MENTALLY RETARDED CHILDREN IN NEVADA: AN APPRAISAL

BULLETIN No. 47

Nevada Legislative
Counsel Bureau

DECEMBER 1960

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CARSON CITY, NEVADA

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FOREWORD

The Nevada Legislative Counsel Bureau is a fact-finding organization designed to assist legislators, State officers, and citizens in obtaining the facts concerning the government of the State, proposed legislation, and matters vital to the welfare of the people. The staff will always be non-partisan and non-political; it will not deal in propaganda, take part in any political campaign, nor endorse or oppose any candidates for public office.

The primary purpose of the Counsel Bureau is to assist citizens and officials in obtaining effective State government at a reasonable cost. The plan is to search out facts about government and to render unbiased interpretation of them. Its aim is to cooperate with public officials and to be helpful rather than critical. Your suggestions, comments, and criticisms will greatly aid in accomplishing the object for which we are all working--the promotion of the welfare of the State of Nevada.

PREFACE

During the 1959 Session of the Nevada Legislature, the Assembly adopted Assembly Resolution No. 18 which memorialized the Legislative Counsel to study methods of educating and training mentally retarded children. As a first step, the Legislative Counsel conferred with officers and members of the Nevada Association for Retarded Children and of the Nevada State Medical Association, with officers of the Nevada Department of Health, and with officers of the San Francisco Regional Office of the U.S. Children's Bureau, on how to execute the study. It was agreed that the study should be executed by the staffs of the Special Children's Clinics of the Nevada Department of Health in Reno and Las Vegas, under the direction of Dr. Samuel L. Ornstein, Senior Clinical Psychologist, and Mrs. Laura Lunn, Psychiatric Social Worker.

In order to provide information on whether mentally retarded children should be in institutions or educated as far as may be possible in conventional schools, it was necessary to execute a broad study. To estimate the need of an institution, it was necessary to determine whether there are methods that would reduce the incidence and prevalence of severe mental deficiency, the number of mentally retarded children in Nevada communities, the community facilities available as alternatives to custodial care, the quantity and quality of care at the Nevada State Hospital, and the school facilities currently and potentially available.

The study presents estimates of the number of mentally retarded children, the severity of their handicap, and discusses what is being done for them now in Nevada. The study includes the topics of prevention, diagnosis, medical and psychological treatment and handling, and education and vocational rehabilitation.

The Legislative Counsel Bureau gratefully acknowledges the valuable assistance of Dr. Paul McCullough, Clinical Psychologist, Mental Health Clinic, Las Vegas; Mrs. Helen Walsh, Social Worker, Special Children's Clinic, Las Vegas; Mr. Marvin Picollo, Director of Special Education, Washoe School District; Mrs. Margaret De Reemer, Secretary, Special Children's Clinic, Reno; Dr. Emmanuel Berger, Department of Health; Dr. Martin Levine, Department of Health; Dr. Sidney J. Tillim, Nevada State Hospital; Dr. Jules Magnette, Nevada State Hospital; Mrs. M. Kay Murphy, R.N., Nevada State Hospital; Mrs. Ethelda Thelan, R.N., Department of Health; Mrs. Mary Williams, R.N., Department of Health; Miss Dorothy Minnis, Public Health Nurse, Washoe County Health Department; Mrs. James Roberts, Reno; Mr. Howard Marr, Principal, Variety School, Las Vegas; Mr. Robert Cooper, Instructor, Variety School, Las Vegas; Mr. Selder, Department of Highways; Dr. Harold Skeels, Director, Community Service Bureau, National Institute of Mental Health; and Dr. Edith Sappington, Medical Director, San Francisco Regional Office, U.S. Children's Bureau.

Printed copies may be obtained without cost from the Nevada Legislative Counsel Bureau, Carson City, Nevada.

J. E. Springmeyer
Legislative Counsel

1959 SESSION, NEVADA LEGISLATURE

ASSEMBLY RESOLUTION NO. 18

By Committee on Public Health and Public Morals:

Memorializing the Legislative Counsel to make certain studies concerning mentally retarded children and to present a report relative thereto to the Fiftieth Session of the Legislature of the State of Nevada for consideration.

WHEREAS, The distressing problems of the mentally retarded have been the subject of many studies by numerous organizations and experts in the field of mental health; and

WHEREAS, The national average of enrolled school children appears to demonstrate that 3 percent of all such children are to a considerable degree mentally retarded; and

WHEREAS, According to this national average, there are approximately 1,700 mentally retarded children in Nevada; and

WHEREAS, This number of children may be divided roughly into 4 categories, namely: (1) preschool age; (2) trainable children; (3) educable children, and (4) children needing institutional care; and

WHEREAS, There is a divergence of opinion among interested persons in this field of study as to whether such children should be in institutions or educated as far as may be in our conventional schools; and

WHEREAS, The Legislative Counsel during 1952 executed a study of all types of handicapped children, of which study a considerable portion was devoted to the mentally retarded; and

WHEREAS, It appears wise to defer any legislative action until more information is available; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, That the Legislative Counsel is hereby memorialized to extend the mentally retarded children portion of the December, 1952, Legislative Counsel study of handicapped children to study the methods of educating and training such children in other states and to present a report relative thereto to the members of the Fiftieth Session of the Legislature of the State of Nevada.

CHAPTER I

BACKGROUND OF THE SURVEY

In recent years, the entire nation has shown increasing concern about the unmet problems and opportunities posed by children and adults who have intellectual limitations.

This increased awareness has taken place because of parent groups which have organized to promote the welfare of their children. On the national level the National Association for Retarded Children has served as a vehicle for coordinating and promoting studies of the cause, prevention, and treatment of this difficulty. On the state level, Nevada Council for Retarded Children has promoted educational and social programs in the area of mental deficiency.

At the request of the Nevada Council for Retarded Children, the Assembly of the Nevada Legislature in 1959 adopted Assembly Resolution No. 18, requesting the Legislative Counsel to extend the mentally retarded children's portion of the December 1952 Legislative Counsel Bureau study of handicapped children,[1] to study the methods of educating and training such children, and to present a report.

Survey to Be Conducted by Special Children's Clinics

Because the Special Children's Clinics of the Department of Health were two agencies in the state concerned with mental deficiency, and because they had the necessary professional staffs, it was agreed that the survey should be conducted by these clinics. The Board of Health consented to this arrangement, and the State Health Officer offered the services of the clinics on a one-day-a-week basis for this purpose.

Scope of Present Survey

In attempting to follow the directive of Assembly Resolution No. 18, it became obvious to the survey participants that an adequate study would have to cover a wide range of investigation in order to provide information on "whether children should be in institutions or educated as far as may be possible in our conventional schools."

To estimate the need of an institution, it must be determined whether there are methods that would reduce the incidence and prevalence of severe mental deficiency, how many mentally retarded there are in the community, what facilities the community has that are alternatives to custodial care, the quantity and quality of care at the Nevada State Hospital, and what school facilities are currently and potentially available.

For these reasons it was felt that this study should present an estimate of the number of children who are retarded, the severity of their hand-

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1 Survey of Handicapped Children in Nevada, Bulletin No. 18, Nevada Legislative Counsel Bureau: 1952.

lcap, and what is now being done for them. It should include the topics of prevention, diagnosis, medical and psychological treatment and handling, and education and vocational rehabilitation.

To this end we have made our study as comprehensive and detailed as possible within the confines of the time alloted to us by the Department of Health.

Goals of a State Program

A sound state program for the mentally retarded should involve the following considerations:

1. Humanitarianism. Any such program should be dedicated to the principle of helping the retarded to help themselves and to search for the causes of this disability, looking toward eventual eradication.

2. Economic Soundness. Money spent on services for the retarded should be reflected in actual tax dollars saved. Every child educated to assume a place in society lessens the cost of state institutions and welfare and correctional programs.

3. Social Expediency. When the problems of retarded children are neglected, the community suffers from the disruption of the family living.

Any program for helping retarded children should be based upon the belief that they need extra help so that they can approach equal opportunities with normal children. The objective is not to obtain normality or to transform those of limited capacity into scholars. The goal of any program for retarded children is to allow them to function as well as possible at their own level of intelligence and ability.

CHAPTER II

WHAT OTHER STATES ARE DOING

Introduction

Interest in the field of mental retardation has accelerated to an amazing degree in the last ten years. All states are doing what Nevada is now doing. They are re-evaluating their programs, critically examining the methods used, and attempting to solve their problems. The greatest interest appears to be in the field of education and in vocational education. Preventive research approaches have also become a major concern. In terms of institutional care, all states are re-evaluating their programs. There is much interest in the amazing chemical developments in the related field of mental health. With new developments in medicine, it is hoped that the rate of discharge of patients will increase. Family care is being used as another successful approach. This is defined to mean that the state assumes the cost for maintenance of a patient in a home other than his own.

California

Because of huge costs in custodial programs, California has approached the problem from several angles. A eugenics law was enacted, not only to prevent mental deficiency, but to ameliorate the social condition of the retarded female who would be unable to manage her affairs without this safeguard. Between 1909 and 1955, 7,500 sterilization operations have been performed in California. The value of this procedure, however, has been extremely controversial. Authorities have expressed the belief that if a person has been throughly evaluated, and it has been determined that this procedure will assist him in maintaining himself outside, the sterilization procedure is valuable.

Having used family care for mental patients since 1939, California began a similar program for the retarded in 1951.

Health services in California are provided both by the state and the counties, and they also have programs that are operated in cooperation with the federal government. Special diagnostic and neurological facilities inherent in the Children's Bureau, programs of prenatal, well baby and crippled children's clinics are well established and operating in most of the state.

In the field of education, California has devised a system which is composed of two categories, identified as Point One and Point Two, for the trainable and the educable child, respectively. These programs are permissive and are supported by the state. Additional support is provided to the local county for extraordinary expenses. The Point Two program is gradually becoming a part of the educational system in all counties in California.

Kentucky

Kentucky is of interest because of a recent legislative research com-

mission investigation of the problems of retarded children published in 1958. It is interesting that their general recommendations pointed out the need for: (1) intensive individual analysis, (2) well-supervised foster homes for those children who were or could be discharged from the training home but do not have suitable homes, (3) expansion of the special education programs, and (4) closer coordination should be effected in the program of the Kentucky training home with all state agencies, including the children's division, department of mental health, the universities and medical schools of the state, and the Kentucky State Department of Education.

Furthermore, they feel that a commission or coordinating council should assume responsibility for the development of both long and short range plans for services to the mentally subnormal of Kentucky. Diagnostic clinics, they felt, were vital and should be established, and the establishment of half-way houses for the mentally subnormal should be considered. These were considered by the legislature and were, or are in the process of being, enacted into law.

Nebraska

Nebraska's program affords interest because of the method of reimbursement for the expense of training the educable mentally handicapped. Between the years 1949-50 and 1953-54, Nebraska's program doubled in size. There were 211 children enrolled when the program was started in 1949; by 1953-54, 478 children were enrolled. Other programs set up at the same time showed a proportionate or greater growth: the home-bound program jumped from 60 children to 228; the program in speech therapy increased from 397 to 1,599.

The following is a statement of how cost of the program is to be handled: "Excess cost payments are made only to local school districts after claim forms are submitted showing that the regular pupil cost has been spent for each pupil. School districts assume total cost and are reimbursed at the end of this term from state funds. Reimbursement cannot exceed $400 for each physically handicapped child, or $100 for each educable mentally handicapped child per year. Due to the extensive need for services throughout Nebraska, it has been financially impossible to follow strictly the plan for per pupil reimbursement. For this reason, a plan for excess cost reimbursement established on the unit basis was developed. This was accomplished with the cooperative planning and agreement of local school officials. Under this plan, the amount of $3,000 per unit is paid on the basis of one teacher or therapist for at least 8 physically handicapped pupils. If less than 8 physically handicapped pupils attend a unit, payment is made on the basis not to exceed $400 per year per pupil."

Of note in this plan was the decision on the part of Nebraska that it would be financially impossible to follow an inflexible plan for per pupil reimbursement and that for this reason a method of excess cost reimbursement was developed through the cooperative planning of local school officials.

New Jersey

New Jersey, through a commission to study the problems and needs for mentally deficient persons published in 1954, has taken a very wide and critical look at all the problems of the retarded in the state. One of the principal

findings was that research is essential to a proper handling of this problem. New Jersey had recently established a Bureau of Research in the Department of Institutions and Agencies. It was the feeling of this group that "The legislature should allocate an amount equal to or at least 5% of the total annual budgets of the institutions for the mentally deficient, the mentally ill, and the emotionally disturbed for the use of the Bureau of Research."

New York

As a matter of historical observation, the first American family care program exclusively for the mentally deficient was initiated in New York in 1933 by the Newark State School at nearby Ballworth, a pleasant village of some 300 population about 17 miles distant. For a number of years the City of Rochester had boarded homeless children there so that the idea of boarding homes was not new. The Newark Program, often described as "American Geel in miniature" (see Appendix "J"), started with school-age children.

Summary

One can say after looking at the programs in a number of the states that everyone is quite concerned over the expense, not only of the program involved, but the expense of not having the proper programs for the prevention and amelioration of this difficulty. Of special note is the great enthusiasm for the use of proper research techniques, the flexibility with which various kinds of programs are being used as alternatives to institutionalization, and the vast range of optimism which is typified by new approaches to these problems.

CHAPTER III

A REVIEW OF PREVIOUS FINDINGS IN NEVADA

Survey of Handicapped Children in Nevada, December 1952

The 1952 survey of handicapped children executed by the Nevada Legislative Counsel Bureau included the area of mental deficiency as one of its sub-categories.

It was primarily concerned with educational problems and used a classification which divided the intellectually sub-average into three groups: (1) slow learners; (2) mentally retarded; (3) feeble-minded. These categories were defined in terms of intelligence quotients (I.Q.'s). The "slow learners" were children with I.Q.'s ranging from 75-89. It was estimated that this included 20 to 25% of the school population. "Mentally retarded" ranged from an I.Q. of 50 to 70, and "feeble-minded" were those with I.Q.'s below 50.

There was little to report in the way of services specifically for the retarded because very few services were then available. A census of all handicapping conditions was taken, and requests were sent to professional people and agencies in the state asking for the number of handicapped children whom they knew.

A total of 646 mentally sub-average children were reported in the following categories:

Slow learners	354
Mentally retarded	225
Feeble-minded	67

These figures do not appear to be valid. The category of "slow learner" had been defined in the 1952 survey as including 20-25% of the school population and yet it is roughly only 1/3 higher than the category of "mentally retarded."

The "mentally retarded" group, if the Weschler Intelligence Scale for Children[1] is used as a measure of the I.Q. range, 50-70, would include less than 2.2% of the general population. Obviously there is a tremendous difference between the actual quantitative relationship of these two groups and the relationship found by the survey.

It is questionable whether the group "slow learners" can be truly considered as a "handicapped" group at all. This would be analogous to terming the 25% of the school population who were the slowest runners as "cerebral palsied."

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1 Revised Weschler Intelligence Scale for Children: Manual-Psychological Corp., New York.

Recommendations

Recommendations of the survey were excellent and mainly concerned with changes in the School Code.

Most of the recommendations were enacted by subsequent legislatures. These recommendations defined, for educational purposes, the meaning of "handicapped child," provided for their education in the school system, allowed for the transfer of handicapped children from one district to another, provided increased "Average Daily Attendance" support from the state. In addition, it established an optional minimum age level for entrance to school of 3 years for children. It provided for teaching hospitalized children and children confined to their homes for medical reasons.

The survey also pointed out the need for in-service training for teachers and the need for special certification of teachers in the area of special education.

Mentally Retarded

The following recommendations were made concerning the intellectually handicapped:

> The comparatively high percentage of mentally handicapped cases reported makes a mental testing program mandatory to determine the true causes underlying these cases. A program of testing by trained professional personnel is prohibitive at present; however much of the testing can be done on the local district level. All of the larger school districts can arrange means of roughly screening sight and hearing defectives. Many districts could find teachers who have had courses in tests and measurements with training in giving mental tests, and who could give standard intelligence tests. Thus a rough screening could be made.
>
> For a more detailed testing, children who appear to have defects as a result of the tests in the schools must be referred to professionally trained personnel. Children with low mental capacity as a result of the school test should be examined by psychologists or psychiatrists.

This recommendation discusses only the first step in a program for the retarded--their location and diagnosis. So limited were the facilities present in 1952 that this minimal standard had not been met.

CHAPTER IV

SPECIAL PROBLEMS IN MENTAL DEFICIENCY

Problem of Definition

One of the greatest sources of confusion in the care of mental deficiency is the difficulty in properly defining the term. Depending upon the inclusiveness of one's definition, one can conclude that 25% of the school population are retarded (as was done in the 1952 Nevada survey of handicapped children), or as little as 3/10 of one percent of the general population are defective.

The four most common criteria used in defining mental deficiency make use of statistical, social-adjustment, developmental, and academic factors.

1. Statistical

A person is defined as "defective" if he is beyond certain statistical limits arbitrarily placed upon a distribution of cases. Thus, on the Weschler Intelligence Scale for Children, the following classifications are given:

I.Q.	Classification	Percent of General Population
130 and above	Very Superior	2.2
120-129	Superior	6.7
110-119	Bright Normal	16.1
90-109	Average	50.0
80-89	Dull Normal	16.1
70-79	Borderline	6.7
69 or below	Mental Defective	2.2

The above classification, a statistical definition, follows the "normal curve" and is a symmetrical grouping around the average score. Such a system of classification is easily understood. I.Q. and percentages are unambiguous. They enable people to be classified and they seem to offer a certain objectivity and scientific exactness to the problem. However, the difficulty is that the I.Q. is rarely a stable number, especially in early childhood. Intelligence tests are heavily influenced by cultural and social factors as well as by educational background. In addition, there are many kinds of intelligence tests which often do not give comparable scores and which have varying degrees of reliability and validity.

2. Social Adjustment

This criterion asks a qualitltave question--can the individual manage his affairs with prudence and foresight?

The great advantage of this criterion is its "common sense" approach. If a person can support himself economically and socially in a prudent manner he is not intellectually deficient; if he cannot, he is defective. This criterion is social in nature and is the one conventionally used when judging adults. It is most difficult to use in childhood because the factors involved are harder to judge.

This criterion is lacking in the opinion of some because it is easily influenced by non-intellectual factors. Someone might not be able to conduct his affairs prudently in a large metropolitan area but might be able to do so in a simpler, less complex, rural community. Thus, non-personal situational factors take on great importance.

3. Developmental

This criterion is the one most commonly used in early childhood. It defines mental deficiency in terms of a slower acquisition of the skills of "self-help," e.g., walking, talking, feeding oneself, and other manifestations of sensory-motor development. One difficulty of this criterion is that it is heavily affected by motor difficulties--cerebral palsy, sensory loss, malnutrition. It also becomes less and less valuable in later life.

4. Academic

Once a child enters the school system, the standard of intellectual adequacy is seen in terms of the adequacy of his academic work. If he doesn't keep up with his classmates in reading, writing and arithmetic he will soon be considered intellectually defective. Because of the special nature of the school environment, this "labeling" may not be true in terms of the child's potentiality for holding a job and successful living after he has left the school situation. Nevertheless, this standard is important and provides, in most cases, the first recognition on the part of the community that the child will need special attention.

Definition

The definition which will be used for this survey will be the one accepted by the American Association on Mental Deficiency as stated in their monograph of September 1959, "A Manual on Terminology and Classification in Mental Retardation."

> MENTAL RETARDATION REFERS TO SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING WHICH ORIGINATES DURING THE DEVELOPMENTAL PERIOD AND IS ASSOCIATED WITH IMPAIRMENT IN ONE OR MORE

OF THE FOLLOWING: (1) MATURATION, (2) LEARNING, AND (3) SOCIAL ADJUSTMENT.

The Criterion Used Changes with the Age of the Child

The difficulty in making an accurate estimate of the frequency of mental deficiency in the general population is the changing importance given to various definitions of mental deficiency at different ages. In the preschool ages, the diagnosis of mental deficiency is almost completely based on physical development. If the child is showing some delay in walking or talking, or shows a discrepancy between his physical development and that of his peers, he is suspected of subaverage intellectual functioning. After the child enters school, the criterion is one of academic attainment. That is, how the child is doing in competition with others in school--is he able to maintain his scholastic achievement and show improvement in academic skills? If there is a discrepancy between his academic behavior and that of his classmates, the child may be considered retarded. Once a child is out of school and has reached adult status, the criterion then becomes one of social competency. An adult, regardless of how deficient in school or how delayed in maturation, if able to maintain himself in the community without concern to the social agencies and the general community, and if he can earn a living and maintain himself with some measure of competency, will not be considered to be retarded but only less intelligent than the other members of the community. He would not and should not be considered as intellectually defective since he is not socially defective.

The Range of Mental Retardation

All categories which are used to separate one group of the retarded from another are arbitrary. Mental retardates do not fall into 3 or 4 discrete groupings. Intelligence is continuous and one group merges into another without really being groupings at all.

Mental deficiency is analogous to other biological measures as weight and height. We can divide people into "tall, average, and small" stature. However, the exact demarcation between one group and another is artificial. What might be "small" in American society would not necessarily be considered "small" in Japanese society because of the difference in the overall group. A height considered "tall" for a woman is not considered "tall" for a man.

In mental deficiency, categories are made for the sake of convenience and simplification so that people can be classified for various academic and social reasons.

Examples of Different Categorizations

The categorization used by The American Psychiatric Association[1] states:

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1 Diagnostic & Statistical Manual on Mental Disorders of the American Psychiatric Association.

The degree of intelligence defect will be specified as mild, moderate or severe, and the current I.Q. rating, with the name of the test used, will be added to the diagnosis. In general, mild refers to functional (vocational) impairment, as would be expected with I.Q.'s of approximately 70 to 85; moderate is used for functional impairment requiring special training and guidance, such as would be expected with I.Q.'s of about 50-70; severe refers to the functional impairment requiring custodial or complete protective care, as would be expected with I.Q.'s below 50. The degree of defect is estimated from factors other than merely psychological test scores, namely consideration of cultural, physical and emotional determinants, as well as school, vocational and social effectiveness.

The Nevada school system classifies the intellectually subaverage into:

1. Educable
2. Trainable
3. Custodial

"Educable" means that the child can benefit from a modified academic program. He requires a "reduction in quantity and scope from the curriculum for regular grades, also method to allow the Special Class leader more time for drill in basic school subjects. ". . .It is for use with pupils who have I.Q.'s ranging from 50 to 79."[1]

Minimal definitions as a trainable child are given as:

Physical Condition a child must:

1. Be able to hear spoken connected language and be able to see well enough to engage in special class activities without undue risk, excepting those children enrolled in classes for the blind or deaf;

2. Be ambulatory to the extent that no undue risk to himself or hazard to others is involved in his daily work and play activities;

3. Be trained in toilet habits so that he has control over his body functions to the extent that it is feasible to keep him in school.

Mental, Emotional, and Social Development a child must:

1. Be able to communicate to the extent that he can make his wants known and to understand simple directions;

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1 A Curriculum Guide: The Educable Mentally Retarded: 1958 State of Nevada Department of Education.

2. Be developed socially to the extent that his behavior does not endanger himself and the physical well-being of other members of the group;

3. Be emotionally stable to the extent that group stimulation will not intensify his problems unduly, that he can react to learning situations, and that his presence is not inimical to the welfare of other children.

The Guide goes on to state:

> The provisions of the statutes and the standards prescribed by the Department of Education and the State Board of Education are aimed toward the best training and education for the handicapped child commensurate with his needs and ability. While the law does not specify standards in this connection, it is evident the legislation is to provide for the education of those pupils whose I.Q. is above 20 but below 50.[1]

As indicated, the psychiatric and educational attempts at categorization are somewhat similar but differ in terms of the I.Q. scores used and the social or educational standards desired--the differences being attributable to the varying purposes for which the classifications were meant to be used.

Comparison Between Typical and Atypical Children

It should be pointed out that a retarded child may be more similar to a normal child than to another intellectually subaverage child. To his friends and acquaintances a child of "mild" deficiency may be quite indistinguishable from a normal child. Indeed, he will have a greater similarity to the average child than to a retarded child who is severely deficient and who cannot talk, walk, or feed himself.

Mental Deficiency Is a Generic Term not a Disease Entity

"Mental defective," or any similar term, does not describe a homogeneous illness or defect with similar causes and outcomes but rather is a lumping of many different disorders on the basis of one symptom.

It is analogous to the symptom "fever." One can have a fever because of measles, an automobile accident, an emotional upset, malaria, or any one of numerous conditions. In the same way, one may be intellectually subaverage because of birth injury or poor care; because one's mother had German measles during early pregnancy or had an unfavorable Rh factor. One can be intellectually subaverage because of a limited and a deprived intellectual, emotional, and social environment.

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1 A Curriculum Guide: The Trainable Mentally Retarded: State of Nevada Department of Education.

Mental deficiency does not suggest a cause, it only states the intellectual functioning of the person. It is descriptive of one facet of the person at a given place and at a given time.

Popular Misconceptions Concerning the Retarded

1. Mentally retarded must be placed in institutions.

FALSE. There are roughly 1,500 children in Nevada who are subaverage intellectually. We have 60 in institutions. Professional people now realize that custodial care is necessary and beneficial in only a small percentage of the retarded.

2. They have greater "criminal tendencies."

FALSE. Criminal tendencies are no greater among the retarded than among people of normal intellect.

3. Sex delinquency and mental retardation are related.

FALSE. Roughly, the greater the degree of mental retardation the less intense is the sex drive. The most severely retarded by the nature of their disability are usually incapable of sexual activity and procreation.

4. "Insanity" and intellectual deficit are similar and go together.

FALSE. There is little relationship between intellectual retardation and severe mental disorders.

5. The future is hopeless if a child is retarded.

FALSE. Prognosis for successful living is very good in many cases of retardation and much better than in some other chronic illnesses.

