish a second community mental health center in Clark County 25. Expand the Reno Mental Health Center into a full community mental health center 27. Provide mental health services to mentally retarded people if needed. 30. Correct major deficiencies in mental health services noted in the NMHI accreditation report 33. Establish halfway houses for people with mental health disorders 35. Provide specified mental health services in Nevada State Prison

Table 2.1 (Continued)

	Suggested Priority Areas of Recommendations by Desired Change in Level of Effort		
	Slight or No Change	*Modest Increase*	*Meeting All the Needs*
Mental Retardation Services	40. Do not reduce existing NMHI mental retardation staff size when Desert Developmental Center opens 42. Consolidate state mental retardation program control by removing control of mental retardation services from the NMHI Director 44 Expand special education and training, as appropriate, for Eagle Valley Children's Home residents 46 Obtain better information on mental retardation programs	39. Improve the NMHI mental retardation program to meet JCAH accreditation standards 41. Provide the equivalent of the Desert Developmental Center services to northern Nevadans, but defer major *facility* construction 43. Improve training of state "Technicians" serving mentally retarded people 45. Provide special services to mentally retarded prisoners	
Alcohol and Drug Abuse Services	47 Obtain better information on alcohol and drug abuse programs and prevalence rates 48 Streamline the organizational structure for alcohol and drug abuse programs	49 Create a comprehensive alcohol abuse treatment program for the Las Vegas area 50. Provide alcohol and drug detoxification services throughout Nevada 51 Establish rehabilitation houses for rural alcohol and drug abusers 52. Establish a full inpatient treatment program for drug abusers	
Vocational Services	53 Provide specified general vocational services in rural areas, with short-term more specialized services in urban areas for rural residents 55 Consolidate the Vocational Training program with specified vocational program 57. Increase referrals from Employment Security to the Vocational Rehabilitation program 58 Obtain better information on vocational service programs 59. Increase referals from nonvocational to vocational service programs		54. Double the Community Training Center minimum funding per client 56. Provide vocational education for emotionally disturbed youth 60. Expand the Vocational Rehabilitation program or shift the caseload emphasis to serve more severely handicapped clients
Medical Services	61. Study the effects of mandatory mental health and mental retardation service coverage in private health insurance 62. Supplement state-operated program funds by billing private and public health insurance to extent feasible		
Residential Living Services	64. Establish standards for developmental homes and sheltered living apartments 65. Consolidate developmental home supervision responsibility	63. Double the size of the developmental home and sheltered apartment living programs	66. Implement standards and supervision for foster homes and Adult Group Care and Family Care Facilities serving mentally handicapped people 67. Refer mentally handicapped foster children for services as appropriate 68. Screen residents of Youth Services Agency facilities for mental handicaps, followed by services as appropriate
Income Assistance	70. Transfer mentally handicapped Aid to Dependent Children recipients to the Supplemental Security Income program, if they qualify.		69. Identify financial assistance recipients with mental handicaps, and refer for services as appropriate 71. Provide a state supplement to the SSI payments to mentally handicapped people

mendations on management practices and organizational structure, for example, can be implemented at little or no additional cost but can enhance the control, coordination, and performance of the service system. Better program management and service effectiveness information can be obtained. Without increasing the overall level of resources expended, Nevada can shift the client focus in certain programs, as outlined in two of our low-cost recommendations. As to priorities among different types of mentally handicapped people, this is a matter for the judgment of state officials and is beyond the province of this study. If state officials choose to maintain the status quo level of effort, the question of the relative emphasis to place on service to people with mental health disorders, mental retardation, or problems of alcohol or drug abuse—that is, who will not be served—is not an easy or comfortable one to answer.

Each of the recommendations shown in the "slight or no increase in the level of effort" column of Table 2.1 was placed there because of its low cost—an estimated increase in annual expenditures in the $0 to $100,000 range—with one exception. Our recommendation for establishment of two Regional Direction Centers would cost approximately $500,000 a year. Regional Direction Centers are included because they are a key element in a set of recommendations primarily aimed at improving the management, coordination, and information in the service system. The presence of Regional Direction Centers would enhance the effectiveness of the other recommendations in that column also aimed at improvement in management, coordination, and information. The total estimated increase in annual expenditures required to implement all recommendations in the "slight or no increase in the level of effort" column is $1.8 million.