CHAPTER V

CAUSES OF MENTAL DEFICIENCY

The general public has long believed that a child is mentally deficient for either of two reasons. First, is the belief that intellectual deficiency is a result of a head injury sustained in a fall. Second, is the assumption that all mental defectives are so because of heredity. While both the factors of brain trauma due to accidents and brain disfunction due to genetic factors are known and involve a certain proportion of the population of retarded, they have less significance than generally assumed. The feeling of shame and embarrassment that parents experience when they have a retarded child is due to such misconceptions. It perpetuates the idea that the poor functioning and poor attainment of the child are attributable to the parents because they have transmitted something undesirable to the child. This intensifies the pervasive idea that the parents are responsible for the child's condition and are being punished for their "sins" by this "act of God." Somehow, too, the assumed "hereditary" origin of mental deficiency appears to many people to absolve them of any necessity for treating or correcting the difficulties. "Hereditary" mistakenly has the connotation of a hopeless condition beyond medical correction.

It has been indicated in the previous chapter that mental deficiency is not a disease or illness, but a more general term describing a great many different conditions with this one symptom in common. Dr. Herman Yannet, Medical Director of the Southbury Training School, states:

> Well over a hundred different etiologies, diseases and syndromes have been described in which mental retardation represents a more or less important symptom. Most of these, however, are extremely rare, some to the point of being considered medical curiosities. About twenty percent are encountered with sufficient frequency to have practical importance.[1]

These causes can be fitted into two major categories: those of a medical nature and those which are of a psycho-social nature. However, people who are retarded usually suffer from a combination or interaction of these causes.

Medical Causes of Mental Deficiency

This category can be divided into three groups on the basis of the time of occurence of the injury. These are the prenatal, paranatal, and postnatal periods.

Prenatal: Injuries of a prenatal nature are of two kinds: those relating to genetic factors and those due to a malfunction in development that occurs after conception but before birth. Genetic causes, which are due to a mutant or recessive gene, are extremely rare. The Special Children's

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1 The Evaluation and Treatment of the Mentally Retarded Child in Clinics: National Association for Retarded Children: New York 1956.

Clinic in Reno, after seeing approximately 400 patients, has found less than five cases which are considered to be due to a recessive gene. It must be kept in mind, however, that the children seen in Special Children's Clinic are usually more severely ill than the ones seen at an older age. There is a second genetic factor which comes into greater prominence within the familial or "garden variety" group of mental deficients. This is the group which is of borderline or mild mental deficiency. Of this group it has been said by Dr. Seymour Sarason:

> The familial or "garden variety" of mental deficiency is the largest sub-group with which we have to deal. Discussions on the etiology of these cases have been based on the relative importance of heredity and environment. I am of the personal opinion that heredity is a factor in determining adaptive capacity of an individual. Having said this, I would like to make clear that such a belief does not at all justify attributing the present level of functioning to genetic factors. One could point to many conditions in which the genetic factor is known but where the range of effect of that factor is large. Because a child and parents get low test scores does not permit us to conclude that the child's current level of functioning is a function of genetic factor. Put another way, we cannot conclude in such case that the current level of functioning is the upper limit imposed by the genetic factor, regardless of the psychological and cultural factors at work.

Other prenatal factors, which are noted to be more common at the Special Children's Clinic, are those having to do with damage which takes place before birth but which is not genetic in origin. The best example of this is a mother, who, by contracting German measles in the first trimester of her pregnancy, has an increased statistical chance that her child will be born defective. Another cause is prenatal maternal pelvic x-ray irradiation - a condition which was more common in the early 1920's and is rarely seen now. It is caused by excessive use of pelvic x-rays on a woman during early pregnancy. Other types of prenatal damage are endocrine disorders which may occur and certain kinds of cerebral injuries. Most prenatal causes of later deficiency are undeterminable, and there is extensive research which suggests that these are dependent upon nutritional and other factors of general health.

It must be pointed out here that an appreciable amount of the "severely retarded" and "mildly severely retarded" children are so afflicted because of prenatal injury. This is often related to the general health and care of the mother. Recent research indicates that these ailments can be reduced by more and better prenatal care under medical supervision. Our best hope for preventing retardation due to prenatal causes is by the proper care of the mother during her pregnancy--adequate nutrition, adequate physical and mental status. General improvement of the care of the pregnant woman would be the most efficacious way of limiting the number of children suffering damage because of prenatal malfunctions.

Paranatal: Less frequent than the general population assumes, but still an important cause of injury is trauma caused by the birth process. Listed in this category are anoxia at birth; i.e., the child's supply of oxygen fails

because of prolonged labor or because the cord is wrapped around the infant's neck, as well as other damage due to the pressures and strains associated with the process of birth. Also, in this group are injuries due to the Rh factor. Recognition of these factors is one of the striking improvements that have been made in recent years in the prevention of mental deficiency. Ten years ago the process involved was not understood; since that time, the cause of this disorder, and its treatment, have been worked out with some detail. At present, a mother who has Rh negative blood and whose child is Rh positive need not give birth to a damaged child. Medical science has devised means of preventing the occurrence of damage in many of these children. Of course, in order to prevent this damage, adequate medical facilities in terms of proper obstetrical wards, techniques, nurses, and physicians trained in the procedures must be available. It is pointed out by Dr. Yannet that "A high incidence of associated neurological abnormalities like cerebral palsy and convulsive disorders are found in this group." Here too, the best assurance of a reduction in birth injuries is the proper care of the mother by a competent obstetrician who is aware of the problems attendant at birth and who can take corrective steps.

Postnatal: Postnatal conditions which cause mental deficiency are diseases of the central nervous system such as meningitis and encephalitis, trauma due to various accidents in infancy, accidental poisoning by lead or carbon monoxide, high fever, and many other kinds of trauma which are scattered in many various disease categories.

In summary, we can say that the medical cause of mental deficiency is extremely varied and involves more than one hundred categories; it extends from the point of conception to the postnatal period and many of the origins of prenatal damage are unknown and their processes poorly understood. The best way of approaching these problems from a medical standpoint is by good general medical care which has as its aim the proper physical and emotional status of the mother and child.

Environmental, Psychological and Social Causes of Mental Deficiency

In recent years it has become increasingly clear that social and psychological factors are of great importance in the etiology of mental deficiency. This is expecially so in the milder phases of mental deficiency, and may even be the predominant cause in cases of borderline malfunction. A common stereotype of the public is the assumption that a child is not "really" mentally deficient unless he has organic brain damage. It has been revealed time and again, however, that children who have suffered from severe types of environmental, social, and psychological deprivation become retarded and show a degree of retardation with as long an effect as those with organic damage. Dr. Lemkau, a specialist in the epidemiology of mental deficiency, states that because of the early tendency in the United States of explaining all mental deficiency in terms of genetic factors, there was very little interest in the psychological and sociological factors involved in mental deficiency. However, he says that there were "constantly appearing cases that would not abide by the rule that 'once a mentally deficient, always a mentally deficient.'"[1] This led to the idea that there were cases in which functional

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1 The Evaluation and Treatment of the Mentally Retarded Child in Clinics: National Association for Retarded Children: New York 1956.

changes interfered with the revelation of capacities. These cases were called by various names--notably "pseudo-feeblemindedness." In some cases, dynamically-oriented treatment procedures "cured" such cases and resulted in a distinct rise of test mental age.

> Research contributed greatly to the return of interest in mental deficiency as a functional state rather than a fixed condition. The net result of this work is a generalization, now widely accepted, that unless the young child received adequate stimulation at appropriate times, certain capacities will not develop and, if stimulation is too long delayed, the capacity may atrophy and disappear, not again to be reclaimed. This concept has received a great deal of support in recent experiments.[1]

To summarize many of the findings in this area, it has been established that an infant who has not received proper care, who has not been treated with love and affection, who has been moved from one foster home to another, who has been treated in a hospital or institution for long periods with aseptic nursing care and without the constant attention of a warm, stable, affectionate person, shows changes in character, personality, and intellectual status with a regression in intellectual factors which may be severe, and which often are permanent in nature if corrective procedures are not instituted. Thus, it has been proven that the intellectual status of a child depends upon receiving the proper love, affection, guidance, and care in these extremely important early years. There are other factors which are not as obvious in their effects as the ones just mentioned, but which, nevertheless, account for many of the intellectually inadequate people that we see. If one takes a group of people living in a remote area, who are a distance from any center of population with no access to libraries or the stimulation of good schools, who come from another culture and speak another language, who are nutritionally impoverished, and whose attitudes are not those of the middle-class Americans, one will find they will show a progressive decline in intelligence test scores with age. As Dr. Lemkau points out:

> Mental deficiency is found to be more common in the lower socio-economic groups of the population. Indeed, many have viewed this fact with alarm because they associate it with data showing that such groups of the population tend to reproduce disproportionately rapidly. This lends weight to the conclusion that the general average rate of the intelligence of the population will fall. Indeed there are some who produce evidence that this is actually taking place. It is, however, also true that the lower socio-economic groups have less opportunity for their full development of intellectual capacities since they are likely to have inferior as well as frustrated educational opportunities throughout their lives, both in school and in their families. If our intelligence tests were completely "culture free" this might control the factor of

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1 Ibid.

> educational opportunities, but even with the best test there would remain the factors of motivation and interest which would operate less in the homes of people who have had little opportunity to develop intellectual curiosity. It is this set of factors which has led to much of the material on the superiority or inferiority of certain racial groups, differences easily assumed to be of racial-hereditary origin but more and more frequently shown to be due to differences in opportunity and motivation as more careful longitudinal studies are designed.[1]

It must also be pointed out that psychological factors are involved in even those children who come from well-established homes of upper middle-class origin. The child may, because of the way he is handled, develop severe emotional disturbances which make him less adequate in meeting the needs of his society. His problems are reflected in lowered grades in school and in a lowered interest in the world around him. The child, although physically in an environment of a stimulating nature, does not utilize this stimulation and shows a depression in his intellectual function.

One thing that is increasingly clear from the research in the field of mental deficiency is that, while subnormality was once considered to be a rather simple problem caused by heredity and immutable to therapy or change, the attitude now is that mental deficiency is a complex, many-faceted problem, the etiology of which is varied and often unknown; but which is a functional state dependent upon both the environment and body of the person. Often the prognosis is not poor. Changes can be made in intellectual status and in functioning to such a degree that therapeutic procedures are not only possible but often strongly advisable. As Dr. Lemkau says: "Mental deficiency is now a very lively and productive field for research and treatment."

Advances have been made in the prevention of mental deficiency through medical science; advances have been made for the correction of mental deficiency through psychological and educational techniques; and mental deficiency has been re-evaluated in terms of its heterogeneous nature, its range and its social nature. In addition, new methods of treatment have changed the area from one of professional unconcern and defeat to one in which there is a great feeling of hopefulness.

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1 The Evaluation and Treatment of the Mentally Retarded Child in Clinics: National Association for Retarded Children: New York 1956.

CHAPTER VI

A CENSUS OF MENTAL RETARDATES IN NEVADA

How many retardates are there in Nevada? What is their degree of defect? What must be the scope of facilities to adequately serve the needs of the state?

In an attempt to answer these questions, a census of known retardates in Nevada was conducted by the authors of this study.

How was the Census Conducted?

The information sheet on the following page was distributed to every known professional person who ordinarily comes in contact with children. This group included every school teacher, physician, osteopath, public health nurse, clinic, and welfare worker in the state.

In addition, the Nevada State Hospital, the Nevada Children's Home, the Nevada School of Industry, the Stewart Indian School, and the United States Public Health Service facilities in the state were contacted.

Varying rates of returns were received. The returns from most institutions, the educational system, the welfare services, and the Health Department clinics were nearly 100 percent; returns from physicans and osteopaths were approximately 10 percent.

It is impossible to estimate with complete accuracy the number of children who were not included in the reports. The greatest possibility of overlooking children would be in the age groups under 6 and over 16 who were not in school.

We reiterate that the criterion of mental deficiency changes with the age of the child. Before school age, he is judged on the basis of motor development; during his school years, the criterion is his academic performance; and after school, social and economic adequacy prevail in making judgment. This means that at varying ages we find a varying prevalence rate. On the basis of internal indices such as the quantitative relationship of one "level" to another, the number of children not attending school that have been counted, and the wide distribution of the questionnaires, it is believed that a good proportion of cases were reported.

The validity of the estimate of intellectual level is dependent upon the competency of the respondents, all of whom are college graduates and specialists in some area relating to children. However, the exactness of the rating of degree of deficiency must await further statistical analysis.

All the findings are given in absolute numerical terms. Prevalence data would have been preferable, especially since the 1960 census was being conducted at the same time as this study. However, the official results of the 1960 census were not available in time to be used in this report. For this reason, a more detailed prevalence study of mental deficiency in Nevada is planned for a future date.

Findings

(SEE TABLE 1.) Eight hundred and fifty-six of the recorded retardates are congregated at Level IV and above. These are the children with an excellent chance for economic and social self-sufficiency in adulthood.

Intellectually handicapped children are usually first recognized in school (note numerical increase at age 6) and continue as problems until they are approximately 15 or 16 years old, leave school, and are probably absorbed by the economic community.

Intellectual problems are recognized quite early in a substantial number of children. One hundred forty-four at 5 years of age and under are noted.

(SEE TABLE 2.) Males are more frequently suspected of retardation than females. The difference at Level I and Level II is small: 131/95, but at Level V, there are two boys for every girl listed. Assuming there is little difference in the proportion of organically damaged children by sex, one must interpret this to mean that boys, because of their personality characteristics--a lack of docility and need for an aggressive rather than passive role and other social factors--are more commonly considered by the community as intellectual problems. Girls avoid the impression and the fact of retardation through social devices which are compatible with the feminine role. This suggests the increasing importance of non-intellectual factors in determining whether a child will be viewed as a retardate.

(SEE TABLES 3, 4 and 5.) The great majority of retarded children are handled by the school system; e.g. at age 11, of 130 retardates located, only 11 are not in school.

Most retarded children are handled in the regular classroom. Of 1057 children in school, 725 are in regular class.

Multiple failures as a method of handling retarded children are common, sometimes to an absurd degree; e.g., one 16-year-old is in the third grade, one 18-year-old is in the fourth grade.

Even at a very low level of intellectual status--Level II--two-thirds of the children between 6 and 16 hears of age are in school.

At Level III--a degree of deficiency which precludes academic learning beyond the fourth grade level--four-fifths of the children are in school. One-half of these children are being handled in regular classrooms--a situation suggesting a strong need for additional special education facilities.

(SEE TABLE 6.) Without exact census data to determine prevalence rates, it would appear that the number of retardates closely parallels the number of people in each county.

It appears that only four counties have too few retarded children to support a special education program for mentally retarded alone under present regulations.

SPECIAL CHILDREN'S CLINIC
WASHOE MEDICAL CENTER
Reno, Nevada

The informant is asked to list each case he knows of mental retardation or suspected mental retardation. Any question which you cannot answer should be marked "UK" for unknown. Do not leave any question unanswered.

If you don't know a retarded child, fill out the questionnaire anyway, answering items A, O, P and R. Use as many questionnaires as necessary.

It is necessary that the child's name be listed so that duplicate forms may be eliminated. However, all names will be handled by the Special Children's Clinic as confidential medical information. The names will be destroyed when no longer needed.

If a child has been in school but has dropped out or has been expelled within the last 2 years, please make a card for him. If you know of a child who has never been in school because of mental retardation, make a card for him.

This information will be used for research on the health problems of Nevada. It may lead to better facilities for the handicapped child.

Five levels are given which serve as a gauge of the severity of the child's handicap. This is a rough rule of thumb. We want your estimate even though we realize how difficult it is to judge.

These five levels are defined as follows:

	Pre-School Age 0–5 Maturation and Development	School Age 6–18 Training and Education
Level I	**Gross retardation; minimal capacity for functioning in sensori-motor areas; needs nursing care.**	**Some motor development present; cannot profit from training in self-help; needs total care.**
Level II	**Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.**	**Can talk or learn to communicate; can be trained in elemental health habits; cannot learn functional academic skills; profits from systematic habit training.**
Level III	**Can talk or learn to communicate; poor social awareness; fair motor development; may profit from self-help; can be managed with moderate supervision.**	**Can learn functional academic skills to approximately 4th grade level by late teens if given special education.**
Level IV	**Can develop social and communication skills; minimal retardation in sensori-motor areas; rarely distinguished from normal until later age.**	**Can learn academic skills to approximately 6th grade level by late teens. Cannot learn general high school subjects. Needs special education particularly at secondary school age levels.**
Level V	**Borderline—Cases in which intellectual and social handicap is of such a nature that it is questionable whether child is retarded or dull-normal.**	**Borderline—Cases in which intellectual and social handicap is of such a nature that it is questionable whether child is retarded or dull-normal.**

CONFIDENTIAL MEDICAL INFORMATION

A. I know a retarded child Yes ☐ No ☐ (If your answer is No, skip to item O.)
Name of child.....

B. Age at last birthday.....years.

C. Sex: ☐ Male ☐ Female

D. Race: ☐ White ☐ Negro ☐ Indian ☐ Other

E. Place of birth.....
(Town) (State)

F. Residence: Name of city, town, or rural place.....
Name of county.....

G. Is child enrolled in school at present time?
☐ Yes (name of school).....
☐ No (give reason).....
☐ Unknown

H. If child is not now in school but has been in past
a. At what age did he start?.....
b. At what age did he stop?.....

I. Grade placement.....

J. Were group or individual intelligence tests given?
a. ☐ Yes (list three most recent) b. ☐ No (skip to question K)

	Date	Name of test	Score
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....

K. Is child now in residential institution?
☐ Yes (give name of institution).....
☐ No

L. Estimate level (see explanatory letter)
☐ Level I. ☐ Level II. ☐ Level III. ☐ Level IV. ☐ Level V.

M. Check at least one of the following reasons for your opinion:
a. ☐ Yes ☐ No Psychological tests.
b. ☐ Yes ☐ No Inadequate academic performance.
c. ☐ Yes ☐ No Social immaturity.
d. ☐ Yes ☐ No Evaluated by Mental Health Clinic.
e. ☐ Yes ☐ No Evaluated by Special Children's Clinic.
f. ☐ Yes ☐ No Evaluated by school psychologist.
g. ☐ Yes ☐ No Other (list if yes).....
.....

N. Does child have additional physical handicap? (Speech impediment, visual handicap, hard of hearing, cerebral palsy, epilepsy, etc.)
☐ Yes (state).....
☐ No

O. Profession of person filling out this form.....

P. Employed by.....

Q. How long have you known child?.....

R. Your name or initials.....

S. Comment (any other unusual social, medical, psychological or educational information)

TABLE I

NUMBER OF CHILDREN BY AGE & LEVEL

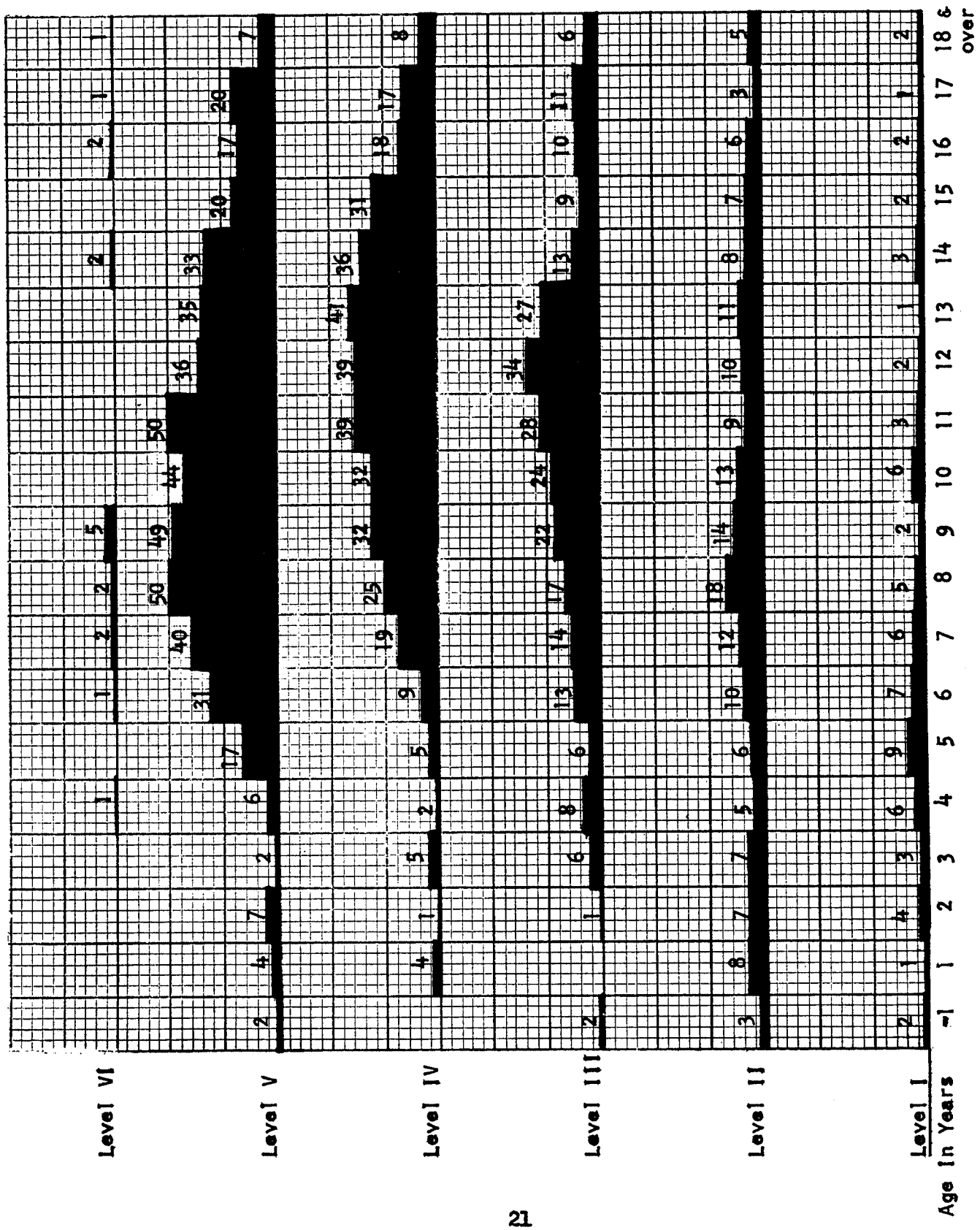
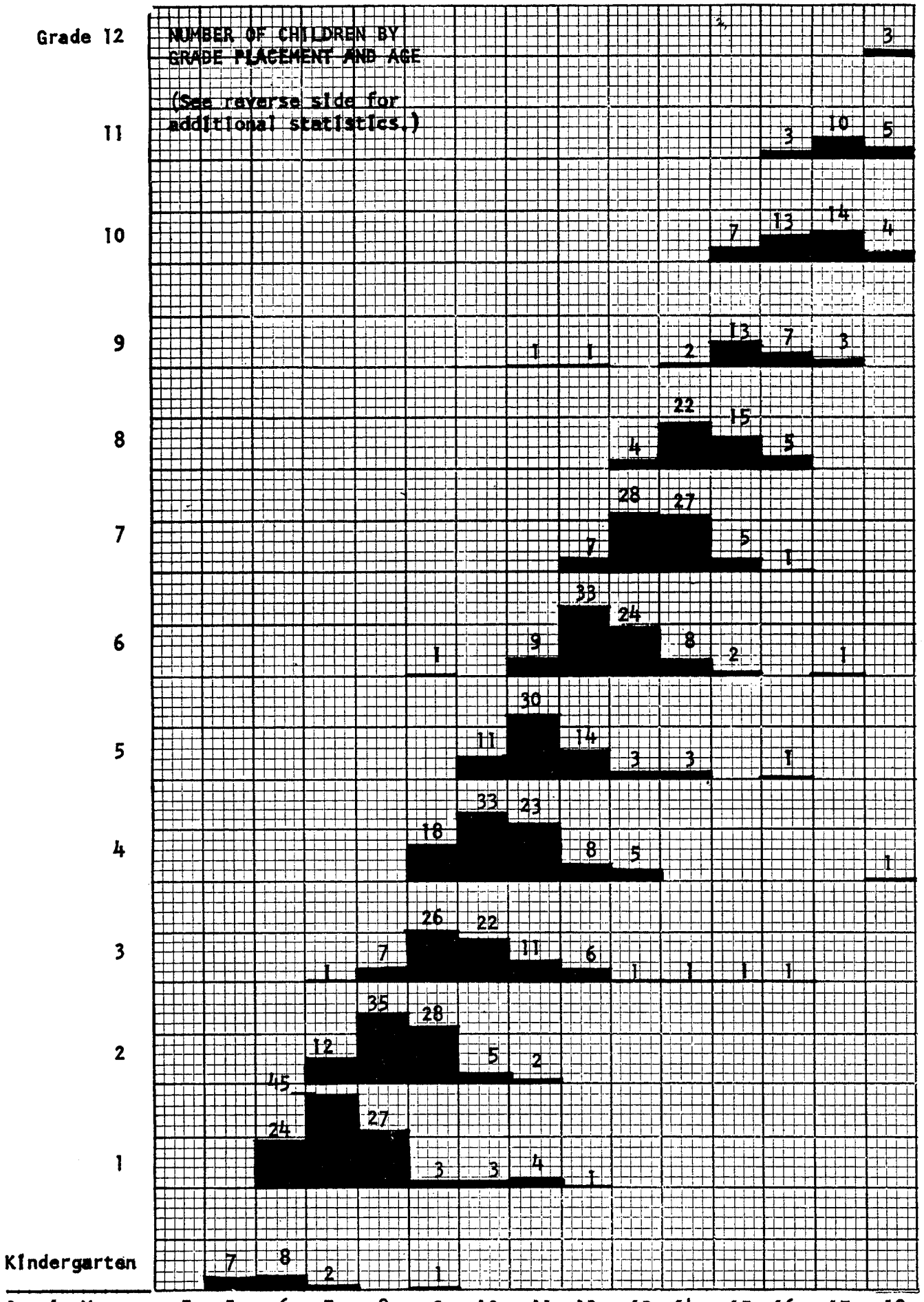


TABLE 2

NUMBER OF CHILDREN BY SEX AND LEVEL

	MALE	FEMALE	TOTAL
Level unknown	12	7	19
Level I	41	26	67
Level II	91	70	161
Level III	165	84	249
Level IV	247	109	356
Level V	331	158	489
	887	454	1341

TABLE 3


NUMBER OF CHILDREN BY GRADE PLACEMENT AND AGE
(See reverse side for additional statistics.)
Grade 12
11
10
9
8
7
6
5
4
3
2
1
Kindergarten
Age In Years
-5 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Number of children not in school - 244

Number of children in special classes - 332
(By far the greatest portion of these - 229 - are from 8 through 13 years of age, with very nearly equal numbers in each age group.)

Unknown or unstated - 69

Total in regular school system - 712

TABLE 4

SCHOOL ATTENDANCE OF CHILDREN AGE 6-16 BY LEVEL

	IN SCHOOL	NOT IN SCHOOL	UNKNOWN
Level unknown	10	3	
Level I	5	32	2
Level II	78	35	5
Level III	194	14	3
Level IV	305	8	8
Level V	381	12	12
	973	104	30

TABLE 5

NUMBER OF CHILDREN IN SCHOOL BY LEVEL AND PLACEMENT

	SPECIAL	REGULAR	TOTAL
Level unknown	4	7	11
Level I	3	2	5
Level II	55	29	84
Level III	102	106	208
Level IV	91	233	324
Level V	76	339	415
	331	716	1047

TABLE 6

NUMBER OF CHILDREN BY COUNTY AND LEVEL

	Total	Level unknown	Level I	Level II	Level III	Level IV	Level V
Co. unknown	6	-	1	2	1	-	2
Churchill	64	3	-	6	10	15	30
Clark	539	9	32	79	104	138	177
Douglas	13	-	-	1	6	5	1
Elko	35	-	3	3	7	14	7
Esmeralda	-	-	-	-	-	-	-
Eureka	6	-	1	1	-	2	2
Humboldt	25	-	1	1	3	5	15
Lander	6	-	1	-	1	-	4
Lincoln	24	2	2	5	1	7	7
Lyon	19	-	3	-	7	4	5
Mineral	56	2	2	6	11	13	22
Nye	38	-	1	4	-	16	17
Ormsby	42	-	1	3	7	7	24
Pershing	19	-	1	2	6	6	4
Storey	4	-	-	1	-	-	3
Washoe	368	2	17	39	61	103	140
White Pine	78	1	2	9	22	29	15
TOTAL	1342	19	68	162	254	364	475

(SEE TABLE 7.) Many children who are intellectually handicapped have other physical handicaps.

(SEE TABLE 8.) Eagle Valley Ranch did not respond to the request for cooperation in conducting an exact census of their population. There are 10 children at this institution, all of Level I and II status.

There are 49 retarded children in the Nevada State Hospital. No child younger than a 2-year-old is accepted. There is no waiting list.

(SEE TABLE 9.) Of the 39 "mongoloid" children located, only 6 are in the Nevada State Hospital. These children are all eligible for admittance to the Hospital. One must assume that most children, even if belonging to an easily-recognized-and-diagnosed unemployable category of retardates, are cared for at home in spite of the availability of custodial facilities.

(SEE TABLE 10.) As this table indicates, mere distance from the Nevada State Hospital has not impeded referrals to it. It is to be noted that Clark County has a proportionately greater number of children in the Nevada State Hospital than has Washoe County, where the Hospital is located.

TABLE 7

NUMBER OF CHILDREN HAVING PHYSICAL HANDICAPS

YES	NO	TOTAL
509	850	1359

TABLE 8

NUMBER OF CHILDREN IN RESIDENTIAL INSTITUTIONS

Nevada State Hospital	49
Nevada Children's Home	6
Stewart Indian School	1
Other	10
TOTAL	66

TABLE 9

MONGOLOID CHILDREN

Nevada State Hospital	6
In School	6
Not In School	27
TOTAL	39

TABLE 10

NUMBER OF CHILDREN IN STATE HOSPITAL BY COUNTY OF ORIGIN

Co. unknown	1
Churchill	2
Clark	23
Douglas	-
Elko	2
Esmeralda	-
Eureka	-
Humboldt	1
Lander	-
Lincoln	1
Lyon	2
Mineral	3
Nye	2
Ormsby	1
Pershing	-
Storey	-
Washoe	9
White Pine	2
TOTAL	49

CHAPTER VII

MEDICAL RESOURCES

In the two chapters immediately preceding, the necessity of a good general medical program for the prevention of mental deficiency is readily apparent.

Proper prenatal care to prevent prematurity and correct such conditions as dietary deficiencies, as well as recognition and early preparation for the care of infants liable to be affected by Rh incompatibilities, is mandatory. The mother should be examined during pregnancy so preventive measures can be taken; e.g. avitaminosis in the mother corrected, Rh factors discovered, and, in general, adequate care taken to insure the mother's being in the best possible condition for the birth of her child.

During actual birth, proper hospital facilities, physicians, and nurses are necessary to detect and prevent mishaps which lead to mental deficiency.

What is a Satisfactory Physician-Population Ratio?

> There is no agreement in the profession as to what is a satisfactory physician-population ratio for today. It is even more difficult to set a satisfactory ratio as a goal for the West a decade hence. In 1957, the ratio of active non-federal physicians per 100,000 population ranged from a low of 70 for North Dakota to a high of 194 for New York and 179 for Massachusetts, and a regional high for New England of 162 physicians per 100,000 population. The national average was 133 and the Western average was 137. Which of these is "satisfactory"--or will be a decade hence?
>
> There is general agreement that no region in the country has too many doctors today, even when it has twice the physicians per 100,000 population that some Western states now have. Certainly no one would argue that any Western state has a surplus of physicians. Many small communities are unable to replace physicians who leave active service. Many posts for public health physicians, psychiatrists, and staff physicians are unfilled. It is common knowledge that not all the medical care needs of the public are being met. Thus, it seems clear that the present Western ratios are not excessive.
>
> In weighing the factors that affect the demand for medical care in the future, both the WICHE Medical Advisory Committee and the U.S. Surgeon General's Consultant Group on Medical Education concluded that present physician-population ratios appear to be an absolute minimum for the next decade.[1]

---

1 WICHE (Western Interstate Commission for Higher Education), Meeting the West's Health Manpower Needs: 1960.

Physician-Population in Nevada

NUMBER OF PHYSICIANS IN NEVADA BY YEAR

Year	Clark County	Washoe County	All Other Counties
1955	67	108	49
1956	76	114	53
1957	81	117	52
1958	92	130	55
1959	95	135	49

TOTAL POPULATION OF NEVADA IN 1950 & 1960

Year	Clark County	Washoe County	All Other
1950	48,289	50,205	61,599
1960	124,782	82,464	72,995
% Increase	158%	64%	18%

NUMBER OF PHYSICIANS PER 1,000 POPULATION IN NEVADA

Year	Clark County	Washoe County	All Other
1955 (est.)	.77	1.6	.73
1960	.76	1.6	.67

It is evident from the above tables that the lack of sufficient medical practitioners in the state as a whole is reaching dangerous levels. Excluding Washoe County, the ratio of physicians to population is as low as North Dakota--the state with the lowest proportion of physicians in the country. Las Vegas and Reno have a tourist population which is enormous in size. These people do not leave their propensity for illness at home. They visit Nevada and overtax a medical staff which is not sufficient for the state's resident population.

What does this mean in terms of the prevention of mental retardation? It means that physicians, being human, are overworked, with insufficient time for study and leisure, and with a lesser amount of time for examining their patients. It means that a clinic, such as the Special Children's Clinic, which is devoted to the diagnosis and treatment of the retarded, has extreme difficulty in areas outside of Reno in recruiting pediatric, psychiatric, and other medical consultants necessary for a job well done.

Is the Physician-Patient Ratio Improving?

ABSOLUTE INCREASE IN PHYSICIANS 1955-1959

Clark County 28 Washoe County 27 All others 0

The preceding figures indicate that there has been an absolute increase in physicians over a five-year period in the state as a whole. Unfortunately, however, this is true only in the case of the largest counties. The majority of counties showed no increase.

In spite of a rise in the number of physicians in Clark and Washoe counties in the five-year period, population growth was so intense that there was no increase in physician-population ratio.

Moreover, there is evidence that the number of medical specialists is inadequate. One example of a pertinent problem relating to mental deficiency is the fact that there are no psychiatrists in the state except in Washoe County. This means that children requiring psychiatric help do not have it available. Children committed to the Nevada State Hospital do not have preliminary psychiatric examinations, and the Department of Health must import medical specialists from Utah and California to keep their programs in operation.

Nurse-Population Ratio

Nurses are deemed equally important in providing adequate health services.

> In considering the supply of nurses, a customary measure is a nurse-population ratio, that is, the number of nurses per 100,000 population.
>
> Based on what is considered good nursing practice today, and on today's demand for nursing services, the National League for Nursing has set 300 nurses per 100,000 population as a recommended minimum for nursing service (see "Nurses for a Growing Nation"). It considers the ratio of 350 nurses per 100,000 population more adequate for today's nursing needs.
>
> These ratios are based on the nurses needed to perform duties that should be carried out by professional nurses and not delegated to auxiliary personnel; it assumes the use of an appropriate number of auxiliary nursing personnel for those functions that can be delegated to nonprofessionals working under proper professional supervision.[1]

PRACTICING REGISTERED NURSES IN NEVADA
1960

Clark County	Washoe County	Other Counties
277	347	137

1 WICHE, Western Council on Higher Education for Nursing: 1959.

NUMBER OF NURSES PER 1,000 POPULATION IN NEVADA IN 1960

Clark County	Washoe County	Other Counties
2.21	4.2	1.74

The two foregoing tables reveal that the nursing ratio in Nevada is somewhat similar to the physician ratio. Washoe County has a reasonable ratio of nurses if we do not consider the influx of tourists. Clark County has a serious shortage, and the rest of the state is in dire need of adequate nursing care.

NUMBER OF LICENSED PRACTICAL NURSES IN NEVADA IN 1960

Clark County	Washoe County	Other Counties
130	134	94

The number of licensed practical nurses indicates a similar trend, except that--with the exception of Washoe County--the probability is that counties are using practical nurses to partially compensate for the shortage of registered nurses. Even in this case, however, Washoe County has more practical nurses than the other areas.

One way to meet the need for registered nurses in southern Nevada is to establish a school of nursing in that area. A program leading to a baccalaureate degree would probably not provide a sufficient number of people to fill the gap. For that reason, the recommendations of the National League of Nursing, which follow, could serve as a guide in establishing a school of nursing in Clark County.

> Along with all the professions, nursing has become increasingly differentiated in recent years. Nurses work directly with people who are ill, in hospitals and doctors' offices; they work as head nurses, public health nurses, and industrial nurses; and they work as supervisors and nurse administrators in public health and hospitals and as teachers of nursing. Because the functions of these three kinds of nurses are different, the National League for Nursing recommends a different educational background for each group.
>
> . . .For professional nurses who give direct care to patients under supervision. . .
>
> . . .A diploma from a hospital school program or associate-in-arts degree from a junior college program is recommended minimum preparation.[1]

Conclusions:

We can conclude from the foregoing data that:

1 WICHE, Nurses for the West: 1959.

1. All Nevada other than Washoe County is suffering from a critical shortage of physicians and nurses.

2. The increase in physicians is not at an accelerated rate and does not lead to the conclusion that the situation will correct itself in time, without help.

3. The estimates made on the basis of population are optimistic inasmuch as they do not take into account the transient population.

4. The lack of medical personnel adversely affects the chances of preventing, diagnosing, or correcting mental deficiency.

Recommendations:

1. Nevada, as a member of the Western Interstate Compact on Higher Education, should make every effort to encourage the founding and expansion of medical and nursing schools in the Western area, with adequate quotas for Nevada itself.

2. Since the need for physicians is so desperate in many counties, the state should be encouraged to organize committees composed of citizens, county officials and physicians to investigate programs to attract physicians to Nevada, perhaps in the same manner that the state encourages the introduction of new industry to Nevada. Perhaps the State Board of Medical Examiners could be consulted on methods to encourage the entry of physicians to Nevada.

3. The formation of a school of nursing in Clark County could be encouraged by partial financial support from the state.

4. The requirement that the Basic Sciences Examination must be passed in order to practice in Nevada could be waived at the option of the Board of Medical Examiners for those physicians who are under 50 years of age and who are specialists recognized by an American Medical Association approved Board of Specialty.

CHAPTER VIII

PREVENTIVE CLINICS IN THE STATE AND COUNTY DEPARTMENTS OF HEALTH

Direct medical services of the Department of Health are oriented, with few exceptions, to those citizens who are not financially able to pay for medical needs of their children met by the private medical community. These services, provided by various clinics, have as their main goal the prevention of illness.

If these services are qualitatively and quantitatively adequate, their impact in the prevention and amelioration of mental deficiency is significant, especially since the group they serve--the financially and socially depressed--is the group that is less likely to have had good medical care, adequate nutrition, and the benefits of a healthy and stimulating environment. In terms of prevention, this medically indigent group is the one which needs the most care but receives the least medical attention.

The two clinics which look to the general health of the prospective mother and the very young child are the the Prenatal and the Well-Baby clinics.

1. Prenatal Clinic

There is one prenatal clinic in the State of Nevada. It is administered by the Washoe County Health Department and supported by federal and state appropriations. The clinic meets once a week and sees about 25-30 patients at each session. It has been in operation for approximately 18 years and is efficiently administered.

Each woman is examined once a month until the seventh month of pregnancy; she is seen once every two weeks in the seventh and eighth months of pregnancy, and in the ninth month is seen weekly. Treatment, when indicated, is given.

Indigents who meet the residence requirement in Washoe County are referred to the County Welfare Clinic for delivery of the child. The majority of the women are indigent, and in their cases the child is delivered by the hospital physician who is "on call" on the day of delivery. For those women who are not welfare recipients, the physician who conducts the prenatal clinic delivers the child at a reduced fee.

Unfortunately, there is no prenatal clinic in Las Vegas. State officials have indicated that federal and state moneys are available to offset the major costs of establishing such a clinic. This program should be initiated, with the cooperation and endorsement of the local physicians.

In other areas of the state, the State Department of Health employs the services of public health nurses to conduct a prenatal care program if the patient is referred by a private physician. There are few referrals.

The County Nursing Service in Las Vegas conducts a visiting program of prenatal care. Two patients were admitted to service during a four-month period in 1960.

Although the Ely-Elko area has sufficient population to maintain a prenatal clinic, such a facility has not been established. A prenatal program could be instituted in this area with the cooperation of the local medical community.

2. Well-Baby Clinics

The purpose of a well-baby clinic is to check children at regular intervals for the purpose of keeping them well and preventing any illness from continuing undiscovered, as well as to administer prophylactic innoculations for preventable infectious diseases. Well-baby clinics generally accept children for service immediately after birth and continue to see the children until age 6.

Babies are seen once a month after birth until the age of 1 year. After 1 year of age, they are seen once every six months. Only preventive work and immunizations are done. If it is discovered that a child needs intensive medical care, he is referred to the family physician or to the proper agency such as Special Children's Clinic, Crippled Children's Clinic, etc.

Well-baby clinics are presently in operation in Reno, Las Vegas, Gabbs and Hawthorne. In Reno, the clinic meets every week for a half-day and sees 18-25 children per week. In Las Vegas, a clinic is held once a month, and 25 children are seen at each of two sessions. Hawthorne and Gabbs have a clinic for one half-day each month.

Discussion

Several conclusions can be drawn from a brief view of prenatal and well-baby clinic services in Nevada: although state and federal moneys are the main financial source for the support of these clinics, the distribution in the state is very spotty and the benefits of these programs are being denied most of the state's population; Las Vegas is without a program compatible with its size; the Ely-Elko area is without any prenatal or well-baby clinics.

Recommendations

1. That steps be taken to establish prenatal and well-baby clinics on a more uniform basis throughout the state.

2. That local physicians be encouraged to endorse and cooperate with a prenatal clinic program in their communities, and so provide a more satisfactory prenatal program throughout the state.

CHAPTER IX

SPECIAL CHILDREN'S CLINICS

The program of Special Children's Clinics for retarded children was established as a demonstration project with cooperation of the federal and state governments within the framework of the State Department of Health. The federal government has provided money for the clinics' operation for a five-year period to demonstrate the value of this service in Nevada. The interest of the federal government in this program has been stated by Dr. Arthur Lesser as follows:

> Largely because of the activities of local parents' groups and the National Association for Retarded Children and the interest shown by many parents who have written to us, the Children's Bureau two years ago undertook to make a study of how the programs for which we have the responsibility may be extended to include mentally retarded children. Last year the Department of Health, Education, and Welfare established a Departmental Committee on Mental Retardation, the function of which was to develop a proposed program for the Department. The Congress has become greatly interested in this problem as exemplified in particular by the interest shown by Mr. John Fogarty of Rhode Island who is Chairman of the House Subcommittee on Appropriations.
>
> The Children's Bureau grant for maternal and child health for 1957 was increased by the House of Representatives last month from almost $12,000,000 to $16,000,000. In so doing the Committee on Appropriations expressed the intention that half of the increase be used for programs for mentally retarded children. Our appropriation for 1957 is now under consideration by the Senate.
>
> We have then an expression of considerable interest on the part of at least one House of the Congress, the Department of Health, Education, and Welfare, and the Children's Bureau in utilizing the resources of public agencies to develop programs for mentally retarded children.
>
> During the past year with the limited funds available, we have made special project grants to health departments in California, Washington, and the district of Columbia (Nevada the following year) to develop demonstration programs for mentally retarded children. We have also seen many expressions of interest on the part of medical schools in setting up special clinics for these children. In these special programs the evaluation of diagnostic clinic is given much emphasis as a focal point for the services being provided.
>
> We find that one of the problems that is already

apparent is that much less attention has been given to the question of how to help the parents with the care and training of the child after the diagnosis has been made. This is in part due to the fact that the pediatricians in these clinics function as clinicians and diagnosticians primarily and work in a way in which they are accustomed to work in pediatric clinics. The problem for the parent, however, really only begins after the diagnosis is established. For him the question is: After the diagnosis--what? It seems to me important to stress that the clinic cannot exist wholly as if it were the total program in itself, but needs to be considered as one resource in a program in which it would be related to other available resources in the surrounding area, such as health and welfare departments, education departments, departments of mental hygiene, councils of social agencies, recreation departments and similar organizations and institutions for the retarded. In the Children's Bureau we are particularly interested in seeing the development of programs which would help those parents who can keep their children at home at least during childhood. We find all too often physicians advise parents to place their children in institutions immediately without consideration for the over-crowded conditions and the long waiting lists which already exist and also without adequate consideration for the wishes and feelings of the parents. Many of them would like to take care of their children at home and many more of them would be able to if they could get the help which they need through a community program. For this reason we are encouraging the development of programs which would include in addition to diagnostic services, social casework, foster home placement, arranging for placement in nursery schools and day care centers, helping parents in child training, parent counseling, group work with parents, arranging for admission to institutions, and evaluation studies of demonstration programs. The State health departments, by virtue of their organization for services, and their relation to county health units, are in a position to assist parents in the care of their children at home, to provide through local physicians, local well-baby clinics and county public health nurses the follow-up services and health supervision of these children. This does necessitate, however a close working relationship and understanding of objectives on the part of the staff in the state health department, the diagnostic center, which may be part of the state health department, or located in a hospital or medical school setting, and the various local health units. It means also intensive work in community organization to develop needed resources. It seems to me that by bringing to the problem of the mentally retarded child the experience in programs which have been acquired in organized health services, we will be in a much better position to help parents to care for

mentally retarded children in their own homes.

> While this program provides a new concept for most health departments, it is one in which we are seeing a rapidly increasing interest. Much of this interest has been created by the parents' group themselves and by individual parents who in a short space of time have organized themselves so effectively. While special clinics and special services of various kinds for the retarded are necessary at this time, we should keep in mind that the ultimate objective of the parents is to have their children participate as much as possible in the regular community programs that exist for all children.[1]

The special children's clinics began functioning in February 1957 in Reno and Las Vegas.

The objectives of the clinics are summarized thusly:

1. To make an etiologic and pathologic diagnosis of the preschool child's mental retardation and determine the extent of mental impairment;

2. To determine the effect of the child's mental retardation on his intellectual, physical, emotional, and sociological growth and development;

3. To give therapy to the "total" child including physical, mental, emotional and social aspects;

4. To ascertain the adjustment of the family to the presence of the mentally retarded child in the family unit:

5. To counsel with the parents as to prognosis and the future management of the retarded child;

6. To train physicians, nurses, psychologists, social workers, and teachers techniques in treating mental retardation;

7. To engage in research in all aspects of mental retardation, including its prevention;

8. To provide an educational facility conducive to the intellectual, social, and emotional growth of the preschool child.

These pediatric clinics are devoted to developmental problems of the preschool child. The medical director is a pediatrician and the staffs of the Reno and Las Vegas clinics consist of a full-time psychologist, a psychiatric social worker, a child development specialist, and a secretary. In

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1 The Evaluation and Treatment of the Mentally Retarded Child in Clinics: National Association for Retarded Children, Inc.

addition, there are part-time pediatricians in both clinics and the necessary neurological, psychiatric, otological, and other consultants as needed. Patients are accepted from all counties in the state. However, there are no available travel funds, and therefore the staff has made no attempt to go into other areas of Nevada and render complete services. If a patient can make the trip to Reno or Las Vegas, he receives the same services offered those who live near the clinics.

The most serious handicap imposed by lack of travel funds has been the inability of clinic staff members to work with outlying professional groups in solving common problems. Lack of funds has also prevented evaluation of available services in these communities and thus has prohibited working with resource people in the patients' own communities.

To Whom Is the Service Available?

All retarded children under 9 years of age are eligible to receive the services rendered by the special children's clinics at no cost. Unlike other state clinics, there are no restrictions because of income. If outside services such as X-rays, electroencephalograms, and neurological consultations are needed, these services are paid for by the parent, unless he is unable to pay.

Clinic Procedure

After application is made, the psychiatric social worker determines whether the case is a proper one for the clinic. If so, the child's medical history and other pertinent information is obtained. The child is then examined by a pediatrician who may request other examinations, such as X-rays, electroencephalograms, etc.; routine laboratory tests are made. There is a complete psychological evaluation of the child to investigate his intellectual and emotional capabilities. Concomitant with these examinations, there is often a dental examination. Requests for information are sent to every clinic or doctor who has previously seen the child. In certain cases, the child will be seen every day or every other day for observation in the clinic's nursery during the diagnostic period. Following these examinations a case conference is held.

Present at the case conference is the psychologist, social worker, and pediatrician who made the examination. In addition, the consultant neurologist, consultant psychiatrist, and public health nurse are always present. If the case has been referred by the school system, or if the child will shortly enter school, a representative from the school attends the conference. Any other agencies such as state or county welfare departments, that have an interest in the child, send representatives to the conference. During the hour-long conference, a diagnosis is established and recommendations are made for an integrated community-wide approach to the child's difficulties. This program may include any number of things, ranging from inclusion of the child in a nursery school training program, psychological counseling with his parents, medical treatment recommended, or recommendations to the school system, welfare departments, or any other agency involved.

The clinics receive approximately 100 new patients a year each. Because of the nature of the work, children are often kept on active status for three

or four years. The active caseload is usually 150 to 200 cases at each clinic.

Although the primary aim of the clinics is to serve the medical and psychological needs of the child, it has been found that the case conference, which sometimes includes as many as 15 participants, is an ideal tool for the professional education and training of community people who are working with children in the community. This function has become more and more valuable because it has been recognized that the impact of the clinic as an educational force permeates the entire community and encourages more sensible and intelligent practices in all the agencies of the state.

REFERRALS BY COUNTY AND SOURCE
TO SPECIAL CHILDREN'S CLINIC, RENO, NEVADA

County	Fiscal Year 1958-59	Fiscal Year 1959-60	Source	Fiscal Year 1958-59	Fiscal Year 1959-60
Clark	1	-	Priv. Phys.	41	39
Churchill	3	3	PHN's*	7	11
Douglas	4	1	CCS	9	9
Elko	2	3	WBC	5	12
Humboldt	3	2	Welfare	7	7
Lyon	4	4	NSCC	1	-
Mineral	5	4	Speech Clinic	7	1
Nye	-	1	MHC	5	-
Ormsby	4	2	Prob. Dept.	-	2
Pershing	2	2	Schools	9	4
Storey	-	1	State Hosp.	2	-
Washoe	66	65	Self	13	12
White Pine	1	2	Sp. Child. Clin.		
CALIFORNIA	12	7	LV	1	-
TOTALS	107	97	TOTALS	107	97

* Referrals from PHN's oftentimes are actually referrals from CCS.

PHN - Public Health Nurse
WBC - Well-Baby Clinic
MHC - Mental Health Clinic
CCS - Crippled Children's Service
NSCC - Nevada Society for Crippled Children

The above table sets forth the referral by source and county of children to the Reno Special Children's Clinic. Most of the children come from Washoe County. The remainder are scattered throughout the other counties and part of bordering counties in California. During the last fiscal year, 65 of the children came from Washoe County and 25 children came from other counties. Thus, about 1/3 of the patients come from other counties in Northern Nevada, and 2/3 come from Washoe County, indicating a sizable representation in counties east of Reno and North of Tonopah. However, this is not proportional to the population of this area. Because of the limitations on travel and itinerant service to areas outside of Reno, these counties have not been proportionately represented.

Budget

Again, it should be emphasized that the federal government provides the finances for operation of the clinic and will do so through June 1961. After June 1961, it will be necessary for the project to be renegotiated, and there is a possibility that if the state government does not share expenses of the clinic, that the federal government will withdraw its contribution. In addition to the $60,000 which was contributed to the 2 clinics by the federal government, the local county provides the housing for the clinics' facilities; and Reno and Las Vegas city governments pay the salaries of 2 secretaries. The total budget for each clinic is $34,000 per year. This is modest when one considers that the full cost of the clinic's operation has been saved if one child is prevented from being institutionalized. Allowing a child to become stabilized in a severely retarded condition costs the state roughly $1,500 per year for the most ordinary custodial care. Over 20 years, this would reach a total of more than $30,000. Therefore, the economies attainable through a preventive and therapeutic program are quite dramatic. In light of this information, a conservative estimate of savings might be placed at $200,000, aside from the gains in human dignity and productiveness.