To begin to resolve most of the major problems we noted, however, expenditures and staff will have to expand. The state goal for the mental health and mental retardation service delivery system cannot be achieved with only a slight or no increase in the level of effort.

Beginning to Face the Facts

State officials might also choose to make some modest increase above the current level of effort in recognition of the massive problems that still prevail with Nevada's mental health and mental retardation service system. By "modest," we mean up to a 50 percent increase in annual expenditures above the FY 1974 level of effort.

If the level of effort is to be increased, we would add certain priority types of recommendations to those already cited for the "slight or no increase in level of effort" case. Recommendations listed in the "modest increase in level of effort" column of Table 2.1 are those which we feel address the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that now are provided.

For people with mental health disorders, we would assign priority to our recommendations in the areas of: identifying people in need of service by screening high-risk groups and screening each schoolchild once; expanding special education to serve all seriously emotionally disturbed children the law now says must be served; restructuring, upgrading, and expanding rural mental health services; providing improved follow-up treatment of people released from residential mental health programs; providing intermediate levels of mental health services to those needing

them over an extended time; and substantially upgrading the skills of mental health technicians.

For mentally retarded people, we would assign priority to our recommendations in the areas of: identification of people in need of service by screening each schoolchild once; increasing special education resources to serve all those children the law now says must be served, and to provide appropriate special education and training to mentally retarded Nevada Mental Health Institute residents; expansion of developmental homes and sheltered apartment living opportunities in the community; providing the equivalent of the Desert Developmental Center's range and quality of services to northern Nevadans; improving the training of state "technicians" who serve mentally retarded people; providing special services to mentally retarded prisoners; and bringing the severely deficient mental retardation program at the Nevada Mental Health Institute up to accreditation standards.

For alcohol and drug abusers, we would assign priority to our recommendations in the areas of: creating drug and alcohol detoxification services statewide; creating a comprehensive alcohol abuse treatment program in the Las Vegas area; creating an inpatient drug treatment program analogous to the one existing for alcohol abuse treatment at the Nevada Mental Health Institute; and creating rehabilitation houses plus an outpatient program in rural Nevada.

We stress that, within the above lists for each type of mental handicap, we do not mean to imply relative priorities by the order in which we present areas of recommendations; and we repeat that state officials must decide on priorities among handicaps. We further note that, immediately above and in Table 2.1, we have described areas of recommendations in brief general terms; the complete recommendations were presented in earlier sections of this chapter.

Implementation of each of the recommendations cited in the "modest increase in level of effort" column of Table 2.1 would require an estimated increase in the level of annual expenditures of approximately $16 million, or about 46 percent above the FY 1974 level of expenditures. Of all the priority recommendations, the one for increasing the number of special education units funded for mentally retarded and seriously emotionally disturbed children is the most expensive, an estimated $5.8 million annually above FY 1974 expenditures. Our estimate of the cost of each of the other recommendations is $1.2 million or less annually, and usually substantially less. Even if Nevada officials approve that $16 million increase in level of effort for the priority recommendations we listed, many of our 71 recommendations, which we regard as necessary to resolve major service system problems for mentally handicapped Nevadans, would not be implemented.

Meeting All the Needs

If Nevada officials decide to make the level of effort required to meet all the needs of each different group of mentally handicapped people, then all of our recommendations should be implemented. The question is whether Nevada officials are willing to make the commitment necessary to achieve the official state goal.

We estimate that the total increase in the level of effort required to implement all 71 of our recommendations would be approximately $27 million per year above the level of FY 1974 expenditures, depending on how state officials implemented the recommendations. This represents a 77 percent increase. One of our recommendations, for increase in the income assistance level in the Supplemental Security

Income program, will benefit both physically and mentally handicapped people; only the cost of the increase associated with the mentally handicapped population is included in the above estimate. Implementation of our recommendations is not inexpensive, but we believe it is necessary if Nevada is to achieve its official goal for the mental health and mental retardation service delivery system.

The fact remains that there are great unmet and inadequately met service needs of Nevadans with mental health disorders, mental retardation, and alcohol and drug abuse problems. It is up to Nevada to say how far it is willing to go in meeting those needs.

The full unabridged main text of this report, published separately as Rand report R-1800-FLF, *Mental Health and Mental Retardation Services in Nevada*, provides details and supporting data for our findings and recommendations.