Referrals to the Nevada State Hospital

During the fiscal year 1958-1959, two children were diagnosed as so obviously damaged that they were referred to the Nevada State Hospital for custodial care. In the following fiscal year, two patients were seen for psychological evaluation only, in order to assist the parents in institutionalizing their children. The cases were clear-cut, and the primary purpose of referral to the clinic was to handle the initial evaluation for placement in the Nevada State Hospital. Another child seen during this period has since been institutionalized. Therefore, during the two-year period in which the Special Children's Clinic of Reno saw 200 children, most of whom were retarded in some degree, only 5 children were referred to the Nevada State Hospital. Inasmuch as the Special Children's Clinic, emphasizing work with children below the age of 6, sees mostly severely and moderately damaged children, this seems to indicate that a very small percentage of this group requires institutionalization. It does not mean that there are no cases where institutionalization is required; but it does mean that it is unnecessary to send every retarded child to the Nevada State Hospital If we have adequate community facilities to handle the problem.

Problems of the Clinics

Major problems that the clinics now face are (1) the stabilization of their future. The next legislature will be the last one in which an adequate arrangment can be worked out with the federal government to share costs of these clinics. Also, (2) travel money is necessary in order to provide services to parts of the state other than the Las Vegas and Reno areas.

Discussion

Aside from the present doubt surrounding the clinics' financial future, there is the problem of growth, a problem inherent in any government service in view of the "population explosion." During the past three years, the special children's clinics have proven efficient in handling the retarded,

and have provided Nevada with one of its few medical services which can be considered comparable to other states. As a matter of fact, the unique federal grant to Nevada, which provides two clinics in the state with the second smallest population, makes our facilities in the particular area for preschool retarded children quantitatively and qualitatively among the best in the nation. For example, California, with a much greater population, has only one such clinic.

The need for intrastate travel money is obvious. Citizens of Clark and Washoe counties receive all the benefits of nursery schools, consultation and close working conditions with the school system, but the other fifteen counties receive only minimal benefits. Patients come in from other counties and are given adequate diagnostic and evaluative programs; but without staff participation from professional people in the community of the patient, it is difficult to assure that the recommendations of the clinics will be carried out. Attempts in this direction have been made by using the public health nurse in the community, by writing letters, and by the occasional visit of staff members to these communities at their own expense. While these efforts have been helpful, they cannot be substituted for full and active participation afforded by adequate travel allowance.

Recommendations

1. That the Nevada Legislature appropriate sufficient money to insure perpetuation of the special children's clinics beyond the end of the demonstration project in June 1961.

2. That travel funds be made available so that complete services can be rendered to counties other than Washoe and Clark.

CHAPTER X

MENTAL HEALTH SERVICES

For the child who is mentally retarded, the functions of mental health clinics are of extreme importance. Indeed, all tools and techniques used in this type of clinic are as necessary to the retarded as to the emotionally disturbed. A program for the mentally retarded must use the mental health clinics and mental health facilities of the state as the coordinating focus of a program oriented toward the individual child's needs.

There are several differences between special children's clinics and mental health clinics. Special children's clinics are pediatrically oriented, with a pediatrician as medical director; mental health clinics are psychiatrically oriented, with a psychiatrist as medical consultant. Special children's clinics are concerned with preschool age children, and are stationary in nature. Mental health clinics serve school age children and the personnel of the clinics travel around the state.

Organization of Mental Health Division

The Division of Mental Health is in the Bureau of Preventive Medicine in the State Department of Health.

The Division consists of 3 outpatient clinics, one in Reno and the others in Elko and Las Vegas. Each clinic has positions for full-time clinical psychologist and a psychiatric social worker. The Reno and Elko clinics have psychiatric consultation. There is provision for a full-time psychiatrist for the Las Vegas Clinic who is medical director of the clinic and responsible for the divisions mental health program in Clark County.

By the end of this survey, a Mental Health Coordinator, trained in psychology and public health, had been designated to head the Division. Another addition to the Division was a clinical psychologist, by arrangement with the State Prison and Children's Home, to provide psychological services to these institutions.

The Division is now in the process of formulating program plans for the next year. One program is intensive work with juvenile delinquents and improved services to adults and children.

The emphasis of the Mental Health Clinics has been on school age children, and the outpatient clinic functions have been the main focus of the program. In a typical case, the child was referred to the clinic by a professional person in the community, possibly a physician or a school principal. The psychiatric social worker would do an initial evaluation of the problem to ascertain whether the clinic could be of help. The social worker and psychologist then outlined a tentative program of interviews and psychological testing to evaluate the problem further. After this initial evaluation, and often in consultation with a physician, a course of action was outlined for the benefit of the child. This might consist of counseling with the child and/or his parents, discussing the results of the evaluation with school teachers, welfare worker, or any other person who would be working with the child. Often, cases necessitated a long period of help before

a satisfactory ending could be found.

Another focus of the mental health clinics was providing a service which was preventive in a true sense. This program educated the public to an understanding of the problems of mental retardation, changing the age-old fear and shame connected with this disability, thereby making a basic positive change in society's handling of this problem. By consulting with physicians, schools, welfare departments, and others who influence and plan programs for children, they recommend steps which enable the community to avoid mistakes and prevent future difficulties.

With effective community-oriented mental health programs, the retarded child benefits as much, or more so, than the child with emotional problems.

How is the Mental Health Clinic Meeting the Needs of the Retarded Child?

1. It provided the first integrated service oriented toward the retarded child as an individual living in a family and in a community. It provided the first professional alternative to institutional care.

2. It encouraged and provided much of the stimulus for special education programs in the schools.

3. It provided the initial planning and motivation which founded the special children's clinics--a facility devoted primarily to the preschool retarded child.

4. It worked closely with parents to establish organizations which provide help for the retarded.

In 1957, with the assistance of maternal and child health funds earmarked for services to retarded children, the Mental Health Clinic sought to regulate its intake so that between 10 and 15% of the children--usually of school age--were those referred for suspected retardation. This percentage was similar to the proportion of maternal and child health grant in relation to the Mental Health Clinic's total budget.

During a two-year period, the Mental Health Clinic's emphasis was on direct clinical services. However, according to the statistics, a significant change occurred in the ratio and actual numbers of retarded children evaluated by the Mental Health Clinic over the past two years. Fifteen children were seen who were referred for suspected retardation, and were so diagnosed. This is an extremely low figure, considering the fact that, although approximately 3% of the general population is estimated to be retarded, such cases constitute 10 to 25% of the usual mental health clinic's load.

The reasons for this contrast in the caseload for each of these biennial periods include:

1. Establishment of other resources to work with the retarded child.

2. A change in approach to the problem by the mental health

clinics.

3. Gaps in administration and changes in personnel.

Survey of 1958

In 1956, the Nevada Association for Mental Health requested the U.S. Public Health Service to conduct a survey of mental health problems in Nevada.

In October 1958, a bulletin entitled "A Study of Mental Health Problems and Services in the State of Nevada" was submitted to the Nevada Board of Health.

The following problems were posed in this study:

1. Authorization of Mental Health Services in the Department of Health

The mental health services in the Department of Health were established by fiat of the State Board of Health, and no authorization of the program has been provided in the statutes. Therefore:

(1) Is it timely to introduce legislation authorizing the Mental Health Clinic in the Department of Health?

(2) At what administrative level should the services be offered? At present, they are organized at a section level. In terms of the eventual scope of the program and the size of the staff, might it not be more realistic to establish them at a division level?

2. Community Mental Health Services Act

Is it appropriate at this time to propose a community mental health services act by which the state may grant funds to local communities, counties or groups of counties to support local mental health programs on a matching basis? The problems of the communities are shown to be diverse and the priorities for development of local services should justifiably be set by local decision. Several other states, including New York, California, Minnesota, Connecticut, New Jersey, and Vermont have recently passed such legislation.

Or, would it meet the needs of Nevada more satisfactorily to follow the lead of Iowa, Kansas, and South Dakota, which have comparable dispersion of their population in authorizing their counties to levy taxes or appropriate funds to support local community mental health centers or clinics?

3. Staff of Mental Health Services in Department of Health

(1) With reference to staffing the mental health services in the Department of Health, the Legislature must determine the number of additional positions, the salary levels, and the standards that will be applied in appointment. A minimum staffing pattern is suggested in this report.

While it may weaken the argument in favor of additional positions in the Department of Health, it is only realistic to point out that development of more mental health positions with high standards of professional training and experience is needed in all of the other departments and institutions involved in the mental health program. A systematic plan to expand the staffs of the institutions, the Departments of Welfare, Probation and Parole, Education, and the University is justifiable at this time in order to meet the minimal requirements for mental health activities of each of these departments and institutions, and to care for the anticipated expanded population of the state during the next decades.

(2) Decision is required about whether or not to permit salary levels for psychiatrists to rise sufficiently high that the Department of Health and other agencies can compete in hiring them. At present, the holding of salaries below the level of the Director of the Department puts a block in the way of recruiting that is virtually insurmountable. Linked to this are decisions regarding part-time employment and permission to engage in private practice while in governmental employ. If the Department is to hire psychiatrists, liberalization of the current rules will be required.

(3) Decision is also required about liberalizing the rule of the Board of Medical Examiners regarding the use of state funds to employ physicians from out-of-state as consultants. Certain skills needed to perform specific consultant tasks for the Department of Health, such as consultation regarding some aspects of the mental health program, are not available in the state, even though the medical specialty from which an outside consultant could be recruited is represented in the medical profession in the state. Provisions making it possible for the state to employ medical consultants of special and outstanding competence no matter where they live could facilitate the mental health program.

The Mental Health Program for Retarded Children

The creation of community resources is highly creditable and should be continued; however, this does not answer all problems of the retarded. Evaluation, counseling, and consulting services should be provided in communities that do not have their own psychologist.

The lack of a sheltered workshop program is particularly important. The school program of special education ultimately fails if the retarded young adult leaves class and has no opportunity for vocational training and work.

The term "sheltered workshop" was defined in 1950 by the National Committee on Sheltered Workshop and Home-Bound Programs of the National Association for Retarded Children as follows:

> A sheltered workshop is a voluntary organization or institution conducted not for profit, but for the purpose of carrying out a recognized program of rehabilitation for physically, mentally, and socially handicapped individuals by providing such individuals with remunerative employment, and one or more rehabilitating services of an educational, psycho-social, therapeutic or spiritual nature.

As indicated in the Mental Health Survey of 1958, the personnel needs are urgent in the mental health ares. The Reno Clinic is handicapped by lack of a clinical psychologist. The Las Vegas Clinic is working with a larger population and trying to meet both adult and child needs. The Hawthorne, Fallon, Yerington and Carson City services have been curtailed because of lack of personnel in Reno. The Elko clinic is without a psychiatric social worker.

Another area of extreme importance to mental retardation is research. In this connection it is interesting to read what the Mental Health Survey of 1958 had to say:

> If the causes of mental ill health and ameliorative procedures by which treatment could be effected were better known, there might be less justification for studying the nature of emotional disturbance, for attempting to understand better the underlying factors and for testing out various approaches to the helping in the problems encountered. At the current state of development of the field of mental health, much study must be undertaken. This is required of those working in health and welfare agencies as well as in the universities and special research institutes. The facts that become available through these activities must be systematized and made the basis for experimental operations in evaluative thought. Time expended in this direction may seem costly at the moment but in the long run may prove to have been used economically.
>
> Research interest in the mental health staff remains undeveloped. For the most part no scheduled time is available to them for research and the budget for research has been restricted to expense for a few pieces of equipment. The staff has some liaison with the University in its program of research.

If the necessary results are to be obtained in Nevada, we will have to determine what problems exist. The way of determining this is by scientific, rigorous, and problem-oriented research. This research should be handled by the Mental Health Clinic because it is staffed with qualified scientific personnel. Unless a research program is instituted, the people of the state will never receive the full benefit of a well-coordinated plan, and problems will be evaluated by a "rule of thumb" method.

Recommendations

1. That the Legislature consider amendments to the law governing the Department of Health that would clearly define the Mental Health Division as a division of the Department of Health.

2. That policies concerning intake, type of patients to be seen, and followup be clearly stated in writing.

3. That research should be emphasized as an integral part of the mental health program and 5% of the mental health budget be committed to this purpose.

4. That a coordinated program be worked out between all mental health services which would include those services provided at the Nevada State Hospital, the Nevada Children's Home, and the state and county welfare departments.

CHAPTER XI

EDUCATION FOR THE RETARDED IN THE PUBLIC SCHOOLS

Since the latter part of the 19th century, the public school system has been the primary focus of training and preparing retarded children for adulthood. The advantages and benefits of this focus are apparent from even a cursory view of the school system. The school system is the agency that traditionally leads in the field of training the youth of the nation, and by its very nature, pervades the entire country and the individual states. Enrollment in school is considered the normal course of events for a child, and parents are made secure by the knowledge that their children are acceptable to the school system.

The benefits of special programs for the retarded accrue both to the retarded child and to the normal child. School systems experience many difficulties when they are not prepared to maintain a program for retarded children, as well as for normal children. A school teacher who is responsible for the education of children ranging in I.Q. from 50 to 150 in a single classroom is faced with a difficult task. Neither the retarded child, nor the child who is average or superior, receives the training he requires. However, until a sufficient number of special education programs are inaugurated, some children will be forced to stay in the same grades for several years, and will receive no benefit from the time spent in that grade. (See Table No. 3, Chapter V.) A retarded child who is kept back for one or more years becomes bored and is a nuisance to the teacher. He is considered not only a slow learner, but also undisciplined. In the end, we find that the child has not benefitted from schooling, but has been set upon a path which can lead to delinquency in adulthood and an inability to maintain himself in a community as an independent adult.

What are the Results of Special Education Programs in the School System?

The answer to this question will depend on how the child succeeds in adulthood after receiving special education in the public school system. Will he be able to maintain himself in the community: Did he avoid institutionalization? Does he become an economic asset?

The following excerpts from research studies will assist in answering these questions:

> Among early inquiries was a follow-up study of graduates of special classes in New York City made in 1925. The group studied consisted of 400 former special class pupils, 218 boys and 182 girls, who had been out of school from one to four years. All but ten of the children were found to be living at home, or in their own establishments if married. Home conditions in 36½ percent of the cases were good, in 42½ percent fair and in 19 percent poor, in 2 percent unknown.
>
> A total of 259 (162 boys and 97 girls), or 64 per-

> cent, were employed for wages. Others, unemployed at the time of the study, had proved their ability to hold positions, so that in all, 334, or 83 percent, of the 400 boys and girls were regarded as employable. Four, or 1 percent, had been committed to institutions; and one boy in prison at the time of the study was later released and went home to live.[1]

In a study of a group of 52 men who were retarded, with I.Q.'s under 60, having adult mental ages from 7 to 9 years of age, the following results were disclosed:

> Only three were married. Unemployment was 13.5 percent. . .However, of the 52 more handicapped men, 75.8 were self-supporting, an achievement which appears to justify the specialized education they received.[2]

A third quotation reveals essentially the same favorable outcome:

> Severely retarded children also show the favorable results of schooling. A study of a sampling of 2,640 former pupils in classes for the trainable in New York City public schools from 1929 to 1956 was reported in 1958 by Dr. Gerhart Saenger. The age range was from seventeen to forty years. It was found that 1,742 (about two-thirds) of the group were living in the community; 686 (about one-fourth) were in institutions; 212 had died since leaving the school. Of those living at home, most appeared to have made a good adjustment to family living and 27 worked for pay at simple jobs.[3]

Children with I.Q.'s below 50 are the most severely retarded that the school system handles, yet the aforementioned studies indicate a favorable prognosis as a result of specialized training in the school system.

How are Retarded Children Grouped Academically?

One of the factors pointed out by the census is that most retarded children are not put in special classes. Children who are borderline or mild defectives are maintained in a normal class and integrated through the expedient of splitting the normal class into three parts: (1) academically superior; (2) academically average; and (3) academically slow. A much smaller number are placed in classes for the "educable" and a minimum are in a class for the "trainable." The standards for these classes are set forth in the recommendations for curriculum by the State Board of Education. (See Appen-

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1 The Mentally Retarded in Society: Stanley Powell Davies, Columbia University Press: 1959.

2 Ibid.

3 Gerhart Saenger, M.D.: Adjustment of Severely Retarded Adults in the Community, N.Y. Interdepartmental Health Resources Board: 1958.

dix No. "E".) "Trainable" and "educable" children are defined by the school system as (1) trainable - an I.Q. of below 50; (2) educable - an I.Q. of between 50 and 79. These figures are not used literally, but are dependent upon the child's social-emotional maturity.

Resources of Nevada's Program for Special Education

In 1869, the Nevada Legislature made provisions for the education of the deaf, dumb and blind between the ages of 8 and 21 years and appropriated $3,000. Duty of county commissions to pay for transportation to the superintendent of public instruction, and the superintendent was to transport persons to the institution for this education and pay costs of support and education.

By law, the state board of education is required to establish uniform rules to be used in calculating the average daily attendance of pupils and the actual number of certified employees to which each school district is entitled for apportionment purposes.

Under the apportionment formula in the Nevada School Code, each school district is entitled to (1) $4,000 per certified employee; (2) $80 per pupil; (3) $40 per kindergarten pupil; (4) one-half of the cost of transportation during the previous year; (5) $500 per handicapped child.

In addition, the availability of local funds must be determined, which local fund shall be the sum of the proceeds of the 70¢ local tax. Also, the district receives that proportion of all monies received by the school districts from the federal government under the provisions of Public Law 874.

The state's apportionment is computed on a yearly basis and consists of the difference between the sum of the 5 minimum requirements list above and the local funds consisting of the proceeds from the 70¢ local tax and federal funds.

The decision on whether a handicapped children's program is initiated rests with the school district.

It should be kept in mind that many of the Nevada counties do not have special educational facilities, but through conscientious individual appraisal of the child, maintain these children in a typical classroom situation with special attention from the teacher and the principal. Some of the smaller counties have one class for the handicapped child in which a heterogeneous assortment of the educable, trainable, physically handicapped and emotionally disturbed are placed. When such a group is maintained, one finds that no individual child's disability is handled correctly, since the differences outweigh the likenesses. The teaching methods that are proper for a blind child are not proper for a trainable or retarded-educable child. The placement goal of a complete program, with the exception of the trainable group, is the reintegration of the child into a typical group, which meets both his academic and social needs.

Washoe and Clark Counties have well-established special education classes. Pilot programs have been in progress in Mineral, Pershing, White Pine and Churchill counties. Humboldt, Lander, Eureka, Storey, Lyon,

Ormsby, Douglas, Esmeralda, Nye, Elko and Lincoln counties have no special education programs.

Clark and Washoe counties have the most complete facilities in special education and are comparable to the best. Their programs are growing each year, they are becoming increasingly efficient in the individual treatment of the children, and they have the benefit of energetic and well-trained personnel.

A. Washoe County

Washoe County maintains several classes for children in the "educable" category, and a class for "trainable" children. There are facilities for the physically handicapped, the blind, and four classes for slow-learning children in an integrated setting. They also have plans to establish a class for children having hearing difficulties. Their staff consists of a psychologist, several counselors, 5 speech correctionists, nurses and other personnel necessary to the program for handicapped children.

B. Clark County

In Clark County, twenty-two special education classes with a total enrollment of 295 students during the 1959-60 school year were in existence. Fifteen of these classes were located in regular school buildings. Six classes were held in a special school known as The Variety School. The minimum age for entrance in special classes was 7 years of age for mentally retarded. The majority of these classes were at the elementary level of grades 1 to 6 and included the "trainable," "educable," slow learner, emotionally disturbed, orthopedically handicapped and visually and aurally handicapped children. Included as part of the special education program is a nursery operated by the Special Children's Clinic. This nursery is operated by agreement with the Nevada State Department of Health and includes children between the ages of 3 and 9 years. The average daily attendance in this nursery was between 13 and 15 children. In return for their support of the nursery, the school district received special pediatric, neurological, psychiatric and psychological services in the Variety School program. Through the combined efforts of The Variety School and Division of Vocational Rehabilitation of the Department of Education, a program of vocational placement for adolescent "educable" children was initiated.

The plans for 1960-61 include the establishment of a half-time position for vocational counselor and an increase to 35 in the number of special education classes. Unfortunately the 1960-61 plans include a change in the entrance requirements, and the minimum age for entrance will be 8 years rather than 7 years.

Ancillary Personnel

The need of a sensible, flexible and rational approach to handicapped and retarded children requires personnel who do not have teaching functions.

These include psychologists, physicians, social workers, counselors, vocational guidance workers and rehabilitation officers. In many cases the persons can be retained on a part-time basis, but, ideally, they should be retained full time. At present, the state makes very little provision for the support of this type of professional staff and yet they provide the greatest benefit to the retarded child as well as the normal child. These persons are necessary to assist the teacher and to maintain contact with the child in planning his total academic life.

Washoe and Clark counties have retained these ancillary personnel. There are a few counselors in some of the smaller counties, but a majority of the school districts do not utilize the services of such a battery of experts.

The mental health clinics of the State Department of Health have in the past maintained some liaison with various school districts in an attempt to provide the services of a psychologist and social worker. The services of a psychologist are necessary to certify a child for inclusion in the special education class. (See Appendix No. "D".) It has been the practice of some of the smaller counties to use psychologists from the University of Nevada to assist in the special education programs.

State Planning in Special Education

At the present time, there is not enough planning at the state level for special education. Most of the recommendations of the Legislature, the laws that have been enacted, and programs in special education have been inaugurated upon the recommendation of the parents of retarded children, local county school boards and mental health clinics of the State Department of Health.

One of the great needs of a special education program is more planning at the state level to provide local counties with consultative, advisory services and to coordinate programs for the handicapped child in the State of Nevada. The programs for the exceptional child in the school system should be guided by a special division of the State Department of Education. The approach should not only be one of clinical and pathological psychology, but should emphasize educational psychology.

In order to establish a well-rounded and uniform program of special education in all school districts, the Department of Education should consider establishing a division of special education, to be staffed by a trained person with a degree of Doctor of Philosophy or Doctor of Education, in the area of exceptional children. His primary role would be that of serving as a consultant to local school districts concerning their special education problems, and planning and coordinating the programs of special education. His second role would be of a clinical nature. This would include the certification of children for admission to special education classes in the less-populated counties. The administrator of a special education program should be provided with the services of a social worker whose function would be to aid him in his clinical work and to work with other social and community agencies in an attempt to integrate the functions of the school systems with these agencies.

Financial Support of Special Education Programs

The Nevada Legislature has been generous in the past, and as these problems have been presented to them, the legislature has appropriated additional funds to carry out the programs. Because of the availability of funds, it is difficult to understand why only two counties have set up complete facilities for special education programs, and only a few other counties have one or two classes which contain heterogeneous groups of handicapped children. In a few counties, population alone explains the lack of special facilities. In other counties, however, there appear to be three factors: (1) the normal and conservative reluctance to inaugurate a new program, such as special education, which has many implications for administrative concern; (2) the distaste of some parents who are sensitive when it is recommended that their children be placed in special classes; and (3) the fact that classroom facilities are considered to be more expensive for a handicapped child than for the typical child. A classroom for normal children will accommodate 25 or 30 children, while a classroom for the handicapped child is generally limited to from 8 to 18 children. In spite of the money made available by the Legislature for the support of special education classes, it appears that one obstacle is lack of money to provide adequate classroom space for the program. The State Department of Education should consider requesting financial assistance to construct the required units to house the classrooms for the special education programs.

Is the Program Being Adequately Supported?

There is no way of ascertaining whether the handicapped program is being adequately supported because of the absence of any studies evaluating the actual cost of the program in individual districts. Such studies are under way and when available will allow this question to be answered.

It is obvious however that there is a great difference in the amount of money expended in the various districts on the actual programs. Some counties have established haphazard, shoddy programs, expending as little money as possible, whereas others have established high standards. Yet, as previously stated, both get equal support.

The Apportionment Formula

In some counties, parents' groups have felt that money which should be devoted to the handicapped program has not been so used. However, the apportionment formula now used means in effect that the money cannot be earmarked, but loses its identity in the general fund of the school district. They are right, however, in their fear that the program is being less than adequately financed at the local level.

Additionally, an apportionment formula cannot take into account the differences in real expenditures of the local school district. There is no incentive therefore to use the money to insure a good program and an inadequate, financially cheap program is reimbursed as well as a more adequate, more costly program.

For these reasons, it is felt that a method of supporting the handicapped program based on an "excess cost reimbursement" formula be used.

Is a Mandatory Program Necessary?

After five years of legislative support for the operation of an educational program for the handicapped child, a majority of the counties still have not established such programs. The probability is that every county, with the exception of 2 or 3, has enough children needing this service to establish such a program even under the present administrative regulations of the State Department of Education. It is felt that the benefits of such a program for the handicapped are so obviously and urgently needed that it should be made mandatory for each district to establish a program for the handicapped child. This assumes that the State Board of Education will be flexible in its requirements. It is conceivable that a district would have only two or three children needing this kind of assistance. The State Department of Education in these cases could reimburse the district for hiring a tutor for these children for 5 half-days a week; this, of course, would be an extreme example, but it would appear that a properly flexible and sensible approach would make sure that even those counties with less than 8 children eligible for inclusion in a class could be reimbursed for the added costs of a handicapped program. This again brings up the question as to whether an apportionment system of distributing funds is pliant enough to meet the need of these programs.

Special Versus Remedial Education

There are incidents, too, in which remedial programs are making use of funds intended for the use of special education. There must be a decision on the part of the Legislature and the State Board of Education as to how far this can be pushed. Normal children with reading problems will benefit from a remedial program. Normal children who have specific difficulties with arithmetic need tutorial work in mathematics. However, to use special education funds and increased ADA funds which are given for the handicapped children for this purpose, seems to be an improper use. While it may be the desire of the Legislature to provide funds for remedial programs, it is felt that a clear-cut distinction must be made between money given for the handicapped child and money given to the typical child who needs remedial work if the intention of the Legislature is not to be abused.

There are examples of counties receiving increased apportionments who do not have a program for the handicapped.

Flexibility of Approach

As has been mentioned, one of the great objectives of special education is to train the child and advance him to a point where he can be reintegrated into the normal school system. The goal of special education is to make the child operate in as normal and average a way as possible, rather than to maintain his status at subaverage functioning. For this reason, a more versatile approach to the way local counties are compensated for the work in special education should be considered. When a child is reintegrated into a typical classroom, the extra load on the school system does not stop. A lack of support for programs to assist the child in returning to a typical classroom fails to complete the most necessary step in rehabilitation. In this situation, the services of a psychologist, a social worker, and additional counselors are drastically needed. The counties are not compensated

for the services of these people to even the same degree as they are for teaching services. At the present time, these ancillary people qualify only for the teacher's apportionment and do not receive the $106 ADA payment for service to the typical child or the $500 ADA support for services rendered to the handicapped child. An apportionment along the lines suggested, or one that will focus attention upon special education should be seriously considered.

Recommendations

1. Programs in special education should be supported by using an "excess cost reimbursement" formula.

2. Support for ancillary personnel should be given.

3. The establishment of programs for the handicapped child should be made mandatory in each school district.

4. An individual with doctorate level training in the area of exceptional children or psychology should be employed within the framework of the State Department of Education.

5. The difference between a remedial program for the typical child and a program for the handicapped child should be more clearly defined.

6. The problem of providing adequate classroom space for the special education program should be considered.

CHAPTER XII

THE PREPARATION OF MENTALLY RETARDED YOUTH FOR GAINFUL EMPLOYMENT

The Clark County School District is at present taking tentative steps toward a vocational training program for the retarded. No other school system in the State of Nevada has as yet contemplated such a program.

The following paper, prepared by members of the Santa Barbara Public School System presents a program of vocational training and placement which may have value for Nevada. It is presented to familiarize the reader with the methods and results of such a program.

(By Leonard Rogers, teacher in the Santa Barbara Public Schools, and Thomas J. Rogers, Director of Special Education)

The Santa Barbara High School Work Education Program for mentally retarded students is a program that presents a realistic approach to the education of mentally retarded students on the high school level by developing a curriculum in terms of the experiences encountered by the student on real work situations in the community.

This program attempts to give the student the status of belonging to an accepted school program while at the same time preparing him for his ultimate role in society.

Students in this program are allowed and urged to participate in all regular school functions. They are members of the student body, attend assemblies, join special interest clubs, participate in school sports, and engage in all school sponsored activities. Students assigned follow a definite course outline, approved by the local Board of Education, and which meets the State's requirements for graduation. The 10th grade students in this program do not participate in an outside work experience. Their program is designed to prepare them for the work-education program in the 11th and 12th grades.

It must be remembered that as in all such programs, class titles are kept as similar as possible to the titles given the classes of regular students at high school. These titles do not limit the content of this course; in actual operation, the program is operated as a core program and cuts across many subject areas.

Students at the 11th and 12th grade level, attend class for four periods in the morning and are on work assignments in the community for 2 to 4 hours in the after-

noon.

One teacher in this program is given the responsibility for job finding, placement and supervision of the student on the job. He is released from teaching duties in the afternoon to carry out this assignment. Since this requires considerable travel, he is given a travel allowance in addition to his salary.

How Jobs are Acquired

A large percentage of the jobs are found by the teacher through personal contact with prospective employers. Local employment agencies are contacted, but generally are able to give very little help.

The type of jobs sought are according to the interests and abilities of the student. For example, one student, with second grade reading ability, was placed in a job in a gas station. He was unable to make change correctly when he began, so he could only service cars. As he learned in school how to make correct change and the answers to many other problems he had encountered on the job, he was gradually given many additional duties, until by the end of the school year he was pumping gas, making change, washing cars, changing tires, parking cars, and assisting the mechanics.

Caution should be observed in obtaining jobs that defeat the purpose of the school program. It is desirable to find jobs that have definite routine requirements, that provide some type of supervision, and will be of the same level as the type of job the student will find when he finishes high school. A large percentage of the work is on a paid basis; however, the learning value of the work experience is emphasized rather than the salary. In fact nonpaid experiences are encouraged when the student enters the program, so that he can explore various fields of endeavor to find the work in which he is most interested. The pay scale of the students on the various jobs has ranged from $0.75 to $1.25 per hour.

How Students are Placed

The teacher begins making contacts for employment before school starts in the fall. Many of the students are still on the same jobs from the previous year, so when school commences in the fall, four out of six students are placed on a job the first afternoon. These students ride with the teacher in the teacher's car. The students remaining at school are placed in a study hall for the two afternoon periods until they are employed. By the second week usually all but a very few of the students are placed on jobs. Those remaining ride with the teacher in his car while he seeks jobs for them. This is an important aspect of the program, since those who are not yet placed are often those who need an intensified counseling program in relation to their attitudes about work, school, community, etc. This had not been planned as a part of the program, but experience has taught us that this close, intimate sort of contact of riding in a car together has opened up opportun-

ities for counseling often not available to the student.

If an employer is available when the teacher makes his first contact, and the employer is receptive to having a student work at his place of business, only one or two employer contacts are necessary. However, since it is not usually possible to see an employer on the first call, it generally requires three or four contacts before a student can be placed.

During the first contact with an employer the teacher inquires as to whether or not a part-time job is possible. He explains the program to the employer and outlines the capabilities, description, and other pertinent information regarding the student for whom he is seeking work experience. If the employer is possibly interested, the student is brought for an interview. It is important to note that the student is not sent on his own. It is felt that this is one of the strengths of the program, since it has been our experience that these students usually are not willing or capable of making the first interview on their own.

Length of Stay on a Job

Since the major emphasis is job exploration of a work situation rather than a permanent job placement, students are generally given a number of work experiences throughout the school year. Length of stay on a job will vary from the student who immediately finds a job that suits him and the employer to the student who will require a number of job experiences throughout the school year.

Reasons for changing jobs are numerous. One boy worked for 2 months in a laundry until he was no longer needed. He then went to work in a garage as a mechanic's helper, but after 3 weeks the employer felt he was still too inexperienced to continue. However, he was placed in another garage where he was assigned to assist with car radio repairs and he worked there for a number of months. His next assignment was in a service station where he remained on the job until summer vacation.

Supervision by the School

Periodic conferences with the employer are part of the planned program. No definite schedule is maintained; however, each employer is contacted at least one time each week. A definite schedule would restrict the teacher from taking care of occasional problems that require immediate attention. These are generally pupil misunderstandings in terms of the job requirements.

Spot checks of the pupil are made at a more frequent interval than the employer conferences. These are made to keep the student aware of his responsibilities to school and employer, and to provide the teacher with information regarding the needs of the pupil on the job so that these needs can be met during the school class session.

Employers are asked to complete a job evaluation form on the students four times a year. This evaluation form lets the teacher know what progress the student is making and enables him to work on any problems the student might have.

Classroom Program

The students spend their first three periods in the morning with the special training class teacher.

Although these are listed as English, mathematics, science and/or social studies, actually they are treated as a core program, with the experiences from the work situation as a basis for the program.

Pupils are encouraged and given opportunities to share and tell of their work experiences. They list the various tasks their jobs demand and explain sometimes with demonstrations, how a task is performed.

As they begin to earn wages and work by the hours, mathematics takes on a new meaning. Ray, who worked servicing cars in a gas station, felt uncomfortable because his boss had to make change for him. He immediately informed the teacher that he wanted to learn how to make change. Varying working hours, changing jobs and salary increases make the figuring of wages a continuing problem which all are eager to tackle. A few students who have made over $25 a week are anxious to learn about filing income tax returns.

Many parents reported on the changes in their child's attitudes towards homework. One couple state "Raymond seems to have 'grown up' this year." Ray's mother stated that his interests had changed from TV to his job and his car. She further stated that she appreciated the fact that he worked overtime until 6:00 p.m. each day, because she didn't have to worry anymore about what he was doing between the time school let out and dinner time.

The English program is based upon everyday needs of living, and comprises such things as filling out job applications, income tax forms, money orders, or bank deposit slips; reading about job openings, bus schedules, union requirements, city maps, telephone directories, books and pamphlets related to their job; making tape recordings of descriptions of their jobs, and observing movies on job requirements. One of their greatest interests is in handwriting. Scores of letters are written to various sources for free materials related to a pupil's specific interests. As the mater-

ials requested are sent to the pupils' homes, they in turn are brought to school and shared with the class, so this forms the basis for their oral English reports.

The work education program lends itself to exploring at school many areas that are normally difficult to discuss in the typical school situation. Some of these areas are: personal hygiene and cleanliness, manners, and courtesy, civic and family responsibilities. Judging from the reaction and reports of the parents, students, teachers, and employers, it is believed that a work-education type of program comes closer to meeting the needs of these mentally retarded high school students than any other program before attempted at one high school.[1]

Recommendation

1. That the individual counties and the State Director of Vocational Education investigate the possibility of initiating vocational training and placement programs for the retarded.

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1 Preparation of Mentally Retarded Youth for Gainful Employment: U.S. Dept. of Health, Education & Welfare: Bulletin No. 28: 1959.

CHAPTER XIII

SOCIAL WELFARE SERVICES FOR RETARDED CHILDREN

Foster Home Care for the Mentally Retarded

Circumstances sometimes necessitate the placement of a retarded child in a setting other than with his own family. For the severely retarded child for whom the outlook is one of complete dependency, who is unable to respond to any meaningful relationship with family members, and whose care becomes a problem to the parents and interferes with the healthy emotional development of the other children, institutional placement would be indicated. In Nevada these children may be placed for institutional care in the Children's Section of the Nevada State Hospital. (See Chapter XIV.) This institution, however, does not take children until they reach the age of two years. Foster home care for these infants, as well as for the moderately retarded requires the development of foster homes geared to meet the needs of the retarded outside their own homes. These other situations are:

1. Children from sparsely settled or rural areas where there is no clinic for diagnostic evaluation, training or educational facility in their community.

2. Temporary placements when crises occur in the home; e.g. illness of the mother, trips where arrangements for the child to accompany the parents cannot be made, possible vacations.

3. Studies made in other states indicate that many retarded children do not develop to their full potential because of the inadequacy of the home. Emotional, physical or cultural environments which do not provide stimulation may result in delayed maturation. Placement of deprived children in foster homes where the environmental experience is enriched frequently results in mental and social growth. One of these studies was conducted at the University of Illinois over a five-year period. The purpose of the experiment was to determine the effects of preschool education on the social and mental development of young educable mentally retarded children. The reports on children included in the study who were placed in foster homes because of neglect and inadequate environment indicated there was an acceleration of mental and social development when adequate stimulation was received through foster home placement and preschool training. Two studies done in Iowa on the mental development of adopted children include a number of children whose mothers were known to be mentally defective and from culturally deprived backgrounds, but who were placed at an early age in average or superior foster homes. The mental development of these children was in the normal range and the researchers concluded that the enriched environment contributed greatly.

The Nevada State Welfare Department is authorized to license foster homes in the state (NRS 424.030, see Appendix "H"). The standards set up by the Department provide for a healthy physical and emotional environment (See Appendix "I"). In addition, foster homes for the placement of retarded

children require foster parents with an understanding and interest in these children and their problems. Development of specialized homes would require more child welfare staff time to help the foster parents before and after placement in order to understand the child's behavior, needs and limitations. As of July 1, 1960, there were 136 licensed homes in the state with a capacity for 282 children and 110 vacancies. In the two centers (Reno and Las Vegas) that provide diagnostic evaluation and educational opportunities for retarded children, there are very few homes available. In Reno there are six licensed homes that will accept retarded children for placement and none in Las Vegas. The Welfare Department plans to recruit such homes and a step in this direction should include a cooperative program of child welfare workers and the clinic staffs specializing in the evaluation and training of the mentally retarded child. This increased understanding of mental retardation on the part of the child welfare worker might serve in the selection and supervision of specialized foster homes.

At the present time the Nevada State Welfare Department administers the plan to provide assistance for handicapped children. The appropriation for the fiscal year, 1960-61, amounts to $14,370. Handicapped children are defined in this program as those who have a limiting condition, physical or mental, which prevents the child from obtaining and utilizing regular educational opportunities to the maximum of his capabilities.

The purpose of the fund is to enable children from the entire state to utilize special training and educational facilities which are available only in the larger population centers of this and surrounding states.

Certain conditions to be considered are:

There must be an educational objective in the plan for each child.

The fund can be considered in relation to short-term use only.

The services provided are:

Foster family care.

Limited special needs.

Transportation to and from the resource facility when related to foster care and in accordance with the purpose for which the fund was established.

Transportation and maintenance for the child and an adult caretaker to obtain medical treatment, surgery, or diagnosis for the child, supplementing programs of the State Health Department (Crippled Children program and Special Children's Clinic) which provide for the actual treatment or diagnosis only.

An example of how the fund has been used is the case of a blind child, who at the age of 5, was referred to one of the Special Children's Clinics as a retardate. He was one of a large family in which there was very little attempt to stimulate him to develop his abilities. His speaking ability was

very limited and he showed no capacity to understand or follow directions. The teacher of a class for visually handicapped children felt that training was indicated before it would be possible to determine his degree of retardation. The family lived in a community where there were no special education classes. This child was placed in a foster home near the school with a family where new experiences were afforded him. He has been able to learn and has developed adequate speech. More adequate funds for foster home care for children from environmentally deprived areas would be needed if there were an adequate number of suitable homes.

In the welfare programs of Nevada, there is considerable overlapping of services which affect planning for handicapped children. In addition, there is a great deal of confusion and conflict between State Welfare, County Welfare, and Probation Departments. Since the Legislative Counsel Bureau is studying welfare programs at this time, this factor will not be discussed in this report.

Day-Care Services

Day-care services are often used by the working mother but they may be used by any parent whose child can profit from a day-care program and make a beginning of relationships with other children.

The special children's clinics in Reno and Las Vegas have day-care services for those preschool-age children undergoing diagnostic evaluations in the clinics. These clinics offer several valuable areas of experience to the children as well as to the parents. Each child utilizes the loosely-structured group only as he or she is ready and able to profit by it in his growth.

There has been a reluctance on the part of community day centers to accept handicapped children in Nevada. However, steps are being taken to integrate some retarded with the normal children.

Discussion

Statistics indicate there are 136 licensed foster homes in the state with 110 vacancies. This again points out the fact that foster homes want the "normal" child, and irrespective of all these vacancies, there are probably that many children who are in need of a substitute home. The paradox of it all is that the Children's Home is being filled with normal children who do not benefit - and may suffer - from institutional living, while the very facility - normal foster home with substitute parents which benefits the normal child - is not being utilized. Even worse, the emotionally, physically, and intellectually handicapped children who would benefit from temporary placement in a group-care facility are denied entrance.

At the present time, approximately $30,000 is being spent by county and state agencies in Washoe County alone to provide residential treatment of disturbed children outside the State of Nevada. Since these distant facilities cannot be properly supervised or evaluated, the justification for a short-term, intensive, remedial treatment center would seem economically sound.

Recommendations

1. A more intensive recruitment of foster homes for handicapped children should be carried out by the Welfare Department.

2. Standards for licensing private residential centers for retarded and handicapped children should be established by the State Welfare Department in conjunction with the State Department of Health.

3. Development of an in-service training program for child welfare workers by staffs of clinics for retarded children to increase knowledge and understanding of retarded children and their needs.

4. A closer working relationship between special children's clinics and day-care centers could help in providing services for the preschool retarded children in the community.

CHAPTER XIV

NEVADA STATE HOSPITAL

Function

Nevada is the only state in the United States that does not have a separate state institution for mentally retarded children. Until 1937, there was no distinction in the commitment of patients to the Nevada State Hospital, and some mentally defective children were committed as a temporary relief measure, subject to placement in a proper school or hospital in a neighboring states. The neighboring states declared themselves unable to accommodate the needs of Nevada, so some placements were made in private "homes" in Nevada. Transfers from private "homes" to the State Hospital began around 1937, although it was discouraged by the Hospital. By 1945, there were six children under the age of 10 placed in four adult wards.

As early as 1945, the Superintendent of the Nevada State Hospital recognized the problem and recommended an immediate change. He stated that "It is the duty and interest of the state or county, whichever has the financial responsibility, to provide such care and training during childhood as will equip for a maximum of self-help in later years. Until such a time when a separate facility may be economically operated, that is, be self-supporting on the moderate rate of pay from the counties, the practical solution is the establishment of a children's annex at the Nevada State Hospital."

Since 1945, the number of mentally retarded children in the Hospital has increased, and at the present time, 29 children are in an old, inadequate, two-story stone building. There are also 21 older children below age 18 scattered in adult wards. A new pediatric building is being completed and nearly ready for occupancy. It was designed to accommodate 30 children, and will take care of those children now housed in the old building. The present plan is to redecorate the old building and move the 21 children present in adult wards to this redecorated building.

Procedures for Commitment to Nevada State Hospital - Nevada Revised Statutes

Sec. 433.300 Mentally deficient, noneducable children.

1. The superintendent is authorized to receive and care for mentally deficient, noneducable children of the State of Nevada over 2 years of age at state expense when:

(a) Properly committed to the hospital; or

(b) Admission of children not over the age of 21 years is requested by a parent, parents or guardian upon application and proof to the superintendent.

2. A minor child over 2 years of age may be received, cared for and examined without commitment, if such examination is ordered by a juvenile court having jurisdiction of the minor in accordance with the provis-

ions of paragraph (c) of subsection of NRS 62.200, in which event the superintendent shall report the result of the examination to the juvenile court and shall detain the child until the further order of the court, but not to exceed 15 days after the superintendent's report. When the child is found to be without specific mental disorder or is considered educable, the child shall not be detained at the hospital, but shall be released to such authority as the juvenile court may order.

Procedure for Discharge from Nevada State Hospital - Nevada Revised Statutes

Sec. 433.550 Discharge of patients.

1. At any time the superintendent may discharge any patient who in his opinion has recovered from his mental illness, or is a dotard and not mentally ill, or who is a person who in the judgment of the superintendent will not be detrimental to the public welfare or injurious to himself.

Discussion

The commitment and intake procedures are confusing and vague. It is not even clear to the various health and welfare agencies whether the child has to be committed through the county court or upon direct application to the Hospital. Intake procedures vary from case to case, with no definite pattern for admitting a patient. This may be handled by the Superintendent, the director of nursing or the resident doctor.

In the discharge of a patient, contact between the institution and the community is virtually absent. There is no social worker available for preplanning or follow-up in the home or community. There are instances when a child should be removed from his home, but should not be placed in an institutional setting. This requires social work planning for a foster or boarding home.

In California, these foster home placements are screened and licensed by field social workers in the Department of Mental Hygiene.

Information should be made available to families regarding admission and discharge procedures, services offered, visitation, etc. A good example is a pamphlet entitled "Parents' Handbook," provided by the Sonoma State Hospital in California. Bulletins should be distributed to all agencies and professional persons so that misinformation and misunderstanding can be avoided.

The minimum age limit of 2 years for admittance to the Hospital is reasonable though from a humanitarian and realistic standpoint, there are exceptional cases which demand institutionalization prior to that age. The Superintendent should be authorized to exercise his own discretion in accepting children under the age of 2.

Of the mentally deficient, the most unmanageable and unstable individuals

are those known as "defective delinquents." Though comparatively few in number, they create problems far out of proportion to their numbers. At the present time, the Superintendent of the Nevada School of Industry at Elko reports no mentally deficient boys in the institution.

Most adult mentally deficient persons have social handicaps which interfere with their ability to meet the competition of their mental or social superiors. Possibly, some of the 91 mental defectives spending their lives in the Nevada State Hospital and occupying valuable space, might, with proper professional assistance, return to the community.

Solution to some of these difficulties would be providing varied facilities for outside-of-the-hospital rehabilitation, such as workshops, boarding homes, farms, etc., where each person could receive care and training suited to his needs.

Population

By 1960, there were 34 mentally deficient patients under the age of 15[1] in the Hospital. In addition to the mentally retarded children, there are 91 mental defectives over age 16 in the Hospital.

POPULATION OF ALL MENTAL RETARDATES
AT NEVADA STATE HOSPITAL FROM 1947 to 1960

1947-48	37
1949-50	25
1951-52	42
1953-54	76
1955-56	82
1957-58	110
1959-60	125

Personnel

At present, there are four physicians serving the entire population of 529 patients, with one designated to make daily rounds of the children's ward. There are ten registered nurses serving the Hospital and supervising the attendants in the children's ward. This means one nurse for every 265 patients, assuming there are two nurses per shift. Three untrained attendants serve two shifts in the children's ward - one from 11 p.m. to 7 a.m., and two from 7 a.m. to 11 p.m. There are also about six adult women patients who assist in the children's ward. A special education teacher works on a voluntary basis five mornings a week.

Numerous recommendations were made in two prior studies of the Nevada State Hospital - one in 1945 conducted by the American Psychiatric Association, and another in 1956 by the Central Inspection Board of the American Psychiatric Association. A portion of their recommendations follow:

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1 This total includes children afflicted with a chronic brain syndrome.

1. A survey of all adult mentally defective persons in the State Hospital should be made to determine the number who are psychotic and in need of treatment in the Hospital.

2. Adequate separate facilities to be provided for low-grade mentally defective children and these facilities should be expanded as required to care for this group in the Hospital. Additional trained staff will be needed.

3. A study of the need for a school for mentally retarded and higher grade mentally defective children in Nevada to be made and provision for such facility should be seriously considered.

Social Work Department

This Hospital does not have a social service department. About 25 percent of the case histories are obtained directly from the relatives and other data may be obtained from county welfare agencies, the district attorneys of the courts, and from personal letters from the members of the patient's family. Information secured in this way is included in the clinical history and filed in the medical record. Patients on trial visit or convalescent leave are not supervised by members of the Hospital staff.

1. The position of head psychiatric social worker should be added to the personnel quota and the services of a well-qualified person should be obtained to fill this position. Additional workers should be added to the personnel quota to meet the standards of the American Psychiatric Association.

2. Office space, including an adequate number of rooms for interviewing new patients and their families will be needed.

3. The duties of the staff of this department should include pre-diagnostic assistance, liaison services for in-patients, and supervision of patients on trial visit.

4. A monthly report of all activities should be made to the Superintendent.

Psychology Department

This hospital does not have a psychologist on its staff. Some psychological testing is done by members of the medical staff. A psychologist from the University of Nevada was paid a fee of $5 an hour to evaluate the results of these tests. A part-time registered nurse who is completing graduate work in psychology at the Univers-

ity of Nevada assists in administering routine and projective psychological tests for selected cases. Patients admitted to the Hospital from the courts usually have had a complete psychological work-up and the record is transferred with the patient. Cases that do not contain adequate psychological work-up are referred for testing to the State Clinical Psychologist who has an office in Reno.

1. A full-time clinical psychologist or two half-time psychologists should be added to the hospital staff.

2. Affiliation with the psychology department at the University of Nevada would be desirable.

3. An office and examining rooms will be needed when a full-time psychologist can be employed.

4. The clinical psychologist should not only perform pre-diagnostic examinations, but take part in the psychotherapy programs of the Hospital, under the supervision of the psychiatrist.

Four years after the study by the Central Inspection Board of the American Psychiatric Association, very few recommendations have been carried out.

Future Institutional Plans

In the past, it has been public policy to segregate each mentally deficient person in isolated residential institutions and colonies. Today, it is economically impossible and socially inadvisable to build elaborate institutions to care for such persons. Only those who cannot be cared for or trained in their own communities should be institutionalized. The problems of the mentally deficient are so varied that no single approach is the answer. To a great extent the development of decentralized community programs in public schools, clinics, workshops, and industries will reduce the number who will need institutionalization. More effective training will ultimately release some not committed and provide more room for others who cannot respond as readily to such instruction. Better physical and psychological services in the institution may likewise restore a reasonable percentage of the most severely handicapped to self-sufficiency and reduce the actual burdens of institutional care.

In view of these potential programs, it would not be necessary for the state to undertake a major building program, once the present needs are met. Future requirements must be anticipated if we are to avoid periodic crises that will cost thousands of dollars in capital expenditures. Fortunately, there is no backlog of mentally retarded children awaiting admittance to the Nevada State Hospital. All other states have long waiting periods for admission to their institutions, thus compelling the commitment of many mentally retarded and handicapped individuals to prisons, reformatories, and other institutions where they create additional burdens for staffs that are already overloaded. The efficiency of these institutions is greatly impaired by the presence of patients who belong elsewhere, and the deficient themselves receive little benefit.

In a regional conference on Mental Retardation, held in March 1959, five states, including Illinois, Indiana, Michigan, Ohio and Wisconsin, considered the problem of over-crowded institutions. It was pointed out that most states had been expending the bulk of their treatment dollar for the care of long-term, chronic, and prognostically unfavorable cases of mental illness and mental retardation. A very small proportion of financial outlay was devoted to facilities needed for early diagnosis, referral, and intensive treatment. The key question was: "What can we do to reverse the upward trend of a growing patient population in institutions for prolonged care?"

In long-range planning, all the states visualize institutions for the mentally retarded, as providing care only for those who are not able to remain in the community because of medical or social difficulties. They believe that the training of the retarded should be carried out at the community level whenever possible, and community services, such as diagnostic clinics, day schools, sheltered workshops, halfway houses, and public school special classes should be developed.

In making recommendations for the mentally retarded in Nevada, several factors should be kept in mind. First, Nevada's lack of institutional facilities can be considered an asset. The state will not have the problem, common to many states, of decreasing the population of overcrowded institutions. The Superintendent of the Nevada State Hospital should be commended for setting definite limits on the intake of retarded children, thereby preventing the Hospital from becoming a dumping ground for all levels of retarded children. In addition, to being detrimental to the child, such practice relieves the family and the community of their responsibility. The children presently in residence at the Nevada State Hospital are severely retarded, able to benefit only from good nursing care.

If fewer mentally retarded persons are to be institutionalized, establishment of services at a local level will be necessary. Such facilities include sheltered workshops, day-care centers, special education classes, and diagnostic clinics.

Recommendations

1. Procedures for admission and discharge of patients from the State Hospital should be more adequately planned, stated, and carried out.

2. No new state hospital for the mentally retarded should be built unless a treatment program can be provided. The present pediatric ward should first have sufficient personnel to offer high standards of treatment.

3. A clinical psychologist with a Ph.D., and a psychiatric social worker with a master's degree should be employed to provide an adequate diagnostic and treatment program.

4. No child under 9 years of age should be committed for mental retardation without first being evaluated by the Special Children's Clinics. A period of hospitalization for the purpose of observation could be provided but this should be prior to actual commitment.

5. For the educable mentally deficient patients over 18 years of age, there should be a coordinated plan with the State Departments of Health, Education and Welfare to rehabilitate and restore these members to the community.

6. Part-time and outpatient facilities should be accessible to families throughout the state. These facilities should be available to local communities as centers where counseling and guidance may be given on the problems of mentally retarded persons and their families. There could be facilities located at Reno, Las Vegas, Ely and Elko.

7. A coordinated program should be worked out between health and welfare agencies.

8. The Nevada State Hospital should continue to accept those children who are severely retarded and who can benefit from custodial care. (See Chapter XV on the Children's Home.)

9. Section 433.300, Nevada Revised Statutes, should be amended in order to allow the Superintendent to exercise his discretion in the acceptance of children under the age of 2 years at the Nevada State Hospital.

CHAPTER XV

STATE CHILDREN'S HOME

Function

The Nevada State Children's Home in Carson City has been a home for orphans, dependent and neglected children since 1870. The capacity of the Home is about 60 children, and during its 80 years of service has seen periods of population change; the peak being 112, the low point about 60. At first, the services were restricted to orphans and half-orphans, but in 1913 the Nevada Legislature broadened the function of the Children's Home to include any children legally declared to be dependent or neglected. The average number of admissions per year over the entire period has been about 20. The rate of payment by counties was raised to $50 per month per child in 1953, which was more than double the amount formerly paid, and it was felt the increase might discourage the easy sending to the Home of all homeless children. All funds are appropriated by the Legislature. Counties in turn may collect from parents if so ordered by the court. As to intake, the children are committed to the institutional care of the Nevada State Children's Home by district judges. The petitions for commitment are usually made by county juvenile officers or by welfare agencies, or private citizens may so petition. The Home exercises control over intake only in the occasional cases when defectives, children with communicable diseases, or known delinquents are placed there by error. At the present time, there are 52 children enrolled at the Children's Home; all are school age. Since the spring of 1959, the nursery has been closed and all preschool children have been placed in foster homes.

Admission, Care and Custody of Children in the Nevada State Children's Home

The statutes provide that:

> No child should be admitted to, received into, or committed to the Nevada State Children's Home who is insane, idiotic, or so mentally or physically deformed as to be incapable of receiving the elements of an education, or who has any contagious disease.

The statutes further provide that:

> A whole orphan is a child both of whose parents are deceased. Upon the written verified application of any citizen of the State of Nevada in behalf of any whole orphan, to the district judge of any county, the district judge sitting either in chambers or as a court, shall issue a citation to be served, respected and enforced as are other judicial writs, commanding the applicant to appear before him at a time and place to be specified, not less than 5 days thereafter and make proof concerning the matter set forth in the application. The judge may, in his discretion, shorten the time. A notice of the hearing must be given in like manner to the nearest relation of the orphan,

> resident in the state. At the same time, the judge must cite the person having control or custody of the orphan to bring him before the judge on the date of the hearing. On the written application of the nearest relation of any whole orphan, the notice of citation in precedent to the hearing may, in the discretion of the judge, be omitted.

In order to define the restrictions and limitations governing admission of children to the Nevada State Children's Home, the Chairman of the Nevada State Welfare Board requested an informal opinion from the Office of the Attorney General.

The Attorney General informed the Chairman that "male whole orphans under 16 years of age and all female whole orphans under 18 years of age are eligible for admittance to the Nevada State Children's Home." The Attorney General also indicated that dependent children, as defined in NRS 201.090, other than orphans, were eligible for admittance to the Children's Home when committed to the Home by a district court. He added that the legal age limitation on admission of a dependent child was "less than 18 years of age."

All children are in the Children's Home by court order, the majority of the orders reading, "until further order of the court." The available family history indicated that children admitted to the Home are predominantly dependent children whose parents might very well have made their own arrangements for placement directly with the casework agency. In short, commitment as a means of bringing about placement of the children, in the majority of the cases, was unnecessary and even undesirable.

There have been few attempts on the part of the courts to determine whether an individual child or family of children would profit from institutional placement. Ideally, such decisions should be made in a joint conference of the agency familiar with the problems of the family and child, the receiving institution being considered; and in cases where the court will be required to commit, the district judge should attend the conference. There are instances in which the consultation of a clinical psychologist would be of value in determining the most advantageous placement of a child.

The question of age limitation resulted from a meeting of the State Welfare Board with several other social agency representatives in an effort to plan for the present and future care of children. Individuals familiar with child welfare problems in Nevada have expressed the sentiment that the Children's Home is no longer needed as an orphanage, and should be reconstructed to meet present day needs, and that the laws governing age restriction and limitations governing the admission of children should be changed in accordance with a new-type residential setting. The tremendous foster home shortage might be aided if the older children could be allowed residence at the Nevada Children's Home. Until 1959, the Children's Home had been filled with children ranging in ages from several months to 6 years. Children within this age group should not be in an institution, but should be placed with foster parents who can act as substitute parents. During the past year, the State Welfare Department has followed a policy of placing all children of preschool age in foster homes.

The statute which limits admittance to "those not insane, idiotic or so mentally or physically deformed as to be incapable of receiving the elements of

an education" is too stringent. Under this statute, epileptic children are prohibited from entering the Children's Home. However, in most instances, these children are medically controlled and are allowed to attend public schools.

Services

There are nineteen employees at the Children's Home: a superintendent, administrative assistant, child welfare worker, one infirmary resident attendant, five house parents, three cooks, one seamstress, three maintenance men, one relief house parent, one secretary, one consulting medical officer. During the last school year a certified elementary school teacher worked 1½ hours four nights a week, and it is planned to continue this tutoring.

Health

Health services for the children are under the direction of Dr. James Thom, a local physician, who has been the medical officer for the Home for many years. He takes care of emergency calls, makes physical examinations of all new arrivals, provides immunization care, performs tonsillectomies, adenoidectomies and other surgery, as well as providing regular physical check-ups. Dental care is arranged through the State Department of Health.

Education

Since 1911, the children have attended the Carson City public schools. A special appropriation based upon expense per child and average number attending from the Home is made during each session of the Legislature. This method insures the Carson City public school system against loss in offering public school facilities to these wards of the state.

Psychological and Psychiatric Services

For the past 10 years the Mental Health Section of the State Department of Health has been furnishing psychological services upon request. The Nevada Legislature approved a part-time psychologist for the Children's Home and State Prison for the 1960-61 fiscal year.

NRS 433.120 states that the Superintendent of the Nevada State Hospital shall have the power and duty to:

> . . .perform neurological and psychiatric examinations at the Nevada State Prison, the Nevada State Children's Home, and the Nevada School of Industry when requested by the superintendents or warden of those institutions.

The psychologist and social worker from the Mental Health Section of the State Department of Health have given of their time to the Children's Home; but, needless to say, they are over-worked and unable to give adequate services to the Home. Dr. Tillim has been designated (NRS 438.080) as the psychiatric consultant. However, it is a function without meaning since he has evaluated only 2 children over a 10-year period. Section 433.080, Nevada Revised Statutes, should be repealed since the establishment of proper services has been prevented. Local consultantships with neurologists and psychi-

atrists from the general medical community should be arranged. The need for these services at present is so small that the most elaborate consultative service would cost less than $1,000 per year.

The necessity for providing additional professional personnel is obvious. Institutional care should always provide for a treatment program to change or modify behaviour in order that a child may return to successful living in his own home. The lack of this professional personnel is by no means a criticism of the present staff's love and care of children. However, one of the most important needs in the state could be met through proper professional staffing at the Home. This staff could provide intensive treatment to disturbed children in order that these children might be returned to their community.

The Future of the Institution in a Changing Child Welfare World

It has been well and truly said that the child survives better psychologically in a poor home of his own than he does in a foster family home or an institution with higher cultural standards and higher value systems. Such is the value of belonging. However, some homes are definitely harmful to children and children must be removed from them and placed in other homes temporarily or permanently, or in institutions. Both foster family care and institutional care are treatment programs to be used for short periods of time to meet dependency situations, and for such periods of time necessary to resolve the problems of a child. These facilities are used as treatment resources to change or modify behavior so that the child may return to successful living in his own home or be placed for adoption.

During the last three decades, most dependent children were placed in institutions and grew up within the walls of those institutions. Today's thinking demands that all child-care programs be closely interwoven with normal community living. This is true not only for dependent children, but for children with handicaps. It is commonplace now for blind children to be included in day-care programs and public school systems. Children with serious emotional disturbances who sleep within the walls of a residential treatment center may go to the public school, or have the freedom of a surrounding neighborhood in which to play. In short, community living is part of the treatment process. Martin Gula writes:

> Community resources are absorbing larger and larger numbers of younger, less disturbed, or less retarded children who can be cared for while living at home or in foster homes. In turn, this means that the more severely disturbed, aggressive delinquent, and severely retarded children are squeezed to the top and referred to institutions. Since these children have more complex treatment needs, institutions are being asked to provide more specialized care and treatment. Conversely, as the quality of treatment in institutions improves, more children become ready for return to their own communities, and the institution presses community agencies and organizations to provide adequate aftercare through counseling, clinical, vocational guidance, foster family and other services.[1]

1 Martin Gula: Child-Caring Institutions, U.S. Department of Health, Education and Welfare: 1958, pg. 4.

The institution which continues to accept children who will not benefit from institutional care is providing no real service. Institutions must insist that they serve appropriate groups of children for appropriate lengths of time, and that they be provided with the funds and the skilled staff who can help the type children that are placed in the institution.

The survey executed on the Children's Home by the Child Welfare League of America in April 1959, gave the following information:

1. Medical advances since the turn of the century have caused parents to live longer, particularly mothers for whom the maternal death rate has been greatly reduced. The full orphan has virtually disappeared from society and there are not many half-orphans.

2. A generally better wage and income level exists for all parents who can work. For children whose parents are deceased or unable to work, there is an economic floor through Social Security, Veterans' Benefit, ADC and and General Assistance. Poverty is no longer a major reason for child placement.

3. A better understanding of a child's need of family ties, a need as real as the need for food, is resulting in more emphasis upon social service measures to strengthen the family. Among these are Marriage Counseling, Adult and Child Guidance Clinics, and Case Work Services, particularly protective services to strengthen family life and prevent placement.

4. The development by children's agencies of foster family homes is an alternative to institutional care. In 1933, there were 140,000 children in institutions; but in 1950, only 95,000. During the same interval of time, the children in foster family homes increased by 60,000. At the present time, about 180,000 children are in foster family boarding homes.

While some institutions with endowment or strong support from their state legislatures may move with considerable rapidity toward providing residential treatment programs for the seriously emotionally disturbed, most institutions can best serve their communities by moving as quickly as possible from long-term custodial care to care for certain older children for whom the community has not yet developed adoptive homes or family boarding homes. They can build up understanding and knowledge of their group care program through improving the casework service to the children in the home, improving house parents or counselors' knowledge of child behaviour and the meaning of parents to children through in-service training, conference attendance, and consultation to staff. In some instances, there must be direct treatment of the children themselves by clinical psychol-

ogists or psychiatrists.

These institutions can and should work toward a plan of a decentralized campus in many instances, in order that children in group care may be assimilated more easily into schools, churches, and other community activities. Above all, the location of the institutional program, according to the several population centers, makes it possible for there to be visiting of the children by the parents, and of the parents by the children. These practices contribute to the re-establishment of a family home, something that is the goal of every modern child welfare agency.

The institution which is decentralized and specialized to the extent of having group living facilities for six to eight girls, or six to eight boys who are in transition from the dependency of childhood to the independence of adulthood, is already on its way toward further specialization. If community organization for child welfare services may indicate, this institution is in a position to be flexible and to coordinate its program much more easily with all other child welfare services than is a large congregate centralized institution. It is likely that the institutional program which is located here and there over the state, a unit here and a unit there, may find it easier to attract qualified married couples to serve as house parents, since in accepting such employment they would not be deprived of normal community contacts so much as in the larger congregate settings. Small units of an institutional program may reasonably be expected to fit more easily into the community and into the minds of the public at large than is true of a traditional congregate facility.

Discussion

Nevada has no residential short-term treatment center for the intellectually, emotionally, or physically handicapped.

The aim of a modern short-term treatment center is to assist the child in achieving maximum social, emotional, and intellectual maturation, with the ultimate goal of returning the patient to his home. It should include all the medical techniques, psychological and social work services, together with such other services as our society commonly provides for the development of independent adults.

The admission of a child to a residential setting is determined by the severity of the other related factors--psychological, social, or somatic. The disintegration of the family constellation, distorted socio-cultural attitudes, and lack of available community facilities and programs often result in further psychological impairment in the retarded or emotionally disturbed child. A treatment center is not an isolated building with custodial care. It first offers a diagnosis, and then the appropriate plan for constructive treatment, training, and care as individually indicated.

Recommendations

1. Normal children should be placed in a normal home situation through an expanded foster home program.

2. Children with difficulties which are remedial should be accepted by the Children's Home for short-term treatment when adequate professional assistance is available.

3. The population of the Home should not exceed 50 children, and additions should be made in areas of cottage-type quarters, with sufficient personnel.

4. The Home should work closely with the Ormsby County School District to provide special education classes.

5. Adequate psychological and casework services should be provided.

6. The statute which provides that psychiatric services are to be provided by personnel of the Nevada State Hospital should be repealed, and authority should be granted to provide that other mental health programs can carry out this needed service.

7. Serious long-range planning should be made for intensive treatment care at the Home.

CHAPTER XVI

PRIVATE INSTITUTIONS FOR THE MENTALLY RETARDED

Description

In Nevada there is one privately owned and operated residential institution for the mentally deficient. It is located between Reno and Carson City and is known as the Eagle Valley Ranch and is operated by the Nevada Children's Foundation, Inc. The institution started operation 13 years ago and was founded by public-spirited altruistic and self-sacrificing people who recognized the need for aiding retarded children.

The are 10 mentally deficient children at the Ranch, ranging from 8 months to 16 years of age. One girl has been there for 13 years. The cost of care is $125 per month per child, and most of the children are placed there by their parents. Some are placed by county welfare agencies until they reach the age of 2 years, when they can be transferred to the Nevada State Hospital.

The Eagle Valley Ranch has severely damaged children who need nursing care. Many should be receiving medical care and have daily medical supervision. However, there is no physician in residence for everyday routine checks. In the event of an emergency or an illness, a physician is called to the Ranch. There is no registered nurse in residence. In some instances, it is necessary to restrain children in their beds or in chairs because of inadequate personnel.

The institution has no professional staff and no professional supervision. They have no proper screening and intake policies. There are no treatment or recreational programs, and until 1960, portions of the physical plant were considered unsafe and unsanitary.

The staff consists of 6 women and a gardener. One woman serves as cook; one is a supervisor; and the other four, attendants. None of these persons are professionally trained to care for the type of patients admitted to the Ranch.

Through the years there has been a question as to the proper jurisdiction of investigating and licensing Eagle Valley Ranch. The first inspection in 1952 by the State Department of Health was primarily for sanitation purposes. From 1952 to 1960, inspections have been sporadic and there has been uncertainty whether the Department of Health or the State Welfare Department had the authority and the responsibility of inspecting and licensing this institution.

In April 1960, the Director of the Nevada State Welfare Department requested an opinion from the Attorney General to define the responsibility for inspecting and licensing the Eagle Valley Ranch. The Office of the Attorney General subsequently reported that the State Department of Health had the necessary jurisdiction to handle the investigation and licensing.

On April 27, 1960, an inspection of the site was made by the Department of Health. A provisional license was issued in May, which is to expire in December 1960 unless certain recommendations are carried out. As of October 1960, most of the recommendations concerning the sanitation and safety aspects of the institution have been carried out. However, the institution is still without a licensed registered or a licensed practical nurse. Until such a person is employed, the institution is in violation of that certain rule and regulation promulgated by the Department of Health, requiring the employment of a registered or practical nurse.

The health laws of the State of Nevada describe a hospital and the inspection and licensing thereof, in the following manner:

> A hospital means any institution, place, building, or agency which maintains and operates facilites for the diagnosis, care and treatment of human illness, including convalescents, and including care during and after pregnancy, to which a person may be admitted for overnight stay or longer. It also includes any sanitarium, rest home, nursing home, maternity home, and lying-in asylum. No person, partnership, corporation, or association, nor any state or local government, unit or any agency thereof, shall establish, conduct or maintain in this state, any hospital without first obtaining a license therefor as provided. Every hospital for which a license has been issued shall be periodically inspected by duly authorized representatives of the State Department of Health. Reports of each such inspection shall be prepared by the representative conducting it upon forms prepared and furnished by the State Department of Health, filed with the State Department of Health.

Accordingly, it would seem that the Eagle Valley Ranch would be properly placed in the category of a "hospital."

Discussion

The special character of an institution for the mentally deficient demands that appropriate standards be required for these special facilities. This is not the case in Nevada. The task of inspecting hospitals, nursing homes, maternity homes, etc., is too great to be accomplished by the methods now being used. Inspections by the State Department of Health are made by sanitarians in the Division of Public Health Engineering, and logically they should work with an authorized person with the Division of Hospital Services in order to make the standards more appropriate for institutions or homes for the mentally deficient. Actually, representatives from the State Departments of Health, Welfare, and Education could cooperatively work toward establishing standards and procedures for operating such homes. Proper child care procedures, inspection of physical facilities, and a sufficient number of personnel per patient should be maintained.

From an overall view, the social and emotional deprivation of this institution is such that would interfere with the emotional development of even severely retarded children. These are the types of children that could very adequately be cared for at the Nevada State Hospital where they could receive

the necessary nursing care.

Recommendations

1. The responsibility for the inspection and licensing of residential homes for the mentally deficient should be clarified by law.

2. Representatives from the State Department of Health, the State Welfare Department and the Department of Education should work in cooperation to establish standards and procedures for proper operation of these private institutions, not only from a health and medical standpoint, but to include training and education of the patients.

CHAPTER XVII

SUMMARY

Previous chapters have set forth the services that are presently available to the retarded child in Nevada, along with the necessary additions to these services to enhance a program which takes as its focus the local community.

The evidence found in the census of retardation proves that institutional facilities are used as a last resort when the local community's handling of the child has broken down. Even for those who are severely retarded in the sense of being unemployable, such as the "mongoloid" group, the use of the State Hospital is still quite unusual, for, of these children, only five are in the State Hospital. A proper objective of the community should be not in placing these children in an institution as the solution to their problems, but rather in strengthening and improving local community resources, thereby ameliorating and treating their difficulties in their own homes. To this end we have shown how a small amount of additional attention to the facilities now present in our communities could provide a complete continuing program for these children in all areas of prevention, diagnosis, treatment, education, and vocational training.

The Problem of Institutional Care

There are two major purposes of an institution: (1) custodial care and (2) remedial treatment.

We have seen that custodial care usually bespeaks, except in those children who are extremely retarded, of a breakdown in the local community's service. At present, the Nevada State Hospital is serving the state's custodial function. Custodial care is adequate, although there is much to be said for more professional diagnostic and intake services and proper physical plant. However, the custodial needs of a state such as Nevada are quite small. While we might presently expect the need for custodial care to rise proportionately to the increase in population, still, with proper preventive, diagnostic, and treatment center facilities available in the local community, we could expect that a proportionate increase might not occur. In any case, we can see that for custodial care our present facilities could be made adequate by the addition of some professional services.

Remedial institutionalization, however, is another matter. At present, the Nevada State Hospital cannot be considered a remedial institution for retarded children. This need would concern those ranging from mild to borderline retardation whose condition could be bettered, with some hope that they would achieve economic and social independence in adulthood. Children needing this service are few numerically since most of them do, and probably would, remain in their homes and benefit from local programs. However, homeless mildly retarded children needing institutional care require a remedial therapeutic milieu situation because of the reluctance of foster homes to take them. It would appear to be sensible and reasonable to use the Children's Home to provide this therapeutic milieu - not only for mildly retarded child-

ren but for other children who need this kind of situation. The professional needs and therapeutic benefits of such an institution would remain the same for a handicapped, a retarded, or an emotionally disturbed child. It probably would not cost a great deal more than the present Children's Home.

We are then suggesting that the Nevada State Hospital continue in its course, taking care of those children and adults who are so severely retarded as to need custodial care and who do not give any promise of responding to a therapeutic environment. Children, retarded and otherwise, who seem to need the special benefits of institutional care in a therapeutic milieu should be handled through the Children's Home, which should be professionalized to the point where it can handle this role. It is not necessary, or possibly even indicated, that an abrupt change in intake policy of the Children's Home be contemplated. Even slight modifications in the Home's interpretation of the state law would enable this function to gradually take place. There is some question whether the law is being interpreted too rigorously to exclude the exceptional child. Children who have handicaps such as epilepsy and retardation are now excluded from the Children's Home, whereas a proper reading of the law might change this situation.

Coordination of State Services for the Retarded

"The problems of the mentally retarded are not and cannot be the sole responsibility of any one department of state government. They are important concerns of several departments and require multiple, but coordinated attack . . ." So states the report of the Conference on Mental Retardation of The Council of State Governments. (See Appendix No. "A".)

The problems of interdepartmental coordination appear to be particularly perplexing in Nevada. As has been stated, there is no effective coordination of services at the highest administrative levels, between the major agencies concerned with the problem of mental retardation, mental health and special education. While some professional workers have set up working relationships with other workers, this has not proceeded in an organized way. The program presented in this survey calls for a close working relationship between departments, as would be expected in a community program. The Special Children's Clinic, the Mental Health Clinic, the Welfare Department, the Children's Home, the school system and the State Hospital would have varying and changing roles to play during the different ages and needs of the child.

To insure that the multiple interdepartmental problems of mental retardation are met, some administrative device to increase coordination and cooperation is deemed imperative. The recommendation in this regard of The Council of State Governments appears very appropriate.

In summary, then, we have outlined a program which takes as its focus, the local community. It looks upon custodial institutional care as a breakdown in local facilities for the care of these children, except in those cases which are clearly custodial. It looks to the Children's Home, not as a future training establishment for all retarded children, but only as a remedial situation for those who, because of their own family and local situation, can benefit from this kind of care.

Recommendations

1. That Nevada State Hospital continue custodial care of the severely retarded.

2. That the Children's Home gradually present itself to the community as a therapeutic and treatment institution for the exceptional child in need of this service.

3. "The Conference, therefore recommend(s) that each state establish an inter-departmental committee, council or board for the joint planning and coordination of state services for the mentally retarded. This interdepartmental agency may be established by the Governor or the Legislature, depending upon conditions prevailing in the state."[1]

4. This committee, council, or board should have a paid executive secretary who would be a full-time civil service appointee.

5. It would also concern itself with other problems needing interdepartmental coordination such as mental health.

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1 In view of its pertinence to the problems of the State of Nevada, it is suggested that all recommendations of the Conference on Mental Retardation of the Council of State Governments be scrutinized by the Legislature for possible action. (See Appendix No. "A" for complete report.)

APPENDIX "A"

REPORT AND RECOMMENDATIONS OF THE CONFERENCE ON MENTAL RETARDATION
called by
The Council of State Governments
New York City

STATEMENT OF PURPOSE

On November 20-21, 1958, the Committee on Mental Retardation of The Council of State Governments called a special conference of outstanding leaders in the field of mental retardation, to develop a comprehensive program for guidance to the states.

In few areas of state government has there been such intense pressure in recent years for the enactment of an effective program to meet the needs of the mentally retarded--young and old. State institutions at present are heavily overcrowded with more than 140,000 residents of all ages and of varying degrees of retardation and mental defect. Buildings are obsolete, archaic and unsuited for a modern treatment program in many instances. Waiting lists for entry into institutions have reached heart-breaking--in fact, politically sensitive--proportions. Thousands of educable and trainable retarded people are receiving no education and no training, and little care. Diagnostic facilities are scarce, and personnel trained and qualified to work in the field is even rarer.

And yet, one of the nation's top research scientists in the field of mental retardation stated that if we did everything we could possibly do today, based on the knowledge that we have today, we probably would prevent at least one half of the cases of mental defect and mental retardation that we know will occur.

As a result, parent groups, relatives of families with retarded children, people with interest and concern for a handicapped group as well as taxpayers visualizing large and costly building programs have focused national attention on this problem to the highest degree that we have known.

Governors and legislators and other state officials as never before are attempting to meet the needs of the mentally retarded and are seeking advice and guidance on how best to organize effective, comprehensive state programs to prevent mental retardation, where possible, to deal with it early, when needed, and to provide vocational and educational facilities in order to keep as many in the community as possible.

It was to assist in responding to this overriding question that The Council of State Governments called this two day conference of experts from the fields of education, welfare, health, mental health and employment, and from state government, the federal government and the universities. Included also was a substantial number of legislators from as far west as Oregon and California to as far east as Connecticut, New Hampshire, and New York. All of them know well the problems of the mentally retarded, following long, serious study and reports as members of legislative committees.

Out of these two full days of lectures and intensive discussion, the conference developed a set of recommendations designed to assist the states in dealing with the following three major questions:

1. What kind of administrative organization is required by the states to carry out a comprehensive program in the field of mental retardation?

2. What kind of legislation should our states pass to modernize their commitment and discharge procedures?

3. What financial arrangements are necessary to execute a comprehensive program?

STATE ADMINISTRATIVE ORGANIZATION

The problems of the mentally retarded are not and cannot be the sole responsibility of any one department of state government. They are important concerns of several departments and require a multiple, but coordinated attack.

1. The conference, therefore, recommended that each state establish an interdepartmental agency, such as an interdepartmental committee, council or board for the joint planning and coordination of state services for the mentally retarded. This interdepartmental agency may be established by the Governor or the Legislature, depending upon conditions prevailing in the state.

2. Such departments as education, mental health, health, welfare, labor, corrections, and institutions of higher education offer programs and services for the mentally retarded. Within a given state there may be other departments concerned with the mentally retarded. Within each of these departments there should be a division or bureau for services to the mentally retarded or a special consultant with specific responsibility for the development and administration of these services.

3. In order to implement these recommendations, the conference recommended that:

(a) Each department head or his deputy should report to the interdepartmental agency on the responsibility of his department for services to the mentally retarded and on the extent to which these services are provided.

(b) The interdepartmental agency should submit reports periodically, with recommendations for legislative and administrative action, to improve services for the mentally retarded.

4. A comprehensive program for the mentally retarded should include intensive efforts to prevent mental retardation in the first place. This means services to prevent birth defects; prenatal care; pediatric care; child health supervision and safety provisions. The state program also should include diagnostic services for development evaluation, an extensive research effort, provisions for the training of professional personnel, and intensive programs for the care, training and welfare of the mentally retarded.

5. To increase the efficient use of personnel and facilities in research, training and treatment, the states should explore the potential of pooling

resources within regions for cooperative, interstate efforts.

6. Wherever possible, services for the mentally retarded should be provided at the community level, with state assistance where needed. State provision should complement services provided at the community level.

7. Any program providing a comprehensive approach to the problems of the mentally retarded must include provision for joint planning between state agencies and local government agencies.

8. Particular attention should be given to the problem of providing appropriate services to the mentally retarded in the rural areas of the states.

9. An effective program for the mentally retarded will give emphasis to services for very young children.

10. Lay groups concerned with the problems of mental retardation should participate in an advisory capacity to those agencies established by the state to deal with the problem.

MODERNIZING COMMITMENT AND DISCHARGE LEGISLATION

The conference adopted the view that major emphasis should be placed on voluntary admissions to institutions for the mentally retarded, rather than judicial proceedings.

The conference recognized that judicial commitments still will be required for a small group of mentally retarded individuals who also are afflicted with severe behavior disorders.

These instances, however, will be relatively few, and the whole trend, the conference agreed, is in the direction of early, voluntary admissions and intensive treatment.

1. Judicial Commitment. When judicial commitment is applied for, provision should be made for referring the case to appropriate community resources for diagnostic evaluation. These community resources should consist of persons competent to make medical, psychological and social evaluations.

(a) The total evaluation should consist of the determination as to whether or not the person is mentally retarded and is suitable for and in need of institutional care.

(b) Upon receipt of the report of evaluation, the court should be required to reject the petition if the evaluation is negative. The court, however, should have jurisdiction to commit or not commit in the event that the evaluation is affirmative.

If the court determines that commitment should be made, it must communicate with the authorities of the proper agency to which it proposes to commit with respect to the availability of space and facilities for the person; if the report from the agency is in the negative, the court must withhold commitment until advised by such authorities that space and facilities are

available.

(c) The authorities of an institution should be authorized to take such action with reference to release, parole or other action with regard to a committed behavior problem child which they deem appropriate as in the case of any other committed patient; but in the event such authorities are of the opinion that the child properly belongs in another type of institution they shall be permitted to apply to the committing court for revocation of such commitment and for commitment to another institution.

(d) The commitment should not constitute an adjudication of incompetency for any other purpose than institutionalization.

2. Voluntary Admission. The same process of evaluation in a community diagnostic facility competent to make medical, psychological and social evaluation should be a prerequisite to voluntary admission as is provided for under judicial commitment.

Upon application of the parent or guardian, and after evaluation which determines that the child should be admitted, a certificate of admission should be executed by the evaluation resource, which would confer jurisdiction on the authorities of the institution or hospital to hold for care and treatment, and to return from unauthorized leave, any person granted admission; provided, that such person shall not be retained for more than thirty days after the receipt of a request from the parent or guardian of a person under maturity age, or the person himself after reaching maturity age or any relative or friend on his behalf, for release of such person. Within such thirty days, the authorities of the institution or hospital may petition for judicial commitment, and such release shall be withheld pending the decision of the court.

FINANCING AN EFFECTIVE PROGRAM

1. Research. The conference adopted the principle that research in the field of mental retardation is essential, and no state program can be effective without devoting state funds for this purpose. In order to establish a productive research effort, including research in prevention, state funds are required to provide a core staff of investigators who can look forward to long-term research activity. Furthermore, mental retardation is uniquely a problem for state governments, and research is essential to evaluate how well the states are carrying on their own programs.

The conference therefore recommended that: Every state appropriate funds for research in the field of mental retardation and that these funds should be made available on a continuing basis for use in a flexible manner. Funds for research can be provided through investing a portion of the fees paid by financially responsible relatives into a research fund dedicated for this purpose.

2. Relative Responsibility. The committee recommended that the states should adopt the principle that parents or responsible relatives financially equipped to pay for the care of their mentally retarded should do so. However, safeguards should be written into the law to ensure that in no instance will such payment cause financial hardship to the family.

It also recommended that the states should review their payment legisla-

tion and consider the possibility of setting some maximum related to the cost of care as the basis for payment.

3. State-Local Sharing in Cost of Education. The conference felt that communities should provide suitable education and training for every child and that incentive programs are needed, financed in part by the state, to ensure the education and training of the special categories which require heavier financial investment.

The conference, therefore, recommended that: Every state should adopt mandatory legislation for the education of the educable mentally retarded and at least permissive legislation for the trainable mentally retarded and that the state should assume the obligation of paying the local school district or community for the additional cost involved in the provision of these educational programs.

4. Departmental Services. The conference felt that state health, employment, corrections and welfare agencies providing various services for children and adults should include the mentally retarded in the services that they provide, in order to achieve the most efficient use of existing resources.

The conference, therefore, recommended that these agencies, whether community or institutional, include the mentally retarded in the services provided by them. It further recommended that increased appropriations should be made available to these employment, health, corrections and welfare agencies and that the funds should be budgeted for the purpose of services to the retarded, at least initially.

5. Personnel. The conference agreed that personnel employed in state institutions for the mentally retarded, although devoted to their work and highly trained in many instances, generally have a lower level of employment prestige and that special financial inducements are required to raise the prestige of employment in the institutional system.

The conference, therefore, recommended that: Competitive salaries be provided for personnel trained in the field of mental retardation and that special inducements should be offered in order to attract and retain the best qualified personnel. In the long run, the conference felt, this step would be most efficient and economical.

The conference further recommended that state and federal funds should be provided to training centers for academic training, at advanced levels, of personnel in the field of mental retardation. A great need, the conference felt, was for the training of teachers and others who in turn could train other personnel.

The conference further recommended that state agencies concerned with mental retardation develop and carry out programs of in-service training for non-professional personnel and that funds be made available for this purpose.

6. Hill-Burton Funds. The conference recommended that Hill-Burton funds should be increased generally and should be made available for the construction of institutions for the mentally retarded.

7. State-Local Finances. The conference agreed that to every extent possible services for the mentally retarded must be community-based. In many instances this will mean financial assistance by the state for such community facilities as day care centers, recreation activities, sheltered workshops, educational facilities, etc.

The conference, therefore, recommended that: Provision be made for states and communities to share in the cost of providing community facilities for the retarded both for non-profit or public agencies, but under full and ample supervision by the state.

8. Maternal and Child Health Grants. The conference recommended that federal maternal and child health grants should not be limited to public health departments but should be made available more flexibly to the agencies designated by the state.

9. Cost Projections. The conference recommended that the states develop plans and project their costs for the next ten years with respect to their building programs and operations, on the basis of the best current thought in the field. This would require careful consultation with leading experts as to the best knowledge available today and the cost involved in putting this knowledge into effect.

Respectfully submitted,

Marjorie D. Farmer, Member,
Connecticut House of Representatives
Chairman, Committee on Mental
Retardation of The Council of
State Governments

Sidney Spector, Executive Secretary
Conference on Mental Retardation

Interstate Clearing House on Mental Health
The Council of State Governments
1313 East 60th Street
Chicago 37, Illinois

January, 1959

APPENDIX "B"

from
MENTAL HEALTH TRAINING AND RESEARCH HIGHLIGHTS
May, 1960
WESTERN INTERSTATE COMMISSION FOR HIGHER EDUCATION

MENNINGER REPORTS TO COLORADO LEGISLATURE

William C. Menninger, M.D., representing the Menninger Foundation and the State Hospital system of Kansas, spoke to the Colorado State Legislature at its invitation, in January 1960. He reported on progress made in the Kansas mental hospital system in the past decade through staff development, and urged Colorado to move in a similar direction. The guidelines which he gave in his talk are applicable to all state hospital systems. "Highlights" has abstracted parts of this. . .reproduce(d) below. . . Complete text of the speech is available from the WICHE office.

A new era of hope is upon us in the field of mental illness. The recent deep concern of the public about our years and years of "man's inhumanity to man" has resulted in a great deal of progress. In Ohio the budget for mental hospitals has been raised from $70 million to $91 million, and a bond issue of $75 million for new hospital construction has been passed; in Pennsylvania, California, Texas, and Tennessee, considerable increases in budgets for state hospitals show the awareness of our leaders. . .

Kansans are proud that the mental hospital population in our state is down 30% in contrast to an average increase of 15% in the reporting area of 15 states. Even with our hospitals not yet adequately staffed, 74% of our new admissions do not stay long. Most of them go home within 6 months. . .

My function here is to tell the story of this change, what the situation was, why and how it came about, and what we have done about it. It begins with manpower shortage during the war and our concern at the Menninger Clinic with training, research, and prevention. We began our training program after the war with 100 doctors. Now about 600 doctors have been trained. . .

The initial rumblings of the "revolution" in Kansas began in 1948.

A state legislator whose relative was being neglected in a state institution became aware of the amazing and successful program at the Winter VA Hospital, which was tied into our new training program. At that time there were 1800 patients in antiquated buildings at the Topeka Hospital and two psychiatrists, neither of whom had been trained. 60 out of every 100 patients admitted remained indefinitely, most of them for life. The per diem allotment per patient of $106 in Kansas ranked us 47th out of the 48 states. Most new admissions were housed in halls for days and weeks before they could be admitted. And like cancer, the longer treatment was withheld for them, the less chance for recovery. . .

WHAT WAS DONE ABOUT IT?

Governor, now Senator, Frank Carlson appointed a committee, composed of

the dean of the medical school, president of the state medical society, a member of the senate, a member of the house, and my brother Karl. They recommended that we buy "brains," i.e., staff, before "bricks," and establish a training program. In my brother's words, "Many patients will get well in a barn if you give them the right doctors and the right treatment. We don't want them to live in barns, but staff and treatment must come first. . ."

The staff of the Menninger Foundation was called upon to establish a training program. Everyone was aware that this would be a long-time and slowly developing process. Governor Carlson put it up to the legislature; the press helped; the public citizen's group helped; the legislators and their wives visited the sorry, decrepit hospital.

What did they see?

> Men endlessly pushing mops on already **over-polished floors**. Gloomy wards with old rocking chairs lined **up against the wall**. Beds in the halls and mattresses on the floor **at night. Uniform** and drab, ill-fitting clothing. Inadequate and **ill-prepared food**, unattractively dished out. Patients cooped **up for days on end--or** literally herded out in large groups on park **benches. Physical** restraints--straight-jackets--all over the place. **Untrained and** often brutal attendants.

The legislature acted by providing a **60% increase** in the budget in 1949; 118% more in 1951; by 1955, three times what we spent in 1948. We began to recruit a professional staff and set up a training program. In addition to doctors, psychologists, social workers, nurses and occupational therapists were recruited and trained. The number of attendants was doubled. Occupational and recreational programs were started.

A new philosophy about and understanding of mental illness arose. A very extensive volunteer system was developed through the help of the citizens of the community.

Within two years the Topeka Hospital population dropped to 1500. Today the population is 1162--36% reduction. Since 1958, 729 patients have been discharged who had been in residence in the hospital for 10 years or more, 128 of them for 20 years or longer. A recommendation that a new hospital be built was never carried out, saving $38 million. . .

I now want to talk generally about programs, staff and training. These remarks and opinions apply to all states as well as Kansas and Colorado.

1. Psychiatric Treatment Programs

It is my conviction that mental illness does have the highest recovery rate of any group of illnesses, if we give the patients a chance to get well. It is not news to you to tell you that the situation in many states does not give the patients a good chance to get well, and this is the current concern in Colorado.

By evolution there was only one mental hospital established in Colorado, and it has continued to grow and grow. It is some distance from the population

center. The result is that is has become much too large. It is located at a distance difficult for convenient access of patients to and from their homes.

There are two possibilities of reducing the size of the State Hospital:

(1) Provide treatment which, at the present time, is simply not possible. As of July, 1959, there were two staff psychiatrists in administrative jobs, 3 psychiatrists on the ward, and 20 first-year psychiatric residents. This means that there is one psychiatrist for every 2,000 patients; one resident for 300 patients. If treatment could be provided with a minimum of one doctor to 50 acutely ill patients, and not less than one to 100 or 150 chronic patients, there is no question that the population of the mental hospital would be greatly reduced.

There can be a further reduction through the development of a new program such as day-and-night hospitals and "half-way houses"--institutions which can help convalescent individuals who are not so sick they have to remain in the mental hospital.

(2) A second and extremely important need in Colorado is for a small combination intensive treatment-training center in the Denver area itself. With such a center near the medical school, close working relationships can be developed with the psychiatric department and other departments of the medical school. . .

2. Finances

This is the crux of the matter in any state. The mental hospital budget in Colorado provides a per diem cost of $4.90. Remember that the average cost in the general hospital today for medical attention runs between $25 and $30 a day. We have no magic in psychiatry, and we can't run what psychiatrists regard as a true treatment hospital on $4.90 a day. The Veterans Administration is spending at least $11 a day on this same type of patient.

This is a tough assignment for every legislature, to try to balance people's health and happiness on one side of the scale, and money on the other. . .

3. Personnel Problems

In Kansas we were much worse off in 1948 than Colorado is in 1959. However, today we compare as follows:

	Colorado (pop. 1959): (6,200 in one hospital)	One for each
Physicians	26	260 patients
Social Workers	3	2,000 patients
Clinical Psychologists	3	2,000 patients
Registered Nurses	49	122.4 patients
Total Employees	2,101	2.85 patients

Kansas (pop. 1959):
(3,693 in three hospitals)

		One for each
Physicians	102	38 patients
Social Workers	43	86 patients
Clinical Psychologists	27	136 patients
Registered Nurses	101	38 patients
Total Employees	2,315	1.6 patients

4. Professional Training

The Department of Psychiatry at the University of Colorado, under the direction of Dr. Herbert Gaskill, is one of the outstanding training centers in the United States. It is paradoxical, therefore, that there is an approved training program for specialists in other fields of medicine at the state hospital, and yet for psychiatrists, only one of three required years is approved.

Extensive training of psychologists, social workers, nurses, and all other professional personnel needed in the treatment of patients must be carried on in the state hospital itself. It is a slow process. It will be difficult to build a faculty even with the help of the medical school. But it can be done, as we have seen in Kansas. . .

APPENDIX "C"

U.S. HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON SPECIAL EDUCATION. SPECIAL EDUCATION AND REHABILITATION STUDY

REGION II, WESTERN REGION WORKSHOP
San Francisco, California

FOREWORD:

Workshop Charge: Each group is expected to:

(a) Identify problems and unmet needs in their particular region, giving substantial supporting evidence that the problems and needs exist.

(b) Make specific recommendations for legislation, indicating estimates of costs, administration of programs, etc.

States included: Arizona, California, Hawaii, Nevada.

Total population: 15,000,000

Conservative estimate of mentally retarded population in Region II is 450,000; of these, 150,000 are children.*

We note here that we dealt with mental retardation as an "umbrella term" without reference to use of terms like mental deficiency or other sub-definitions. "Mental Retardation is a chronic condition present from birth or early childhood and characterized by impaired intellectual functioning as measured by standardized tests. It manifests itself in impared adaptation to the daily demands of the individual's own social environment. Commonly these patients show a slow rate of maturation, physical and/or psychological, together with impaired learning capacity."**

The group meeting in San Francisco established four basic philosophical principles*** on which it proceeded:

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* A report of the California Dept. of Mental Hygiene suggests that as of 1975 there will be 642,000 mentally retarded in that state, compared to 390,000 at present. Of these, 68,000 will be "dependent;" 140,000 "trainable" and 434,000 "educable." The population of California in 1975 is estimated between 17 and 20 million. Increase in percentage is due to increased population, improved medical care and change in morbidity rate.

** Group for the Advancement of Psychiatry, "Basic Considerations in Mental Retardation: A Preliminary Report," #43, Dec. 1959.

*** cf. McBride, Donahoe, "1959 Report of the Joint Interim Committee on the Education and Rehabilitation of Handicapped Children and Adults," California Legislature. (See Addendum)

1. Keep the mentally retarded person in the community.

2. The family is the recognized basic unit in the application of evaluative, educative and habilitative services for the mentally retarded person.

3. The acceptance of and provision for services for the mentally retarded person is a community responsibility during his lifetime.

4. The mentally retarded are more like other people than different from them.

To implement these principles it is essential that there be:

1. Provision of adequate services for the mentally retarded person at the community level and

2. Coordination of available community resources.

The group discussed seven broad areas of need. These were as follows, according to priority:

1. Diagnosis, evaluation and ongoing developmental services for mentally retarded children and adults.

2. Recruitment and training of professionals.

3. Coordination of services to implement evaluation, training and rehabilitation of the child.

4. Preparation of young mentally retarded adults for employment in the community and sheltered workshops.

5. Community planning and attitudinal problems of the community.

6. Research.

7. Information Exchange: this was a specific referral to the need for standardized records, health and scholastic, for handicapped children on a nationwide basis.

The discussion which followed quickly reduced these seven areas to five, namely:

1. Diagnosis, evaluation and ongoing developmental services for mentally retarded children and adults.

2. Recruitment and training of professionals, especially in the fields of social work, psychology, education and rehabilitation counseling, with emphasis on in-service training.

3. Preparation of young mentally retarded adults for employment in the community in secondary schools and in sheltered workshops, as well as sheltered employment.

4. Research: medical, social and psychological.

5. Community planning.

The remaining two areas either did not involve federal action and/or financial support or were sub-sumed under the five which were retained.

In the discussion which followed, evidences of the diverse characteristics of the region were recognized as underlying the discussions in every area of concern. Some characteristics which would be obvious in regional planning were:

A few large metropolitan centers.
Some small, well-integrated and stable communities far from large cities.
Communities of perhaps 30,000 population which are serving rural and suburban populations of many thousands more.
Large rural areas of sparse population, located far from sources of potential service.
Small communities which historically accept some major responsibility for the mentally retarded as opposed to those unused to this concept.
Diversified transportation patterns.
Transient armed services populations.
Transient migratory workers.

Of the present population of 450,000 mentally retarded in Region II, we recognized that the following is true:

15,750 are severely retarded and totally dependent.
49,500 are moderately retarded and trainable.
447,750 are mildly retarded and educable.

AREAS OF CONCERN AND CONCLUSIONS:

AREA 1: DIAGNOSIS, EVALUATION AND DEVELOPMENTAL SERVICES

Need: The team approach of using appropriate disciplines - medical, social and psychological - in evaluating retarded children and adults and in providing accompanying parent counseling while close relationship with existing community resources is maintained.

The present federal program of establishing and stimulating establishment of diagnostic centers is inadequate. The need for this comprehensive service is basic to economically sound education and habilitation services.

Program: Four approaches are suggested:

A. To establish clinic facilities in urban centers for evaluating mentally retarded children and adults and to offer family counseling with follow-up referral to other appropriate services.

These centers would be staffed by a core team from the medical (pedia-

trician, neurologist, psychiatrist), social work, psychological and rehabilitation counseling professions. Other needed professions such as nursing, education and various specialized medical disciplines would be drawn in as required.

Communities which serve large rural areas could support, populationwise, such a center even though the population of the community per se might be small, provided appropriate disciplines were available or could be made available in that community.

In order to evaluate the potential of the retarded person properly and participate in a plan for his future, it would be required:

(1) that there be gathered together knowledge of his health, intelligence, personality and family circumstances, and

(2) the fitting of such knowledge into an appreciation and command of the resources available in the community to meet the individual's needs and to maximize his opportunities for independent living. So far, the approach is almost always to fragment the child or adult into a medical problem, or an educational problem, or a social problem, depending on the exigency. There is no question that difficulties in dealing with the problems of the retarded individual are multiplied because of inadequate knowledge about the individual and improper short-range and long-range planning. This knowledge and planning, in terms of the individual's makeup, potential and the community resources, would be the responsibility of the coordinated team approach of the center.

Costs: The estimated cost for professional staffing on a per case basis, on an average, would be about $250.00 for each individual evaluated. This would be exclusive of costs of building and equipment, transportation and hospitalization.

The group felt strongly that while a firm initial assist from the federal government is indicated, perhaps similar to the Hill-Burton program for hospital facilities, eventual stabilization of such a program might be attained by generally extending Crippled Children's Services to include, specifically, the mentally retarded.

Advantages: Not only does the center provide the necessary team approach but it accomplishes a number of other very important objectives, such as:

(1) Integrating available community resources as a by-product of helping to carry out the short and long range plans for the individual based on his evaluation. This is a must and is made possible by the fact that the core team has many spheres of influence and communication in the community.

(2) Providing in-service training to various professional disciplines. For example, in his early training, the general medical practitioner could be assisted in developing skills in dealing with diagnosis and evaluation of mental retardation. Such training - and this could be extended to teachers, social workers, nurses, etc. - could be carried back to smaller communities where it could be applied at the local

level on a "little" team approach. This eventually makes for adequate evaluation and planning on a local level, using all available resources - private, voluntary and tax-supported. Eventually, the center sees only those cases where the coordinated community resources have failed to come up with an evaluation.

(3) Developing the research setting necessary for many facets of research.

B. Expand provisions of crippled children's services to include the mentally retarded so that the team approach might then be used in a variety of settings, probably through expansion and enrichment of existing programs.

C. Set up a separate agency in the Dept. of Health for diagnosis, evaluation and family counseling in relation to mental retardation.

D. Expand support funds to state vocational agency to include services to mentally retarded adults who can only hope to achieve less than self-support. This program could provide for many currently being served in public institutions and at much less cost.

One participant in the group stated that he had been informed that one state hospital with about 4,000 mentally retarded patients felt that at least 2,900 could be returned to the community with some type of necessary resources provided. Of these 2,900, 100 would attain, eventually, complete self-care; and between 300-500 could be employed in the community if a living situation were provided. The consensus of opinion was that legislation in the order of the Hill-Fogarty-Elliott so-called Independent Living Bill is timely and sound.

AREA II: RECRUITMENT AND TRAINING OF PROFESSIONALS

Need: Professionals in a variety of disciplines are needed, both on a service level and in leadership positions. This would include public health nurses, social workers, medical people. The need for special education teachers and vocational counseling experts at the secondary school level was especially stressed.

Program: Provide scholarships and fellowships to train, on a priority basis, (1) classroom teachers, (2) leaders in supervisory administration in the field of mental retardation and (3) rehabilitation counselors for the secondary and adult school programs.

It was recommended:

1. Increase number of scholarships to five times as many as are now available. One group member in charge of teacher training estimated that he could have used 50 grants this year to meet best the needs of applications for his program; he received 10.

2. Increase number of fellowships for leadership training by 10 times the number presently available.

3. Provide inclusive training courses on rehabilitation counseling, especially for counselors at the secondary school level.

4. Provide grants-in-aid for professional training in the field of mental retardation to medical personnel, social workers, visiting nurses, etc. as part of the total rehabilitation approach.

5. Continue and step up general teacher recruitment for all areas of study, since stimulation of this kind will also help the field of mental retardation.

AREA III: PREPARATION OF YOUNG ADULTS FOR EMPLOYMENT IN THE COMMUNITY OR IN SHELTERED WORKSHOPS.

Need: 1. Coordination of the secondary special education and training programs with vocational rehabilitation services.

2. Development of sheltered workshops for testing, evaluation and training of mentally retarded adults and provisions of employment in sheltered setting in keeping with the broadly rehabilitative concept of the Independent Living Proposals of H.R. 3465 as introduced by the Hon. Carl Elliott.

Program: 1. Establish field consultants in the U.S. Office of Vocational Rehabilitation; they would be specialists in problems of the severely handicapped person whether mentally retarded, emotionally disturbed, neurologically damaged, etc.

2. In line with provisions of H.R. 3465, provide sheltered workshops, where the need is demonstrated, for the purpose of rehabilitation.

3. Increase federal funds available to state vocational rehabilitation agencies to serve specifically those persons who would not meet the criterion of vocational rehabilitation, but might profit from this service to the extent of being able to leave an institution, relieve an attendant at home, or give such relief to sorely pressed families as to strengthen family capabilities in dealing with the problem.

4. Drop the age limit for permissive vocational services to at least 14 so that young adults will realize the greatest possible benefits from school while reaching toward realistic future goals.

AREA IV: RESEARCH

Need: To encourage and support, especially in longitudinal studies and in prevention, research. Medical, social and psychological research have specific bearings on improved methods of education and more productive vocational training. Existing studies are continually opening up new horizons of hope.

There is also a need for more specific knowledge on teaching and training methods with young retardates, predictive techniques relative to vocational goals and training methods relative to more productive work. Underlying these specifics are a need for a vast amount of research in prevention and basic knowledge about mental retardation.

Two recent break-throughs, one relating to phenylketonuria as a cause of mental retardation and the other in the isolation of a genetic factor in mongolism, are the two greatest medical discoveries in this field in recent times. The group wished to memorialize the federal government to the effect that research thinking and research projects in mental retardation

will give the greatest hope for the future in the light of the present birth rate.

The vast number of research studies which might profit all of mankind (not just the obviously handicapped) are indicated in the definitive resume Mental Subnormality by Doctors Masland, Sarasen and Gladwin. Here are indicated some of the huge gaps in our knowledge of medicine and the social sciences. Why and how of brain functions are among the great mysteries still unknown to Man.

AREA V: COMMUNITY PLANNING

The group felt that total community planning is a sensitive relationship between federal, state and local authorities and that sound, total community organization must be implicit in any program whether it be a grant for a workshop or support funds for special needs. Hence, the following needs are articulated without specific suggestions for implementation, with some exceptions:

Establish a Study Commission on Mental Retardation (HEW) or provide funds for regional studies.

Establish a consultant on mental retardation in the U.S. Office of Vocational Rehabilitation.

Aid in establishment of residential schools in rural areas with a program which would provide that students could return to their own homes on weekends and for vacation periods.

Study means of reinforcing existing programs of diagnosis, counseling, residential care, recreation, etc.

Provide a plan for emergency beds: families who manage most of the time are seen to encounter bankruptcy as a result of emergency problems. Investigate a plan for catastrophe insurance.

Establish national standards for institutions, private and public.

It was felt that Information Centers would serve to educate the community and help to change attitudes, as well as give real service in coordination of community programming.

Encourage labor unions to determine realistic means of offering job opportunities to the mentally retarded.

Establish pilot projects in residential facilities for adults who can use the community; this is equally needed by those who first take independent jobs, but are not ready for independent living and by those who will remain in sheltered workshops for the rest of their lives.

Strengthen social security benefits.

Encourage the American Bar Association to set up legal counseling

on an ability-to-pay basis for the mentally retarded and their families.

Establish fellowships for recreation specialists who would work with the mentally retarded. Encourage the concept of integration of recreation facilities where feasible.

GENERAL OBSERVATIONS

The following were general comments made during the course of the two days workshop.

The Intelligence Quotient is no longer considered static and with education and habilitation services the functional I.Q. often can be raised. With the raising of the I.Q., the individual becomes more feasible for partial or total self-support.

When mental retardation is a secondary problem to severe physical handicap, we often see the physical needs being met; when mental retardation is primary, the child or adult is turned away from services - public and private - for amelioration of minor physical defects on the basis of the retardation. The time has come to clarify our thinking.

Mental retardation is a SYMPTOM which calls for the whole team approach in order to get a true diagnostic picture.

Social adjustment, including opportunities for community living, work, recreation, medical and dental care, must be conceived as an integral part of habilitation and rehabilitation.

The question was posed to the group of means of achieving economy by elimination of duplication of services. It was unanimously agreed that this problem does not obtain in the field of mental retardation since current services are so tentative. On the other side of the coin, all agreed that substitution of preventive and rehabilitative measures for some services which are now considered necessary should result in savings of huge proportions in the future, (i.e., institution care to be supplanted by all the implications of Independent Living legislation).

IN CONCLUSION

Miss Mary Switzer, Chief of the U.S. office of Vocational Rehabilitation, in a paper recently quoted Goethe:

> Thou might among the sons of earth
> Build it anew. In thine own soul build it once more;
> Begin a new life's course with clear vision
> Sing to the world a new song.

The group expressed gratitude for the opportunity offered by the two days of the workshop. In looking within themselves for some of the answers to questions posed, members of the group found resources and knowledge which they themselves had not wholly recognized. They brought forth their own contributions, shared material and the sharing became a creative experience.

Hence, the Workshop served a dual purpose; that of reflecting local needs to the Congress and that of being a renewing experience for those who participated so that they go back to their jobs with new vigor and enthusiasm.

Two major conclusions emerged from the process of sharing:

1. We are not using the present community to its fullest potential, but

2. In order to do this, a new element is necessary: large scale implementation of the essential ingredients for independent living. These are, as we have said, diagnosis, family counseling, education, recreation, work training, job placement, resident facilities and modification of the emotional climate of the community toward acceptance of the individual who is "different."

The group expressed gratitude to Congressman Graham Barden and his committee for their accomplishments in helping the handicapped person fulfill his true role in the community. The group also expressed pleasure at being involved in the complex study which Congressman Carl Elliott and his subcommittee have undertaken.

Martin Levine, Ph.D.
Margarete Connolly
Co-chairmen, Workshop 5

3/29/60

ADDENDUM

. . .Motivated in part by humanitarian impulses and in part by the recognition of the high cost of outmoded methods of institutional care or isolation within the community and aided by new insight and understanding of the problems and potentials of the mentally retarded, legislators have, in recent years, supported extension and improvement of educational programs for the mentally retarded. . .

Much the same as the so-called normal person, the mentally retarded develops physically with his chronological age, and with his development comes changes in his physical, educational and social needs. This changing pattern of needs suggests a continuity based upon developmental processes. . .

The following statements are submitted either as established general principles of social behavior or of social needs:

1. As children, the mentally retarded and their parents are entitled to competent unbiased medical and psychological diagnostic service.

2. Families of mentally retarded children should have competent counseling and guidance to aid them in the acceptance and the fulfillment of their responsibilities to their children and other members of their families when needed, to avoid the development of unhealthy attitudes within the home.

3. Parents have an obligation to provide for their children and when possible and desirable should not be deprived of the privilege of having their

children with them.

4. When circumstances are favorable, both the parent and child make better social and psychological adjustments when the child is in the home.

5. There is a wide range of individual difference among the mentally retarded as there is among persons of normal intelligence. The mentally retarded are more like persons of normal mental ability than they are different from them.

6. As children they are entitled to education opportunities to the extent that they are capable of benefitting from them.

7. As adolescents they have the same basic needs as other young people for social contact and opportunity for social development.

8. As chronological adults they have the right to engage in the maximum constructive self-directed activity of which they are capable.

9. The mentally retarded are entitled, within their capacity, to all the gratifications and satisfactions enjoyed by persons of normal mental abilities.

10. Individual behavior is modifiable. To a great extent behavior is learned and under conditions favorable for learning vocational and other appropriate behavior can be learned by the mentally retarded.

11. Vocational and other behavior appropriate to chronological adulthood can be acquired through social learning and imitation in settings adjusted to the level of the individual's capacity.

12. The mentally retarded tend to learn most efficiently when dealing with concrete specific materials and situations.

13. Measures of mental capacity alone may not be valid or reliable indicators of vocational adjustment. Beyond a critical minimum, additional increments of intelligence appear to be less significant than motivation, maturity, social competence, independence and desirable work habits.

14. In order to build motivation and to provide a frame of reference for the appropriateness of behavior, it is necessary that the mentally retarded have a goal for the concept of "self." The mentally retarded person is more likely to behave as an adult if he sees himself as an adult.

15. The maintenance of a mentally retarded child or adult in his home and community is far less costly to the State than institutional care.

McBride-Donahoe: "1959 Report of the Joint Interim Committee on the Education and Rehabilitation of Handicapped Children and Adults," California Legislature, Sacramento, California.

APPENDIX "D"

IDENTIFICATION AND CLASSIFICATION

The enactment of the 1956 School Code and its revisions in 1957 were a much-needed step forward in providing the legislative machinery permitting boards of trustees to make such special provisions as deemed necessary for the education of physically or mentally handicapped minors. In establishing these classes and the rules and regulations to govern their operation, the board of trustees must plan its program to meet those standards prescribed by the State Department of Education.

The standards prescribed by the State Department of Education for the establishment and operation of classes for the handicapped are included here for information.

STATE BOARD RULES FOR HANDICAPPED PROGRAMS

Adopted June 14, 1957

1. Each school district wishing to provide a service to handicapped children shall submit to the State Department of Education an application for approval of the proposed program each year. The application shall contain a complete description of each service to be provided on forms provided by the State Department of Education. Such application shall be filed not later than July 1 for the program planned for the school year beginning on the same date.

2. Teachers for the handicapped must be approved by the State Department of Education for work in that field.

3. Children enrolled in a handicapped program who are from 3 to 6 years old shall be credited with attendance in the same manner that children over 6 are credited.

4. Any program must maintain an A.D.A. of 8 or more pupils to be eligible for state aid. (Best 6 months)

5. The A.D.A. for programs where a class situation prevails shall be computed by allowing one day of attendance for each 3 hours class time, provided that any one child may not earn more days of attendance than there are days in the school month. For programs that involve individual instruction, 30 minutes of instruction shall be counted as one day of attendance, provided that any one child may not earn more days of attendance than there are days in the school month.

6. No child can be placed in a class for mentally retarded until:

   a. The parents or guardians are consulted.

   b. The child has been examined and approved for admission by a psychologist.

7. Physical Condition a child must:

a. Be able to hear spoken connected language and be able to see well enough to engage in special class activities without undue risk, excepting those children enrolled in classes for the blind or deaf;

b. Be ambulatory to the extent that no undue risk to himself or hazard to others is involved in his daily work and play activities;

c. Be trained in toilet habits so that he has control over his body functions to the extent that it is feasible to keep him in school.

8. Mental, Emotional, and Social Development a child must:

a. Be able to communicate to the extent that he can make his wants known and to understand simple directions;

b. Be developed socially to the extent that his behavior does not endanger himself and the physical well being of other members of the group;

c. Be emotionally stable to the extent that group stimulation will not intensify his problems unduly, that he can react to learning situations, and that his presence is not inimical to the welfare of other children.

The statutes NRS 388.440 through 388.540 are the legislative enactments which deal with the education of physically or mentally handicapped minors. There is provision exempting a child from participation in the program in case he or his parents object. Before a child may be enrolled in one of the special programs there must be acceptance and agreement on the part of the parents. The psychologist must determine whether the child can profit by education.

The provisions of the statutes and the standards prescribed by the Department of Education and the State Board of Education are aimed toward the best training and education for the handicapped child commensurate with his needs and ability. While the law does not specify standards in this connection, it is evident the legislation is to provide for the education of those pupils whose I.Q. is above 50 but below 80.

The goals behind this legislation are manifold. The first is that we shall more adequately provide training and education for all of our children commensurate with their needs and capacities. Children who have never been with other children because of marked deviations may now receive social training. Extensive physical and psychological examinations will give a thorough knowledge of the needs and abilities of these children. The biennial review and restudy of each child will help the parents and educators to be alert to possible changing areas in the child's growth and development.

The law provides for the separation of trainable and educable pupils. Many communities will have enough pupils within the 50 to 79 I.Q. range to set up groupings based on the mental age, physical development, social competency, and adjustment of each child. Suggested groupings are primary, intermediate,

and junior high, which groupings should not be interpreted as being mandatory. Each child will need to be carefully evaluated before any grouping is made, and transfer from one group to another should follow only after a study of the pupil's needs.

The value of grouping will be found in the fact that Special Class children have a feeling of accomplishment similar to that of normal children when promotion takes place. It will make possible a program of higher interest for each child because it will enable the teacher to work with an age group having similar needs.

Educators, physicians, school nurses, mental hygienists, and social workers are applying modern practices in the identification, treatment, and education of all mentally retarded youth.

APPENDIX "E"

EDUCATION OF PHYSICALLY OR MENTALLY HANDICAPPED MINORS

388.440 "physically or mentally handicapped minor" defined. As used in NRS 388.440 to 388.540, inclusive, "physically or mentally handicapped minor" means a physically or mentally defective or handicapped person under the age of 21 years who is in need of education. Any minor who, by reason of physical or mental impairment, cannot receive the full benefit of ordinary education facilities shall be considered a physically or mentally handicapped person for the purposes of NRS 388.440 to 388.540, inclusive. Minors with vision, hearing, speech, orthopedic, mental and neurological disorders or defects, or with rheumatic or congenital heart disease, or any disabling condition caused by accident, injury or disease, shall be considered as being physically or mentally handicapped.

388.450 Special provisions for education of handicapped minors.

1. Subject to the provisions of NRS 388.440 to 388.540, inclusive, the board of trustees of a school district may make such special provisions as in its judgment may be necessary for the education of physically or mentally handicapped minors.

2. The board of trustees of a school district may establish uniform rules of eligibility for instruction under the special education programs provided for by NRS 388.440 to 388.540, inclusive. The rules and regulations shall be subject to such standards as may be prescribed by the state department of education.

388.460 Handicapped minor need not take advantage of special provisions. No minor shall be required to take advantage of the special provisions for the education of physically or mentally handicapped minors if the parent or guardian of the minor files a statement with the board of trustees of the school district showing that the minor is receiving adequate educational advantages.

388.470 Examination of mentally retarded child by psychologist; consultation with parents or guardian; consultation with psychiatrist.

1. Before any child is placed in a school or class for mentally retarded children:

(a) A consultation shall be held with his parents or guardian.

(b) He shall be given a careful individual examination by a competent psychologist approved by the state department of education, or by a person serving under the supervision of such a psychologist and approved by the state department of education, to determine whether the child can profit by education.

2. A psychiatrist may be consulted in any specific case when the board of trustees of a school district deems it necessary.

388.480 Residence of minor. Any school district furnishing education to physically or mentally handicapped minors shall furnish such education to any resident handicapped minor of the school district.

388.490 Age of admission to special schools, classes. Handicapped minors may be admitted at the age of 3 years to special schools or classes established for such minors, and their attendance shall be counted for apportionment purposes as if they were already 6 years of age.

388.500 Special ungraded schools; powers of trustees.

1. Physically or mentally handicapped minors may be instructed in special ungraded schools or classes for the instruction of handicapped minors.

2. Boards of trustees of school districts may:

(a) Purchase sites and erect buildings for such purposes in the same manner as other school sites or school buildings may be purchased and erected.

(b) Rent suitable property at an economical rental for special or ungraded rooms.

(c) Accept gifts or donations of sites and buildings for such purposes.

388.510 Transportation. The board of trustees of a school district may provide for the transportation of pupils assigned to special schools or classes for physically or mentally handicapped pupils.

388.520 Minimum standards prescribed by state board of education; limitations on apportionments. The state department of education shall prescribe minimum standards for the special education of physically or mentally handicapped minors. No apportionment of state funds shall be made by the superintendent of public instruction to any school district for the instruction of physically or mentally handicapped minors until the program of instruction maintained therein for such handicapped minors is approved by the state department of education as meeting the prescribed minimum standards.

388.530 Computation of average daily attendance. The state board of education shall establish rules and regulations for the computation of average daily attendance of pupils enrolled under the provisions of NRS 388.440 to 388.540, inclusive.

388.540 Attendance reports. The attendance of all physically or mentally handicapped pupils instructed in accordance with the provisions of NRS 388.440 to 388.540, inclusive, including those instructed under cooperative arrangements for vocational rehabilitation with the state department of education, shall be reported annually, together with all other attendance, on forms prescribed by the superintendent of public instruction.

APPENDIX "F"

NEVADA STATE DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH NURSING
NEVADA RESIDENT LICENSED PROFESSIONAL NURSES AS OF APRIL 15, 1960
DISTRIBUTION BY TYPE OF EMPLOYMENT AND COUNTY OF RESIDENCE

County	Institutional Staff	Institutional Education	Institutional Administration	Education School of Nursing	Public Health	School Nurses	Office	Private Duty	Industrial	Field Unknown	Other - P.T., Anesthesia, etc.	Inactive	Totals
Totals	374	4	41	11	26	30	111	92	8	29	35	230	991
Churchill	6		1		1	1	1				3	4	17
Clark	157	2	16	2	4	14	37	18	3	9	15	63	340
Douglas	1					1	2					2	6
Elko	11		2	1	2	1	4	2		1	1	5	36
Esmeralda													0
Eureka						1							1
Humboldt	5				1			1		1	1	7	17
Lander			1				1	1				2	5
Lincoln	4				1							5	10
Lyon	7		1		1	1		3				5	18
Mineral	4		1		2		1					1	9
Nye	1				1				1			1	4
Ormsby	5		1		3	1	5	3		1	1	9	29
Pershing	6		1		1							5	13
Storey	1					1					1	1	4
Washoe	156	2	16	8	8	6	57	64	2	16	12	99	446
White Pine	10		1		1	3	3		2	1	1	14	36

Source: Nevada State Board of Nurse Examiners, Reno, Nevada, Application for licensure and renewals, 1960.

APPENDIX "G"

NEVADA STATE DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH NURSING
NEVADA RESIDENT LICENSED PRACTICAL NURSES AS OF APR. 15, 1960
DISTRIBUTION BY TYPE OF EMPLOYMENT AND COUNTY OF RESIDENCE

	INSTITUTIONAL	PRIVATE DUTY	OFFICE	INDUSTRIAL	REST HOMES	OTHER FIELDS - P.T., DENTAL, ETC.	FIELD UNKNOWN	INACTIVE	TOTALS
TOTALS	251	42	28	4	15	6	12	87	445
Churchill	14		2				1	8	25
Clark	100	6	12	2	3	3	4	16	146
Douglas								2	2
Elko	21	1						3	25
Esmeralda									0
Eureka					1			2	3
Humboldt	7	2				1	1	2	13
Lander	2							2	4
Lincoln								3	3
Lyon	4	1					1	3	9
Mineral	5		1					2	8
Nye	3	2		1				3	9
Ormsby	7	1			1			1	10
Pershing	3						1	3	7
Storey									0
Washoe	77	29	12		10	2	4	32	166
White Pine	8		1	1				5	15

Source: Nevada State Board of Nurse Examiners, Reno, Nevada, applications for licensure and renewals, 1960.

APPENDIX "H"

FROM NEVADA REVISED STATUTES

424.010 "Foster home" defined. Any family home in which one or more children under 16 years of age not related by blood, adoption or marriage to the person or persons maintaining the home are received, cared for, and maintained for compensation or otherwise shall be deemed to be a foster home for children.

424.020 Minimum standards; regulation of foster homes.

1. The state welfare department, in cooperation with the state board of health, shall:

(a) Establish reasonable minimum standards for foster homes.

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

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

424.030 Licensing of foster homes.

1. No person shall conduct a foster home as defined in NRS 424.010 without receiving an annual license to do so from the state welfare department.

2. No license shall be issued to a foster home until an investigation of the home and its standards of care has been made by the state welfare department.

3. Any foster home that conforms to the established standards of care and prescribed rules shall receive a license from the state welfare department, which shall be in force for 1 year from the date of issuance. On reconsideration of the standards maintained, the license may be renewed annually.

4. The license shall show:

(a) The name of the persons licensed to conduct the foster home.

(b) The exact location of the foster home.

(c) The number of children that may be received and cared for at one time.

5. No foster home can receive for care more children than are specified in the license.

424.040 Inspection of foster homes. The division of child welfare services of the state welfare department, or its authorized agent, shall visit every licensed foster home as often as is necessary to assure that proper care is given to the children.

424.050 Investigation of unlicensed foster homes. Whenever the state welfare department shall be advised or shall have reason to believe that any person is conducting or maintaining a foster home for children without a license, as required by this chapter, the state welfare department shall have an investigation made. If the person is conducting a foster home, the state welfare department shall either issue a license or take action to prevent continued operation of the foster home.

424.060 Removal of children from undesirable foster homes. If at any time the division of child welfare services of the state welfare department shall find that a child in a foster home is subject to undesirable influences

or lacks proper or wise care and management, the division of child welfare services shall notify any agency or institution that has placed the child in the home to remove the child from the home. If the child is in a foster home where he has been placed by his parents, relatives or other persons independently of an agency, the division of child welfare services shall take necessary action to remove the child and arrange for his care.

424.070 Placement of child for care, adoption; approval of placement by state welfare department. No person other than the parents or guardian of a child and no agency or institution in this state or from any other state may place any child in the control or care of any person, or place such child for adoption, without sending notice of the pending placement and receiving approval of the placement from the state welfare department.

424.080 Parental rights and duties: Termination by order of district court. Except in proceedings for adoption, no parent may voluntarily assign or otherwise transfer to another his rights and duties with respect to the permanent care, custody and control of a female child under 18 years of age, or a male child under 21 years of age, unless parental rights and duties have been terminated by order of a court of competent jurisdiction.

424.090 Applicability of chapter. This chapter shall not apply to homes in which children are placed by their own parents or legal guardians, and where the total cost of care is provided by the parents or guardians.

424.100 Penalties. Any person who violates any of the provisions of this chapter is guilty of a misdemeanor, and upon conviction shall be punished by a fine of not less than $40 nor more than $500, or by imprisonment in the county jail not to exceed 6 months, or by both fine and imprisonment.

APPENDIX "I"

NEVADA STATE WELFARE DEPARTMENT

-STANDARDS FOR FOSTER HOME CARE OF CHILDREN-

1. The Foster Family

1. The foster home is maintained primarily by and for a family unit as its home and shall not provide room and board on a commercial basis for adults. Commercial care of aged, maternity, or convalescent patients must not be combined with foster care of children. The household must not include persons whose presence is detrimental to the health and welfare of children.

2. Except in unusual circumstances, the family should be a complete group - that is, both mother and father must be present in the home.

3. The foster family must have an understanding of children's growth and problems and must be able to give constructive training and discipline. The family must be able to give children under their care affection, and a feeling of security, be able to accept the children as members of the family group as long as they are in the family home, and to work with the agency in preparing the child for leaving the foster home.

4. Members of the foster family must be free of physical or mental conditions that jeopardize the health or interfere with the care of the child. Statements from a licensed physician concerning the health of all family members will be required.

5. The foster mother must not be employed regularly outside the home.

6. There must be adequate income in the home, exclusive of board payments for the child, to assure adequate food, clothing, and other necessary items for the entire foster family.

7. Whenever both foster parents are out of the home, there must be a competent person left in care of the children.

8. The age pattern of the normal family group will be taken into consideration in the placement of children in the foster home.

9. When religious affiliation is known or preference indicated, the foster parents should be of the same religious faith as the child placed with them.

10. The foster family and the agency will work together in making arrangements for the natural parents, guardian, and close relatives to visit the child at reasonable times in order to preserve the ties of the child with his own family.

11. The foster family must be of good character and habits. Five satisfactory references, from persons not related to the applicants, will be required.

12. The foster family must be a harmonious unit which is conducive to

the normal growth and development of the child.

II. The Foster Child

1. A physical examination shall be given to each child, preferably before his admission to a foster home. The arrangements for the examination will be made by the agency the natural parents.

2. The child must receive adequate food at regular times, sufficient clothing for his needs, rest appropriate to his age, normal play opportunities and social contacts. The child must not be given the feeling that he is different from other children because of his family circumstances.

3. The child must receive appropriate training in habits and behavior, such as toilet training, care of his teeth, etc. He should have responsibility for home duties appropriate to his age and physical condition. Discipline should be administered according to the needs of the individual child, and for the purposes of teaching.

4. The child must attend school regularly if of school age, and have opportunity to attend the church of his choice.

5. The agency, natural parents, or guardian must be notified as soon as possible of injury to or illness of the foster child.

6. The number of children cared for in the home shall approximate a normal family, except where the home has facilities and personnel to adequately care for more than a usual number, or in cases where it is desirable to keep a large family together. Age and sex of the children cared for will be determined by the facilities available, as well as by the wishes of the foster family. In usual circumstances the maximum number of children shall be limited to six, including those of the foster family. No more than two children under the age of two years shall be cared for at one time. It is usually not advisable to combine day-care and full-time care.

III. The Foster Home

1. The home should be located in an area where the child is not exposed to unusual hazards.

2. It should be reasonably accessible to educational and church facilities, medical care, and visits from parents and the agency.

3. It must be free from fire hazards. Inspection by the local fire department will be required by the agency. Heating of the home must be adequate, and heating appliances must be sufficiently protected. It must have adequate lighting, ventilation, bathing and toilet facilities. If the home is not on a community sewage disposal system, the facilities must be approved by the Department of Public Health.

4. The home must have facilities for proper care, refrigeration, and preparation of food.

5. There must be a properly tested water and milk supply for rural homes,

which will be determined by the Department of Public Health.

6. The home must have sufficient room to care for children. Children must sleep in bedrooms which have individual beds for each child, except in instances where two children of the same sex and the same family may be sleeping together. Beds must not be crowded together, and not more than three persons shall sleep in the same room. Children should occupy a different bedroom than the foster parents except in the case of infants under the age of one year. Sleeping arrangements shall not impose crowding upon members of the foster family.

7. There should be sufficient play space, indoors and outside. Outdoor play space must be protected from traffic and other hazards.

8. The child should have sufficient space to keep his own clothing and other personal belongings, and a separate towel, wash cloth and tooth brush.

9. The home shall be comfortably furnished and shall have reasonable housekeeping standards although the primary emphasis will be upon homemaking.

EXCERPT FROM

"THE MENTALLY RETARDED IN SOCIETY"

BY STANLEY POWELL DAVIES

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XIV. Family Care

In the village of Geel, Belgium, the principal occupation is the care of mental patients in family homes. This unusual service was the forerunner of family care for the retarded.

According to legend, an Irish princess, Dymphna, fleeing from her irate father, took refuge in Geel in the year 853. She was pursued by the king's soldiers and beheaded. It was said that some "lunatics" who witnessed the scene were shocked into sensibility. The cures were considered miraculous, and Dymphna became the patron saint of the mentally ill. Her tomb became a shrine and as rumors spread, hundreds of mental sufferers came to the shrine for help. There was no hospital in the small town and kind-hearted villagers took the bewildered strangers into their homes.

Whatever the truth of the legend, it is a fact that Geel has provided for the mentally ill in private homes for hundreds of years. So far as we know, this was the beginning of family care. This remarkable service has continued through the centuries and is still growing.

As time passed a hospital was established and about the middle of the nineteenth century the facilities evolved into a state colony for mental patients, now maintained as a modern treatment center with a medical director in charge. All types of mental disorders are received. Before World War II, with only a 200-bed hospital, some 3,600 mental patients were in family care. Many authorities believe that the cost of care is probably less at Geel than anywhere in the world where adequate treatment is given.

Some 500 patients are cared for at the Geel Colony each year. . .